CHAPTER-I
SOCIAL SECTOR

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SOCIAL SECTOR

1.1 Introduction

This Chapter of the Audit Report for the year ended 31 March 2016 deals with the findings on audit of the State Government under Social Sector.

The names of the State Government Departments and the total budget allocation *vis-a-vis* expenditure incurred under Social Sector during the year 2015-16 are given in the following table:

Table-1.1

(₹ in crore)

Sl. No.	Name of the Departments	Total Budget Allocation	Expenditure
1.	School Education	984.90	860.97
2.	Higher and Technical Education	288.18	234.79
3.	Sports and Youth Services	31.90	23.10
4.	Art and Culture	15.03	13.63
5.	Medical and Public Health Services	552.60	374.13
6.	Water Supply and Sanitation	252.60	197.08
7.	Information and Public Relations	14.36	12.33
8.	Labour and Employment	20.18	15.14
9.	Social Welfare	175.62	137.92
10.	Disaster Management and Rehabilitation	19.96	23.34
11.	Local Administration Department	32.96	32.48
12.	Personnel & Administrative Reforms	2.77	2.54
13.	Urban Development and Poverty Alleviation	254.60	164.84
Total		**2,645.66**	**2,092.29**

Source: Appropriation Accounts, Government of Mizoram, 2015-16.

1.2 Planning and conduct of Audit

Audit process starts with the assessment of risks faced by various departments of Government based on expenditure incurred, criticality/complexity of activities, level of delegated financial powers, assessment of overall internal controls *etc*.

After completion of audit of each unit, Inspection Reports containing audit findings are issued to the Heads of the Departments with a request to furnish replies to the audit findings within one month of receipt of the Inspection Reports. On receipt of replies, audit findings are either settled or further action for compliance is advised. Important audit observations arising out of these Inspection Reports are processed for inclusion in the Audit Report, which is submitted to the Governor of State under Article 151 of the Constitution of India.

The audits conducted during 2015-16 covered an expenditure of ₹ 134.05 crore out of the total expenditure of ₹ 2,092.28 crore of the State Government under Social Sector. This Chapter

contains findings on two Performance Audits *viz.* 'Implementation of Right of Children to Free and Compulsory Education Act, 2009' and 'National Rural Health Mission' and two compliance audit paragraphs.

PERFORMANCE AUDIT

SCHOOL EDUCATION DEPARTMENT

1.3 Right of Children to Free and Compulsory Education Act 2009 (RTE Act)

The Constitution (Eighty-Sixth Amendment) Act 2002 inserted Article 21-A in the Constitution of India to provide free and compulsory education of all children in the age group of six to fourteen years as a Fundamental Right in such a manner as the State may, by law, determine. The Right of Children to Free and Compulsory Education (RTE) Act 2009 which represents the consequential legislation envisaged under Article 21-A, means that every child has a right to full time elementary education of satisfactory and equitable quality in a formal school which satisfies certain essential norms and standards. The Article 21 - A and the RTE Act came into effect from 1 April 2010.

Sarva Shiksha Abhiyan (SSA) is the main vehicle for implementing the provisions of the RTE Act. The SSA Framework of Implementation and Norms for intervention has been revised to correspond to the provisions of the RTE Act. The Rights perspective under the RTE Act has also brought in new monitoring mechanisms to ensure that child rights under the Act are protected. The RTE Act provides for constitutionally created independent bodies like the National and State Commissions for Protection of Child Rights to perform this role. A performance audit on implementation of Rights of Children to Free and Compulsory Education Act 2009 in the State revealed the following significant findings:

Highlights

In the absence of actual child survey, audit could not authenticate the veracity of the Department's data on the number of children who had attained the age of enrolment.

(Paragraph 1.3.7)

The State could not establish schools for elementary education in all the eligible habitations within a period of three years from the commencement of the Act in the State. Six habitations with 412 children and nine habitations with 853 children eligible for Primary Schools and Upper Primary Schools respectively as per neighbourhood norms were not provided with schools

(Paragraph 1.3.8)

₹ 743.16 lakh released for procurement of school uniforms during 2010-11 for 1.86 lakh school children by Government of Mizoramremained unspent due to non-completion of procurement formalities.

(Paragraph 1.3.12)

₹ 37.22 crore was incurred on salary of teachers in Aizawl and Lunglei who were deployed for non-educational works during 2010-16 which was against the provision of the RTE Act.

(Paragraph 1.3.13.2)

As on 31 March 2016, 67 Primary and 34 Upper Primary Schools were in operation without obtaining requisite recognition certificate from the Department of School Education.

(Paragraph 1.3.15)

₹ 35 lakh for construction of additional class rooms meant for Class VIII were diverted on irregular works in three districts during 2011-12.

(Paragraph 1.3.17.2)

1.3.1 Introduction

The Right of Children to Free and Compulsory Education (RTE) Act, 2009 became operative with effect from 1 April 2010. It provides that all children in the age group of six to fourteen years have a right to free[1] and compulsory[2] education in a neighbourhood school till completion of Elementary Education (1st to 8th Class). *Sarva Shiksha Abhiyan* (SSA) is the main vehicle for implementing the provisions of the RTE Act.

After the operation of the RTE Act in the State in April 2010, the Government of Mizoram notified the Mizoram Right to Children to Free and Compulsory Education Rules on 23 March 2011. The Department of School Education, SSA Mission and State Council of Education Research and Training (SCERT) have been vested with the responsibility of implementation of the Act in the State. As of 31 March 2016 there were 1,950 Primary Schools (PS) and 1,511 Upper Primary Schools (UPS) with an enrolment of 1,21,040 and 93,277students respectively. A performance audit of the implementation of the RTE Act was carried out to assess the status of implementation of the Act.

The RTE Act 2009:

(i) Gives children the right to free and compulsory education till completion of elementary education in a neighbourhood school and ensures compulsory admission, attendance and completion of elementary education to every child in the six to fourteen years age group;

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1 'Free education' means that no child shall be liable to pay any kind of fee or charges or expenses which may prevent him or her from pursuing and completing elementary education.

2 'Compulsory education' means obligation of the appropriate government to provide free elementary education and ensure compulsory admission, attendance and completion of elementary education to every child in the age group of six to fourteen years.

(ii) specifies the duties and responsibilities of appropriate Governments, local authority and parents in providing free and compulsory education, and sharing of financial and other responsibilities between the Central and State Governments;

(iii) lays down the norms and standards relating *inter alia* to Pupil Teacher Ratios (PTRs), buildings and infrastructure, school-working days, teacher-working hours;

(iv) provides for rational deployment of teachers by ensuring that the specified pupil teacher ratio is maintained for each school and prohibits deployment of teachers for non-educational work, other than those specified in the Act;

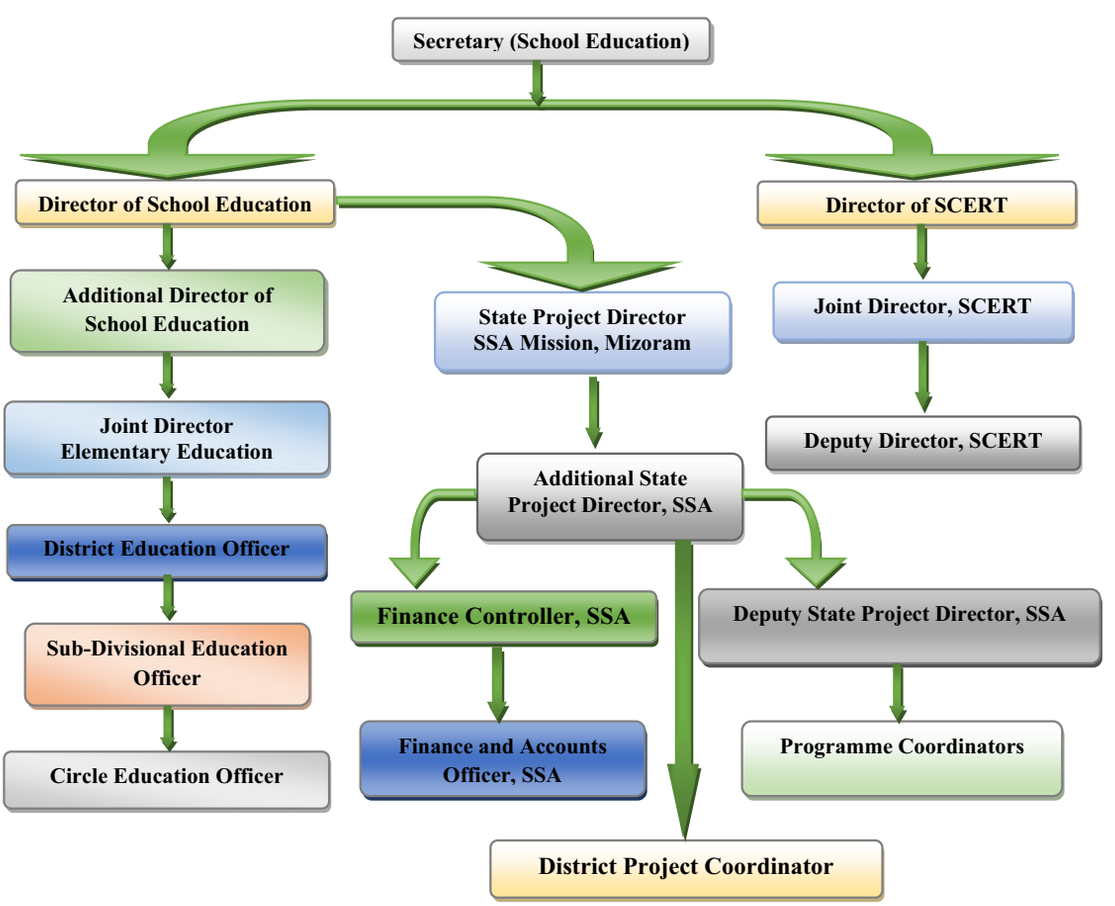
(v) provides for appointment of appropriately trained teachers, *i.e.* teachers with the requisite entry and academic qualifications; and

(vi) requires the protection and monitoring of children's rights and redressal of grievances by the National and State Commissions for Protection of Child Rights.

1.3.2 Organisational Set-up

The Organogram of the School Education Department responsible for implementation of the Act is as shown in the Chart below:

Chart-1.3.1



1.3.3 Audit Objectives

The performance audit was undertaken to get a reasonable assurance that-

- The RTE Act achieved its objective to make elementary education a fundamental right for all children between ages of six to fourteen years of age within three years *i.e.* 31 March 2013;
- The funds allocated were being utilised in an economical and efficient manner; and,
- The RTE Act was implemented and monitored in a planned manner.

1.3.4.1 Audit Scope and Sample

The performance audit covered the period from 2010-11 to 2015-16. Two districts *viz.* Aizawl and Lunglei Districts out of eight Districts in the State were selected on the basis of Probability Proportional to size sampling without Replacement (PPSWOR) method. In each selected district, four blocks[3] (three rural and one urban) were selected on the basis of Simple Random Sampling without Replacement (SRSWOR) method. In each selected district, 30 schools (20 Government and 10 Aided Schools) were selected using SRSWOR method.

1.3.4.2 Audit Methodology

Audit methodology included examination of records, issue of audit queries/ observations, joint physical verification along with departmental officials, photographic evidence and questionnaires duly authenticated by the departmental officials wherever relevant.

Audit commenced after an entry conference held on 28 April 2016 with the officers of the Administrative Department and Head of the Department, wherein audit objectives, scope and criteria were discussed. The draft report was sent to the Government in September 2016 for their response. Replies of the State Project Director, SSA Mission, Mizoram have been received but the replies of the Government were awaited (February 2017). An Exit Conference was held in November 2016 with the Special Secretary of the Administrative Department, State Project Director, SSA Mission, Mizoram and other officers of the Department in which audit findings were discussed. The report has been finalised after considering the replies received and deliberations in the Exit Conference. The replies received have been suitably incorporated in the report wherever relevant.

1.3.5 Audit Criteria

The main sources from which audit criteria were drawn are the following:

- RTE Act 2009 of GoI;
- Mizoram Right of Children to Free and Compulsory Education Rules 2011;

[3] Name of blocks in Aizawl District : Aibawk, Saitual, Bawngkawn and Darlawn
Name of blocks in Lunglei District : Station (Urban), Bunghmun, Eastern and Station (Rural)

- SSA Framework for Implementation;
- Annual Work Plan and Budget, SSA;
- District Information System for Education (DISE) Report of SSA Mission, Mizoram;
- Mizoram SSA Financial Regulation 2012; and
- Various orders, notification, circulars, instructions issued by MHRD and State Government.

1.3.6 Acknowledgement

Indian Audit and Accounts Department acknowledges and appreciates the co-operation of Officers and Staff of School Education Department, Mizoram and State Project Office, SSA Mission, Mizoram. We also appreciate the support of District, Block and School level authorities in the sampled districts in the course of the Performance Audit.

AUDIT FINDINGS

The important points noticed during the course of audit are discussed in the succeeding paragraphs.

1.3.7 Coverage

Section 3(1) of RTE Act envisages that every child of the age of six to fourteen years shall have a right to free and compulsory education in a neighbourhood school till completion of elementary education.

Audit observed that the Department did not conduct any child survey during 2011-16 to ascertain the number of children who had attained the age of enrolment. In the absence of real time data, the SSA Mission, Mizoram sourced the data of children attaining the age of enrolment from All India Census (2011-12) and the projected population of National University of Educational Planning and Administration (NUEPA) during 2012-16.

The SSA Mission, Mizoram has maintained data of children enrolled in all Primary and Upper Primary schools (both recognised and unrecognised) in the State during 2010-16 in computerized format of Unified District Information System for Education (U-DISE).

The following table shows the details of children enrolled, not enrolled, number in PSs and UPSs during 2010-16.

Table-1.3.1

Year	Number of children who have attained the age of enrolment (As per projection on Census data)			Number of Children enrolled (As per DISE Data)		
	PS	UPS	TOTAL	PS	UPS	TOTAL
2010-11	NA	NA	NA	1,30,306	82,510	2,12,816
2011-12	93,933	94,422	1,88,355	1,25,005	87,793	2,12,798
2012-13	94,823	94,657	1,89,480	1,52,760	1,08,498	2,61,258
2013-14	94,086	95,106	1,89,192	1,24,039	93,924	2,17,963
2014-15	93,231	95,806	1,89,037	1,20,522	94,426	2,14,948
2015-16	92,444	93,933	1,86,377	1,21,040	93,277	2,14,317

Source: Departmental records

Audit noticed that the data on number of children enrolled, maintained by the School Education (SE) Department in DISE was much higher than the projected data of Census 2011. The Department attributed the difference to inclusion of under and over-aged children. However, in the absence of actual child survey, audit could not authenticate the veracity of data maintained by the SE Department.

The details of children not enrolled/dropped out during 2010-16 are as shown in the following table.

Table-1.3.2

Year	No. of children not enrolled		Number of Dropout children		Non enrolment Percentage		Dropout Percentage	
	PS	UPS	PS	UPS	PS	UPS	PS	UPS
2010-11	5,033	4,726	NA	NA	NA	NA	NA	NA
2011-12	2,978	5,256	7,531	7,984	3.17	5.57	6.02	9.09
2012-13	2,986	4,376	8,854	5,873	3.15	4.62	5.80	5.41
2013-14	2,169	1,939	35,384	24,058	2.31	2.04	28.53	25.61
2014-15	2,618	2,826	18,130	6,481	2.81	2.95	15.04	6.86
2015-16	1,973	1,564	13,491	4,797	2.13	1.67	11.15	5.14

Source: Departmental records

Audit noticed that-

- The non-enrolment percentage decreased from 3.17 to 2.13 for Primary School and 5.57 to 1.67 for Upper Primary School during 2011-16.
- The Dropout percentage in Primary School increased sharply from 6.02 (2011-12) to 28.53 (2013-14) and in Upper Primary School from 9.09 to 25.61 due to elimination of fake enrolment in schools till 2012-13.

While accepting the audit observation (November, 2016), the State Project Director, SSA Mission, Mizoram stated that U-DISE is the main source of data of children enrolled in schools and household survey could not be conducted due to lack of funds. In the Exit Conference, the Department ensured (November 2016) that these irregularities would be checked from 2017-18 onwards.

1.3.8 Mapping and Establishment of schools

Section 6 of RTE Act envisages that the appropriate Government and local Authorities shall establish, within such area or limits of neighbourhood, as may be prescribed, a school, where it is not so established, within a period of three years from the commencement of the Act (March 2013). Further, Section 5 (3) of Mizoram RTE Rules stipulates that for the purpose of determining and for establishing neighbourhood schools, the State Government/ local authority shall undertake school mapping and identify all children, including children in remote areas, children with disabilities, children belonging to disadvantaged groups, children belonging to weaker section within a period of one year from the appointed date and every year thereafter, update this list as on 30 October every year.

Scrutiny of records of the State Project Director, SSA Mission revealed that though school mapping was undertaken by the Mizoram Remote Sensing Application Centre (MIRSAC) during February 2011 the data on school mapping was not accepted by the Department on grounds of incomplete information.

