CHAPTER-I

SOCIAL SECTOR

CHAPTER I: 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 units under Social Sector.

The names of the major State Government departments and the net budget provision and expenditure of the State Government under Social Sector during the year 2015-16 are given in the table below:

Table 1.1.1 - Net budget provision and expenditure of major departments

(₹ in crore)

Sl. No.	Name of Department	Budget Provisions (Original and Supplementary)	Expenditure
1.	Education, Sports & Youth Affairs & Arts and Culture	1519.55	1282.89
2.	Health & Family Welfare	589.11	604.87
3.	Public Health Engineering	505.51	323.12
4.	Urban Development	189.55	49.01
5.	District Council Affairs and Social Welfare	195.58	189.99
6.	Labour	48.04	27.84
7.	Housing	77.57	68.63
8.	Revenue	58.58	56.84
	Total	**3183.49**	**2603.19**

Source: Budget Estimates and Appropriation Accounts

1.1.1 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 and concerns. The audits were conducted during 2015-16 covering the expenditure of ₹ 1,054.85 crore incurred by various departments (including expenditure pertaining to previous years audited during the year) of the State Government under Social Sector. The chapter contains Performance Audits on 'Right of Children to Free and Compulsory Education Act, 2009' and 'National Rural Health Mission' and two Compliance Audit paragraphs.

The major observations under Social Sector detected in audit during the year 2015-16 are given below:

PERFORMANCE AUDIT PARAGRAPHS

EDUCATION DEPARTMENT

1.2 Right of Children to Free and Compulsory Education Act, 2009

Highlights

Education is one of the most important indicators of social progress of a nation. The Government of India had formulated the National Education Policy in the year 1986 and Right to Education Act in 2009 which inter alia provided universal elementary education of good quality for children of the age group 6-14 years through provision of schools with appropriate infrastructure and within an approachable distance. The policy was implemented under the flagship programme Sarva Shiksha Abhiyan (SSA) financed by the Government of India and the State Government in the ratio of 90:10. In exercise of the powers conferred by the RTE Act, Meghalaya Right of Children to Free and Compulsory Education (MRCFCE) Rules was notified in August 2011 by the Government of Meghalaya (GoM). Though the State had achieved enrolment level of 95 to 98 per cent during 2010-16, the performance audit revealed deficiencies in preparation of perspective plan, attainment of universal elementary education, coverage of Out of School Children (OOSC) and Children with Special Needs (CWSN), alarming proportion of untrained teachers, inadequate infrastructural facilities, funds lying unfruitful in incomplete civil works, shortages in distribution of free textbooks and uniforms, short release of funds by the GoI and GoM and lack of adequate supervision and monitoring.

Annual Plan was being prepared without having a perspective plan and without interacting with the community at village/habitation level.

(Paragraphs 1.2.7.1 & 1.2.7.2)

There was lack of basic amenities and facilities such as safe drinking water, library, electricity and playground and shortages in uniform grant, availability of free textbooks and shortages in grant of transport allowance.

(Paragraphs 1.2.8.6 (i), 1.2.8.7 & 1.2.8.8)

Expenditure of ₹ 483.88 crore incurred on incomplete civil works were lying unfruitful for periods of three to six years.

(Paragraph 1.2.8.10)

Seventy seven *per cent* of Primary School Teachers and eighty five *per cent* of Upper Primary School Teachers were untrained. There was a shortage of 1,748 teachers in Primary School with 224 Primary Schools having only one teacher with 7,769 children enrolled therein.

(Paragraphs 1.2.8.11 (i) and (ii))

Provision of reserving 25 *per cent* of the strength of the class in unaided schools for children belonging to weaker sections and disadvantaged groups was not being implemented.

(Paragraph 1.2.8.12 (ii))

Funds amounting to ₹ 908.46 crore were short released by the Government of India (₹ 830.16 crore) and State Government (₹ 78.30 crore) due to inadequate spending of funds.

(Paragraph 1.2.9)

Monitoring and supervision of the scheme in terms of constitution, composition and meetings of the State Advisory Committee, constitution and functioning of the Meghalaya State Commission for Protection of Child Rights, inspections and internal audit was not satisfactory.

(Paragraph 1.2.10)

1.2.1 Introduction

Elementary education is one of the most important sectors of socio-economic development with tremendous potential to enhance all aspects of quality of human life. Government of India (GoI) included education in the Concurrent list in the year 1976 and also brought out a National Policy of Education in 1986 which was updated in 1992. Article 21A[1] of the Constitution of India states that the State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine.

GoI also formulated the Right of Children to Free and Compulsory Education (RTE) Act in 2009 which *inter alia* provides universal elementary education of good quality for children of the age group 6-14 years through provision of schools with appropriate infrastructure and within an approachable distance. The policy is implemented under the flagship programme Sarva Shiksha Abhiyan (SSA) financed by the GoI and the State Government in the ratio of 90:10. The SSA Framework of Implementation and Norms for Intervention has been revised to correspond to the provision of RTE Act.

In exercise of the powers conferred by Sec 38 of the RTE Act 2009, 'The Meghalaya Right of Children to Free and Compulsory Education (MRCFCE) Rules' was notified in August 2011 and amended in May 2014 by the Government of Meghalaya (GoM).

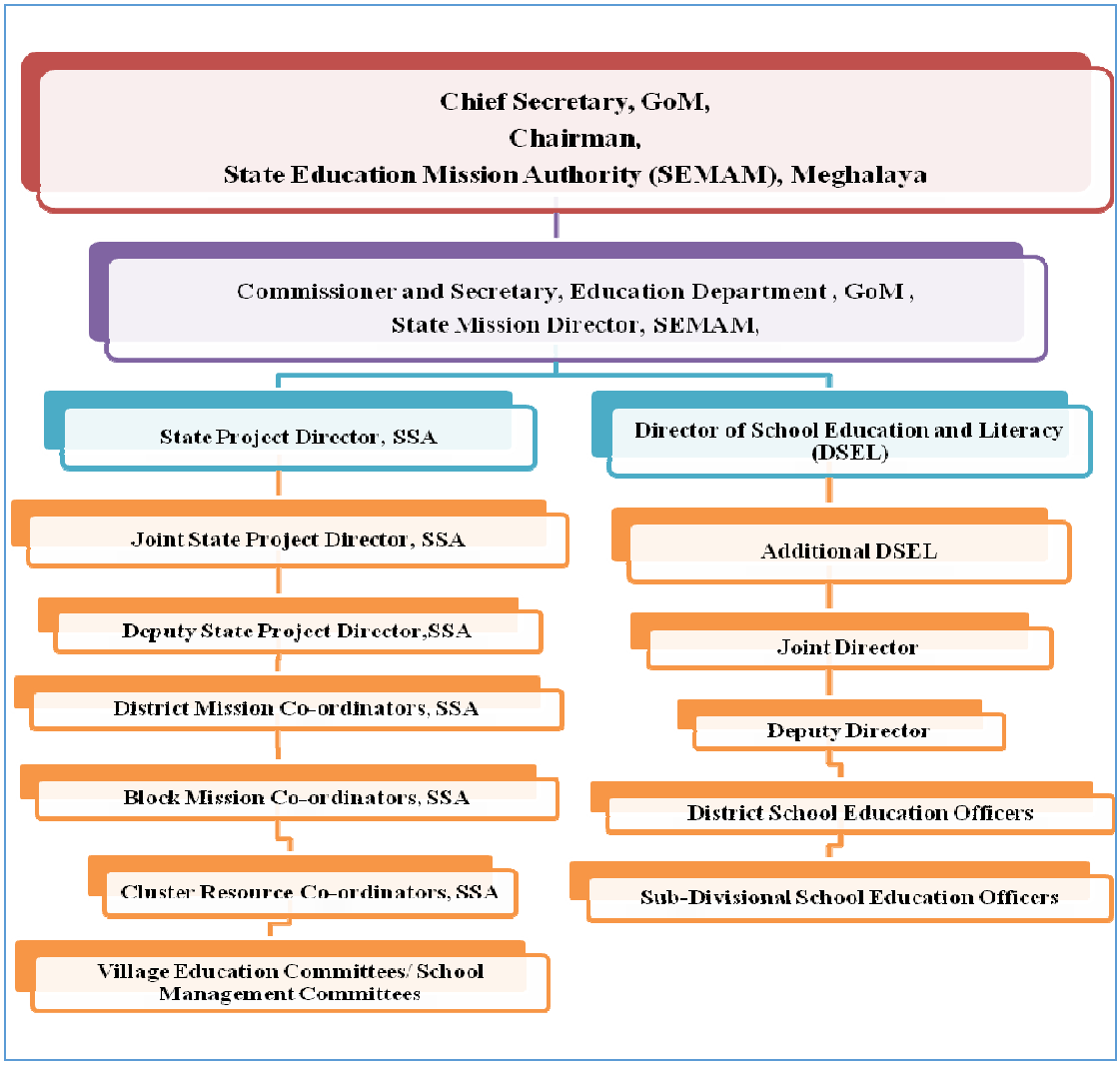
Organisational set up

The RTE Act is being implemented by the State Education Mission Authority, Meghalaya (SEMAM) constituted in July 2002 and registered under the Meghalaya Societies Registration Act, 1983. The SEMAM is headed by the Chief Secretary,

[1] The Constitution (Eighty-sixth Amendment) inserted Article 21 A in 2002.

Government of Meghalaya as its Chairman and he is assisted by the Commissioner & Secretary, Education Department as Mission Director, State Project Director (SPD) and Director of School Education and Literacy (DSEL) at State level. At field level, the scheme is implemented through District Mission Co-ordinators (DMCs)/District School Education Officers, Block Mission Co-ordinators (BMCs)/Sub-Divisional School Education Officers (SDSEOs), Cluster Resource Co-ordinators (CRCs) and Village Education Committees (VECs)/School Management Committees. The organisational chart is shown below:

Chart -1.2.1 – Organisational chart



1.2.2 Scope and methodology of Audit

The Performance audit covered the period from 2010-11 to 2015-16. The Performance audit commenced with an Entry Conference held on 15 April 2016 wherein the audit objectives, criteria, scope and methodology were discussed. It was attended by the Commissioner & Secretary, Education Department, GoM, State Project Director, SSA, Special Officer, SSA and Officials from the Finance Wing of SEMAM. The draft

Report was issued to the SPD, SEMAM and Principal Secretary, Finance Department, Government of Meghalaya in November 2016.

After completion of audit, the audit findings were discussed with the Commissioner & Secretary, Education Department, Government of Meghalaya and State Project Director, SEMAM in an exit conference held on 25 November 2016. The replies and views of the Department have been incorporated at appropriate places.