As per information furnished by the Department, during 2015-16, out of 950 identified habitations in the State, 936 habitations had Primary Schools. Of the habitations without schools, 6 habitations with 412 children were eligible as per neighbourhood norms for Primary School. Similarly, 910 habitations were covered with Upper Primary School. Out of remaining uncovered 40 habitations, there were 9 eligible habitations with 853 children as per neighbourhood norms.

Thus, the State could not establish schools for elementary education in all the eligible habitations within a period of three years from the commencement of the Act in the State.

The State Project Director, SSA Mission stated (November, 2016) that school mapping was undertaken by MIRSAC during 2011 and updated on annual basis. The reply is not acceptable as this was the same survey which had not been accepted by the Department.

1.3.8.1 Provisions for children where no school exists in the neighbourhood

As per Rule 4 (4) of Mizoram RTE Rules 2011, for children from small hamlets, as identified by the State Government/Local Authority, where no school exists within the area of limits of neighbourhood norms, the State Government may make adequate arrangements, such as free transportation, residential facilities and other facilities, for providing elementary education in a school.

State Government did not make any arrangement of transport facilities to the children of small hamlets where no school exists. However, residential facilities were provided by the Department in 11 hostels in the State for covering some of the children of uncovered habitations.

1.3.9 Planning

Effective and efficient planning is a pre-requisite for achieving the objective of RTE Act. The Guidelines on SSA envisages a decentralized, need-based and participatory planning through a bottom-up approach with a focus on planning for universal access, equity, participation and quality. For this, every district level authority was required to formulate a need based prioritised Annual Work Plan and Budget (AWP&B) with a broad indication of resource availability to a district in a particular year, based on data sourced from School Development Plan (SDP) prepared by the School Management Committee (SMC), District Information System for Education (DISE) and Household Survey Reports.

Scrutiny of records of SSA Mission, Mizoram revealed that none of the 60 sampled schools in the two test-checked Districts had drawn their SDPs during 2010-16 on the ground of non-availability of experts and constant changes in members of SMCs. SSA Aizawl District had not conducted household survey after December 2010, while SSA Lunglei District conducted household survey only in selected villages to identify Out of School Children (OoSC).

In the absence of SDPs and household survey, district level authorities prepared their AWP&Bs using the DISE data mainly to assess the requirement of schools with respect to profile of students, enrolment, teachers and infrastructure. Thus, the district authorities could not formulate a well-informed need based plan at the district level. At the State Level, the AWP&Bs of SSA Mission were prepared by consolidating AWP&Bs of the districts.

The State Project Director, SSA Mission, Mizoram while accepting (November 2016) the audit observations stated that DISE data was the main source of data for preparation of AWP&B. Further, it was also asserted that Household survey was conducted only once as the Department had to obtain approval from GoI. Again, SDPs were not considered in the planning process as suggestions on SDPs by school authorities could not be adopted by the SSA. The fact remains that a decentralised need-based and participatory plan through a bottom up approach was not made.

1.3.10 Mainstreaming of Out of School Children

Section 4 of the RTE Act envisages special provisions for children not admitted to or who had not completed elementary education. Special training is to be provided to out of school children for mainstreaming them into regular schools at their age-appropriate class after identification of never enrolled children or those who dropped out before completing elementary education. Again, as per Rule 6 (1) of Mizoram RTE Rule 2011, the Local Authorities (Local Council/ Village Council) are required to maintain records of all children, through a household survey, from their birth till they attain 14 years.

The details of OoSC identified and mainstreamed during 2010-16 as per information provided by SSA Mission, Mizoram are indicated in the following table.

Table-1.3.3

Year	OoSC from last year	OoSC fresh identified	Total OoSC	OoSC Mainstreamed	OoSC not mainstreamed
2010-11	2,889	7,467	10,356	6,445	3,911
2011-12	3,911	4,310	8,221	4,936	3,285
2012-13	3,285	4,077	7,362	4,446	2,916
2013-14	2,916	6,843	9,759	8,865	894
2014-15	894	2,441	3,335	2,307	1,028
2015-16	1,028	4,674	5,702	3,510	2,192

Source: Departmental records

The State Project Director, SSA Mission, Mizoram claimed (May 2016) that the OoSC in the age group of six to fourteen years were identified by household survey at the block, district and State level and headmasters and regular teachers were providing Special training in schools. The reply is not acceptable in view of the following facts.

- No proper household survey was conducted to identify out of school children. After December 2010 no survey was conducted under SSA Aizawl District, whereas under SSA Lunglei district, household survey was conducted only in selected villages.
- The Local authorities (Village Councils) did not maintain any records of all children under their respective jurisdictions.
- Joint inspection of 60 sampled schools revealed that no OoSC was admitted at age appropriate classes in any of the schools and no teacher provided special training to OoSC in schools during 2010-16.

Thus, the claims of the Department that it covered 32,701 OoSCs in the State during 2010-16 could not be authenticated during test check.

The State Project Director, SSA Mission, Mizoram claimed (November 2016) that though household survey was not conducted during the audit period, identification of OoSC was undertaken every year in all the villages with the help of Cluster Resource Centre Coordinators and Village Education Committees.

The reply is not acceptable as documentation supporting the claim of the Project Director was not produced to audit.

1.3.10.1 Deployment of Special Trainers for Out of School Children

Section 4 of RTE Act envisages providing special provisions for children not admitted to, or who had not completed elementary education. Special training for age-appropriate admission of OoSCs was to be provided by the SSA in the form of residential or non-residential courses organised in school premises or safe, secure and accessible alternative facilities.

Scrutiny of the records at SSA Lunglei district revealed that during 2010-16, Special Trainers (ST) were recruited to impart special training to OoSCs in Residential Bridge Centres (RBCs) and Non-Residential Bridge Centres (NRBCs). However, during 2010-14 these STs were deployed in regular schools as NRBCs in the district came into operation only from 2014.

The details of year wise Special Trainers/Education Volunteers recruited for NRBCs but engaged in regular schools and expenditure incurred towards their salaries during 2010-16 are shown in the following table:

Table-1.3.4

Year	Number of STs recruited ranged between	Fund provided under OoSC intervention (₹ in lakh)	Remuneration of STs deployed in regular schools (₹ in lakh)	Percentage of diversion
2011-12	108 and 134	155.78	45.93	29
2012-13	15 and 200	249.05	51.30	21
2013-14	63 and 129	146.57	46.20	32
2014-15	62 and 75	97.95	19.29	20
2015-16	12 and 33	132.57	9.96	8
Total		**781.92**	**172.67**	**22**

Source: Departmental records

It can be seen from the table that out of ₹ 781.92 lakh released during 2011-16 for OoSC intervention to SSA Lunglei District, ₹ 172.67 lakh (22 *per cent*) was towards payment of remuneration of Special Trainers posted in regular schools which were not imparting any special training to OoSC. Further, no criteria of professional qualification was fixed for recruitment of the Special Trainers.

While accepting the facts, the District Project Coordinator, SSA Lunglei district stated (July 2016) that this was done to make up the shortage of teachers due to superannuation, transfer *etc.* and these schools were left with single teacher or no teacher.

The reply is not acceptable as Special Trainers were specifically recruited to provide trainings to OoSCs and shortage of regular teachers should have been met by redeployment of the excess teachers elsewhere as highlighted in Paragraph 1.3.13.1.

1.3.11 Facilities for disabled children

Rule 7 of the Mizoram RTE Rules 2011 envisages that in respect of children with disabilities which prevent them from accessing the school, the State Government/Local Authority will endeavour to make appropriate and safe transportation arrangements for them to attend school and complete elementary education. Also, the SSA implementation framework, under Paragraph 3.12 envisages provision of aids and appliances to all children requiring assistive devices.

It was observed that instead of arranging transport facilities, the Department during 2011-16 provided transport allowances at the rate of ₹ 100 to 250 per month for 10 months to the identified disabled children (ranging between 271 and 1716) and an expenditure of ₹ 90.39 lakh was incurred.

Scrutiny of the records of the District Project Office (DPO), SSA Aizawl district revealed that during 2010-11 and 2014-15 an expenditure of ₹ 5.73 lakh and ₹ 10.54 lakh respectively was incurred towards procurement of various aids and appliance for free distribution to children with special needs.

Audit noticed that out of ₹ 5.73 lakh and ₹ 10.54 lakh incurred on procurement of appliance and assistive devices for orthopedically impaired children during 2010-11 and 2014-15, aids, devices and appliances worth ₹ 3.76 lakh (65 *per cent* of total items procured) and ₹ 10.32 lakh (97 *per cent*) respectively were lying idle (as of June 2016). (**Appendix-1.3.1 and 1.3.2).** Reasons for non-distribution of the aids and appliances were not on record.

Wheelchairs lying idle

Hearing aids and other devices lying idle

While accepting the facts, the District Project Coordinator, SSA Aizawl district stated (July 2016) that the appliances which were still lying in the custody of the office would be distributed to the beneficiaries within the financial year. Further progress in this matter was awaited (February 2017).

1.3.12 Provision of school uniforms

The RTE Act mandates free and compulsory education for all the children in Government Schools. In line with this provision of the Act, SSA guidelines stipulates to provide two sets of uniforms for all girls and children belonging to SC/ST/BPL families in Government Schools within a ceiling of ₹ 400 per child per annum. The SSA norm envisages procurement of uniform to be decentralized to the school level by SMCs of the respective schools.

Scrutiny of the records revealed that ₹ 743.16 lakh was released by GoI to provide free school uniforms to 1.86 lakh school students in the State during 2010-11. The SSA Mission,

Mizoram did not disburse the fund to the SMCs as the SSA Mizoram apprehended that the SMCs in the State would not be in a position to handle procurement of uniform. As the fund remained unspent, ₹ 743.16 lakh was adjusted by GoI from fund released in the subsequent year.

The State Project Director, SSA Mission, Mizoram while accepting (November, 2016) the audit observation stated that non provision of school uniforms was not only due to non-completion of procurement formalities but also due to non-formation of SMCs. However, the fact remains that the students were deprived of school uniforms during 2010-11.

1.3.13 Provision for qualified teachers

As required under Section 23 of the RTE Act, 2009, the Central Government has notified National Council of Teacher Education (NCTE) as the academic authority to lay down the minimum qualifications for a person to be eligible for appointment as a teacher. NCTE has prescribed (August 2010) minimum qualification for recruitment of teachers in primary and upper primary schools.

It was noticed that though the RTE Act was implemented in Mizoram from the year 2010, the Education Department notified the minimum qualification of teachers in the line of NCTE notification after a gap of five years in March 2015.

As per information furnished by the State Project Director, SSA Mission, Mizoram the year wise position of teachers in primary and upper primary schools including unqualified teachers during the period 2010-16 were as under.

Table-1.3.5

Year	Number of teachers			Number of unqualified teachers			Percentage of unqualified teachers
	PS	UPS	Total	PS	UPS	Total	
2010-11	5,768	6,343	12,111	2,112	2,043	4,155	34
2011-12	5,634	7,276	12,910	2,222	3,147	5,369	42
2012-13	4,715	5,613	10,328	2,041	2,042	4,083	40
2013-14	4,660	5,911	10,571	1,954	2,424	4,378	41
2014-15	4,971	6,784	11,755	401	754	1,155	10
2015-16	4,758	6,688	11,446	105	565	670	6

Source: Departmental records

It can be seen from the above table that though the percentage of unqualified teachers has declined considerably from around 40 *per cent* during the period 2011-14 to 6 *per cent* in 2015-16, 105 Primary teachers and 565 Upper Primary teachers were unqualified as of 31 March 2016. It may also be mentioned that in absence of regular teachers, special trainers were being deployed against regular vacancies as highlighted in Paragraph 1.3.10.1. These factors would bound to have an impact on the quality of education imparted at those schools where such unqualified teachers and special trainers were deployed.

While accepting the audit observation, the State Project Director, SSA Mission, Mizoram stated (November, 2016) that all untrained teachers had been enrolled in Diploma in Elementary Education courses and would obtain requisite professional qualification at the end of 2016-17.

1.3.13.1 Deployment of Teachers

As per the RTE Act, one teacher should be provided for every 30 students for Primary School and one teacher for every 35 students for Upper Primary School. It also further envisages (i) at least two teachers per Primary School and (ii) in respect of Upper Primary School at least one teacher per class so as to provide at least one teacher each for Science and Mathematics, Social Studies and Languages.

Audit observed that the Department had not fixed the sanctioned strength of teachers for the Schools nor did it rationalise posting of teachers in Primary School and Upper Primary Schools.

Scrutiny of records of the State Project Director, SSA Mission, Mizoram revealed that during 2010-16 the number of Primary Schools managed by a single teacher ranged between 37 and 95 and number of such Upper Primary Schools ranged between 4 and 16. The number of students enrolled in single teacher Primary School ranged between 2812 and 5963 and that in single teacher Upper Primary Schools ranged between 59 and 503 as detailed in the following table.

Table-1.3.6

Year	Number of single teacher schools				Total	Total Enrolment
	PS	Enrolment	UPS	Enrolment		
2010-11	95	5,963	16	503	111	6,466
2011-12	37	2,971	5	139	42	3,110
2012-13	44	3,713	4	86	48	3,799
2013-14	60	3,284	4	76	64	3,360
2014-15	67	2,963	6	145	73	3,108
2015-16	64	2,812	6	59	70	2,871

Source: U-DISE, SSA Mizoram

Further scrutiny of the records of SSA Lunglei District revealed that out of 257 primary schools in the District during 2015-16, nine Primary Schools were managed without any regular teachers and consequently, these schools were manned by Special Trainers. Besides, another nineteen Primary Schools had only single teachers and were supplemented with Special Trainers. As Special Trainers deployed did not possess the requisite professional qualification as mandated in the RTE Act, it would have had an impact on the quality of education.

Joint inspection by audit team along with departmental staff in 60 sampled schools in SSA Aizawl and Lunglei Districts revealed that 53 schools (Primary School: 9 schools *plus* Upper

Primary School: 44 schools) had the Pupil Teacher Ratio (PTR) in excess of norms in Primary School in the range between 4 and 24 in Aizawl District and 3 and 47 in Lunglei District and in Upper Primary School, in the range between 2 to 14 (Aizawl District) and 2 to 23 (Lunglei District). The detailed position of 60 inspected schools showing deployment of teachers was shown in **Appendix-1.3.3.**

While accepting the audit observation, the State Project Director, SSA Mission, Mizoram stated (November, 2016) that the SSA Mission could make such schools functional only by providing Special Trainers to avoid increase in out of school children.

The reply of the State Project Director is not acceptable as the distribution of teachers in Primary and Upper Primary Schools in the sampled districts did not comply with the provisions of the RTE Act and indicated that teacher distribution had not been rationalised.

1.3.13.2 Deployment of teachers in non-educational work

Section 27 of RTE Act prohibits deployment of teachers for non-educational work, other than decennial census, elections and disaster relief.

Scrutiny of records in two sample districts, however, revealed that during 2010-11 to 2015-16, teachers recruited under SSA Mission and by the School Education Department in Primary and Upper Primary schools were engaged for non-educational works as Coordinators, Project Assistants, Data Entry Operators, Additional State Project Director, Deputy District Project Coordinator, Block/Cluster Resource Coordinators, Project Assistant *etc.* in Circle, Block, District and State level offices. The Department incurred ₹ 37.22 crore towards the salary cost of those teachers as detailed below.

Table-1.3.7

Name of Office	Year	Number of teachers deployed in non-educational works	Total salaries incurred on such teachers (₹ in lakh)
SSA, State Project Director	2010-16	14 to 24	324.50
SSA, Aizawl District	2010-16	53 to 63	970.58
SSA, Lunglei District	2010-16	4 to 11	90.72
School Education Department, Aizawl District	2010-16	33 to 34	1,127.29
School Education Department, Lunglei District	2010-16	31 to 46	1,209.04
Grand Total			**3,722.13**

Source: Departmental Records

While teachers recruited on regular basis were being deployed for non-educational works in violation of RTE Act, Special Trainer who did not possess required professional qualification were being used to manage or supplement in schools with no or deficit number of teachers as highlighted in previous paragraph.

The State Project Director, SSA Mission, Mizoram stated (November 2016) that the issue had been brought to the notice of the Department for consideration. Response of the Department was awaited (February 2017).

1.3.14 Pre-School Education

Section 11 of the RTE Act 2009 envisages that the State Government may make necessary arrangement for providing free Pre-School Education to prepare children above the age of three years for elementary education and to provide early childhood care and education for all children until they complete the age of six years. Further, Paragraph 4.4.1 of SSA guidelines stipulates for the stronger convergence of SSA with the ICDS programme of Ministry of Women & Child Development to promote Pre-school education.

The following table shows the status of implementation of Pre-School education in the State during 2010-16.

Table-1.3.8

Year	Number of Primary Schools	As per Department (Number)		As per DISE (Number)	
		Schools with Pre-School facility	Children enrolled for Pre-School	Schools with Pre-School facility	Children enrolled for Pre-School
2010-11	868	396	13,308	No records	
2011-12	865	396	10,525	-do-	
2012-13	859	396	11,250	552	38,646
2013-14	856	0	Nil	321	36,909
2014-15	851	66	1,403	320	37,780
2015-16	836	66	1,712	395	38,355

Source: Departmental records

It can be seen from the above table that as per the data of the Department Pre-School Education was provided in 396 Early Childhood Care & Education (ECCE) centres attached to Primary Schools till 2012-13. No Pre-School Education was provided in any of the schools during 2013-14. Since 2014-15 Pre-School Education had been provided in 66 Primary Schools. The number of children enrolled for Pre-School Education ranged between 1,403 and 13,308 during the period 2010-16.