1.2.3 Audit Sampling

As per the Sampling methodology, three districts (out of seven) were selected using Probability Proportionate to Size (PPS) with number of schools in the district determining the size. Four Blocks in each selected districts were selected using Simple Random Sampling Without Replacement (SRSWOR) method. From the three selected districts, 90 schools (30 schools in each district) were selected using SRSWOR. The number of schools selected included 70 *per cent* having both Primary and Upper Primary schools and 30 *per cent* schools having Primary and/or Upper Primary classes as detailed below:

Table-1.2.1 – Districts/Blocks/Schools selected

Sl. No.	Name of the selected district	Name of the selected blocks	No. of schools selected from the Block		
			Govt.	Aided	Total
1	West Garo Hills	i. Betasing	10	3	13
		ii. Dalu	4	1	5
		iii. Dadenggiri	4	2	6
		iv. Tikrikilla	3	3	6
		Sub-Total	**21**	**9**	**30**
2	East Khasi Hills	i. Mawphlang	5	2	7
		ii. Mawsynram	10	3	13
		iii. Pynursla	5	3	8
		iv. Shella Bholaganj	1	1	2
		Sub-Total	**21**	**9**	**30**
3	Jaintia Hills	i. Amlarem	5	2	7
		ii. Laskein	6	3	9
		iii. Khliehriat	4	2	6
		iv. Thadlaskein	6	2	8
		Sub-Total	**21**	**9**	**30**
		Grand Total	**63**	**27**	**90**

1.2.4 Audit Objective

Performance audit of the RTE Act was carried out to ascertain whether:-

- the RTE Act achieved its objective to make elementary education as fundamental right for all children between ages of 6-14 years within 3 years,
- the funds allocated were being utilised in an economic and efficient manner,
- the RTE Act was being implemented and monitored in a planned manner.

1.2.5 Audit Criteria

The findings were benchmarked against the following sources of criteria:

- Right of Children to Free and Compulsory Education Act, 2009
- Rules laid down for Right of Children to Free and Compulsory Education Act, 2009
- Scheme guidelines based on Right of Children to Free and Compulsory Education Act, 2009
- Meghalaya Right of Children to Free and Compulsory Education Rules, 2011
- Various orders, notifications, circulars, instructions issued by MHRD/State Governments
- Annual Work Plan and Budget prepared by MHRD/ State Government
- District Information System for Education
- Other Guidelines under RTE Act, 2009.

1.2.6 Acknowledgement

The Indian Audit and Accounts Department acknowledges the cooperation of the Education Department of the State Government and the State Education Mission Authority, Meghalaya (SEMAM) in providing necessary information and records for audit.

Audit Findings

1.2.7 Planning

Proper planning is the key factor for any department to achieve the targeted goal as per vision of the Government. Planning is a process for identifying the needs that exist in a particular area for achieving specific goals, evolving strategies to address them and proposing suitable activity as per the strategy. Deficiencies noticed in planning process are discussed in the following paragraphs:

1.2.7.1 Perspective plan not prepared

As per Financial Management and Procurement (FMP) Manual of SSA, the State and districts were required to prepare Perspective plan to achieve universalisation of elementary education by March 2013. Keeping the Perspective Plan in view, the Annual Plan was required to be prepared every year.

Scrutiny revealed that Annual plans for 2010-16 were prepared at the Blocks, Districts and State level after holding workshops. These Annual Plans were however, framed without preparing the Perspective Plan. In the absence of Perspective Plan which defines the overall goals and targets, the programmes of SSA were implemented on the basis of Annual targets alone without proper consideration of long term goals. As a consequence, the enrolment of children under elementary education which was supposed to be universalised by March 2013 had not been achieved even upto 2015-16 (as discussed in ***paragraph 1.2.8.2).***

The Special & Nodal Officer, RTE, DSEL-SSA while accepting the audit observation stated (August 2016) that the State Education Department was implementing the National Programme on School Standards and Evaluation (Shala Siddhi) from 2016-17 in all schools incorporating the Meghalaya School Improvement Plan (MSIP) to understand the need based aspects of schools at the ground level. A Perspective plan will be developed from the outcome of MSIP.

1.2.7.2 Bottom up approach of planning not adhered

The Planning process was required to follow a bottom up approach by constituting planning teams at village/habitation, block and district level. These planning teams were required to visit each habitation, interact with community and hold consultative meetings ensuring participatory planning. The planning teams at village/habitation level were however, not constituted during 2010-16. School Development Plan, which is the fundamental requirement for planning was not prepared by many schools (discussed in ***paragraph 1.2.8.12 (v)***). The Annual plans were being prepared at the Block, District and State level after holding workshops alone.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) that SSA is following a bottom up approach as Block level Officers collect plan proposals from the School Management Committees and collate it into the District Plan. He however, admitted that documentation of school development plans had not been rigorously followed. He also mentioned that with implementation of MSIP, the planning process would improve in the near future.

1.2.7.3 Household surveys not done

The main source of data required for planning and plan formulation were household surveys (HHS), yearly updation of HHS data, District Information System for Education (DISE) data and research studies. HHSs were however, not conducted by the SEMAM and yearly planning was based on the projections of Census and District Information System for Education (DISE) data alone.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that paucity of funds limited the HHS activities.

1.2.8 Programme Implementation

Programme implementation deals with access of children to school, enrolment, out of school children, Pupil Teacher Ratio, creation of school infrastructure, release of various grants to schools, distribution of free textbooks and uniforms, interventions for special focus groups and quality of education, access to computers, availability of classrooms, availability of qualified teachers and teacher's training. Irregularities noticed by audit in the programme implementation are discussed below:

1.2.8.1 Access of children to school

As per Rule 4 of the Meghalaya Right of Children to Free and Compulsory Education Rules 2011, a primary and an upper primary school shall be established within a

walking distance of one kilometre and three kilometres of the neighbourhood respectively.

As of March 2011, there were 356 habitations having 1,856 children which did not have access to primary schools. By March 2016, while the number of eligible habitations decreased to 50, number of children without primary schools increased to 1,999. The position was however, better in respect of children having access to upper primary schools since only 165 children in 3 habitations did not have upper primary schools as of March 2016 compared to 2,320 children in 453 habitations in March 2011.

On being pointed out, the Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) that the State had continuously sent proposals to the GoI for new schools in habitations without school under Annual Working Plan and Budget (AWP&B) which had however, not been sanctioned due to absence of neighbourhood norms based on population as brought out in ***paragraph 1.2.8.12 (i).***

1.2.8.2 Enrolment

The RTE Act 2009 stipulates that every child of the age of six to fourteen years shall have the right to free and compulsory education in a neighbourhood school till the completion of his or her elementary education. The status of eligible children (6-14 years) and their enrolment[2] during 2010-16 in the State is given in the table below:

Table-1.2.2 - Status of enrolment in the State

(Units in number)

Particulars	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Child population (6-14 years age)	N/A*	618740	627856	630729	633431	627781
Enrolled (6-14 years)	563314	591528	596212	605767	611230	614283
Percentage of enrolled	-	96	95	96	96	98

Data not available
Source: DSEL, Shillong

It would be seen from the above that the status of enrolment in the State ranged between 95 *per cent* and 98 *per cent* during 2010-16. Enrolment at the end of 2015-16 stood at 98 *per cent* while 13,498 children were not enrolled in schools. As such, the State which already had an enrolment level of 96 *per cent* in 2011-12 could register an increase to 98 *per cent* at the end of 2015-16 thereby failing to achieve universalisation of the elementary education by March 2013 as envisaged under the Act.

The State Project Director, SEMAM stated (January 2017) in his reply that SEMAM used the Census data (2011) regarding number of children between age group 6-14 years up to 2012-13. However, all out efforts have been made to improve enrolment after completion of household survey taken up recently.

Further, details of enrolment (6-14 years only) in Government schools[3] and other schools during the period covered by audit are detailed in the table below:

[2] In Government, Government Aided, SSA and all other schools
[3] Government, Government Aided, and SSA schools

Table-1.2.3-Status of enrolment in Government *vis-a-vis* other schools

(Units in number)

Year	Enrolment in				Enrolment in other schools	Grand total of enrolment
	Government	Government Aided	Schools opened under SSA Scheme	Total		
2010-11	117986	201509	164442	483937	79377	563314
2011-12	123639	202535	173279	499453	92075	591528
2012-13	123709	185728	170542	479979	116233	596212
2013-14	124698	181075	173649	479422	126345	605767
2014-15	121450	183086	172927	477463	133767	611230
2015-16	120245	184860	173803	478908	135375	614283

Source: DSEL, Shillong

As is evident from the table above, enrolment in Government schools had reduced by 1 *per cent* (4,83,937 in 2010-11 to 4,78,908 in 2015-16) in comparison to a significant 71 *per cent* increase in enrolment of other schools (79,377 in 2010-11 to 1,35,375 in 2015-16) signifying that Government schools need to improve their quality of education and infrastructural facilities so as compete with other schools.

1.2.8.3 Gender Parity Index

Gender parity index (GPI) is the ratio of the female-to-male/male-to-female values of the gross enrolment. A GPI of 1 indicates parity between male and female.

Audit analysis revealed that the State fared well in terms of GPI and provided equal opportunities to the girls as that of the boys in elementary education as detailed in the table below:

Table-1.2.4 - Gender Parity

(Units in number)

Year	No. of Children enrolled[4]	No. of boys enrolled	No. of girls enrolled	Ratio of girls to boys
2010-11	483937	236906	247031	1.04
2011-12	499453	244899	254554	1.04
2012-13	479979	236035	243944	1.03
2013-14	479422	235623	243799	1.03
2014-15	477463	237135	240328	1.01
2015-16	478908	238187	240721	1.01

Source: DSEL, Shillong

As is evident from the above table, the State was successful in providing equitable access to elementary education to girls.

1.2.8.4 Drop out rate

As per the SSA Framework, the thrust is on bridging of gender and social gaps and a total retention of all children in schools.

Dropout details of the primary and upper primary schools[5] in the State of Meghalaya and in three selected districts during 2010-11 to 2015-16 are detailed below:

[4] In Government, Government Aided and SSA schools

[5] Government, Government Aided and SSA schools

Table-1.2.5 - Details of dropouts

(Units in number)

Year	State		East Khasi Hills		West Garo Hills		Jaintia Hills	
	Enrol-ment*	Dropouts during the year (%)	Enrol-ment	Dropouts during the year (%)	Enrol-ment	Dropouts during the year (%)	Enrol-ment	Dropouts during the year (%)
2010-11	569148	56786 (10)	130082	4343 (3)	130570	12320 (9)	63769	6941 (11)
2011-12	600612	53808 (9)	133513	6076 (5)	136561	13910 (10)	71678	4500 (6)
2012-13	577591	94540 (16)	116484	24607 (21)	135186	18222 (13)	71515	10243 (14)
2013-14	589005	58164 (10)	118399	5212 (4)	132427	18211 (14)	76908	4146 (5)
2014-15	597846	37859 (6)	120376	1468 (1)	129497	14016 (11)	79650	3400 (4)
2015-16	613324	35599 (6)	126607	983 (1)	128931	11309 (9)	82369	4093 (5)

Enrolment includes children studying in classes I to VIII irrespective of age
Source: DSEL, Shillong

It can be seen from the table above that the percentage of dropouts in the State has come down from 10 *per cent* in 2010-11 to 6 *per cent* in 2015-16. Similarly, in two selected districts i.e. East Khasi Hills and Jaintia Hills district, percentage of dropouts had reduced from 3 *per cent* to 1 *per cent* and 11 *per cent* to 5 *per cent* respectively during the period covered by audit. However, there was no improvement to curtail the dropout rates in West Garo Hills district. Rather, it was higher than State average (6 *per cent*) at 9 *per cent.* Not only drop outs, even number of enrolment was going down.

As of March 2016, the total dropout rate in the State still stood at 6 *per cent* which defeats one of the objectives of the RTE Act to contain the dropouts. Thus, Government has failed to contain dropouts through the implementation of the scheme.

The State Project Director, SEMAM stated (January 2017) in his reply that data of dropped out children by age group was not maintained as number of repeaters by age-group was not captured under Unified District Information System for Education (U-DISE).

1.2.8.5 Out of school children

The SSA Manual envisages that the State should adopt specific strategies for bringing Out Of School Children (OOSC) into the education system. OOSC could belong to remote school-less habitation, could be working children, street children, deprived children in urban slums, bonded child labourers, *etc.* Accordingly, Project Approval Board (PAB) approves funds for coverage[6] of these OOSC to bring them into the education system. The year wise number of OOSC approved by PAB, coverage, amount approved by PAB, actual release and expenditure incurred during 2010-16 is depicted in the table below:

[6] Coverage implies mainstreaming of OOSC children by providing them special training or directly enrolling them in school in an age appropriate class

Table-1.2.6 – Details of OOSC

(₹ in lakh)

Year	No. of OOSC appro-ved by the PAB[7]	OOSC covered during the year (%)	Amount approved by PAB	Actual release (%)	Funds available including unspent balance of previous year	Expendi-ture (%)	Unutilised funds (%)
1	2	3	4	5	6	7	8=6-7
2010-11	10177	8820 (87)	271.16	188.43 (69)	-	84.22 (45)	104.21 (55)
2011-12	11645	1031 (9)	1451.9	40.60 (3)	144.81	29.12 (20)	115.69 (80)
2012-13	29715	8759 (29)	1337.18	400.88 (30)	516.57	134.90 (26)	381.67 (74)
2013-14	39205	15126 (39)	921.32	367.91 (40)	749.58	257.99 (34)	491.59 (66)
2014-15	25426	17593 (69)	419.53	154.67 (37)	646.26	144.94 (22)	501.32 (78)
2015-16	21624	12813 (59)	708.19	8.32 (1)	509.64	79.51 (16)	430.13 (84)
Total			**5109.28**	**1160.81**		**730.68**	

Source: DSEL, Shillong

As is evident from the above table, coverage of OOSC identified declined drastically from 87 *per cent* in 2010-11 to 59 *per cent* in 2015-16. There was still a backlog of 8,811[8] OOSC at the end of 2015-16 exhibiting lack of efforts for speedy mainstreaming of OOSC so as to achieve the objective of universalisation of elementary education.

Further, as against the funds approved for mainstreaming of OOSC in the PAB, actual release was maximum at 69 *per cent* in 2010-11 and thereafter was much lower and absolutely meagre in 2011-12 and 2015-16 at 3 *per cent* and 1 *per cent* respectively. The shortfall in release of funds by the GoI was primarily due to failure to utilise the funds during the previous year. Furthermore, as against the available funds, utilisation of funds was also extremely poor and ranged between 55 *per cent* and 84 *per cent*. As of March 2016, unutilised funds stood at ₹ 430.13 lakh (₹ 1,160.81 lakh *minus* ₹ 730.68 lakh). However, in comparison to budget allocation, utilisation was only 14.30[9] *per cent*. Failure to utilise the funds reflects poor implementation and monitoring of the scheme.

The State Project Director, SEMAM stated (January 2017) in his reply that unwillingness of the child to attend regular school even after completion of special training programme is the main reason for not being able to mainstream the identified OOSC. Further, a larger population of OOSC were from migrant families coming from different parts of the country as labourers. He also stated that funds received at the end of the year led to adjustments/cuts by GoI thereby resulting in non-utilisation of entire released amounts.

The reply was not tenable as GoI does not release funds component wise and as such it depends upon the SEMAM to prioritise released funds accordingly and the Department had huge unspent balance at the end of each financial year (2010-16).

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7 Including backlog of previous year

8 21624-12813=8811 during 2015-16

9 ₹ 730.68 lakh out of ₹ 5109.28 lakh

1.2.8.6 Inclusive Education of Children with special needs

The term 'Children With Special Needs' (CWSN) refers to children who are challenged with various problems such as that of vision, hearing, speech, orthopaedically impaired, learning disability, cerebral palsy, mental retardation, autism and multiple disability. Inclusive Education (IE) is intended to enable CWSN to attend regular schools like other children.

The SSA Manual for CWSN stipulates that expenditure up to ₹ 3,000 per year (except in the year 2012-13 for which the rate was fixed at ₹ 2,600 per year) could be incurred on a child with minimum of 40 *per cent* disability in line with the Persons With Disabilities (Equal Opportunities, Protection of Rights & Full Participation) Act 1995 (PWD Act, 1995). The total number of CWSN approved by the PAB, approved amount, number of CWSN covered, expenditure incurred and expenditure per CWSN covered during 2010-16 is detailed in Table 1.2.7 below:

Table-1.2.7- Coverage of CWSNs

Year	No. of CWSN approved by PAB	Approved amount (₹ in lakh)	No. of CWSN covered	% of CWSN covered	Expenditure incurred (₹ in lakh)	% of expenditure against PAB approval	Expenditure per covered CWSN (₹)
2010-11	10246	307.38	8080	78.86	47.739	15.53	590.83
2011-12	10990	329.7	8134	74.01	221.822	67.28	2727.1
2012-13	12861	334.39	10067	78.28	170.035	50.85	1689.03
2013-14	9797	293.91	7308	74.59	247.977	84.37	3393.23
2014-15	11944	358.32	8177	68.46	260.33	72.65	3183.69
2015-16	10298	308.94	6863	66.64	168.163	54.43	2450.28
Total	**66136**	**1932.64**	**48629**		**1116.07**		

Source: DSEL, Shillong

As is evident from the table above, the percentage of coverage of identified CWSNs declined from 78.86 *per cent* in 2010-11 to 66.64 *per cent* in 2015-16. Against the total PAB approval of ₹ 1,932.64 lakh for 66,136 CWSN, SEMAM could cover only 48,629 CWSN (74 *per cent*) incurring an expenditure of ₹ 1,116.07 lakh during 2010-16. Further, there was no uniformity in expenditure incurred per covered CWSN during 2010-16 as it varied drastically between ₹ 591 and ₹ 3,393. This indicates that apportioning of funds for covered CWSN was ad hoc thereby depriving the CWSN the benefits envisaged under the scheme as discussed in the subsequent paragraphs:

i. Payment of transport allowance

As per Meghalaya Right of Children to Free and Compulsory Education Rules 2011, in respect of children with disabilities which prevent them from accessing the school the State Government/Local Authority will endeavor to make appropriate and safe transportation arrangements for them to attend school and complete elementary education.The State Education Department provides transport allowance to the eligible distant children to facilitate them in attending school.

Audit observed that during 2015-16, PAB had approved and released ₹ 8.13 lakh as transport allowance to 271 eligible children of East Khasi Hills district at the rate of ₹ 3,000 per child. Contrary to the PAB's approval, the eligible children were paid

transport allowance at the rate of ₹ 2,400 only resulting in short payment of ₹ 1.63 lakh[10] thus providing reduced benefits than originally approved.

The State Project Director, SEMAM stated (January 2017) in his reply that due to late receipt of funds by the SEMAM, fund was released as 1st instalment for the period of 8 months to the beneficiaries with a view that the remaining amount would be released on receipt of 2nd instalment from GoI and GoM. He also stated that the 2nd instalment was released to the SEMAM at the end of the year.

The reply was not tenable as GoI does not release funds component wise and as such it depends upon the SEMAM to prioritise released funds accordingly and the Department had unspent balance at the end of each financial year (2010-16).

ii. Preparation of Individualised Education Plan

The SSA Manual requires that Individualised Education Plan (IEP) should be prepared for every CWSN stating the needs, special services required and the possible achievement of a child within a specified time frame. The IEP is to be constantly reviewed by the District/Block level functionaries to monitor the individual performance of each child.

Contrary to the above provision, IEP was not prepared as envisaged in the SSA Manual as detailed in the table below:

Table-1.2.8- Preparation of IEP for CWSNs

Year	No. of CWSNs covered	No. of IEP prepared (%)
2010-11	8080	95 (1)
2011-12	8134	140 (2)
2012-13	10067	645 (6)
2013-14	7308	1296 (18)
2014-15	8177	1907 (23)
2015-16	6863	1505 (22)

Source: State Inclusive Education Co-ordinator, SPD, Shillong

As is evident from the above table, preparation of IEP for covered CWSNs was dismal (1 *per cent* to 23 *per cent*) during 2010-16. This indicated that the progress and individual performance of large number of CWSNs was not monitored.

The State Project Director, SEMAM stated (December 2016) in his reply that due to shortage of manpower under Inclusive Education (IE), it was difficult to prepare IEP for each individual enrolled as CWSN.

[10] 271 x ₹ 600

iii. Assistance to visually /hearing impaired children

The SSA Framework stipulates that all CWSNs requiring assistive devices should be provided with aids and appliances such as hearing aids and Braille textbooks either through convergence with the Ministry of Social Justice and Empowerment, State Welfare Departments, National Institutions, voluntary organisations or NGOs or through SSA funds.

Scrutiny of records however, revealed that the distribution of Braille textbooks and hearing aids to the identified and enrolled CWSNs during 2010-16 was deficient as shown in the table below:

Table-1.2.9-Assistance to blind and hearing impaired children

Year	Total No. of blind children identified during the year	No. of blind children enrolled	No. of enrolled blind children provided Braille textbooks (%)	Total No. of Hearing impaired children identified during the year	No. of hearing impaired children enrolled	No. of hearing aids distributed (%)
2010-11	459	459	320 (70)	2147	1978	743 (38)
2011-12	757	444	0 (0)	2518	1984	641 (32)
2012-13	656	391	199 (51)	2593	1660	954 (58)
2013-14	727	618	436 (71)	1906	1441	1093 (76)
2014-15	534	309	258 (83)	2205	1473	181 (12)
2015-16	504	244	178 (73)	1711	1142	433 (38)

Source: State Inclusive Education Co-ordinator, SPD, Shillong

As is evident from the above table, the percentage of enrolled blind children provided with Braille textbooks was poor and ranged between nil and 83 *per cent* during 2010-16. The percentage of enrolled hearing impaired children provided with hearing aids and appliances improved from 38 *per cent* in 2010-11 to 76 *per cent* in 2013-14. But again fell sharply to 12 *per cent* and 38 *per cent* in 2014-15 and 2015-16 respectively. As such, there was no improvement during the period under audit. Thus, the SEMAM had failed to provide the requisite aids and appliances to the CWSNs thereby increasing the probability of their dropping out.

1.2.8.7 Infrastructure

Availability of basic facilities in schools is an important determiner for motivating children to enrol in and attend school regularly. SSA Framework stipulates provision for drinking water, toilets for boys and girls, boundary wall, playground, library, *etc.,* in the schools.