DISE data depicted an entirely different set of figures, the number of schools that provided Pre-School Education ranged from 552 to 395 and the number of children enrolled in Pre-Schools ranged from 38,646 to 38,355. Thus, the authenticity of the data on Pre-Schools in the State could not be corroborated in audit.

Further, the SE Department had not taken any steps to converge the Pre-Schooling programme with the ICDS programme of the Social Welfare Department (December 2016).

The State Project Director, SSA Mission, Mizoram stated (November, 2016) that ECCE was no longer implemented under SSA since 2013-14 as per instructions of GoI and Social Welfare Department became responsible to implement ECCE.

The reply is not acceptable as ECCE was implemented during 2014-15 and 2015-16 in 320 and 395 primary schools respectively as per DISE data. The reply did not, however, clarify the discrepancies between the DISE data and Departmental data.

1.3.15 Recognition of Schools

Section 18 (1) of RTE Act envisages that no school, other than a school established, owned or controlled by the appropriate Government or the local authority, shall, after the commencement of the Act, be established or function, without obtaining a certificate or recognition from such authority, by making an application in such form and manner, as may be prescribed. Further, Rule 11(1) of the Mizoram RTE Rules 2011 stipulates that every school, other than a school established, owned or controlled by the State Government shall make a self-declaration for grant of recognition.

Scrutiny of records of the Directorate of School Education revealed that during 2010-16, number of Primary School and Upper Primary School were running without obtaining certificate of recognition as detailed in the following table.

Table-1.3.9

Year	No. of schools running without obtaining certificate of recognition	
	Primary	Upper Primary
2010-11	32	22
2011-12	29	18
2012-13	36	19
2013-14	40	20
2014-15	40	18
2015-16	67	34

Source: Departmental records

As can be seen from the table though the number of schools running without recognition increased from 32 to 67 (Primary School) and 22 to 34 (Upper Primary School) during 2010-16, the Department did not take any appropriate action.

Reply of the Department was awaited (February 2017).

1.3.16 Provision of reservation in unaided schools

Section 12 (1) RTE Act provides for admission of at least 25 *per cent* of the strength of Class I from children belonging to weaker section and children belonging to disadvantage group from the neighbourhood and providing them free and compulsory education till completion of elementary education by unaided schools and specified category schools. Further, Rule 5 of

the Mizoram RTE Rules 2011 envisages that children belonging to weaker and disadvantaged groups shall constitute children belonging to BPL families approved by the Rural Development Department. However, no specific provision was made in the Mizoram RTE Rules 2011 making it mandatory for 25 *per cent* reservation in private unaided schools for children belonging to weaker section and disadvantage group.

It was noticed in audit that the Department had not adopted (as of August 2016) the list of BPL families for identification of children belonging to weaker and disadvantaged section of the society. Thus, the State has not introduced the system of 25 *per cent* reservation of such children in unaided schools.

Due to non-implementation of 25 *per cent* reservation in private unaided schools, children belonging to weaker section and disadvantage group were deprived of free and compulsory elementary education in privately run unaided schools.

In the Exit Conference, the Special Secretary stated (November 2016) that the Government was actively considering the issue for implementation of this provision of the Act for which a Committee had been constituted.

1.3.17 Availability of Infrastructure in schools

Section 19 of the RTE Act envisages providing all weather buildings[4] to schools. Norms pertaining to infrastructure and standards were to be fulfilled by all schools within a period of three years from the date of commencement of the Act.

Scrutiny of the records revealed that many schools did not have basic infrastructure facilities even after six years of implementation of the RTE Act as shown below:

Table-1.3.10

Facilities	No. of schools which did not fulfil	
	As on 01.04.2010	As on 31.03.2016
Separate toilets for boys and girls	940	58
Safe and adequate drinking water facility to all children	306	161
Mid-day meal kitchen shed	1,360	66
Play ground	1,596	1,192
Boundary wall and fencing	1,233	1,042
Library facilities	2,183	63
Electricity Connection	1,461	996

Source: Departmental records

[4] All-weather building consisting of (a) at least one class-room for every teacher and an office-cum-store-cum-Head teacher's room, (b) barrier-free access, (c) separate toilets for boys and girls, (d) safe and adequate drinking water facility to all children, (e) a kitchen where mid-day meal is cooked in the school, (f) play-ground and (g) boundary wall/fencing

It can be seen that though there was considerable improvement in providing basic infrastructure in the area of separate toilets for boys and girls, Mid-day meal kitchen shed and Library facilities and to a fair extent in Electricity connection; a large number of schools were deficient in infrastructure facilities. Shortages of infrastructure in the schools were brought to the notice of the Department from time to time by the concerned school authorities in the data captured format of U-DISE. Accordingly, the requirements of infrastructure in schools were included in the Annual Work Plan & Budget prepared by the SSA, but no further actions had been taken and the schools remained deficient of these facilities.

While accepting the audit observation, the State Project Director, SSA Mission, Mizoram stated (November 2016) that infrastructure gaps in schools existed due to insufficiency of funds under capital head and development of infrastructure would be taken up after availability of funds.

1.3.17.1 Construction of new schools

The opening of new Primary and Upper Primary Schools within the areas of the limits of the neighbourhood shall be as per the norms laid down by the State Government under the State RTE rules.

Scrutiny of the records of State Project Director, SSA Mizoram revealed that during 2010-16, approval for construction of 31 new Primary Schools and 68 new Upper Primary schools was accorded by GoI as shown in the following table.

Table-1.3.11

Year	No. of new Primary schools		No. of new Upper Primary schools	
	Approved	Constructed	Approved	Constructed
2010-11	Nil	Nil	Nil	Nil
2011-12	21	Nil	63	Nil
2012-13	6	21	Nil	63
2013-14	1	Nil	5	Nil
2014-15	3	Nil	Nil	Nil
2015-16	Nil	Nil	Nil	Nil
Total	**31**	**21**	**68**	**63**

Source: Departmental records

It can be seen from the above table that 21 out of 31 approved Primary Schools and 63 out of 68 approved Upper Primary Schools were constructed during the period 2010-16. Ten Primary Schools and five Upper Primary Schools approved during 2013-15 were not constructed due to non-release of the funds from GoI. Reasons for non-release of the funds were not on record.

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observations.

1.3.17.2 Construction of additional classrooms

During 2011-12, GoI approved construction of 349 additional class rooms for Class VIII at the rate of ₹ five lakh per class room in the eight districts and released ₹ 17.45 crore. Scrutiny of records of the State Project Office, SSA Mission, Mizoram revealed that in three Districts (Champhai, Kolasib and Mamit) the concerned District Project Coordinators had diverted ₹ 35 lakh for execution of some other unapproved works without construction of seven additional classrooms as per the details given in the following table.

Table-1.3.12

District	Sl. No.	Amount diverted (₹in lakh)	Details of diversion
Champhai	1	5.00	Additional classroom for class VIII was not constructed but the fund was used for renovation of the whole school building of Government Middle School, Champhai.
	2	5.00	Additional classroom for class VIII was not constructed but the fund was diverted for extension of kitchen/dining hall etc. at JNV, Khawzawl.
Kolasib	3	5.00	Diverted for extension of building at Zotlang Upper Primary School.
	4	5.00	Diverted for extension of BRC Building at Kawnpui.
	5	5.00	Diverted for renovation of DPO, Kolasib building.
	6	5.00	Utilised for renovation of DPO, Kolasib building.
Mamit	7	5.00	Additional classroom at Tarabonia Upper Primary School not constructed due to boundary dispute between Mizoram and Tripura and the fund is reported to be still with the concerned VEC.

Source: Departmental records

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observations.

1.3.18 Financial Management

1.3.18.1 Budget allocation and actual release of funds

The fund under SSA was shared by Centre and State at the ratio of 90:10. The Ministry of Human Resource Development (MHRD) released fund directly to the SSA Mission and State Government also transferred its share to the SSA Mission till 2013-14. However, since 2014-15, the funds were first received by the State Finance Department and thereafter it was released to the SSA Mission for implementation of the scheme.

The position of year wise fund released by the Central and State Governments against the outlay approved by MHRD, GoI and expenditure incurred there against during 2010-16 is depicted in the following table.

Table-1.3.13

(₹ in crore)

Year	Approved Outlay	Availability of Funds					Expenditure	Closing balance
		Opening balance	Central Release	State Release	Misc. receipt	Total		
2010-11	116.72	3.33	101.15	7.00	1.43	112.92	90.60	22.33
2011-12	200.03	22.33	108.14	10	1.67	142.13	139.62	2.51
2012-13	236.72	2.51	153.21	16.89	0.87	173.47	164.34	9.14
2013-14	193.03	9.14	106.58	12.71	1.56	129.99	128.58	1.40
2014-15	210.46	1.40	147.40	12.18	0.60	161.58	122.91	38.67
2015-16	206.83	38.67	94.38	15.44	0.69	149.18	137.33	11.85
Total	**1,163.79**		**710.86**	**74.22**	**6.82**		**783.38**	

Source: Departmental records

It may be seen from the above table that against the approved outlay of ₹ 1,163.79 crore, GoI was required to release ₹ 1,047.41 crore as per the funding pattern, of which GoI released ₹ 710.86 crore. The short release of funds by GoI was due to adjustment of unspent balances which was attributable to inability of the State Government to utilise the available funds and submit UCs in time for further release of funds.

Further, as per the funding pattern, the State Government was to release ₹ 78.98 crore during 2010-16, but released only ₹ 74.22 crore, resulting in short-release of State share of ₹ 4.76 crore.

The State Project Director, SSA Mission, Mizoram (November 2016) stated that short receipt of fund from MHRD was not only due to adjustment of unspent balance but also due to insufficiency of fund at MHRD in some cases and non-receipt of sufficient state matching share.

The fact however remains that due to short-receipt of funds the Mission was deprived of funds meant for the implementation of the RTE Act amounting to ₹ 336.55 crore.

1.3.18.2 Delay in release of SSA funds

As per GoI instructions contained in the release orders of fund, the fund should be released to the SSA Mission within fifteen days from the date of receipt. Scrutiny of records revealed that during 2014-15 and 2015-16, there was delay ranging from 10 to 118 days in releasing of fund from the State Government to the SSA Mission, resulting in delay in implementation of the programme. The delay was less pronounced during the year 2015-16. The details of grants released by GoI to the State Government and transfer of the same by the State Government to the SSA Mission, Mizoram during 2014-17 (upto April 2016) as shown in the following table.

Table-1.3.14

Year	Date of release by GoI	Amount released (₹ in lakh)	Actual date of release by State	Amount released (₹ in lakh)	Period of delay* (in days)
2014-15	29.05.2014	4,039.02	10.07.2014	2,019.51	25
			01.08.2014	1,000.00	47
			29.08.2014	1,019.51	75
	22.10.2014	2,996.98	11.12.2014	2,996.98	32
	10.03.2015	6,144.90	22.04.2015	4,217.00	26
			10.07.2015	642.63	102
			23.07.2015	1,201.16	118
			23.07.2015	84.11	118
	19.02.2015	744.75	15.05.2015	744.75	68
	25.03.2015	69.30	25.06.2015	69.30	75
	30.03.2015	744.75	25.06.2015	744.75	70
2015-16	18.05.2015	932.65	09.07.2015	932.65	33
	19.10.2015	5,257.18	16.11.2015	5,257.18	11
	30.03.2016	3,247.68	26.04.2016	3,247.68	10

*Source: Departmental records *- after allowing 15 days' time*

Further, ₹ 61.45 crore and ₹ 7.45 crore released by GoI in March 2015 was irregularly retained in Civil Deposit by the Directorate of School Education Department after the money was drawn from the Government Treasury in March 2015.

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observation.

1.3.18.3 Diversion of SSA funds for payment of committed liabilities

During the year 2013-14, GoI released ₹ 106.58 crore as its share with the instruction (December 2013) to the State Government to release the deficit state matching share of ₹ 7.80 crore for obtaining the next instalment of grants-in-aid from GoI. However, the State Government sanctioned only ₹ 3.43 crore as state matching share. Due to short release, no further release of fund for the year was made by GoI.

Further scrutiny revealed that due to non-release of further instalment during 2013-14, the SSA Mission, Mizoram in order to make up the deficiency of funds to meet the committed liabilities of ₹ 677.85 lakh for payment of salaries of teachers for the month of March 2014, diverted ₹ 267.45 lakh from the savings of various interventions of 2013-14. The balance amount of ₹ 410.40 lakh was met from diverting the fund meant for interventions of payment of teacher salaries for 2014-15.

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observation.

1.3.18.4 Deduction and utilisation of supervisory cost

The SSA framework for implementation does not provide any provision for deduction of monitoring and supervision cost from the approved cost under civil works *viz.* construction of new schools, construction of additional classrooms, toilets and boundary walls.

Scrutiny of the records of SSA Mission, Mizoram revealed that the State Project Office (SPO) and District Project Offices (DPOs) had irregularly deducted ₹ 354.26 lakh from the approved fund of ₹ 85.96 crore during 2010-16 towards monitoring and supervision cost by the State and District level authorities as detailed in the following table.

Table-1.3.15

(₹ in lakh)

Year	Funds released to districts	Deductions at various levels (percentage deducted)		
		SPO	DPOs	Total
2010-11	2,363.80	35.46 (1.5)	70.91 (3)	106.37
2011-12	1,281.89	19.23 (1.5)	38.46 (3)	57.69
2012-13	2,779.36	41.69 (1.5)	83.38 (3)	125.07
2013-14	Nil	Nil	Nil	Nil
2014-15	Nil	Nil	Nil	Nil
2015-16	2,171.02	21.71(1.0)	43.42 (2)	65.13
Total	**8,596.07**	**118.09**	**236.17**	**354.26**

Source: Departmental records

The irregular deduction would have affected the extent and quality of work. Further, scrutiny of the records at office of the SPO and two sampled DPOs (Aizawl and Lunglei districts) revealed that the following amounts were spent for purposes other than the monitoring and supervision of works.

- **State Project Office:** During 2010-11, ₹ 4.13 lakh was spent on TA of officials, books, advertisement, renovation of office rooms *etc.* and the remaining amount of ₹ 9.30 lakh was incurred on payment of third party monitoring charges. The unspent balance of ₹ 22.04 lakh which formed part of the closing balance of the year 2010-11 was adjusted by GoI in the next year fund release.
- **DPO, Aizawl District:** Out of ₹ 17.15 lakh deducted during 2011-12, ₹ 15.65 lakh was irregularly spent for office renovation, vehicle hiring/repairing, procurement of office equipment, training travelling expenses *etc.* and the remaining balance of ₹ 1.50 lakh was diverted to Sub Divisional Education Officers for inspection of schools.
- **DPO, Lunglei District:** Out of ₹ 35.25 lakh deducted during 2012-13, ₹ 30.28 lakh was spent by the DPO on various activities[5] and the remaining fund of ₹ 4.97 lakh was utilised on travelling expenses of officials.

[5] Procurement of Green board (₹ 9.94 lakh), Renovation of various buildings/schools (₹ 17.55 lakh), Procurement of laptop (₹ 0.44 lakh), procurement of chalk *etc.* (₹ 1.57 lakh) and Vehicle repairing (₹ 0.78 lakh)

The State Project Director, SSA Mission, Mizoram replied (November 2016) that the supervisory cost was deducted at the State and district level as per the provision of SSA Manual on Financial Management and Procurement of SSA (Para 26.7) which *inter-alia* states that supervision cost and equipment bought for monitoring quality, if any, built into the unit cost can be retained at the district/State level for expenditure on supervision.

The reply is not acceptable as no supervision cost for monitoring quality was built in the unit cost of civil works approved by GoI.

1.3.18.5 Audit by Chartered Accountants

Paragraph 7.12.2 of SSA Framework of implementation provides for statutory audit of SSA accounts annually by the Chartered Accountant Firms.

Scrutiny of records of the State Project Director, SSA Mission, Mizoram revealed that the accounts of the SSA Mission, Mizoram for the years 2010-16 were duly audited annually by Chartered Accountant firms. Further, scrutiny of the audited reports of the Chartered Accountant for the years 2010-16 revealed that in every year's report, the Chartered Accountants had observed that in the balance sheet, there was a discrepancy of ₹ 83.59 lakh due to difference in cash and bank balance since 2003-04. The SSA Mission, Mizoram has appointed a Chartered Accountants firm[6] to reconcile the accounts during 2014-15. The issue was yet to be resolved.

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observation. The reply was, however, silent as to why the discrepancy between cash and bank balance could not be reconciled by the Chartered Accountant even after lapse of more than one year.

1.3.19 Monitoring and Evaluation

1.3.19.1 State Advisory Council

As envisaged in Rule 26 of the Mizoram RTE Rules, 2011, the State Government has constituted (April 2010) the State Advisory Council (SAC) under the Chairmanship of Minister of School Education Department with 14 members from different departments/experience in connection with elementary education who will hold the office for a period of two years from the date of assumption of office. The SAC has to conduct meetings once in three months to monitor the implementation of RTE in the State.