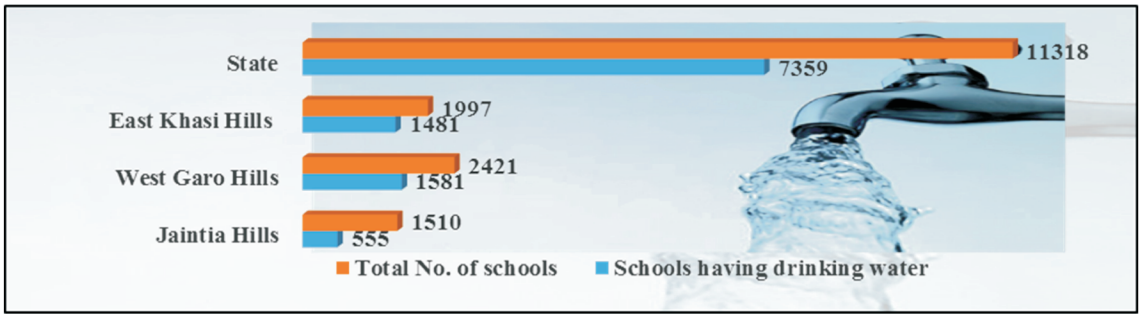
Scrutiny of the availability of basic amenities in Government schools[11] in the State as well as in three selected districts as of March 2016 is detailed below:

i. Drinking water

Safe drinking water is the most important human need in present times. The status of availability of drinking water (primary and upper primary schools) is detailed in the chart below:

[11] Government + Government Aided + SSA Schools excluding Central Government schools

Chart -1.2.2- Availability of drinking water



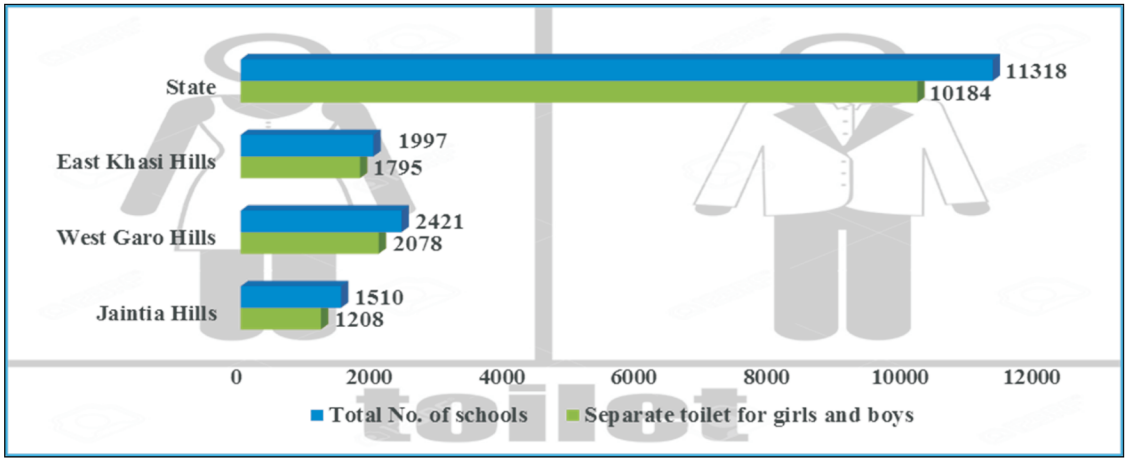
Source: SPD, SEMAM, Shillong

As is evident from the above table, 35 *per cent* schools in the State did not have drinking water facilities. The situation in three selected districts (West Garo, East Khasi and Jaintia Hills district) was that 35 *per cent*, 26 *per cent* and 63 *per cent* of the schools respectively were not having drinking water facilities.

ii. Separate toilet for girls and boys

Availability of separate toilets for girls and boys is an essential basic facility required for motivating children to attend school. The availability of separate toilet for girls and boys (primary and upper primary schools) is detailed below:

Chart -1.2.3- Separate toilet for girls and boys



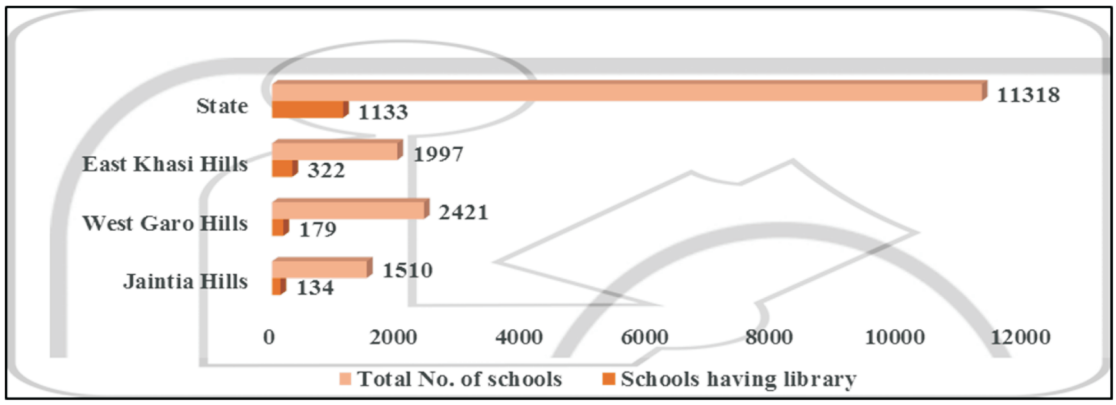
Source: SPD, SEMAM, Shillong

As can be seen from above, while 90 *per cent* of the schools in the State and East Khasi Hills district had separate toilet for girls and boys, in two selected districts of West Garo Hills and Jaintia Hills, the availability of separate toilets was comparatively low at 86 *per cent* and 80 *per cent* respectively.

iii. Library facilities

The importance of library in schools in the present day cannot be overemphasised. A well-stocked library is not only a source of information but also a means to keep abreast of latest topics. The status of library facilities in schools (primary and upper primary) is detailed below:

Chart -1.2.4- Library facilities



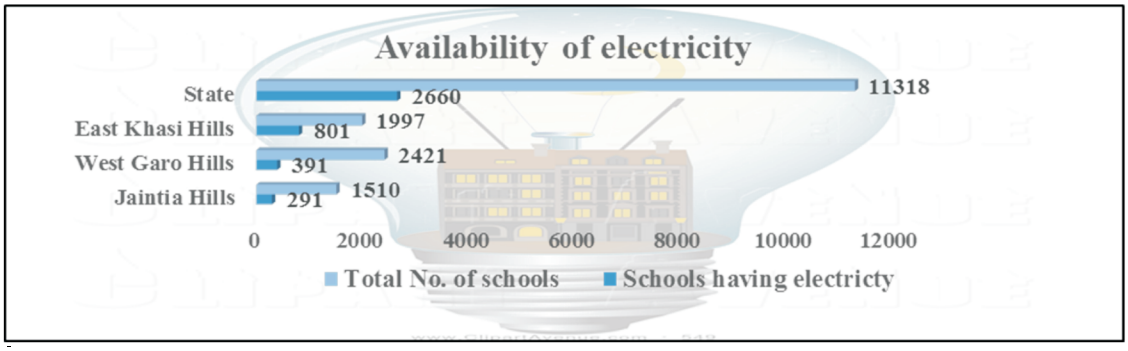
Source: SPD, SEMAM, Shillong

As is evident from the above chart, the availability of library in schools in the State as well as in selected three districts is in a deplorable condition. In the State, only 10 *per cent* of the schools had library facilities while in the selected districts of East Khasi Hills, West Garo Hills and Jaintia Hills districts, only 16 *per cent*, 7 *per cent* and 9 *per cent* respectively of the schools have library facilities.

iv. Availability of electricity

Electricity in schools is needed for providing lively classroom atmosphere as well as for running computers and electrical equipment. The status of availability of electricity in schools (primary and upper primary) is detailed below:

Chart -1.2.5-Availability of electricity



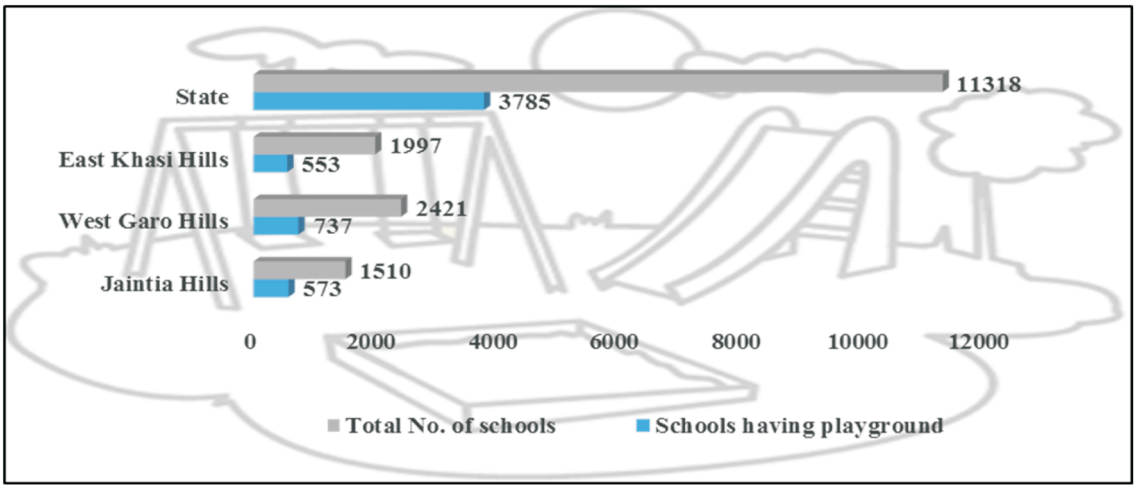
Source: SPD, SEMAM, Shillong

As is evident from the above chart, only 24 *per cent* of the schools in the State had electricity facilities. In the three selected districts, the position of schools having electricity was also low at 40 *per cent*, 16 *per cent* and 19 *per cent* in East Khasi Hills, West Garo Hills and Jaintia Hills districts respectively.

v. Availability of playground

Availability of playground in schools is essential for all round development of the children. The status of availability of playground in schools (primary and upper primary) is detailed in the Chart below:

Chart -1.2.6-Availability of playground



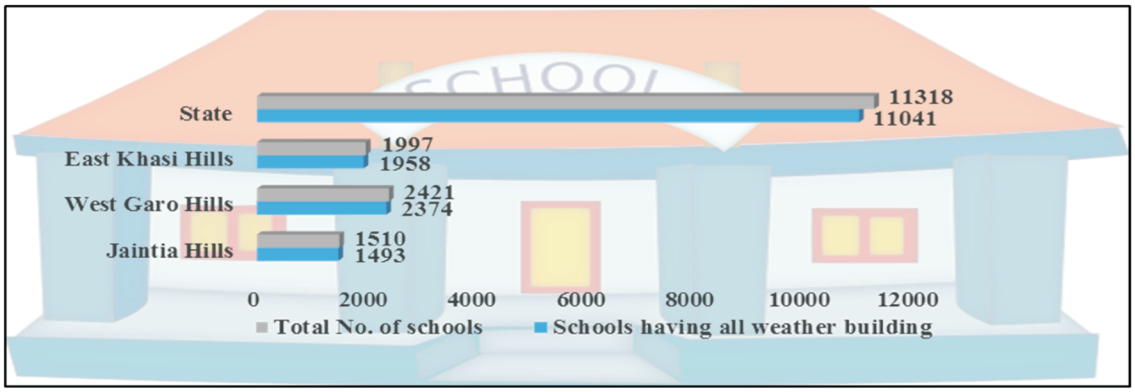
Source: SPD, SEMAM, Shillong

As is evident from the above chart, 33 *per cent* of the schools in the State had playground facilities. While in the three selected districts, the position of schools having playground stood at 28 *per cent*, 38 *per cent* and 30 *per cent* in East Khasi Hills, Jaintia Hills and West Garo Hills district respectively.

vi. All weather school building

An all-weather school building is a pre-requisite for providing conducive learning environment to the students. The status of availability of all-weather school buildings (primary and upper primary) is detailed in the Chart below:

Chart -1.2.7-Availability of all-weather school building



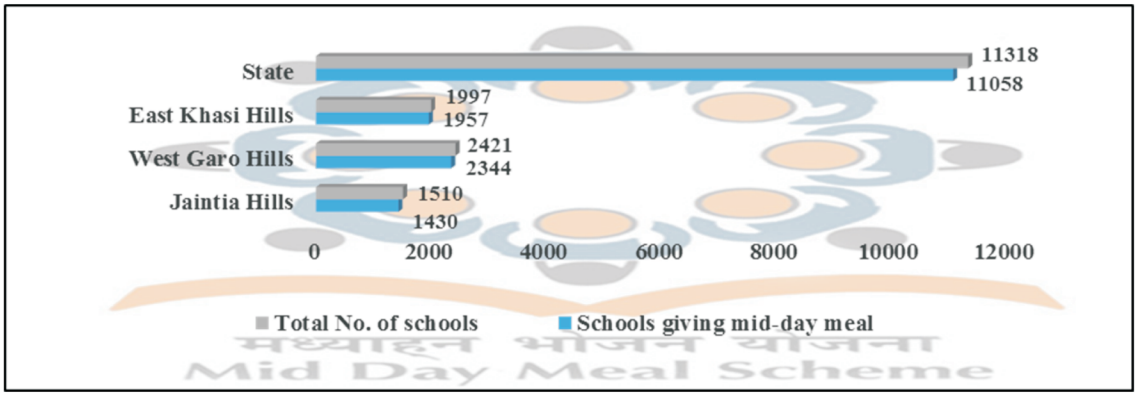
Source: SPD, SEMAM, Shillong

As is evident from the above chart, 98 *per cent* of the schools in the State had all weather school building. As of March 2016 however, 277 schools in the State were without all-weather school building which needs the attention of the Department.

vii. Availability of mid-day meal

Mid-day meal was launched by GoI in September 2004 to provide cooked meal to children so as to enhance enrolment, retention and attendance of the children. The status of availability of mid-day meal in schools (primary and upper primary) is detailed in the Chart below:

Chart -1.2.8-Availability of Mid-day meal



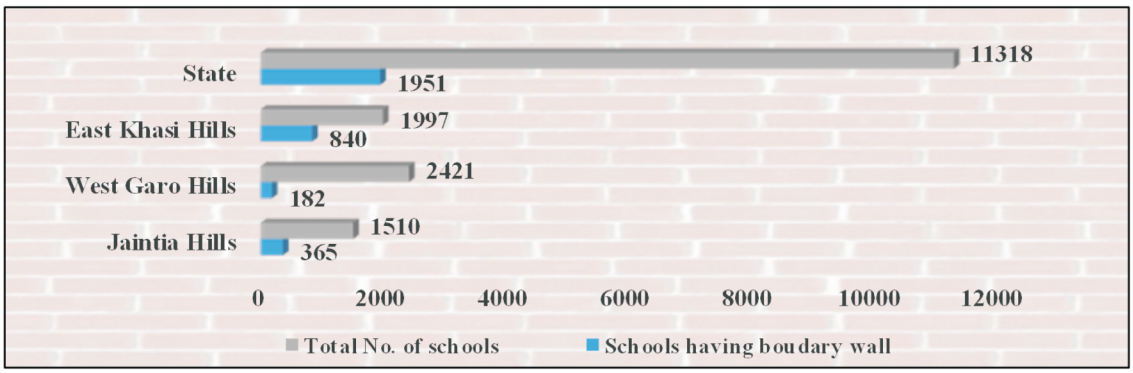
Source: SPD, SEMAM, Shillong

As is evident from the above chart, 98 *per cent* of the schools in the State were providing mid-day meal to the enrolled children while in the three selected districts, the position of schools providing mid-day meal stood at 98 *per cent*, 97 *per cent* and 95 *per cent* in East Khasi Hills, Jaintia Hills and West Garo Hills district respectively.

viii. Availability of boundary wall

Availability of boundary wall in the school ensures protection of the children from external threats and ensures their safety during school hours. The status of availability of boundary wall in schools (primary and upper primary) is detailed in the Chart below:

Chart -1.2.9-Availability of boundary wall



Source: SPD, SEMAM, Shillong

As is evident from the above chart, only 17 *per cent* of the schools in the State had boundary wall facilities while in the three selected districts, the position of schools having boundary wall stood at East Khasi Hills district-42 *per cent*, Jaintia Hills district-8 *per cent* and West Garo Hills district-24 *per cent*.

Infrastructural facilities in the State were not satisfactory especially in terms of availability of drinking water, library, electricity, playground and boundary wall in primary and upper primary schools. Poor infrastructure facilities in the schools adversely impact the enrolment, retention, motivation to attend class and quality of education.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that despite fund constraints, the Department was putting lot of efforts to meet the gaps in

infrastructure and the Government with its meager fund allocation finds it difficult to improve all areas of the school.

The reply was untenable as the available balance of funds with SEMAM had been increasing over the years (***paragraph 1.2.9***). Further, GoI had been short releasing funds due to Department's inability to utilise the available funds effectively.

1.2.8.8 Release of grants

(i) Payment of School Maintenance Grant to ineligible schools

As per Financial Management and Procurement (FMP) Manual of SSA, schools having up to three classrooms were eligible for maintenance grant subject to a maximum of ₹ 5,000 per school per year. Government aided schools or other private schools were however, not eligible for the school maintenance grant.

In contravention of the above provision, school maintenance grant of ₹ 2.40 lakh ***(Appendix 1.2.1)*** was paid to 48 ineligible schools in Jaintia Hills district during 2010-16 while denying the maintenance grant to 393 eligible schools during the same period.

The State Project Director, SEMAM stated (December 2016) in his reply that the matter was being examined for taking corrective measures.

(ii) Uniform grant

School uniforms constitute an expense which poor families were often unable to afford, and thus becomes a barrier for many children to pursue and complete elementary education. SSA norms provides for supply of two sets of uniforms for all girls and ST/SC/BPL boys in Government/Aided schools within a ceiling of ₹ 400 per child per annum.

Scrutiny of records regarding disbursement of uniform grant to all girls and ST/SC/BPL boys studying in Government[12] schools revealed that 16 *per cent* to 97 *per cent* of the eligible children were deprived of uniform grant during 2010-16. Figures for the period 2012-15 were alarmingly high as 82 *per cent* to 97 *per cent* of the eligible children were deprived of uniform grant. Out of ₹ 56.32 crore approved by the Project Approval Board (PAB), only ₹ 42.44 crore was released for uniform grant during 2010-16. Further, out of ₹ 42.44 crore released, only ₹ 17.33 crore i.e. 41 *per cent* of the funds were utilised. Failure to utilise the available funds reflect inefficiency in implementation of the scheme by SEMAM thereby depriving the eligible children of the intended benefits. The details of eligible children, approval of the PAB, actual fund released, actual utilisation, the number of children deprived of the uniform grant and amount short released is detailed in the table below:

[12] Government, Government Aided and SSA schools

Table-1.2.10-Details of uniform grant in State

(₹ in lakh)

Year	No. of eligible children	PAB Approval		Actual release		Actual Utilisation		No. of children deprived (%)	Amount short released
		No. of children	Amount	No. of children	Amount	No. of children	Amount		
2010-11	Proposal was not sent by the SEMAM.								
2011-12	Proposal was not approved by the PAB.								
2012-13	347525	347525	1390.1	347525	1390.10	61317	245.27	286208 (82)	0
2013-14	347104	347104	1388.42	0	0	61728	246.91	285376 (82)	1388.42
2014-15	354921	354921	1419.68	354921	1419.68	9054	36.22	345867 (97)	0
2015-16	358536	358536	1434.14	358536	1434.14	301125	1204.50	57411 (16)	0
Total			**5632.34**	**1060982**	**4243.92**	**433224**	**1732.90**		**1388.42**

Source: SPD, SEMAM, Shillong

Further, scrutiny of records relating to disbursement of uniform grant in three selected districts during 2012-16 revealed the following picture:

Table-1.2.11- Uniform grant in three selected districts

(₹ in lakh)

Year	East Khasi Hills				West Garo Hills				Jaintia Hills			
	No. of children sanctioned as per PAB	Amount released by SEMAM	Amount of expenditure incurred	No. of children provided uniform (%)	No. of children sanctioned as per PAB	Amount released by SEMAM	Amount of expenditure incurred	No. of children provided uniform (%)	No. of children sanctioned as per PAB	Amount released by SEMAM	Amount of expenditure incurred	No. of children provided uniform (%)
2012-13	45870	0	0	0	89316	0	0	0	49045	0	0	0
2013-14	46473	183.48	142.27	35567 (77)	87456	0	0	0	52208	0	0	0
2014-15	48180	0	0	0	85880	0	0	0	54776	0	0	0
2015-16	50200	200.80	176.50	44126 (88)	82742	330.97	330.97	82742 (100)	55983	223.932	127.97	31992 (57)

Source: DMCs of East Khasi Hills, West Garo Hills and Jaintia Hills

In the three selected districts, no children were provided uniform grant during 2012-13 and 2014-15. Even during 2013-14, East Khasi Hills district gave uniform grants to 77 *per cent* of the eligible children. West Garo Hills and Jaintia Hills district could not provide any uniform grant. During 2015-16, East Khasi Hills and Jaintia Hills district could disburse uniform grant to only 88 *per cent* and 57 *per cent* of the eligible children.

The State Project Director, SEMAM stated (January 2017) that funds were released to School Managing Committees through the district offices for providing uniforms to children and that during 2012-13, though the entire fund on uniform was released to School Management Committees, they failed to utilise the funds during that year. He also stated that due to the above fact funds on uniforms were not released during 2013-14 and 2014-15 and expenditure during 2013-14 and 2014-15 was actually the amount adjusted against the release during 2012-13. The State Project Director also stated that during 2015-16 the entire amount was again released to the School Management Committees as approved by the PAB.

The reply confirms the audit observation that the targets of disbursement of uniform grants were not achieved as SEMAM failed to monitor timely utilisation of the uniform grant by the School Management Committees.

1.2.8.9 Distribution/transportation of free textbooks

As per the FMP Manual, free textbooks are to be provided to all children within an upper ceiling of ₹ 150 per child at Primary level and ₹ 250 per child at Upper Primary level in Government/Aided schools. The charges on textbook development, printing, transportation *etc.* will also be included in the cost of textbooks, provided cost does not exceed the upper ceiling.

According to the information furnished (January 2017) by the State Project Director, SEMAM, the achievement of target for supply of free textbooks to the enrolled children in the State during 2010-16 was as detailed below:

Table-1.2.12- Distribution of free textbooks in the State

Year	PAB Approval		Actual Release		Actual utilisation	
	Primary (No.)	Upper Primary (No.)	Primary (No.)	Upper Primary (No.)	Primary (No.)	Upper Primary (No.)
2010-11	472653	150568	472653	150568	472653	150568
2011-12	434482	134666	434482	134666	434482	134666
2012-13	348046	169776	348046	169776	348046	169776
2013-14	416775	163022	416775	163022	416775	163022
2014-15	416978	172027	416978	172027	416978	172027
2015-16	218740	180945	218740	180945	218740	180945

Source: SPD, SEMAM, Shillong

As can be seen from above, the Department had fully achieved the targets set for supply of free textbooks during 2010-16.

Crosscheck of data regarding the position of distribution of free textbooks to the enrolled children in three selected districts during 2010-16 was however, as under:

Table-1.2.13- Distribution of free textbooks in three selected districts

Name of the District	No. of children enrolled	No. of children given textbooks	Shortfall (-)/ Excess (+)
East Khasi Hills	745564	733183	(-) 12381
Jaintia Hills	452925	452925	-
West Garo Hills	692723	643668	(-) 49055
Total	**1891212**	**1829776**	(-) **61436**

Source: DMCs of three selected districts

As can be seen from Tables 1.2.12 and 1.2.13 above, even though as per SPD, SEMAM the State had fully achieved the targets set for supply of free textbooks, East Khasi Hills district and West Garo Hills district could not provide free textbooks to 61,436 children during 2010-16.