Scrutiny of the records revealed that contrary to the provisions of the Mizoram RTE Rules, 2011, the members appointed during April 2010 continuously held the office till March 2013. Again, those new members who were appointed during March 2013 had been holding the office till August 2016 even after the expiry of two years. Further, the State Advisory Council managed to conduct a single meeting (September 2013) since its constitution till August 2016.

[6] M/s Anil Hitesh & Associates

Thus, to that extent, the monitoring envisaged under RTE was not being done in the State.

While accepting the audit observation, the State Project Director, SSA Mission, Mizoram stated (November 2016) that the issue had been taken up with the Government.

1.3.19.2 School Management Committee

A School Management Committee (SMC) consisting of the elected representatives of the local authority, parents or guardians of children admitted in such schools was required to be constituted in all the Government and aided schools within six months of implementation of the Act and was to be reconstituted every two years. The SMC was to monitor the working of the school, prepare and recommend School Development Plan, monitor the utilisation of the grants received from the appropriate Government *etc.*

Joint inspection of 60 Government and Aided Schools under SSA Mission, Aizawl and Lunglei District revealed the following:

- 14 out of 60 schools did not constitute SMC.
- 23 schools did not reconstitute SMC every two years.
- None of the SMCs prepared School Development Plans during 2010-16.
- None of the SMCs imparted any Special training to children identified for such special training.
- However, all the 60 schools maintained separate bank account for the money received for implementation of various activities under RTE Act. The accounts of the SMCs were audited annually by Chartered Accountants during 2010-16.

Thus, the grass-root level planning and implementation of SSA at the School level was not as per the spirit of RTE Act.

In reply, State Project Director, SSA Mission, Mizoram stated (November 2016) that since all 60 schools having separate bank accounts received funds for implementation of various activities, the question of 14 out of 60 schools not constituting SMCs was doubtful.

The contention is not acceptable as joint physical verification was conducted along with Department officials. However, there was no record maintained regarding the constitution of SMCs, its members, minutes of meetings *etc*. In the Exit Conference (November 2016), the Special Secretary assured that necessary relevant records would be maintained henceforth at the State Level.

1.3.19.3 State Commission for Protection of Child Rights

The Mizoram Right of Children to Free and Compulsory Education Rules, 2011 envisages setting up of a State Commission for Protection of Child Rights. Till the setting up of such commission, the State Government shall constitute an interim authority known as the Right to Education Protection Authority (REPA) within six months of the commencement of the Act or the constitution of the State Commission for Protection of Child Rights, whichever is earlier.

The State Commission for Protection of Child Rights or the REPA shall set up a child help line, accessible by SMS, telephone and letter, which would act as the forum for aggrieved children/ guardians to register complaints regarding violation of rights under the Act, in a manner that records but does not disclose, their identity.

Scrutiny of the records revealed that the State Government has not set up State Commission for Protection of Child Rights till date (March 2016), however, REPA consisting of a Chairman and five members was set up during September 2010. The School Education Department notified (March 2013) that any person having any grievance relating to the right of a child under the Act may make a written complaint to local authority of the concerned jurisdiction. However, no proper channel on child help line, accessible by SMS, telephone, as envisaged in the Act, was set up.

Thus, in the absence of proper channel for lodging complaints on violation of child rights, no complaint regarding violation of child rights was received by the REPA during 2010-16.

While accepting the audit observation, the State Project Director, SSA Mission, Mizoram stated (November 2016) that the matter will be brought to the notice of appropriate authority.

1.3.19.4 Evaluation study on implementation of RTE Act

As per the guidelines on SSA, independent research and supervision by autonomous research institutions and third party evaluations should be encouraged.

Scrutiny of the records revealed that the Joint Review Mission was organised during 2011 by the MHRD, GoI to monitor the overall programme implementation in all the States in the country. However, no evaluation study/impact assessment of implementation of RTE Act in the State had been taken up by any agency at State level during 2010-16 so far (September 2016).

The State Project Director, SSA Mission, Mizoram accepted (November 2016) the audit observation.

1.3.20 Conclusion

The performance audit of implementation of RTE Act revealed short comings in implementation of the scheme at the ground level. The credibility of Annual plans of SSA was doubtful in the absence of regular household survey and School Development Plans. The Department has not rationalized posting of teachers which resulted in imbalance of posting of teachers in schools where many schools remain overstaffed while others functioning with single or no regular teachers. The implementation of the Act also suffered due to delay in releasing of State Matching Share from the State Government and underutilisation of the available funds by the Department. Non implementation of 25 *per cent* reservation of children belonging to weaker and disadvantage group in unaided schools and non-setting up of proper system for addressing complaint on violation of child rights are areas of major concern which are yet to be addressed by the Government.

1.3.21 Recommendations

The Government may consider the following recommendations to improve the implementation of the RTE Act.

- Household surveys should be conducted at regular intervals to identify children eligible for enrolment and also ascertain actual enrolment in schools.
- The Department should ensure that no school in the State is functioning without proper recognition.
- The Department should ensure effective participation of School Management Committees in planning and implementation of the Act.
- Appropriate steps should be initiated by the Government to rationalize posting of teachers in schools. Teachers recruited for schools should not be deployed for non-educational works.
- 25 *per cent* reservation in unaided schools for children belonging to weaker and disadvantaged groups should be introduced as per the provisions of the Act.
- The State Commission for Protection of Child Rights to address any grievances on violation of child rights should be constituted at the earliest.

HEALTH & FAMILY WELFARE DEPARTMENT

1.4 Performance Audit on National Rural Health Mission

National Rural Health Mission (NRHM) was launched in April 2005 throughout the country with special focus on 18 States. Mizoram was one of the states selected for implementation of the Mission in 2005. The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. The Mission was funded under three main components *viz*. (i) Reproductive and Child Health (RCH), (ii) Strengthening of Health System and (iii) National Disease Control Programme.

Performance audit on National Rural Health Mission in the State covered activities/ programmes funded under the components of RCH Flexipool *viz.*, Strengthening of Health systems including Infrastructure, Mobile Medical Units, Patient Transport Systems (for referral and emergency), procurement of equipment and drugs, support to ASHA workers and VHSNC, Maternal and Child health interventions, Adolescent Health interventions and immunisation. Some of the significant audit findings are highlighted below:

Highlights

Facility surveys for identifying the health care needs of the people at the grassroots were not conducted in the State. District Health Action Plans were prepared without aggregating the Block and Village Health Action Plans.

(Paragraphs 1.4.7.1 & 1.4.7.2)

Loans to the tune of ₹ 15.40 crore released during 2011-16 from the Mission Flexipool fund to various other programs were not returned to the Mission Flexipool.

(Paragraph 1.4.8.6)

₹ 4.16 crore was spent on upgradation of CHCs at Khawzawl & Hnahthial from the Mission Flexipool without approval of GoI.

(Paragraph 1.4.8.8)

Seven out of 49 Sub Centres reconstructed/ constructed during 2012-14 at a total cost of ₹ 45.14 lakh were non-operational.

(Paragraph 1.4.9.3)

Mobile Medical Units (MMU) with an aim of taking the health care to the doorstep of the needy were not fully functional. Many machines (X-Ray, Ultrasound, ECG and power back up) were nonfunctional.

(Paragraph 1.4.14)

Under *Janani Suraksha Yojana,* which had twin objective of reducing maternal and infant mortality by providing cash incentives to pregnant women, ₹ 1.43 crore was due for payment to eligible pregnant mothers and ASHA workers as of March 2016.

(Paragraph 1.4.16.1)

1.4.1 Introduction

The National Rural Health Mission (NRHM)[7] was launched in April 2005 throughout the country with special focus on 18 States. Mizoram was one of the states selected for implementation of the Mission in 2005. The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. Key features to achieve the goals of the Mission include making the public health delivery system fully functional, accountable to the community, human resource management, community involvement, decentralisation, rigorous monitoring and evaluation against standards *etc*.

1.4.2 Organisational Structure

At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The activities under the Mission are carried out through the State Health Society (SHS). The Mizoram State Health Society was registered under the Societies Registration Act on 17 November 2005. The Governing Body of the SHS is headed by the Chief Secretary. The Executive Committee of the SHS is headed by the Principal Secretary, Health and Family Welfare Department. The State Programme Management Support Unit (SPMSU) acts as the Secretariat to SHS and is headed by the Mission Director.

At the district level, there are District Health Societies (DHSs) headed by the Deputy Commissioners of the eight Districts of the State who act as Chairpersons of the Governing Body of DHS and their Executive Committees are headed by the respective Chief Medical Officers (CMOs). The organisational chart is given below.

Chart-1.4.1

[7] The National Urban Health Mission (NUHM) as a sub-mission of an over-arching National Health Mission (NHM) was launched on 20 January 2014, with National Rural Health Mission (NRHM) being the other sub-mission of National Health Mission.

1.4.3 Audit Objectives

The objectives of the performance audit are to assess whether:

- Planning and action taken for strengthening of infrastructure of healthcare facilities was as per revised IPHS guidelines;
- Strengthening of human infrastructure at healthcare facilities was prioritised;
- The objective of improving Maternal and Infant mortality rate by implementation of various interventions under Reproductive and Child Health (RCH) has achieved the desired result;
- The required quality assurance mechanism was in place and functioning effectively;
- The mechanism of data collection, management and reporting which serve as indicators of performance was robust and reliable.

1.4.4 Scope and coverage of Audit

The performance audit covering the period from 2011-12 to 2015-16 was conducted during May to September 2016 and covered the activities and programmes funded under NRHM RCH Flexi-pool which encompassed the strengthening of infrastructure of healthcare centres at different levels, human resource management, implementation of schemes related to maternal health, institutional delivery, child health, immunisation, family planning, early detection, *etc.* The performance audit involved scrutiny of the records and other evidence at the State Mission Directorate and at two (Mamit and Lawngtlai) out of nine District Health Societies (DHSs), two District Hospitals (DHs), two Community Health Centres (CHCs), seven Primary Health Centres (PHCs) and 18 Sub Centres (SCs) of the sample Districts, selected on the basis of simple random sampling without replacement method (SRSWOR).

1.4.5 Audit Methodology

The audit methodology involved the examination and analysis of the records/documents of SHS Aizawl, Mizoram and DHSs of sample districts and sample hospitals/health facilities and interview of JSY beneficiaries/ASHA workers.

Audit commenced after an entry conference was held on 29 April 2016 with participation of the officers of the Administrative Department and Head of the Department, wherein audit objectives, scope and criteria were discussed. The draft report was sent to the Government in October 2016 for their response. However, replies of the Government were awaited (March 2017). Mission Director, NHM furnished the reply to the Report. An Exit Conference was held in November 2016 with the Deputy Secretary of the Administrative Department, Mission Director (MD) NHM, Mizoram and other officers of the State Health Society in which audit finding were discussed. The Report has been finalised after considering the replies of Mission Director, NHM, Mizoram to audit observations and deliberations in the Exit Conference.

1.4.6 Audit criteria

Audit criteria adopted for arriving at audit conclusions were derived from the following:

- NRHM Framework for Implementation (2005-12);
- NHM Framework for Implementation (2012-17);
- NRHM Operational Guidelines for Financial Management;
- Indian Public Health Standards (IPHS) – Guidelines (2007) and (Revised 2012) for Sub-Centres (SCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District/ Sub-Divisional Hospital and District Hospital;
- Operational guidelines for Quality Assurance in public health facilities 2013;
- State Programme Implementation Plans (PIPs) and District Health Action Plans (DHAPs)

Acknowledgement

Indian Audit and Accounts Department acknowledges and appreciates the co-operation of Officers and Staff of State Health Society, Mizoram. We also appreciate the support of authorities of District Health Societies and Health facilities in the sampled districts during the course of the Performance Audit.

AUDIT FINDINGS

The important points noticed during the course of audit are discussed in the succeeding paragraphs.

1.4.7 Planning

1.4.7.1 Baseline survey/Annual facility survey

Under the Mission, District Health Action Plan (DHAP) is to be prepared on the basis of preparatory studies, mapping of services and facility surveys conducted at village, block and district level, which would act as the baseline for the Mission against which progress would be measured. This exercise needs to be taken up at regular intervals to assess the progress under the Mission. This would help assess the status of the facilities *vis-à-vis* Indian Public Health Standards (IPHS) norms.

However, it was observed in audit that no baseline/ annual facility survey was conducted in the State. In the absence of a comprehensive database of health facilities, Audit could not analyse the gaps between demand for and availability of services in each facility.

1.4.7.2 Preparation of Health Action Plans

The NRHM strives for decentralised planning starting from the village and block level plans and to consolidate the plans into the DHAP which forms the basis of all interventions under

the Mission. The DHAP was to be prepared by the DHS and approved by the DHM. Further, a Programme Implementation Plan (PIP) for the State was to be prepared annually by the SHS by aggregating the DHAP of each district with a bottom to top approach. The District plan was also to be approved by the State so as to enable DHM to implement the scheme as per the approved plan.

However, during the scrutiny of records it was noticed that:

- In sample districts, no village and block level plans were prepared. The situation may be the same throughout the State. DHAPs were also not approved by the respective District Health Missions (DHMs).
- Bottom up approach planning was not adopted in respect of planning for drugs and equipment, *etc*.
- Though District plan was compiled at the SHS, a mechanism for according approval to District plans was not established.

The absence of the comprehensive village and block plans hindered the goal of decentralised planning. As a result, audit could not assess village-centric health issues and measures taken to improve the health conditions *etc*.

While accepting the audit observation, MD NHM attributed the non-preparation of village and block health plan to late receipt of the guidelines for preparation of a Programme Implementation Plan (PIP).

As regards planning for drugs and equipment, MD NHM stated that it was done at the State level to have the uniformity in the rates of drugs and equipment. It further added that district data was available at the State level and hence plans for SC clinic, infant warmers *etc*. were prepared solely at the State level.

The reply is not acceptable as the preparation of village and block health plan is a basic exercise not linked to receipt of the guidelines for preparation of PIP for a given year. Further, data available at the State Level may not appropriately prioritise local requirements. SHS should involve concerned stakeholders at the grassroots level in planning within the time frame.

1.4.8 Financial Management

1.4.8.1 Funding Pattern

The funding pattern of the Scheme in the State is 90:10 of Central share and State share. The funding to the State is based on the approved State Programme Implementation Plans (PIPs), which has five components[8]. Performance audit covered activities undertaken under NRHM

[8] (i) NRHM Reproductive and Child Health (RCH) Flexible Pool, (ii) National Urban Health Mission (NUHM) Flexible Pool, (iii) Flexible Pool for Communicable Diseases, (iv) Flexible Pool for Non-Communicable Diseases and (v) Infrastructure Maintenance.

RCH Flexi pool. The position of receipt and expenditure of funds under NRHM RCH Flexi pool during 2011-12 to 2015-16 is as given in the following table.

Table-1.4.1

(₹ in crore)

Year	Opening Balance	Receipts	Total	Expenditure	Closing Balance
2011-12	11.56	33.12	44.68	34.33	10.35
2012-13	10.35	50.64	60.99	57.48	3.51
2013-14	3.51	45.08	48.59	45.71	2.88
2014-15	2.88	34.40	37.28	34.54	2.74
2015-16	2.74	81.31	84.05	76.08	7.97

Source: SHS's records

1.4.8.2 Release of funds

As per the operational guidelines on Financial Management, funds were to be released based on the utilisation of previous funds in a minimum of two or more tranches. GoI releases funds in May and October or as and when required, subject to the approval of a Programme Implementation Plan (PIP) by the National Programme Coordination Committee (NPCC).

During 2011-12 and 2015-16, it was observed that ₹ 45.33 crore was sanctioned/released[9] at the close of the financial year by GoI. The change in funding pattern (*i.e.* releasing through the State budget instead of direct transfer to SHS) from 2014-15 resulted in further delay in transfer of funds to SHS account. As on August 2016, ₹ 2.10 crore of central funds pertaining to 2014-15 and 2015-16 was pending for release by the State to SHS.

The MD NHM accepting the facts stated (December 2016) that the SHS faced greater financial constraints after the change of funding pattern.

1.4.8.3 Release of funds to the Districts

As per operational guideline, SHS should transfer the funds to the districts within 15 days of the receipt of funds, which was in turn to be released to Village Health Sanitation and Nutrition Committee (VHSNC), Sub Centres, PHCs, CHCs and Sub-District Hospitals *etc*. However, it was observed that the funds were not released to the Districts within the stipulated time. Out of ₹ 3.98 crore approved in 2014-15, ₹ 1.16 crore was released in January 2015 and remaining funds (2014-15) along with funds approved in 2015-16 were released in August 2015 and January 2016.

The MD NHM stated (December 2016) that the SHS did not receive funds in time during 2014-15 due to which only 30 *per cent* was released to the districts during 2014-15.

[9] Includes sanctions at the close of financial year and released in next financial year

1.4.8.4 State Matching Share

The State should deposit its share in the same financial year and confirm the credit of State's share of PIP (based on total releases under NRHM) within 15 days of the end of financial year. As on March 2016, backlog of State Matching Share was ₹ 6.02[10] crore.