Further, scrutiny of records of District Mission Co-ordinator, West Garo Hills district regarding transportation of textbooks from the district to the blocks revealed that the district incurred an expenditure of ₹ 19.34 lakh during 2010-16. As per the vouchers supporting the payments, these textbooks were transported from the district to the blocks through 15 vehicles[13]. Crosscheck of registration number of nine vehicles with

[13] 13 and 2 vehicles were Meghalaya and Assam registered vehicles respectively

the data of the District Transport Officer, Tura revealed that while five vehicles[14] were registered as 'Goods Carrier', three other vehicles were registered as private vehicles. Of these, two vehicles were two-wheelers[15] and one was Maruti Alto[16]. One of the vehicles[17] was a bus registered in the name of the Secretary, Meghalaya Board of School Education (MBOSE). Thus, the cost of transportation of books from the district to the blocks appears to be inflated by showing two-wheelers, Maruti Alto and bus belonging to MBOSE as transport vehicles. As such, the entire amount of ₹ 19.34 lakh incurred on transportation could not be vouchsafed in audit. However, the amount of transportation incurred on two wheelers, Maruti Alto and bus registered in the name of MBOSE amounting to ₹ 2.38 lakh was fictitious and needs further investigation.

The State Project Director, SEMAM stated (December 2016) that the matter was under investigation.

1.2.8.10 Status of Civil works

Construction of school buildings/additional classrooms is one of the major interventions under RTE Act/SSA so that adequate accommodation is provided to children.

At the State level, the overall position relating to civil works as on 31 March 2016 was as under:-

Table-1.2.14- Details of Civil Works in the State

Type of buildings	Target	Completed	Incomplete works		Expenditure incurred on incomplete works (₹ in crore)
			In-progress	Not taken up	
Lower Primary	2934	2730	157	47	483.88
Upper Primary	2219	2032	163	24	
Additional Classrooms	7235	6724	185	326	
Office-Cum-Store-Cum-Head Teacher's Room (Primary)	12	7	3	2	
Office-Cum-Store-Cum-Head Teacher's Room (Upper Primary)	10	6	2	2	
Ramps	2576	2269	274	33	
Total	**14986**	**13768**	**784**	**434**	**483.88**

Source: State Civil Works Co-ordinator, SEMAM, Shillong

As is evident from the above table, out of 14,986 civil works, 1,218 civil works were lying incomplete. Most of the works were sanctioned by the PAB during 2010-13 but were lying incomplete even after a lapse of 3 to 6 years of their approval. Out of 1,218 civil works, 434 civil works had not been taken up. As such, funds to the tune of ₹ 483.88 crore incurred on 1,218 incomplete works were lying infructuous till the date of audit (July 2016).

[14] ML08 B 5389, ML08 B 5972, ML08 A 8877, ML08 B 4199 and ML08 B 5247
[15] ML08 5893 and ML08 8877
[16] ML08 B 0826
[17] ML08 9795

Cut imposed by the GoI due to failure to utilise funds as per the FMP Manual was the main reason for delay in completion of civil works. The cut imposed by the GoI has been discussed in ***paragraph 1.2.9.***

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that the main reasons for delay in completion of civil works was State border dispute, monsoon, law and order problem, delay in receipt of funds from GoI/GoM and the present system of routing GoI funds to SEMAM through GoM.

The reply was not tenable as SEMAM had failed to adequately spend the funds resulting in GoI imposing cuts on further releases. Further, Department/SEMAM had failed to streamline the administrative mechanism for transfer of funds from GoI to SEMAM after enactment of the RTE Act 2009.

➢ *Status of civil works in selected districts*

Scrutiny of records relating to civil works undertaken under SSA in three selected districts during 2010-16 revealed the following deficiencies:

i. East Khasi Hills District

a. Incomplete works

Scrutiny of records revealed that 47 civil works[18] valuing ₹ 6.30 crore approved in the PAB of 2010-11 and 2011-12 were lying incomplete till the date of audit (July 2016) resulting in expenditure of ₹ 4.78 crore incurred on those works lying unfruitful.

b. Works not taken up

Audit further observed that civil works in 30 schools valuing ₹ 3.51 crore which were approved in the PAB of 2010-13, were not taken up due to land not being available. Equal number of works were to be carried out in 30 new schools by replacing the earlier approved schools with a list of new schools. Even till the date of audit (July 2016), the list of new schools had not been finalised and work not taken up. Further, records were also not available to show that PAB had permitted the replacement of the original list of schools with the new list.

ii. Jaintia Hills District

a. Incomplete works

Scrutiny of records revealed that 95 civil works approved in the PAB of 2010-11 and 2011-12 were lying incomplete till the date of audit (July 2016) resulting in expenditure of ₹ 5.09 crore incurred on those works still lying unfruitful.

iii. West Garo Hills District

The details of the civil works (school wise) undertaken in the West Garo Hills district during 2010-16 were not furnished to Audit despite repeated requests.

[18] Construction of additional classrooms and school building

1.2.8.11 Quality of education

Quality education is contingent upon the teachers' professional qualification, attendance of teachers as well as children, training of the teachers, computer assisted learning, *etc.* The deficiencies observed in the parameters which determine the quality of education are discussed in the succeeding paragraphs.

i. High proportion of untrained teachers

Rule 17 of the Meghalaya Right of Children to Free and Compulsory Education Rules, 2011, stipulates that the State Government shall provide adequate teacher education facilities to ensure that all teachers, who do not possess the minimum qualifications[19] as per the RTE Act, are to acquire such minimum qualifications within a period of five years from the commencement of the Act.

Despite having seven District Institute for Education and Training (DIETs) under Director of Education, Research and Training (DERT) and National Institute of Open Schooling (NIOS) centres, majority of the teachers[20] in the State were untrained (not having specified minimum qualification) even after lapse of six years of enactment of the RTE Act as detailed below:

Table-1.2.15- Position of trained and untrained teachers in the State

Year	Primary			Upper Primary			Total			Teachers trained
	Trained teachers (%)	Untrained teachers (%)	Total	Trained teachers (%)	Untrained teachers (%)	Total	Trained teachers (%)	Untrained teachers (%)	Total	
2010-11	4584 (23)	15627 (77)	20211	2100 (15)	11866 (85)	13966	6684 (20)	27493 (80)	34177	Nil
2011-12	4048 (20)	15926 (80)	19974	2196 (15)	12542 (85)	14738	6244 (18)	28468 (82)	34712	Nil
2012-13	3926 (21)	15100 (79)	19026	1910 (14)	11846 (86)	13756	5836 (18)	26946 (82)	32782	Nil
2013-14	4031 (21)	14952 (79)	18983	1983 (14)	12022 (86)	14005	6014 (18)	26974 (82)	32988	4385
2014-15	4210 (22)	14688 (78)	18898	2096 (15)	12038 (85)	14134	6306 (19)	26726 (81)	33032	3437
2015-16	4311 (23)	14833 (77)	19144	2186 (15)	12032 (85)	14218	6497 (19)	26865 (81)	33362	Nil

Source: DSEL, Shillong

As is evident from the above table, 77 *per cent* and 85 *per cent* of the primary and upper primary teachers respectively were untrained in the State (March 2016). There was no improvement in the position of untrained teachers both in the primary as well as upper primary schools during the period covered by audit.

Further, during the period covered by Audit, only 4,385 and 3,437 untrained teachers were trained during 2013-14 and 2014-15 respectively. No teachers were trained during 2010-11 to 2012-13 and during 2015-16.

Failure to reduce the percentage of untrained teachers indicates that no sincere efforts were made by the SEMAM for training the teachers for attaining the minimum qualification as per the NCTE norms. The percentage of untrained teachers remained the same even after lapse of 5 years thereby signifying that the quality of education imparted to the children under the Act was being compromised.

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[19] For primary: Class XII + Diploma in Elementary Education. For Upper Primary: Graduate + Bachelor in Education (B.Ed)

[20] Government +Aided+ SSA

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that in-service training for Diploma in Elementary Education was underway. During the Exit Conference (November 2016), the Commissioner & Secretary, Education Department stated that new recruitments would be made as per NCTE norms only.

ii. Shortage of teachers in primary schools

Framework for implementation of SSA and RTE Act provides that there should be at least two teachers in primary section and at least one teacher for every class in Upper Primary Schools with pupil teacher ratio (PTR) of 40:1 and 35:1 respectively. Besides, one teacher each for science and mathematics, social studies, languages and a full time head-teacher was required to be posted in every Upper Primary School. No school should be with a single teacher. These parameters were to be achieved by March 2013.

While the placement of teachers in upper primary schools satisfied the norms specified under the RTE Act, there was a shortage of 1,748 teachers in primary schools[21]. The position of teachers in the upper primary and primary schools as of March 2016 is shown in the table below:

Table-1.2.16- Shortage of teachers in Primary schools

Year	Upper Primary (Government, Government Aided and SSA schools)			Primary (Government, Government Aided and SSA schools)			
	No. of children enrolled	No. of teachers required as per RTE Act	Teachers in position	No. of children enrolled	No. of teachers required as per RTE Act	Teachers in position	Shortfall (+)
2010-11	134666	10089	13891	434482	24796	20197	4599
2011-12	169766	11259	14661	430846	23035	19961	3074
2012-13	162352	10795	13636	415239	21066	19016	2050
2013-14	172027	11051	13867	416978	20879	18961	1918
2014-15	179756	11211	13980	418090	20728	18832	1896
2015-16	190480	11425	14062	422844	20827	19079	1748

Source: DSEL, Shillong

As is evident from the above table, there was consistent shortage of teachers in the primary schools. Though the shortages have been decreasing during 2010-16, State had failed to achieve the PTR even after lapse of three years of the targeted date of compliance.

Further, contrary to the provisions of the Act, the State till March 2016 had 224[22] single teacher primary schools with 7,769 enrolled children therein.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that rationalisation of teachers was under process.

iii. Implementation of Computer Aided Learning (CAL)

Computer Aided Learning (CAL) is an important component under SSA and its real purpose is to make teaching learning process practical and simple. CAL not only makes learning interesting and joyful, but also induces novelty in thinking approach of the

[21] Government, Government Aided and SSA

[22] East Khasi Hills:13, West Khasi Hills:7, Jaintia Hills:44, Ri-Bhoi:3, West Garo Hills:111, East Garo Hills:17, and South Garo Hills:29

children thereby enhancing their imaginative power. In Meghalaya, Government and SSA upper primary schools having electrical connection and enrolment of more than 30 students were eligible to be provided with CAL.

The position of implementation of CAL in eligible schools in three selected districts during 2010-16 is detailed below:

Table-1.2.17- Implementation of CAL in three selected districts

Year	East Khasi Hills			West Garo Hills			Jaintia Hills		
	Total No. of eligible Schools	No. of Schools covered under CAL during the year	No. of schools where CAL actually functioning	Total No. of eligible Schools	No. of Schools covered under CAL during the year	No. of schools where CAL actually functioning	Total No. of eligible Schools	No. of Schools covered under CAL during the year	No. of schools where CAL actually functioning
2010-11	362	-	-	309	-	-	342	39	25
2011-12	442	41	41	309	25	25	360	39	33
2012-13	446	-	-	309	-	-	364	-	-
2013-14	439	-	-	309	-	-	366	-	-
2014-15	448	6	6	309	9	9	369	2	2
2015-16	448	-	-	309	21	-	369	5	5
Total	**448**	**47**	**47**	**309**	**55**	**34**	**369**	**85**	**65**

Source: DMCs of East Khasi Hills, West Garo Hills and Jaintia Hills

From the above table, it can be seen that during the period under audit:

i. Implementation of CAL in the East Khasi Hills district was not satisfactory as only 41 Upper Primary Schools in 2011-12 and six Upper Primary Schools in 2014-15 could be covered under CAL. At the end of 2015-16, out of 448 Upper Primary Schools, CAL was implemented in only 47 Upper Primary Schools (10 *per cent*) leaving 441 Upper Primary Schools without CAL facilities.

ii. In the West Garo Hills district, CAL was implemented only in 25 Upper Primary Schools in 2011-12 and 9 Upper Primary Schools in 2014-15. Though 21 Upper Primary Schools were covered during 2015-16, they had not been made functional (July 2016). At the end of 2015-16, out of 309 Upper Primary Schools, CAL was implemented in only 55 Upper Primary Schools (18 *per cent*) leaving 254 Upper Primary Schools without CAL facilities. Even out of 55 Upper Primary Schools covered under the CAL, only 34 (62 *per cent*) were functioning.

iii. In the Jaintia Hills district, CAL was implemented only in 85 Upper Primary Schools during 2010-16. At the end of 2015-16, out of 369 Upper Primary Schools, CAL was implemented in only 85 Upper Primary Schools (23 *per cent*) leaving 284 Upper Primary Schools without CAL facilities. Even out of 85 Upper Primary Schools covered under the CAL, only 65 (76 *per cent*) were functioning.

Implementation of CAL in 10 *per cent* to 23 *per cent* of the Upper Primary Schools of the three selected districts was far from satisfactory. The slow progress of the CAL had resulted in depriving 77 *per cent* to 90 *per cent* of children of the eligible schools from the benefits of computer aided learning.

The State Project Director, SEMAM stated (December 2016) in his reply that fund constraint was one of the reason for which schools proposed were not fully approved by the PAB.

1.2.8.12 Implementation and compliance of the RTE Act, 2009

The deficiencies observed in implementing and complying with the various mandatory provisions of the RTE Act, 2009 are detailed in the succeeding paragraphs:

i. Neighbourhood norm based on population not notified

Under Sec 6 of the RTE Act, the local authority is to establish a school within three years of the commencement of the Act in such area or limits of the neighbourhood as may be prescribed.

The State Government had notified (August 2013) the neighbourhood norms in terms of distance only under the Meghalaya Right of Children to Free and Compulsory Education (MRCFCE) Rules, 2011. Though GoI had asked the State to notify the definition of neighbourhood incorporating population norms, this had not been done. Due to absence of notification of neighbourhood norms in terms of habitations based on the population, the PAB did not approve setting up of new schools during 2013-14. Even during 2014-15 and 2015-16, only five and 19 new primary schools respectively were approved with the directive to assess future requirements through GIS mapping of schools based on population.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that the State norms for Neighbourhood definition had been tabled in the Cabinet.

ii. Enrolment, Identification of poor children belonging to disadvantaged sections, plans to increase enrolment, increase in enrolment

Sec 8 of the RTE Act 2009 stipulates that the government should ensure that the child belonging to weaker section and disadvantaged group are not discriminated against and prevented from pursuing and completing elementary education on any grounds.

The Education Department had issued notification regarding reservation[23] for children belonging to weaker section and disadvantaged group in the neighbourhood school in August 2013 i.e. after a lapse of 4 years of enactment of the Act. Apart from the notification, the Department had not even fixed the rates for reimbursement for children enrolled from the weaker sections of the society by the un-aided schools. As such, rights of the poor children belonging to the weaker and disadvantaged sections were not protected and they were deprived of their intended benefits as envisaged under the RTE Act.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) that Local Authorities are oriented about the need to identify children eligible for reservation. However, till date, application for reimbursement or claims for reservation had not been received.

[23] As per provisions of RTE Act, 2009, at least 25 *per cent* of the strength of each class should be reserved for children belonging to weaker sections and disadvantaged group in the unaided neighbourhood schools.

Reply was not tenable as the Department, apart from issue of notification regarding children belonging to weaker sections and disadvantaged groups in the neighbourhood schools in August 2013, had not taken any further steps. It had even till January 2017 not finalised the rate for re-imbursement.

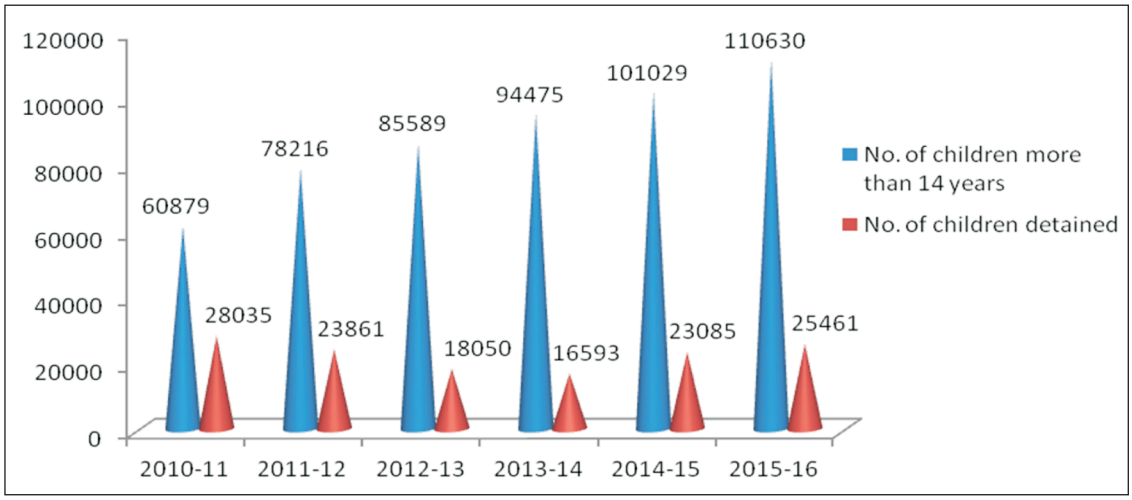
iii. Identification of children of more than 14 years but still in elementary education

As per the provisions of the RTE Act, every child of 6-14 years of age has a right to free and compulsory education till completion of the elementary school. The Act also provided that every child be admitted in a class appropriate to his/her age and that no child be held back in any class or expelled from school till the completion of elementary education.

The position of children aged more than 14 years but still in elementary school and children who were detained during 2010-16 is shown in the Chart below:

Chart -1.2.10

Position of children aged more than 14 years but still in elementary education



Source: SPD, SEMAM

In the three selected districts, the position of children aged more than 14 years but in elementary school and children who were detained during 2010-16 was as follows:

Table-1.2.18- Position in selected districts

Year	East Khasi Hills		West Garo Hills		Jaintia Hills	
	No. of children more than 14 years	Percentage of increase as compared to 2010-11	No. of children more than 14 years	Percentage of increase as compared to 2010-11	No. of children more than 14 years	Percentage of increase as compared to 2010-11
2010-11	14973	-	12352	-	6860	-
2011-12	17575	17	19063	54	8546	25
2012-13	17620	18	17224	39	10721	56
2013-14	19753	32	20963	70	10519	53
2014-15	21478	43	23823	93	8986	31
2015-16	21304	42	26909	118	11091	62

Source: SPD, SEMAM

As is evident from the above table, the number of children aged more than 14 years but in elementary education had increased by 42 *per cent,* 118 *per cent and* 62 *per cent* in East Khasi Hills, West Garo Hills and Jaintia Hills districts respectively during 2010-16. The Department however, could not furnish the year-wise data regarding number of children detained in the same class.

Thus, the Department did not implement the provisions of the RTE Act of not detaining any enrolled child till the completion of elementary education. Further, the number of children aged more than 14 years but still in elementary education showing an upward trend indicated that the Department had also failed to admit every child in a class appropriate to his/her age.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that as the system of Continuous and Comprehensive Evaluation (CCE) had not been fully implemented, 'no-detention' policy was difficult to implement. He also stated that the State Academic Authority was working to put the system in place.

iv. Providing of pre-school education facilities to children

As per the RTE Act, the Central/State Government has to provide for 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. In order to provide pre-school education, SSA emphasises convergence with the Integrated Child Development Services by providing specific support to existing ICDS centres from funds available under the head 'Innovative Activities'.

Though the convergence was to be carried out with the ICDS by holding regular inter departmental meetings at State, district, and block level between SSA officials and the ICDS programme officials, joint training of Anganwadi workers, primary school teachers and health workers for a convergent understanding of benefits of pre-school for primary school enrolments, this was not done.

The Special & Nodal Officer, RTE, DSEL-SSA in his reply admitted (August 2016) that the ICDS and the Education Department had not converged in the manner that it was mandated. He also stated that the pre-primary structure was more of private sector initiative, nevertheless, the Education Department was seriously studying the possibilities to extend its wings to incorporate pre-primary on a large scale.

v. Formulation of School Development Plan

As per the RTE Act and MRCFCE Rules, every School Management Committee shall prepare a three year School Development Plan (SDP) comprising three annual sub-plans. The SDP so prepared shall be the basis for the plans and grants to be made by the appropriate Government or local authority, as the case may be.

In three selected districts of East Khasi Hills, Jaintia Hills and West Garo Hills districts, the formulation of SDPs is detailed below:

Table-1.2.19-Position of SDPs in selected districts

Particulars	2010-11			2011-12			2012-13			2013-14			2014-15			2015-16		
	EKH	WGH	JH	EKH	WGH	JH	EKH	WGH	JH	EKH	WGH	JH	EKH	WGH	JH	EKH	WGH	JH
1. Total No. of schools	1929	1846	3622	2002	1852	1289	1972	1855	1635	1931	1853	1615	1969	1861	1624	1990	1858	1681
2. No. of schools where School Development Plan (SDP) have not been prepared	1266 (66)	1846 (100)	0	1266 (63)	1852 (100)	0	1072 (54)	1855 (100)	0	1026 (53)	1853 (100)	797 (49)	1004 (51)	1861 (100)	796 (49)	999 (50)	1858 (100)	795 (47)

Source: DMCs, East Khasi Hills and West Garo Hills district

As is evident from the above table, while in the selected districts, no school in West Garo Hills district had prepared the SDPs during 2010-16. In East Khasi Hills and Jaintia Hills district, 50 *per cent* to 66 *per cent* and 47 *per cent* to 49 *per cent* of the schools respectively had not prepared SDPs. Failure of such large number of schools to prepare SDPs indicated that the district plans which had to source its data from the SDPs were not framed on actual data.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that the Meghalaya School Improvement Plan (MSIP) in line with the NPSSE/Shaala Sidhdhi was under process for improvement of education through school standards and evaluation. Once the programme was implemented the School Development Plan will be replaced by MSIP.

vi. De-recognition of schools due to non-compliance to standards; schools running without certificate of recognition

Under the RTE Act, no school, other than those owned/controlled by the Government/Local Authority, is to be established without obtaining certificate of recognition. Any person who establishes or runs a school without obtaining certificate of recognition becomes liable to fine which may extend to one lakh rupees.

Scrutiny of records of the SPD, SEMAM revealed that 115 unrecognised schools have been functioning in the State without obtaining the certificate of recognition till the date of audit (July 2016). Similarly, in three selected districts, 109 un-recognised schools[24] were running as of March 2016 without obtaining the certificate of recognition.