While accepting the delay in depositing State Matching Share, the MD NHM stated (December 2016) that the State Matching Share of ₹ 6.02 crore was released to SHS in October 2016.

1.4.8.5 Untied fund/Maintenance grant/ *Rogi Kalyan Samiti* (RKS) grant

During 2011-16, the SHS released ₹ 14.42 crore to the districts towards untied/maintenance/ RKS grant. SHS reported the entire release to the Districts as utilised. But it did not have information on actual utilisation out of the releases.

While accepting the facts the MD NHM stated (December 2016) that the State was taking necessary actions to receive the reports in time from the Districts.

1.4.8.6 Loans from RCH Flexipool to other programmes

Due to paucity of funds in a programme/activity, SHS released funds from one account to another on temporary loan basis. Ministry also allowed (January 2015) states to utilise funds available in one programme/scheme of the Mission for another programme subject to the conditions that (i) Funds loaned temporarily will be returned to the original programme head/ account, once funds become available in the programme, for which funds were temporarily borrowed and (ii) This should not be taken as a norm, but only in exceptional circumstances.

However, it was noticed that SHS was routinely giving temporary loans from NRHM RCH Flexipool to other programmes. The loans to the tune of ₹ 15.40 crore released during 2011-12 to 2015-16 to the various programmes were not returned, which would apparently impact implementation of various interventions funded under the NRHM RCH Flexipool.

While accepting the audit observation MD NHM stated (December 2016) that due to non-release of funds from GoI/State treasury in time, temporary loans were released to other programmes from NRHM RCH Flexipool and the same would be recouped as and when funds would be available in other activities.

The fact, however, remained that since the temporary loans were not returned for lengthy periods the various programs under NRHM RCH Flexi pool would have been adversely affected. Further, temporary loans were treated as expenditure resulting in the distortion of expenditure figures under NRHM RCH Flexipool.

[10] State matching share on the total funds released under NRHM/NHM

1.4.8.7 Funds from Mission Flexipool kept in cash chest

As per operational guideline for Financial Management, there should be a separate bank account for RCH, Mission Flexipool and Immunisation *etc.,* under the group main account of NRHM. As stipulated, the SHS maintained separate bank accounts at Mizoram Rural Bank, Dinthar, Aizawl. Further scrutiny of the records/documents revealed that the SHS operated a second account at the same branch for the amount drawn on AC bills from Mission Flexipool. The funds were mainly used for civil works. The funds were kept in the bank account upto 31 July 2015, there after the entire balance was withdrawn from the bank and kept in the cash chest maintained in the SHS office. The cash balance in the cash chest was ₹ 1.06 crore as on March 2016. Holding large amounts in cash is fraught with risk of temporary misappropriation.

Further, during the scrutiny of the subsidiary cash book, it was noticed that the SHS had withdrawn an amount totalling to ₹ 51.40 lakh between July 2013 and July 2015. However, the purpose for which the money was withdrawn was not written in detail. In the absence of bills/ vouchers, audit could not verify the genuineness of the expenditure incurred and the possibility of funds being misappropriated could not be ruled out.

While accepting the audit observation, the MD NHM stated (December 2016) that as per verbal instruction of higher authority, second bank account was operated to account for ongoing civil works. It was further stated that ₹ 51.40 lakh was withdrawn for temporary loan and action was being taken to recoup the amount.

No record in support of withdrawal of ₹ 51.40 lakhas temporary loan and purpose of loan could be produced to audit. The reply also did not clarify as to why cash worth ₹ 1.06 crore was kept in the cash chest and corrective action was not taken to prevent holding of heavy cash balance in the cash chest.

1.4.8.8 Utilisation of funds for unapproved works/activities

It was observed in audit that funds were utilised by the SHS for works/activities not approved by GoI like upgradation of CHCs and purchase of vehicles, as detailed below:

- **Upgradation of CHC into 50 bedded SDH at Khawzawl**

SHS took up the upgradation work of CHC Khawzawl into a 50 bedded hospital from Mission Flexipool Funds at an estimated cost of ₹ 3.79 crore without the approval of GoI. The civil work started from June 2013 and was still in progress (2016). The SHS incurred ₹ 2.29 crore as on March 2016. In addition, SHS also spent ₹ 31 lakh on the water supply and sanitary work.

SDH Khawzawl under construction

- **Upgradation of CHC into SDH (Phase-1) Hnahthial**

SHS took up the upgradation work (Civil work) from April 2012 out of Mission Flexipool Fund at a cost of ₹ 1.34 crore without the approval of GoI. The work was completed at a total expenditure of ₹ 1.56 crore including the cost of internal sanitary and electrification work. The newly upgraded hospital was made operational in April 2015.

While accepting the facts the MD NHM stated (December 2016) that as per verbal instruction from higher authorities this wrong procedure had to be taken up and added that the State would try to avoid such situation in the future.

- **Purchase of vehicles**

As per the NRHM guidelines, interest earned shall be treated as grants-in-aid and shall be utilized for the same purpose for which the State PIP or District PIP is approved and shall also be subject to the same programme norms/guidelines as the grants-in-aid for the programme. This was to be factored into while approving the State PIPs.

Audit observed that SHS purchased three vehicles costing ₹ 29 lakh during April/ May 2013 from the cumulative interest of the funds deposited in the account without approval of GoI.

MD NHM stated (December 2016) that *ex-post facto* approval was given for purchase of three vehicles for emergency health care in several CHC, PHC and Sub-Centre level clinics.

The reply is not factually correct because these vehicles had been allotted to the Health Minister, MD and State Programme Officer (SPO). Keeping in view the allocation of the vehicles, this expenditure should have been from the State budget.

1.4.8.9 Statutory and Concurrent Audit

NRHM Operational Guidelines for Financial Management requires appointment of Statutory and Concurrent Auditors for audit of the accounts of SHS and DHSs including accounts of

CHCs/PHCs/Sub Centres/Village Health Sanitation & Nutrition Committees/*Rogi Kalyan Samitis*/National Disease Control Programmes.

During scrutiny of the records, Audit observed that:

- M/s Saraswati & Co., was appointed as the Concurrent Auditor for four financial years 2010-11, 2011-12, 2012-13 and 2013-14; thereafter M/s Kiran Joshi & Associates, was appointed as the Concurrent Auditor for three financial years 2014-15, 2015-16 and 2016-17 in violation of the condition of appointment for maximum two years in the guidelines.
- Appointment of the Concurrent Auditor was delayed by 175, 195 and 142 days during 2011-12, 2012-13 and 2014-15 respectively, which impacted the time schedule of submission of reports.
- The concurrent audit was carried out by the selected auditors on quarterly basis instead of monthly basis as stipulated.
- Both the Statutory Auditor and the Concurrent Auditor had not submitted their Reports for the year 2015-16 (as of December 2016).

Thus, the deficiencies in audit process and selection of auditors as pointed out above hampered timely completion of audit and submission of audit report to the Ministry of Health and Family Welfare.

The MD NHM stated (December 2016) that due to good performance of M/s Kiran Joshi & Associates during 2014-15 the firm was re-appointed for two consecutive years 2015-16 and 2016-17.

The reply is not tenable as this was in violation of extant instructions and the reply was silent on the issue of delayed appointment and delay in submission of reports by the Auditors.

1.4.9 Availability of Physical Infrastructure

As on 31 March 2016, there were nine District Hospitals, two Sub District Hospitals, nine CHCs, 57 PHCs and 370 Sub Centres in the State. The number of rural health facilities available in the State had been almost static. The position of District Hospitals, Sub District Hospitals, CHSs, PHCs and Sub Centres in the State in 2012 and 2016 is given in the following table.

Table-1.4.2: Position of Health Centres

Year	District Hospital	Sub District Hospital	CHC	PHC	SC
2012	8	3	9	57	370
2016	9	2	9	57	370

Source: SHS's records

The categorisation and mapping of the facilities in the State was not consistent and differed from source to source as indicated in the following table.

Table-1.4.3: Varying position of Infrastructure

	District Hospital	Sub District Hospital	CHC	PHC	SC
As per Gazette Notification	9	2	9	57	370
SHS MIS report	8	3	9	57	370
Information by Directorate of Health Services	12	12		57	372

While accepting the audit observation the MD NHM stated (December 2016) that the State had issued a Gazette notification on 13 June 2016 on mapping of facilities.

The fact remains that the varying position still persisted as information in the Gazette notification issued by the Directorate of Health Services differs from information in MIS Report as well as information specifically provided by the Directorate of Health Services on the request of Audit. These discrepancies regarding categorisation and mapping of facilities available in the State needs to be reconciled.

1.4.9.1 Upgradation of PHCs to 24 hours emergency service

As per IPHS, the PHCs over one hour journey time away from CHC can be upgraded to provide 24 hours emergency service. All 57 PHCs in the State are over one hour journey time away from CHC. However, 16 PHCs are yet to be upgraded to provide 24 hours emergency service.

The MD NHM stated (December 2016) that due to un-availability of human resources and infrastructure, the State could not follow IPHS norms.

1.4.9.2 Availability of basic facilities in Sub Centres

NRHM aims to bridge gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revitalization of the existing physical infrastructure, such as health centre buildings and fresh construction or renovation, wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. Due to non-conduct of annual facility survey, Audit could not assess the status and incremental gains made in infrastructure available at all health centres.

However, audit observed lack of basic facilities like proper water supply, electricity connection, compound wall, toilet *etc*. during the visit to Sub Centres.

Table-1.4.4: Sub Centres without basic facilities

No. of Sub Centres test-checked	Electric connection	Water supply	Toilet	Compound wall
18	4	13	2	17

While accepting the facts the MD NHM stated (December 2016) that the SHS was trying its best to improve the basic facilities of Sub Centres.

1.4.9.3 Non-functioning Sub Centre

As per available information, during 2012-13 and 2013-14, SHS approved construction/ reconstruction of 49 Sub Centre, the construction of which have been completed. Out of these, 7 Sub Centre does not figure in the list of 370 Sub Centre notified by the Government in May 2016. As such, apparently these Sub Centre have not been put to use. This resulted in unfruitful expenditure of ₹ 45.14 lakh spent on their construction.

1.4.9.4 Repair instead of reconstruction of Sub Centre

SHS proposed to reconstruct West Phaileng Sub Centre in 2012-13. However, village council could not provide the land for the site of new construction. SHS spent ₹ 6.00 lakh on repair/ renovation of the existing building. However, during the site visit it was observed that the existing Sub Centre remained in poor condition as shown below.

West Phaileng Sub Centre in poor condition

1.4.9.5 Entrustment of work without calling tenders

As per the general financial rules and CPWD works manual, no work should be entrusted without proper procedures and call of tenders if the estimated amount is more than ₹ 50,000. However, it was observed that civil works of ₹ 1.02 crore were taken up in Mamit and Lawngtlai Districts without calling for tenders during 2011-12 to 2013-14. It was noticed that the records showed only entrustment of work was done as per the instruction of the Health Minister to different agencies.

Table-1.4.5: Entrustment of work without calling tenders

Year	District	Amount (₹ in lakh)	Civil work
2011-12	Mamit	5.12	Repair work
	Lawngtlai	2.22	Repair work
2012-13	Mamit	31.00	Construction/reconstruction for 5 Sub Centre @ ₹6.20 lakh
	Lawngtlai	15.82	Construction of Type-III Quarters.
2013-14	Mamit	18.60	Construction/reconstruction of 3 Sub Centre
		14.76	Construction of Type-III Quarters.
	Lawngtlai	14.51	Construction/reconstruction of 2Sub Centre
Total		**102.03**	**--**

MD NHM accepted (December 2016) the audit observations.

1.4.9.6 Non-operation of Auxiliary Nurse Midwife School and Girls hostel

SHS took up construction of Auxiliary Nurse Midwife school and Girls hostel at Lawngtlai at a cost of ₹ 2.80 crore under the centrally sponsored scheme for upgradation/strengthening of Nursing Services during the year 2010-11. The construction of the school and the hostel was completed by December 2013 and June 2014 respectively. During visit to the site (July 2016), audit noticed that the buildings were surrounded by tall grass and were lying nonoperational since their construction.

Non-operational ANM School and Girls Hostel

The MD NHM stated (December 2016) that operationalisation of the school/hostel was still under process. The reply was silent as to why the school and the hostel could not be operationalised even after a lapse of three years of their construction.

1.4.10 Procurement of equipment

1.4.10.1 Upgradation of Infrastructure in District Hospitals

GoI approved ₹ 2.12 crore in 2015-16 for implementing the following activities:

- Purchase of Power Supply (250 KVA) for Champhai District Hospital - ₹ 30 lakh
- Four bedded dialysis centre at District Hospital Lunglei - ₹ 113 lakh.
- OT equipment (three OTs) for Civil Hospital Aizawl - ₹ 69 lakh.

Scrutiny of the records/documents revealed that:

- **Power Supply (250 KVA) for District Hospital Champhai**

The funds provided under Mission Flexipool for purchase of Power Supply was diverted for the procurement of Ultrasound Machines and X-ray machines for District Hospitals at Champhai and Mamit costing ₹ 28.09 lakh, which was not approved by GoI. However, it was noticed in audit that procurement and installation of Power Supply at District Hospital, Champhai was done from the funds available under the Forward Linkage Scheme for upgradation of District Hospital, Champhai.

The MD NHM stated (December 2016) that as the power supply was already procured from the forward linkage scheme, fund available was utilized for purchasing ultrasound machines and 300 MA X-ray machines.

The reply highlights the fact that funds were sought in an *adhoc* manner without assessing the actual requirement as funds were obtained for the same work twice under two different schemes leading to diversion of funds under one scheme.

- **Setting up four Bedded Dialysis Centre at District Hospital, Lunglei**

SHS proposed to set up four bedded dialysis centre at District Hospital Lunglei estimated at ₹ 1.13 crore. GoI approved the proposal in 2015-16. The proposal for setting up the four bedded Dialysis centre at District Hospital *inter-alia* included procurement of four Dialysis Machines, two Reverse Osmosis (RO) Plants, four Dialysis Beds, Multi-parameter Monitor, Air conditioner, Civil work, furniture, minor equipment *etc*. SHS procured four dialysis machines along with RO plants at ₹ 40 lakh. Instead of installing all the machines in District Hospital Lunglei, SHS diverted (January 2016) two units to Civil Hospital, Aizawl deviating from the plan approved by GoI. As of August 2016, none of the machines were installed as the construction of dialysis rooms was not completed.

The MD NHM stated (December 2016) that due to higher case-loads at Civil Hospital, Aizawl, two bedded dialysis centre was also set up in the Hospital.

Audit also noticed that as per the agreement, 80 *per cent* of the total amount should be released to the vendor against the dispatch documents at sight. The balance 20 *per cent* should be released after satisfactory installation and commissioning of the equipment. However, SHS paid entire amount resulted in payment of ₹ 8.00 lakh before satisfactory installation and commissioning.

Further, SHS procured two RO plants at the unit cost of ₹ 4.26 lakh against estimated unit cost of ₹ 15 lakh. The basis for estimating the cost of plant was not available in the proposal. As such, audit could not assess whether SHS procured RO plants of the specification which was needed and also cannot with certainty assure that the RO plants that had been procured would fulfil the operational requirement of dialysis centre.

- **Procurement of equipment for Civil Hospital, Aizawl**

GoI approved ₹ 69 lakh for procurement of OT equipment (*viz.*, OT light, Operation Table, Diathermy and Anaesthesia Workstation) for improvement of infrastructure of Civil Hospital Aizawl.

SHS procured OT Light and Diathermy as per the plan. However, instead of procuring Operation Tables and Anaesthesia Workstation, from the balance fund available, Bone Drill, X-ray machines, Laparoscope, CO^2 Inflation set costing ₹ 34.50 lakh were procured. Further, total cost of the equipment procured was more than the funds approved by ₹ 6.46 lakh.

MD NHM stated (December 2016) that due to urgent requirement in Civil Hospital, Aizawl, it was decided to procure the equipment during the meeting between the Mission Director, the Director Health and the Medical Education and Medical Superintendent of Civil Hospital.

However, the fact remains that the fund were not utilized for the purpose for which it was sanctioned. It is not clear how the requirement of Operation tables and Anaesthesia Workstation was met as the same were not procured.

1.4.10.2 Procurement of Radiant Infant Warmers and Neonatal Resuscitators

In order to strengthen delivery points of all levels in the four High Priority Districts (HPDs), in 2014-15, SHS proposed to equip 65 Sub Centre and 6 PHCs with New Born Care Corners (NBCC) at a total cost of ₹ 88.75 lakh. Against this proposal, GoI approved for 58 new NBCCs for ₹ 49.30 lakh at the unit cost of ₹ 0.85 lakh. Instead, SHS procured 70 Infant Warmers and 58 Resuscitators at a total cost of ₹ 36.07 lakh. Out of 70 Infant Warmers procured, 22 were allotted to four District Hospitals, one each to one Sub-District Hospital, one CHC and one UHC, which was outside GoI approved list. Remaining 45 were distributed to PHCs/ Sub Centres including two Sub Centres which was not in the approved list. Thus, only 43 were issued to Sub Centre/ PHCs appearing in the approved list.

Similarly, out of 58 Resuscitators procured, 15 were issued to health care centres such as PHCs, CHCs and District Hospitals which was outside GoI's approved list.

Thus, out of 58 PHCs/Sub Centres approved by GoI, only 43 PHCs/Sub Centre were provided NBCCs, thereby, 15 Sub Centres in the approved list were denied of NBCCs.

The MD NHM (December 2016) replied that other hospitals having Special New-born Care Units (SNCUs) were included for supply of Radiant Infant Warmer as there was an approved budget of ₹ 5 lakh for upgradation of SNCUs, however, expenditure was booked under Mission Flexipool. It was also replied that since the approved rate was lower than expected, fund was utilised for the upgradation of existing SNCUs.

1.4.11 Utilisation of funds for Procurement of drugs

GoI approved ₹ 2.46 crore towards implementation of National Iron Plus Initiative (NIPI) during 2014-15 and 2015-16. Funds were to be utilised for the purchase of Iron Folic Acid

(IFA) syrup, IFA Tab and Albendazole Tab for children. While approving, GoI insisted for procurement of drugs through competitive bidding. However, the Department purchased medicine worth ₹ 1.37 crore (August 2015) from M/s SL Sailo Pharmacy, Aizawl through quotations obtained from the three firms, as detailed below:

Table-1.4.6: Tender details

Sl. No.	Item	Amount (₹ in lakh)	Tender notice	Bidders
1.	Tab Iron Folic Acid (for age group 10-19 years)	71.14	7 October 2014	1. SR Pharmacy, Aizawl 2. KC Pharmacy, Aizawl 3. SL Sailo Pharmacy, Aizawl
	Iron Folic Acid (syrup)	16.77		
2.	Albendazole (age 5-10 years children)	4.06	20 January 2015	
	Albendazole (age 10 -19 years children)	18.38		
3.	Tab Iron Folic Acid (Small Pink)	26.43	20 January 2015	
Total		**136.78**	**-**	**-**

The points noticed in the audit are given below:

- In respect of item at Sl. No. 1, the State Government did not go for competitive bidding, whereas in case for procurement exceeding ₹ 25 lakh open tender should have been called for. Moreover, restricted tender notice was issued on 7 October 2014, the bidders submitted quotations the next day and comparative statement compiled and Supply Orders was placed on the same day.
- In respect of the above items at Sl. No. 2 and 3, comparative statement of prices offered by the bidders was prepared on 19 January 2015, whereas restricted tender was issued on 20 January 2015, which is indicative of the fact that bidding process was not transparent. Also, no formal letters from the respective bidders were found on records, along with their quotations
- As per procedure/practice followed, selection of bids is approved by the purchase committee. In the above cases, no approval of the purchase committee was obtained. Moreover, entire tendering process and issue of supply orders was completed in two days.

MD NHM stated (December 2016) that late receipt of approval by GoI (September 2014) necessitated emergency procurement so as to avoid disruption in supply chain and administration of tablets. It was further stated that since the floating of the tender was time consuming, the procurement was undertaken on an urgent basis by resorting to restricted tender. As regards bidding, it was stated that no formal letter was provided by bidders along with their respective quotation since the whole restricted tenders were processed in a rush to avoid further delay. In respect of tenders for items at Sl. No. 2 & 3, it was stated that MD NHM signed restricted tender on 19 January 2015 following which three firms were contacted and the firms responded immediately with their quotations and comparative statement was prepared on the same day, where as restricted tender was issued by the section on 20 January 2015.

The contention of resorting to restricted tender on the grounds of urgent requirement is not tenable as the procurement for Albendazole and Tab Iron Folic Acid was initiated only in January 2015 *i.e*. after a gap of three months from the receipt of approval by GoI, and open tendering procedure could have easily been followed without fear of disruption of supply chain. The Government must ensure that violation of all existing rules and provisions regarding procurement is not done and in such cases the matter should be investigated and responsibility fixed.

1.4.11.1 Purchase of drugs under National Iron Plus Initiative (NIPI)

SHS procured (March/ April 2016) Albendazole, IFA syrup and IFA tabs worth ₹ 1.05 crore from M/s S.L. Sailo Pharmacy without following a fair, transparent and competitive bidding process to ensure the best value for money in the procurement of drugs under NIPI. Audit observed that

- M/s S.L.Sailo Pharmacy made a representation (May 2015) to the Minister, Health & Family Welfare to allow them to continue to supply IFA tab, Albendazole etc., which was marked to SHS for favourable consideration.
- Instead of wide publicity in national newspapers, the tenders were advertised in two local newspapers only (July 2015).

1.4.12 Free Drugs Service Initiative

To mitigate the out of pocket expense on health care, GoI launched a free drugs service initiative in 2013. GoI approved ₹ 1.98 crore towards implementation of free drugs services in the State in 2014-15, which included provisions for establishment of information technology (IT) backed supply chain and logistics system and procurement of drugs. GoI again approved ₹ 0.53 crore in 2015-16 for procurement of drugs under the scheme.

As per the operational guidelines, the State was to put in place a transparent and robust procurement system, IT backed drugs supply chain and logistics system, integrated quality assurance system, standard treatment guidelines and prescription audit system, *etc*. However, implementation of the scheme had not yet started in the State.

Scrutiny of records revealed the following lapses/shortcomings due to the non-operationalisation of free drug service initiative.

- Central Medical Store (CMS) continued to issue medicines to a non-functional PHC, Kanhmun in Mamit District. However, the stocks were received by Chief Medical Officer, Mamit.
- Expired medicines were found in stock in 13 healthcare centres out of 29 hospitals/ centres test-checked in Audit, as illustrated in **Appendix-1.4.1**.

MD NHM stated (December 2016) that in 2014 an agreement with Centre for Development of Advanced Computing (C-DAC) was processed for ₹ 1.00 crore. However, as C-DAC demanded

more than ₹ 1.00 crore before finalisation of the agreement additional funds were proposed in the supplementary PIP for the year 2016-17. MD NHM added (December 2016) that medicines for Zawlnuam PHC were mistakenly issued by CMS to Kanhmun Sub-Centre. It was further stated that Health facilities had been instructed to return unused medicines.

1.4.13 Mobile Medical Unit

Under NRHM, one Mobile Medical Unit (MMU) was to be provided in each district to serve outreach areas with an aim of taking the healthcare to the doorstep of the needy people. There were a total of nine units in the State, one unit each for nine districts of the State. A Mobile Medical Unit consists of three vehicles, one for carrying medical and para-medical personnel, second for carrying basic laboratory facilities and the third for carrying diagnostic equipment. During 2011-12 to 2015-16, SHS spent ₹ 2.46 core on the operationalization of MMUs in the State.

It was noticed in audit that the larger size of the vehicles in narrow hilly road conditions and shortage of manpower and non-working equipment hindered effective functioning of MMUs in the State. It was also noticed that six X-ray machines, six Ultrasound machines, seven ECG machines, and six power back up were non-functional.

As per guideline, mobile health team was to work for six days a week. Performance of MMUs in the State during 2014-15 and 2015-16 was as indicated in the following table.

Table-1.4.7: Performance of MMU

Unit	2014-15			2015-16		
	Number of months with			Number of months with		
	no health camps	less than five health camps	five or more health camps	no health camps	less than five health camps	five or more health camps
Aizawl West	7	4	1	-	2	10
Aizawl East	4	6	2	-	5	7
Lunglei	1	9	2	-	8	4
Serchhip	10	2	-	1	8	3
Lawngtlai	6	3	3	-	7	5
Mamit	12	-	-	-	-	12
Kolasib	10	2	-	1	9	2
Champhai	5	7	-	2	8	2
Saiha	12	-	-	1	11	-

It was noticed in audit, that in the sampled districts, services of the Staff of the units were utilized in the District Hospitals, which indicated that the MMU were not conducting regular outreach services. During joint physical verification it was noticed that MMU vehicles in Mamit District were non-operational as could be seen from the following photographs

Non-functioning MMU vehicles, Mamit

While accepting the audit observation the MD NHM stated (December 2016) that size of the vehicle and the poor road condition during long monsoon season greatly hampered the operation of the MMUs in the State.

1.4.14 Human Resources

Indian Public Health Standards of the various public health facilities have been prescribed under the mission, to provide basic primary health care/optimal specialized care and to sustain the acceptable standard of quality of care.

1.4.14.1 Medical health care professionals in District Hospitals

District Hospital is a hospital at the secondary referral level responsible for a district. Its objective 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 the people. IPHS prescribes minimum essential manpower required for a functional district hospital to provide all desirable services.

Position of staff in the sample District Hospitals as on March 2016 as compared to IPHS is shown in the table below:

Table-1.4.8: Personnel in position in DHs

District Hospital	Post	No. of essential staff as per IPHS	Personnel in position	Shortage
Lawngtlai	Medical	29	7	22
	Nurses and Para Medical	76	9	67
Mamit	Medical	29	7	22
	Nurses and Para Medical	76	18	58

Further, Audit observed that specialists as shown in the following table, required as per IPHS were not available in the sample District Hospitals as on March 2016.

Table 1.4.9: List of specialist medical professionals not available

District Hospital	List of Specialist /Medical professionals not available
Lawngtlai	Medicine, Surgeon , Ophthalmologist, Radiologist, Pathologist, Psychiatrist
Mamit	Surgeon, Obstetric & Gynaecologist, Anaesthetist, Ophthalmologist, Orthopaedist, Dentist

The position may not be entirely different in other District Hospitals, except those located in the State Capital as brought out in Paragraph 1.4.14.2.

The MD NHM stated (December 2016) that due to shortage of manpower, IPHS norms could not be followed.

1.4.14.2 Medical health care professionals in CHCs

Community Health Centres (CHCs) which constitute the secondary level of health care were designed to provide referral as well as specialized health care to the rural population. IPHS for CHCs have been prescribed to provide optimal specialized care to the community and achieve and maintain an acceptable standard of quality healthcare. In order to provide, all desirable services, IPHS prescribes minimum essential staff required for a functional CHC.

Position of staff in the sample CHCs as on March 2016, as compared to IPHS was as indicated in the following table.

Table-1.4.10: Personnel in position in CHCs

CHC	Post	No. of essential staff as per IPHS	Personnel in position	Shortage
Chawngte, Lawngtlai	Medical Officer/Specialist	12	2	10
	Nurses	10	4	6
Kawrthah, Mamit	Medical Officer/Specialist	12	2	10
	Nurses	10	6	4

Further, Audit observed that specialists as shown in the following table, required as per IPHS were not available in the sample CHCs as on March 2016.

Table-1.4.11: List of specialist medical professionals not available in CHCs

CHC	List of Specialist/Medical Professionals not available
Chawngte in Lawngtlai District	Medical Superintendent, Public Health Specialist, Public Health Nurse, General Surgeon, Physician, Obstetrician & Gynaecologist, Paediatrician, Dental Surgeon, Anaesthetist
Kawrthah in Mamit District	

MD NHM stated (December 2016) that due to shortage of manpower IPHS norms could not be followed.

1.4.14.3 Medical health care professionals in PHCs

PHC is the first contact point between village community and the medical officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. To ensure round the clock access to public health facilities, IPHS prescribes minimum essential staff required for a functional PHC.

There are 57 PHCs in the State. Out 57 PHCs, no doctor was posted in 7 PHCs as on March 2016. There were shortage of para medical staff in PHCs during 2011-16 as shown below:

Table-1.4.12: Status of staff in PHCs

Year	Lab Technician	Pharmacist	Health Worker (Female)	Health Worker (Male)	Health Assistant/ Lady Health Visitor
2011-12	35	51	57	57	57
2012-13	24	55	57	57	57
2013-14	23	50	57	57	57
2014-15	24	45	57	57	57
2015-16	20	48	57	57	57

Sources: SHS

In seven sample PHCs it was noticed that no allopathic doctor was posted in Borapansury PHC since 2014.

MD NHM stated (December 2016) that due to unavailability/absence of candidates, out of 40 posts approved under NHM, only 28 posts were filled up.

1.4.14.4 Position of manpower in Sub-centres

In the public health sector, a sub centre is the most peripheral and first point of contact between the primary health care system and community. As per IPHS, a sub centre (type A) should be essentially manned by a female health worker and a male health worker. Audit observed that no health workers (male) were posted in 16 to 27 sub-centres during 2011-12 to 2015-16 except in 2014-15 as shown in the following table.

Table-1.4.13: Personnel in position in Sub Centre

Year	Number of Sub Centres where no	
	Health Worker (Male) posted	Safai-Karamchari posted
2011-12	19	NA
2012-13	21	NA
2013-14	27	NA
2014-15	0	NA
2015-16	16	92

Sources: SHS

Out of the 18 Sub Centres test-checked in two sample districts, 14 Sub Centres were posted with both male & female health workers. Of the remaining 4 Sub Centre, one Sub Centre had two female health workers and balance three Sub Centre were managed by only one female health worker each.

1.4.14.5 Staffing in two Hospitals in Aizawl district

As per the data on the human resources, two city hospitals in Aizawl district *i.e.* Civil Hospital, Aizawl and Referral Hospital, Falkawn are having more medical officers and staff nurses as compared to IPHS norms in many disciplines as illustrated in the following table.

Table-1.4.14: Personnel in position in city hospitals

Discipline	Essential as per IPHS	Personnel in position	
		Civil Hospital	Referral Hospital, Falkawn
Medicine	2	6	4
Obstetrics and Gynaecology	2	5	2
Orthopaedics	1	3	3
Dental	1	3	4
ENT	1	3	3
Staff Nurse	45	158	79

Sources: SHS

However, other District Hospitals and CHCs were facing shortage of Medical officers and Staff nursesas highlighted in previous paragraphs.

MD NHM stated (December 2016) stated that Referral Hospital, Falkawn was being strengthened to decrease the heavy workload of Civil Hospital, Aizawl and a Medical College was planned to be established.

The fact however remains that the personnel-in-position at Civil Hospital, Aizawl and Referral Hospital, Falkawn exceeded IPHS norms by 351 *per cent* and 175 *per cent* respectively.

1.4.14.6 Training and Capacity Building

To develop the skilled and specialized health professionals in the field of maternal and child health, various training and capacity building programmes were approved for the Nurses, Medical Officers, ANM and other Paramedical staffs *etc.,* under RCH Flexi pool in the approved Plans.

Scrutiny of the records of the SHS revealed that out of total 4254 resource persons (other than ASHA workers) targeted to be trained under various programmes, only 1531 resource persons were trained during 2011-16 as detailed in **Appendix-1.4.2**. None of the training programmes approved during 2014-15 to 2015-16 were implemented in full. Non-achievement of the targets was attributed to insufficient funds. Thus, the objective of

developing skilled and specialised health professional in the field of Maternal and Child Health was partially achieved.

MD NHM accepted (December 2016) the audit contention.

1.4.15 Reproductive and Child Health

The important services for ensuring maternal health and care included antenatal care, institutional delivery care, post-natal care and referral services. One of the major aims of the safe motherhood programme was to register all pregnant women within 12 weeks of pregnancy, provide them four antenatal check-ups (including check-up at the time of registration), Iron Folic Acid tablets for 100 days, two doses of tetanus toxoid (TT) and advice on the correct diet and vitamin supplements and in case of complications refer them to more specialized gynaecological care.

In this connection the following points were noticed in audit:

(i) Registration and Check ups

As per the data provided, number of registered pregnant women receiving subsequent check-up after registration ranged from 54 to 73 *per cent* for 1st visit (20-24 weeks) and 64 to 77 *per cent* for 3rd visit (34-36 weeks). SHS did not maintain data for the 2nd visit (28-32 weeks).

MD NHM stated (December 2016) that HMIS monthly reporting formats did not capture the 2nd ANC visit.

(ii) Iron Folic Acid Administration

Administration of Iron Folic Acid (IFA) for pregnant women ranged from 45 to 72 *per cent* during 2011-16.

MD NHM stated (December 2016) that shortage in administration of IFA was due to shortage of tablets at the Sub Centres.

1.4.15.1 Janani Suraksha Yojana (JSY)

JSY scheme was introduced in April 2005 replacing the earlier National Maternal Benefit Scheme (NMBS). JSY had the twin objectives of reducing maternal and infant mortality by providing cash incentive to pregnant women.

The primary objective of the JSY scheme was to increase the institutional deliveries and achieve the target of 100 *per cent* institutional deliveries by 2010.The State is yet to achieve 100 *per cent* institutional deliveries. Domiciliary deliveries were around 10.60 to 16.40 *per cent* of the total deliveries during 2011-12 to 2015-16.

Table-1.4.15: Institutional/domiciliary deliveries

Year	Total deliveries	No. of institutional deliveries	No. of Domiciliary deliveries (In percentage)
2011-12	22,103	18,488	3,615 (16.4)
2012-13	21,464	18,709	2,755 (12.8)
2013-14	21,055	18,814	2,241 (10.6)
2014-15	22,348	19,659	2,689 (12.0)
2015-16	20,080	17,951	2,129 (10.6)

Most of the domiciliary deliveries were not attended by the Skilled Birth Attendants as indicated in **Table 1.4.16**. It ranged from 56.4 to 78.1 *per cent* of the total home deliveries during 2011-12 to 2015-16. This would be associated with attendant risk for the mother and child. It was also noticed that there were number of cases of new born not visited by a health worker within 24 hours of home delivery, however, number of such cases were on decline during 2011-16,

Table-1.4.16: Deliveries without skilled birth attendants

Year	No. of domiciliary deliveries	No. of domiciliary deliveries not attended by Skilled Birth Attendant (In percentage)	No. of new born not visited by health worker within 24 hrs of home deliveries
2011-12	3,615	2,038 (56.4)	2,242
2012-13	2,755	1,702 (61.8)	1,735
2013-14	2,241	1,488 (66.4)	1,294
2014-15	2,689	2,101 (78.1)	1,198
2015-16	2,129	1,622 (76.2)	1,058

(i) Delay and non-payment of incentives to eligible mothers

As per the guidelines, incentive payment to the mother was to be made at the time of delivery. However, it was noticed in audit that incentives were not given to mothers at the time of delivery. Number of mothers not getting incentives as on March 2016 in the State was 10,843 (backlog from Saiha district not reported) and the amount due for payment was ₹ 0.76 crore. Details of delay in payment of incentives in respect of test checked Hospitals/Sub Centres is indicated in the following table.

Table-1.4.17: Delay in payment of incentives

Facility	Upto six months	More than six months and upto one year	More than one year
District Hospital,Mamit	56	62	-
Sub Centre Cheural	7	12	6
Sub Centre Sangau	26	26	47

Audit also observed that:

- Though deliveries were conducted in Sub-Centres/Other Hospitals, payment was made in the PHC, Phuldungsei in Mamit District against the policy guideline of spot payment.
- Maintenance of JSY payment register was not updated with full address and contact number of the beneficiaries. This would make it difficult in tracking and verification of backlog payments.

(ii) Delay in payment of incentives to ASHA workers

As per the guideline, incentives to ASHA workers should be made in two instalments; 50 *per cent* for staying with pregnant woman in the health centre for delivery and 50 *per cent* one month after delivery when BCG vaccine is administered to the child and she has helped in registration of birth of the new born. In the test-checked health facility centres, there was no record to show that ASHA workers had helped the mother in this regard. Hence, the basis for payment of incentives was also not clear. Thus, audit could not draw an assurance that ASHA workers motivated the pregnant woman to opt for institutional delivery.

Further, payment to the ASHA workers was not made in time. As on March 2016, 11,102 ASHA workers did not get incentives (backlog from Saiha district not reported) of ₹ 66.61 lakh. Delay in timely payment of incentives would discourage ASHA workers in discharging their duties and it would have adverse impact on the scheme.

MD NHM stated (December 2016) that the State would ensure that beneficiaries get the incentives in time in future through introduction of Public Financial Management System and Direct Benefit Transfer payment mode.

1.4.15.2 *Janani Suraksha Karyakram* (JSSK)

Janani Suraksha Karyakram (JSSK) is an initiative which entitles all pregnant women delivering in a public institution, to free transport from home to health facility and drop back, free drugs and consumables, free diagnostics, free blood whenever required, free diet during stay in the facility. Similar entitlements are available for sick newborn till 30 days of birth.

However, it was observed that entitlements are restricted at ₹ 350 and ₹ 1,600 for drugs and consumables for normal delivery and C-section respectively, ₹ 100 per day for diet and ₹ 800 for transport. Further, it was noticed in Audit that in District Hospital Lawngtlai, 118 deliveries were conducted during March 2016 to June 2016. In respect of 110 deliveries, there were delays in payment of entitlements. In all test-checked health care centres, the payment documents did not contain detail of addresses and contact numbers of the beneficiaries.

During the exit conference, MD NHM assured (December 2016) that steps were being taken to improve the situation.

1.4.15.3 Immunisation & Child Health

An infant who has received one dose of BCG; three doses each of DPT, OPV and Hepatitis B; and one dose of Measles before one year of age is considered as fully immunized. SHS in 2012-13 set targets of achievement of 100 *per cent* full immunization by 2014-15. The achievement made is shown in the following table.

Table-1.4.18: Immunisation

Year	Target set (in percentage)	Percentage of fully immunised infants as per HMIS	Short achievement (in percent)
2012-13	90	85	5
2013-14	95	85	10
2014-15	100	81	19
2015-16	100	83	17

It can be seen from the above table that the State missed the target of full immunisation of children. The target and achievement of fully immunised infants in sample districts of Mamit and Lawngtlai as per HMIS data for the period 2012-13 to 2015-16 is as given below:

Table-1.4.19: Target and achievement of full immunisation in test-checked districts

Year	Test-checked District	Annual Target (Infants)	Fully immunised (Infants)	Percentage of fully immunised infants	State Percentage
2012-13	Mamit	1,812	1,340	66.61	85
	Lawngtlai	2,866	1,809	62.04	
2013-14	Mamit	1,780	1,243	69.50	85
	Lawngtlai	2,837	1,514	53.20	
2014-15	Mamit	1,698	1,216	72.60	81
	Lawngtlai	2,640	1,442	52.00	
2015-16	Mamit	1,698	1,479	84.80	83
	Lawngtlai	2,640	1,537	51.70	

It can be seen from the above table that the achievement in sample districts was much lower than the State average except in Mamit district during 2015-16.

MD NHM accepted (December 2016) the fact.

1.4.15.4 *Rashtriya Bal Swasthya Karyakram* (Child Health Screening and Early Intervention Services Programme)

Rashtriya Bal Swasthya Karyakram (RBSK) aims at screening children from 0-18 years for 4 Ds- Defects at birth, Diseases, Deficiencies and Development delays including disabilities. Child screening under RBSK is at two levels community level and facility level. While facility based new born screening at public health facilities like PHCs/CHCs/District Hospitals was to be conducted existing health manpower like Medical Officers, Staff Nurses & ANMs; the

community level screening would be conducted by the Mobile health teams at *Anganwadi* Centres and Government aided Schools. As per the operational guideline, Mobile health teams are required to carry out screening of all children in the pre-school age enrolled at *Anganwadi* centres at least twice a year and children studying in the Government and Government aided schools at least once in a year

As per the guidelines, a mobile health team comprises of two Medical Officers (*Ayush*), one ANM/Staff Nurse and one Pharmacist. GoI approved 11 mobile health teams in addition to the existing 18 teams. At present, there are 29 teams with overall 57 Medical Officers, 19 pharmacists and 15 ANMs in the State.

As per monthly reports, screening of the beneficiaries ranged from 80 to 102 *per cent* of the different target groups during 2013-14 to 2015-16. Achievement against targets in terms of *Anganwadi* Centres/School coverage gave a different picture as follows;

Table-1.4.20: Targets and Achievements of health screening of children

Year	No. Anganwadi centre		No. of Schools	
	To be visited	Actually visited (percentage)	To be visited	Actually visited (percentage)
2013-14	3,960	2,931 (74.02)	2,785	2,327 (83.55)
2014-15	3,960	3,323 (83.91)	2,833	2,497 (88.14)
2015-16	4,488	3,183 (70.92)	2,852	2,194 (76.93)

Thus, the authenticity of claim made in the monthly report was questionable.

MD NHM stated (December 2016) that coverage of target beneficiaries had improved in 2015-16 as compared to previous years, but the high incidence of schools not visited during 2015-16 arose because of high rainfall hampering the visit to many villages.

(i) Referral support for secondary/tertiary care

Under the guidelines of RBSK (February 2013), State should conduct mapping of public health institutions through collaborative partners for provision of specialized tests and services. Private sector partnership/ NGOs providing specialized services can also be explored in case services at public health institutions providing tertiary care are not available. `

GoI approved a total of ₹ 4.20 crore during 2013-16 for referral support to 27,357 children for surgeries under selected disease such as Rheumatic Heart Disease, Congenial Heart Disease, Cleft Lip and Cleft Palate and Dental conditions *etc*. However, the scheme for referral support for tertiary care has not been implemented in the State.

MD NHM stated (December 2016) that steps had since been taken by the RBSK State Programme Management Unit. It further added that several private and public health facilities were contacted with a request to partner with them for provision of secondary and tertiary care/ treatment to clients under RBSK, however, only a few institutes responded.

The fact, however, remains that even after a lapse of three years, tertiary care were not provided to the targeted children.

1.4.16 Family Planning

GoIlaunched 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 family planning includes terminal method to control total fertility rate and spacing methods to improve couple protection ratio.

SHS spent ₹ 1.99 crore under Family Planning programme during 2011-16.The table below indicates target and achievement of family planning during 2011-16.

Table-1.4.21: Target and achievement of family planning

Year	Vasectomy/NSV		Tubectomy		Laparoscopy		Oral pills cycle		IUD insertion	
	T	A	T	A	T	A	T	A	T	A
2011-12	10	0	3,520	2,033	Nil	157	Nil	52,400	5,000	3,036
2012-13	10	1	6,000	1,999	Nil	137	Nil	48,367	6,750	2,738
2013-14	15	0	4,750	1,732	Nil	132	Nil	64,555	5,000	2,818
2014-15	8	0	3,600	1,543	Nil	113	Nil	52,338	5,000	2,530
2015-16	4	0	3,600	1,329	Nil	75	Nil	63,599	5,000	2,480

(T= Target, A= Actual)

As per the data available with SHS, there were no cases of failures and complications in respect of IUD insertions and vasectomy cases. However, 165 complication cases and 25 failures were reported in case of Tubectomy cases during 2011-12 to 2015-16.

(i) Cash assistance to the beneficiaries of Family Planning

With a view to encourage people to adopt permanent method of Family Planning, GoI has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilisation for the loss of wages for the day on which he/ she attended the medical facility for undergoing sterilisation.

Scrutiny of the records revealed that cash assistance given to the acceptors of sterilisation in sample districts (Mamit and Lawngtlai) was delayed considerably ranging from 73 to 1,141 days during 2012-16.

(ii) Irregular supply of Family Planning materials

All the spacing methods, *viz*. Intrauterine Contraceptive Devices (IUCDs), Oral pills and condoms are required to be available at the public health facilities beginning from the Sub Centre level. Additionally, Oral pills, condoms and emergency contraceptive pills also should be available at the village level through trained ASHA workers.

Scrutiny of the records revealed that supply of materials for all the spacing methods to the districts were very irregular. The fact of the non-availability of the pills and medicines was also established during interview of 21 ASHA workers in sample districts.

1.4.17 National Iodine Deficiency Disorder Control Programme (NIDDCP)

With a view to cover a wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf-mutism, cretinism, still-birth, abortion *etc*., GoI launched a 100 *per cent* centrally assisted National Goitre Control Programme (NGCP) in 1962, renamed as National Iodine Deficiency Disorders Control Programme (August 1992). The State Government made an expenditure of ₹ 187.76 lakh under the programme during 2011-16.

As per norms, an independent Iodine Deficiency Disorders (IDD) Control Cell should be established in each State/Union Territory to supplement the resources of the States/Union Territories for augmentation of the staff and facilities of prototype material for supporting health education activities for the promotion of consumption of iodised salt for the effective control of Iodine Deficiency Disorders.

The State Government established IDD Control Cell during 1986. However, it conducted meeting only once (3 August 2012) during 2011-16. Thus, programme related works were handled by the Department without due guidance and monitoring by the IDD Control Cell.

Though the programme was implemented since long, the control and eradication of the Iodine Deficiency Disorders had not improved as observed from the surveys conducted during 2011-16. Prevalence of this disorder ranged between 6.38 and 8.24 *per cent* of the persons surveyed.

1.4.18 Quality of Health Care

1.4.18.1 Setting up of organisation structure for quality assurance

Ministry of Health and Family Welfare developed the Quality Assurance Guideline 2013 to address the concerns of the public and also the technical components of service delivery in a comprehensive manner. For strengthening the quality assurance activities, organization arrangement needs to be to set up at State Level and District Levels with the roles and responsibilities defined for each level. However, SHS has not put in place entire coordinated organization set-up/ mechanism as of March 2016. Further, due to delay in setting up of co-ordinated organisation structure, each level of the organisation had not fully assumed assigned duties and responsibilities as per the guidelines.

(i) State Level

State Quality Assurance Committee (SQAC)

SQAC was required to conduct a review meeting once in six month. However, only one meeting was conducted by SQAC during 2013-14 to 2015-16. Agenda of the meeting conducted

was also mainly on report on status of SQAU/DQAU and no review on key performance indicators (KPIs) pertaining to Reproductive, Maternal, Newborn, Child Health was done by the Committee.

While accepting the audit observation MD, NHM stated (December 2016) that the meeting would be conducted regularly and SQAC would review the KPIs in the next meeting.

State Quality Assurance Unit (SQAU):

State Quality Assurance Unit (SQAU), the working arm under SQAC visited 9 DHS only on a single occasion in 2015-16. Out of 9 reports, action was taken in respect of 4 reports only. Audit could not verify and check inputs of these reports as these reports were not made available to audit.

MD NHM stated (December 2016) that the reports were available for all the visited facilities. However, the reports were not produced to audit.

Quality Assurance Assessors (Empanelled):

SQAU was constituted recently in April 2016, even though State Quality Assurance Committee (SQAC) was formed in November 2014. Names of empanelled Quality Assurance Assessors notified by the State were not made available to audit.

MD NHM stated (December 2016) that the State would prepare and issue the State Empanelment letter as soon as possible.

(ii) District Level

District Quality Assurance Committee (DQAC):

No meeting was conducted by DQAC against the mandate of once in a quarter. No monthly data on key performance indicators of District Hospitals was received by DQAC/DQAU in two sampled districts during 2013-14 to 2015-16. In the absence of fully functional District units (DQAU), no field visits could be conducted by the units of sampled districts.

District Quality Assurance Unit (DQAU):

No DQAU was put in place with required functionaries as per guidelines and only one programme assistant was engaged in all districts except Aizawl West.

The MD NHM stated (December 2016) that DQAC/DQAU was not fully functional due to shortage of manpower and with the approval of three posts of the Consultant in three Districts, DQAC would be functional within the Financial year.

(iii) District Hospital Level

District Quality Team (DQT) was available in each sampled district.

DQT which requires reporting regularly to DQAC/DQAU on the outcome level indicators such as sterilisation deaths, complication and failures as well as maternal and infant deaths

did not report to the DQAC/DQAU in the sampled districts. Teams in the sampled districts did not conduct audit on the death cases. DQTs failed to have internal assessment of the facilities.

The MD NHM while accepting the audit observation stated (December 2016) that DQTs would start to review, audit and report as the State Quality Assurance Programme had since taken up the Family Planning Indemnity Scheme.

1.4.19 Findings of survey

- **Survey of pregnant women registered under JSY**

Interview of 71 beneficiaries in two districts revealed that beneficiaries were aware of the schemes such as JSY and JSSK and role of ASHA workers *etc*. and they were also getting benefits from the health schemes implemented in the State. Summary of the survey findings of pregnant woman is as shown in the following table.

Table-1.4.22: Summary of Survey findings of pregnant women

Sl. No.	Total number of beneficiaries interviewed	Health workers not visited within 2-7 days	Extra expenditure during delivery	Delay in payment of incentives
1	71	8	15	52

- **Survey for ASHA workers**

Every ASHA worker is expected to be a fountain-head of a community participation in public health programme in her village. She is to be provided a drug kit to deliver first contact health care. During the interview of 21 ASHA workers in the two sample districts, audit found that required equipment/ pregnancy kits and medicines *etc.,* were not available with many of them. Findings of the interviews of ASHA workers are summarised below:

Table-1.4.23: ASHA workers without equipment/medicines

District	No. of ASHA workers	Thermo-meter	Disposable Delivery Kit	Pregnancy Kit	Blood Pressure Monitor	Weighing Scale	Paracetamol Tablets	Iron Pills	Deworming Pills
Lawngtlai	8	3	8	2	7	Nil	3	5	7
Mamit	13	6	13	6	13	2	12	10	12

The MD NHM while accepting the audit observation stated (December 2016) that the proposal was made for procurement of ASHA worker equipment in the PIP 2015-16.

1.4.20 Data collection, management and reporting

1.4.20.1 Health Management Information System (HMIS)

NRHM framework envisages intensive accountability structures based on internal monitoring through computer based monthly Health Management Information System (HMIS). Each DHS was to develop a computer based Management Information System and report monthly to the SHS. The computerization of health centres under NRHM up to block level and networking were necessary for reporting through HMIS.

However, it was noticed in audit that the reporting from the block/main centres was not done in the sample districts due to internet connectivity problem. Consolidation in the District/ State Level was also not fully inclusive due to non-updating of data of the centres in time.

In Lawngtlai District, during 2015-16, out of the total reports of 468 from Sub Centre to be compiled, only 425 reports were consolidated. In case of PHCs, only 52 reports consolidated against 60 reports to be generated. Thus, the data provided during 2015-16 were not realistic.

MD NHM while accepting the audit observation stated (December 2016) that concerned district officials were always instructed to submit the missing reports.

Further, it was noticed that there was a mismatch between data in HMIS and information furnished by sample Sub Centre/ PHCs/ CHCs regarding number of pregnant women registered and number of deliveries at PHCs/ CHCs for the year 2015-16, as indicated in the following table.

Table-1.4.24: Comparison of HMIS data

Item	HMIS data	Information provided by sample health care centres
Number of pregnant women registered at Sub Centre	740	709
Number of delivery at PHCs	356	403
Number of deliveries at CHCs	315	680

MD NHM stated (December 2016) that HMIS reports generated by the health centres were not modified or changed at any level or at the data entry point and assured that discrepancies in HMIS reports and data provided by health care centres would be checked properly. The State Government need to ensure data authenticity as the success of NRHM was dependent on accurate data.

1.4.20.2 Mother Child Tracking System (MCTS)

Mother Child Tracking System (MCTS) is a name-based tracking system whereby pregnant women and children can be tracked for their Ante Natal Care and immunisation along with a feedback system for the ANM, ASHA workers *etc.,* to ensure that all pregnant women receive their ante-natal care check-ups and post-natal care, and further children receive their full immunisation. MCTS is still not up to the mark in Mizoram due to poor internet service connectivity in the rural districts. Presently, data feeding has been done at National Informatics Centre (NIC) for the whole state by outsourcing staffs from September 2015. During 2015-16, State could register 82 and 96 *per cent* of the pregnant women and children respectively.

1.4.20.3 Infrastructure of facility based reporting

With a view to 100 *per cent* facility based reporting on HMIS and MCTS, GoI approved a new activity ‘procurement and installation of V-Sat (including all hardware like Antenna, router/

indoor unit) for State and District Head Quarters' with a cost of ₹ 15 lakh during 2015-16. For Aizawl East and Aizawl West Districts, 2 Mbps dedicated lease line internet connection was installed, whereas V-Sat internet connections with cost of ₹ 11 lakh were provided in 7 district headquarters. However, functioning of V-sat connection was reported to be inadequate for data uploading. During field visit in Lawngtlai, Audit found that installed internet facility was not working.

1.4.21 Monitoring and Evaluation

1.4.21.1 Monitoring and Evaluation at the State Level

Mission envisages review of the implementation of the scheme by the State Health Mission, the Governing Body and the Executive Committee as per the mandates stipulated. Scrutiny of records revealed that the State Health Mission, Governing Body and Executive Committee did not perform their mandated duties and responsibilities as discussed in the following list:

- State Health Mission under the Chairmanship of the Chief Minister has to provide health sector oversight, consider the policy matter relating to health sector and review of the progress in implementation of NRHM *etc.*

  However, the State Health Mission reviewed the scheme once in September 2014 during 2011-12 to 2015-16, against its mandate of once in six months.

- Governing Body will have full control of the affairs of the Society and it should consider the annual budget and annual action plan and monitor the financial position of the society *etc*.

  However, the Body held its meeting once in August 2014 during audit period, against its mandate of twice in a year.

- Executive Committee will be responsible for acting for and doing all deeds on behalf of the Governing Body. The Committee was required to hold a meeting at least once in three months or more frequently if necessary.

  However, only five meetings against the required 20 meetings were held during the five year period.

1.4.21.2 Constitution of District Level Vigilance and Monitoring Committees

As per the NRHM framework, District/City Level Vigilance and Monitoring Committees (District/City Level VMC) under the Chairmanship of a Member of Parliament (*Lok Sabha*) in each District/ City is required to be constituted to monitor the progress of implementation of NHM. The District/City Level VMC would also review strict adherence to prudent fiscal norms, inter-sectoral convergence, community participation and monitoring.

Further, as per norms, meetings of the District/City Level VMC at each level are to be held at least once in every quarter after giving sufficient notice to the Hon'ble MPs/MLAs and all other members. At the end of every quarter, the State Government will provide the detailed

status reports of the meetings of the District/City Level VMC held, after compiling the requisite information received from the districts.

Scrutiny of the records revealed that District Level Vigilance and Monitoring Committees were constituted in four districts during 2010-12, in two districts during 2012-14 and in the remaining two districts (Aizawl and Kolasib) District/City Level VMC were constituted only during 2014-15. Further, numbers of meetings held by the District Level VMC at each district level were very less ranging from four to seven only against the requirement of 20 meetings at each district level during 2011-16. Thus, delay in constitution of District/City Level VMC. VMCs and non-arranging the required meetings adversely affected the community based monitoring of activities and relevant inputs for the integrated planning.

1.4.21.3 Public hearing/dialogue and non-display of Citizen Charter not conducted

NRHM framework stipulates that public hearing (*Jan Sunwai*) or public dialogues (*Jan Samwad*) would need to be conducted and Citizen Charter need to be displayed at health facilities.

Scrutiny of the records revealed that *Jan Sunwai* and *Jan Samwad* were not conducted and Citizen Charter was not displayed at health facilities in the state of Mizoram during 2011-16.

1.4.21.4 Impact of NRHM on MMR and IMR

Millennium Development Goals (MDG) (2015)[11] set to reduce IMR to 27/1000 live births and MMR to 109/100,000 live births by 2015. However, the targets set by the State Government to reduce IMR was not in line with MDG and in respect of MMR it was better than MDG. As of 31March 2016, the State was able achieve MDG both in respect of IMR and MMR and stood at (i) IMR-26/ 1000 live births and (ii) MMR-100/100000 live births. However, there was fluctuation during the period 2011-16 as could be seen from the following table.

Table-1.4.25: State Position of IMR, MMR

Year	IMR		MMR	
	Target	Achievement	Target	Achievement
2011-12	30	29	92	55
2012-13	35	28	65	61
2013-14	32	35	60	76
2014-15	34	37	70	95
2015-16	32	22	60	88

A comparison of audited districts with State reflected a fluctuating trend. In Lawngtlai District, MMR was high as compared with Mamit and State as shown in the following table.

[11] The **Millennium Development Goals** (**MDGs**) were the eight international development goals for the year 2015 that had been established following the Millennium Summit of the United Nations in 2000. All 189 United Nations member states at that time committed to help achieve the following Millennium Development Goals by 2015. Each goal had specific targets, and dates for achieving those targets.

Table-1.4.26: Comparison with audited district

	2011-12		2012-13		2013-14		2014-15		2015-16	
	IMR	MMR	IMR	MMR	IMR	MMR	IMR	MMR	IMR	MMR
Mamit	26	142	12	0	21	87	31	79	16	164
Lawngtlai	31	53	28	115	35	248	33	53	26	185
State	29	55	28	61	35	76	37	95	22	88

1.4.22 Conclusion

Facility surveys intended for identifying the health care needs of the people at the grassroots were not conducted in the State. District Health Action Plans were prepared without aggregating the Block and Village Health Action Plan. State Health Society is routinely giving temporary loan to other programmes from Mission Flexipool. Monitoring of utilisation of substantial funds released needs strengthening and institution of systems as funds were not released in time. The loans to the tune of ₹ 15.40 crore released during 2011-16 from the Mission Flexipool fund to the various programmes were not returned to the Mission Flexipool. Further, ₹ 4.16 crore was spent on upgradation of CHCs at Khawzawl & Hnahthial from the Mission Flexipool without approval of GoI. Out of 49 Sub Centres (SC) reconstructed/constructed during 2012-14, seven SCs constructed with ₹ 45.14 lakh were non-operational, while civil works of ₹ 1.02 crore were taken up in Mamit and Lawngtlai without calling of tenders during 2011-16. MMU intended to serve outreach areas with an aim of taking the health care to the doorstep of the needy people were not fully functional as per aims and objectives envisaged under the Mission. Overall, six X-ray machines, six Ultrasound machines, seven ECG machines, and six power back up were non-functional resulting in grounding of vehicles. Under *Janani Suraksha Yojana*, ₹ 1.43 crore was due for payment to eligible pregnant mothers and ASHA workers as on March 2016. Further, Monitoring on implementation of the scheme by the State Health Mission/ Governing Body and Executive Committee is in adequate.

1.4.23 Recommendations

The Government may consider to:

- undertake a comprehensive baseline survey to assess health service needs and plan effectively for the creation of requisite physical and human infrastructure to meet the gaps in health services within a reasonable time frame;
- ensure all provisions relating to financial management are followed, to ensure timely implementation of the programme;
- ensure procurement through open, transparent and competitive systems to maximize value for money
- ensure that the mobile medical units in the State are made operational; and,
- ensure that incentives under JSY are paid in time and referral services for tertiary care is provided to children of specific health conditions under Child Health Screening and Early Intervention Services Programme.

COMPLIANCE AUDIT PARAGRAPHS

SOCIAL WELFARE DEPARTMENT

1.5 Grant of old age pension to ineligible beneficiaries

Social Welfare Department granted old age pension of ₹ 1.48 crore to ineligible beneficiaries during 2010-15.

In pursuance of the Directive Principles of State Policy in the Constitution of India GoI introduced the National Social Assistance Programme (NSAP) in 1995 to lay the foundation for a National Policy for Social Assistance to the poor.

Indira Gandhi National Old Age Pension Scheme (IGNOAPS) is one of the schemes under NSAP. As per revised guidelines (September 2007) of the IGNOAPS, central assistance is to be provided for Old Age Pension strictly according to the following conditions:

- Age of applicant shall be 65 years or higher (60 years and above since 1 October 2012),
- The applicant must belong to a household Below the Poverty Line (BPL) according to the criteria prescribed by GoI,
- Amount of Old Age Pension will be ₹ 200 per month per beneficiary and ₹ 500 per month since 1 April 2011 for age group of 80 years and above for the purpose of claiming central assistance, and
- GoI recommended (November 2012) that for all pension schemes of NSAP, the State may contribute at least an equal amount so that a pensioner receives at least ₹ 400 per month with effect from 1 October 2012.

Scrutiny (September 2015) of the records of the District Social Welfare Officer, Aizawl East revealed that the Department prepared beneficiary list every year. However, while preparing the beneficiary list, non-BPL beneficiaries getting old age pension under IGNOAPS before revised guidelines of September 2007 were not deleted from the beneficiary list. The Department sanctioned and disbursed Old Age Pension totalling to ₹ 1.48 crore to 3356 and 804 beneficiaries of non-BPL households in the age group less than 80 years and 80 years & above respectively during 2010-11 to 2014-15 as shown in the following table

Table-1.5.1

(₹ in crore)

Year	Pension disbursed to Non-BPL Pensioners age group of upto 79 years		Pension disbursed to Non-BPL Pensioners age group of 80 years and above		Total amount disbursed to Non-BPL pensioners
	No.	Amount	No.	Amount	
2010-11	675	**0.20**	160	0.05	**0.25**

Year	Pension disbursed to Non-BPL Pensioners age group of upto 79 years		Pension disbursed to Non-BPL Pensioners age group of 80 years and above		Total amount disbursed to Non-BPL pensioners
	No.	Amount	No.	Amount	
2011-12	660	**0.20**	162	0.11	**0.31**
2012-13	671	**0.20**	158	0.10	**0.30**
2013-14	674	0.20	161	0.11	**0.31**
2014-15	676	0.20	163	0.11	**0.31**
Total	**3,356**	**1.00**	**804**	**0.48**	**1.48**

Source: Departmental records

While accepting the facts the District Social Welfare Officer, Aizawl East stated (January 2016) that the pension was disbursed to the destitute beneficiaries selected before the introduction of the revised Guidelines 2007.

The contention is not acceptable because the payments had been made during 2010-15. This has happened due to failure of the District Social Welfare Officer to delete non-BPL beneficiaries from the eligible beneficiary list in conformity with the Revised Guidelines 2007 which led to payment totalling to ₹ 1.48 crore to the ineligible non-BPL beneficiaries.

HEALTH & FAMILY WELFARE DEPARTMENT

1.6 Infructuous expenditure

The Director, Hospital & Medical Education under Health & Family Welfare Department incurred an infructuous expenditure of ₹ 50 lakh due to installation of water treatment plants at five Government Hospitals without ensuring water source for water treatment plants.

Public Health Engineering (PHE) Department, Government of Mizoram (GoM) is responsible for distribution of water to Government Hospitals on payment basis.

Scrutiny (August 2015) of the records of Office of the Director, Hospital & Medical Education (H&ME) revealed that a Gurgaon based firm[12] submitted a *suo moto* proposal (01 February 2012) to the then Minister of Health & Family Welfare (H&FW) Department, GoM for setting up of 25,000 Litre Per Day (LPD) water treatment plant (WTP) with solar powered pumping system at one referral and eight District Hospitals in Mizoram on Build, Own, Operate and Transfer (BOOT) basis. The proposal *inter-alia* included that the firm would undertake the geological survey and identify the water sources for the WTPs. Under the direction of the Minister, H& FW Department, the proposal was sent to the Director, H&ME to take immediate action.

[12] M/s INTERGEN Energy Limited, Sohna road, Gurgaon

Further, it was noticed that the Director, H&ME, without carrying out the economic viability analysis of the proposal with reference to the requirement of water and proposed recurring cost towards water bills entered into Memorandum of Understandings (MoUs) (May/December 2012) with the firm. Subsequently, purchase orders were issued (between February 2012 and October 2012) to the firm for installation of five 25,000 LPD solar water treatment plants at one referral and four District Hospitals[13]. It was observed that though the firm proposed to identify the water sources for WTPs, the same was not included in the MoUs as well as purchase orders. Reasons for this omission were not on record. Thus, purchase orders were issued without ensuring the source of water for the WTPs. The purchase orders provided that (a) the firm would operate and maintain the water treatment plants for the first ten years and thereafter ownership would be transferred to the Government hospitals, (b) the hospitals would pay 48 paisa per litre of water produced by the firm for the first ten years and (c) Rupees ten lakh would be paid as an advance to the firm and the balance amount required for execution of the project would be brought in by the firm. The firm installed the WTPs between March 2013 and December 2013.

The Director disbursed (between March 2012 and February 2014) ₹ 50 lakh to the firm for installing the five plants in the District level Hospitals.

Further, scrutiny revealed that the water treatment plants at Government Hospitals, Aizawl and Lawngtlai were not functional since installation, while other three plants at Government Hospitals, Falkawn, Mamit and Champhai remained non-operational since April, August and June 2013 respectively due to non-availability of water source. The Directorate of H&ME paid ₹ 12.84 lakh to the firm for supply of 26.75 lakh litres of water to the three hospitals.

In (November 2014) the firm offered to transfer the water treatment plants to the Government at a cost of ₹ 8.43 crore which was not agreed to. In (November 2014) the Director, H&ME recommended the Department to approach the Ministry of DONER, GoI for possible funding under NLCPR for procurement of WTPs, but, the Department did not pursue the matter. The WTPs remained idle and presently the requirement of water of the hospitals is being met from the supplies through PHE Department and rain water harvesting.

Thus, due to installation of water treatment plants at Government Hospitals without ensuring water source, expenditure of ₹ 50 lakh on water treatment plant proved to be infructuous.

The Department stated (December 2016) that as per Clause 3 of the MoU the firm was responsible for making necessary survey and investigations required for the Project and supposed to ensure the availability of water sources for installation of WTPs. It further added that the District Medical Superintendents were instructed to verify and report the present condition of the WTPs.

[13] (i) State Referral Hospital, Falkawn, (ii) District Hospital (DH), Lawngtlai, (iii) DH, Mamit, (iv) DH, Champhai and (v) Civil Hospital, Aizawl

The fact remains that full payment (₹ 50 lakhs) had been released to the firm even though the WTPs were not functioning. Thus, expenditure of ₹ 50 lakh incurred for installation of WTPs proved to be infructuous because WTPs could not be operational due to lack of water source.

FOLLOW UP OF AUDIT OBSERVATIONS

1.7 Non-submission of *suo moto* Action Taken Notes (ATNs)

With a view to ensure accountability of the Executive in respect of all the issues dealt with in various Audit Reports, the Public Accounts Committee (PAC), issued (May 2000) instructions for submission of *suo moto* ATNs on all paragraphs and reviews featured in the Audit Report within three months of its presentation to the Legislature. For submission of the Action Taken Notes (ATNs) on its recommendations, the PAC has provided six months' time.

A review of follow up action on submission of *suo moto* ATNs disclosed that there were pendency in respect of the Audit Reports for the years 2011-12 to 2013 14. The Audit Report for the year 2014-15 was laid on the table of the State legislative assembly on 31 August 2016, replies were awaited (February 2017).

1.8 Response to audit observations and compliance thereof by the Executive

Accountant General (Audit) conducts periodical inspections of Government Departments to test-check the transactions and verify the maintenance of significant accounting and other records as per the prescribed rules and procedures. These inspections are followed by Inspection Reports (IRs) issued to the Heads of Offices inspected, with a copy to the next higher authorities. Rules/ orders of the Government provide for prompt response by the Executive to the IRs issued by the Accountant General and to give a reply within a month of issuance of IRs.

As of March 2016, a review of the outstanding IRs issued during 2008-16 revealed that 595 paragraphs relating to 131 IRs remained outstanding as shown in the following Table:

Table-1.8

Name of the Sector	Opening Balance (up to 2013-14)		Addition during the year 2014-15		Disposal during the year 2014-15		Closing Balance	
	IR	Paras	IR	Paras	IR	Paras	IR	Paras
Social	118	518	43	223	30	146	131	595

1.9 Audit Committee Meetings

State Government had notified (04 September 2013) constitution of an Audit Committee to consider and take measures for timely response and speedy settlement of outstanding paragraphs of Inspection Reports lying in different Departments.

During 2015-16, three audit committee meetings were held in which 67 paragraphs were settled.