The Director of School Education and Literacy, Meghalaya functioning under the SEMAM is the authority for monitoring and regulating the functioning of schools in the State. Despite penal provisions provided under the RTE Act, neither any punitive action has been taken nor any fines imposed by the SEMAM.

The State Project Director, SEMAM stated (January 2017) in his reply that steps would be undertaken for closure of those schools which do not comply with the RTE Act.

[24] East Khasi Hills district: 63, West Garo Hills district: 1 and Jaintia Hills district:45

1.2.9 Financial Management

As per the SSA Manual, the GoI would release funds directly to the bank account of the State Implementing Society in two instalments in a year. Further instalments would be released to the Society only after the State Government has transferred its matching funds to the Society and expenditure of at least 50 *per cent* of the funds transferred (Centre and States) has been incurred. The objective is to allow States to fully utilise the allocation for elementary education. The second instalment shall be released based on the progress in expenditure and the quality of implementation.

The year wise details of funds approved and released by GoI and GoM to SEMAM and by SEMAM to DMCs during 2010-16 is shown below:

Table No.1.2.20- Available funds and release by SEMAM

(₹ in crore)

Year	Opening balance	PAB approvals		Actual releases		Shortfall in release		13th Finance Commission	Other receipt	Total funds available	Release by SEMAM to DMCs	Expendi-ture
		GoI Share	GoM Share	GoI	GoM	GoI	GoM					
2010-11	45.78	249.07	27.67	185.41	4.91	63.66 (26)	22.76 (82)	0.00	3.66	239.76	171.25 (71)	174.61
2011-12	65.15	403.16	44.80	144.11	18.30	259.05 (64)	26.50 (59)	19.00	23.52	270.08	181.50 (67)	197.35
2012-13	72.74	427.69	47.52	186.71	29.40	240.98 (56)	18.12 (38)	10.00	15.01	313.86	219.73 (70)	249.07
2013-14	65.01	350.36	38.93	283.41	29.60	66.95 (19)	9.33 (24)	11.00	36.42	425.44	271.79 (64)	280.39
2014-15	145.05	312.69	34.74	204.05	30.31	108.64 (35)	4.43 (13)	0.00	36.17	415.58	174.51 (42)	314.59
2015-16	100.98	257.15	28.57	166.27	31.41	90.88 (35)	-2.84	0.00	3.03	301.69	166.84 (55)	210.04
Total		**2000.12**	**222.23**	**1169.96**	**143.93**	**830.16**	**78.30**	**40.00**	**117.81**	**1966.41**	**1185.62**	**1426.05**

Source: SPD, SEMAM, Shillong

As is evident from the above table, though GoI and GoM had to release ₹ 2,000.12 crore and ₹ 222.23 crore respectively during 2010-16, there was a short release of ₹ 830.16 crore and ₹ 78.30 crore by GoI and GoM respectively. The shortfall in the release of share by GoI and GoM ranged from 19 *per cent* to 64 *per cent* and 13 *per cent* to 82 *per cent* respectively. The shortfall in release of funds was mainly on account of inability of the Department to fully utilise the funds released during the year. As a result, unutilised funds were adjusted against the budget provision of the next year. Thus, due to inability to spend the available funds, the programme was deprived of Central and State assistance to the tune of ₹ 908.46 crore[25]. Out of the short released funds received by the SEMAM, it further released only 55 *per cent* to 71 *per cent* of available funds to DMCs. Curtailment of funds by the GoI and GoM and by SEMAM to District Mission Co-ordinators (DMCs) affected the efficient implementation of the RTE Act as due to paucity of fund household surveys were not conducted, there was ad hoc apportioning of funds for enrolled CWSNs, lack of infrastructure[26] in Government, Government aided and SSA schools, *etc.* as pointed out in the earlier paragraphs.

The deficiencies noticed in financial management of the scheme are discussed in succeeding paragraphs.

[25] Central share: ₹ 830.16 crore + State share: ₹ 78.30 crore

[26] Drinking water, separate toilet for girls and boys, library facilities, availability of electricity/ playground/all weather school building /boundary wall , etc

1.2.9.1 Diversion of funds

i. Uniform grant utilised for payment of staff salary

During 2015-16, PAB approved an amount of ₹ 2.24 crore to DMC, Jaintia Hills district for uniform grant to the eligible children. Due to paucity of funds, the SPD, SEMAM however, instructed (December 2015) the DMC, Jaintia Hills district to pay the teachers' salary for the months of October, November and December 2015 from the balance available under Civil works/Uniform grant/or any other fund available which will be replenished in the next release on receipt of GoI share of 2nd instalment. The DMC, Jaintia Hills district accordingly diverted funds to the tune of ₹ 50.48 lakh from the uniform grant to pay the salary of teachers as shown in the table below:

Table No. 1.2.21-Diversion of uniform grant

₹ in lakh

Sl. No.	Name of the Block	Amount approved by PAB for Uniform	Amount utilised for salary of teachers
1	Thadlaskein	66.85	14.18
2	Laskein	44.49	14.15
3	Khleihriat	59.62	-
4	Saipung	29.18	9.62
5	Amlarem	23.8	12.53
	Total	**223.94**	**50.48**

Source: DMC, Jaintia Hills District, Jowai

This diversion consequently resulted in 23,991 out of 55,983 eligible children being deprived of the uniform grant during 2015-16 (Refer ***paragraph 1.2.8.8***). Again, contrary to the SPD's assurance, funds diverted from uniform grant for payment of salary to teachers had not been replenished till the date of audit (August 2016).

1.2.9.2 Audit by the Chartered Accountant Firm

As per the SSA norms, a Chartered Accountant should audit the accounts of the State Implementation Society annually and submit an annual audit report. The deficiencies observed in this regard are detailed below:

i. Selection of same Chartered Accountant Firms

As per Financial Management and Procurement (FMP) Manual of SSA, the Chartered Accountant selected for audit of the State Implementation Society shall be engaged initially for a period of one year. If found suitable, services of the Chartered Accountant firm may be extended on an annual basis for a maximum of further two years. However, in no case should a Chartered Accountant firm be entrusted with the external audit responsibility for a period exceeding three years.

Contrary to the FMP Manual of SSA, same Chartered Accountant firm was selected for periods exceeding three years as detailed below:

Table-1.2.22-Selection of Chartered Accountant Firm

Year	Name of the Chartered Accountant Firm			
	SEMAM	**East Khasi Hills**	**West Garo Hills**	**Jaintia Hills**
2010-11	R. Pal & Co.	R. Pal & Co.	Sanjay Hazarika	Randal & Co.
2011-12			D. Das & Associates	Kiron Joshi & Associates
2012-13				D. Das & Co.
2013-14			Ajit Paul & Co.	D. Das & Co.
2014-15	A. Paul & Co.	Randal & Co.	Kiron Joshi & Associates	A. Paul & Co.

Source: Audit Reports

As is evident from the above table, same Chartered Accountant firm was selected for audit of the SEMAM as well as District Mission Co-ordinator (DMC), East Khasi Hills district consecutively for 4 years in a row. However, in case of West Garo Hills and Jaintia Hills district, rotation of Chartered Accountant firm was done in line with the SSA norms.

ii. Delay in completion of audit by the Chartered Accountant Firms and in submission of Audit Report to GoI

As per FMP Manual of SSA, the Chartered Accountant firm should complete the audit by 31st August every year. Thereafter, the State Government would comment on the audit report received from the implementing society and forward it to Government of India for acceptance by 1st November every year.

Contrary to the above provisions, there were delays ranging between 2 and 4 months in completion of audit by the Chartered Accountant and resultant delay ranging between 1 month and 3 months in submission of Audit Reports to GoI as detailed below:

Table-1.2.23-Delay in completion and submission of Audit Reports

Year of accounts	Scheduled date of completion of audit	Actual date of completion of audit	Delay (months)	Scheduled date of submission of Audit Report to GoI	Actual date of submission	Delay (months)
2010-11	August 2011	09-01-2012	4	1st November 2011	25-01-2012	3
2011-12	August 2012	10-01-2013	4	1st November 2012	28-01-2013	3
2012-13	August 2013	20-12-2013	4	1st November 2013	26-12-2013	2
2013-14	August 2014	20-11-2014	3	1st November 2014	24-11-2014	1
2014-15	August 2015	02-11-2015	2	1st November 2015	12-11-2015	Nil

Source: SPD, SEMAM, Shillong

As can be seen from above table, due to delay in completion of audit, there was also resultant delay in submission of Audit Report to the GoI. Audit also noticed that these Audit Reports were forwarded to GoI without any comments of the State Government.

The State Project Director, SEMAM while accepting the audit observations stated (January 2017) in his reply that corrective measures would be taken for future implementation in selection of Chartered Accountants Firms and to adhere to the timelines set by GoI.

1.2.9.3 Improper accounting of RTE Fund

i. Discrepancy in the Fund Account

There were discrepancies in the balance of 'Fund Account' in the Balance Sheets of SEMAM and three selected districts (East Khasi Hills, Jaintia Hills and West Garo Hills districts) as on 31 March 2013 and 31 March 2014, as detailed below:

Table-1.2.24 - Discrepancy in Fund Account

(₹ in lakh)

Balance Sheet of	Accounting Year	Closing balance of Fund A/c as on 31 March	Opening balance of Fund A/c as on 01 April	Overstatement (+)/ Understatement (-)
SEMAM	2012-13 and 2013-14	9733.77	9790.56	(+) 56.79
DMC, EKH		615.58	634.57	(+) 18.99
DMC, WGH		3042.58	2963.85	(-) 78.73
Jaintia Hills	2010-11 and 2011-12	1086.09	1030.46	(-) 55.63

Source: Audit Reports of SEMAM & DMCs for 2012-13 & 2013-14

The reasons for the discrepancies were neither on record nor stated though called for (June 2016).

Audit cannot draw any assurance regarding the accuracy of the financial statements due to discrepancy in the opening and closing balances of the 'Fund Account'.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that the discrepancy was being rectified.

ii. Charging of depreciation

FMP Manual of SSA does not provide for charging of depreciation on fixed assets created under the SSA/RTE Act. The GoI also reiterated that depreciation should not be charged.

Scrutiny of the financial statements of SEMAM, DMC, East Khasi Hills, DMC, West Garo Hills and DMC, Jaintia Hills district however, revealed that depreciation were charged on the fixed assets as detailed below:

Table-1.2.25 - Charging of depreciation

(₹ in lakh)

Year	Depreciation Charged			
	SEMAM	DMC, EKH	DMC, WGH	DMC, Jaintia Hills
2010-11	37.53	6.68	5.46	2.82
2011-12	46.18	11.89	2.95	10.37
2012-13	56.78	18.99	2.41	6.27
2013-14	Nil	Nil	Nil	7.47
Total	**140.49**	**37.56**	**10.82**	**26.93**

Source: Audit Reports of SEMAM & DMCs

Charging of depreciation not only contravened the provision of the FMP Manual but also resulted in understatement of income in 'Income and Expenditure account' and 'Capital Fund account' of SEMAM in the Balance Sheet during the respective years.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that depreciation charged on fixed assets under SEMAM was done as per the universal accounting rule and on submission of the balance sheet to the GoI, the same was accepted.

The reply was not tenable as the action was in violation of the FMP Manual.

1.2.10 Monitoring and supervision

Regular monitoring and evaluation is a key factor for effective and efficient implementation of any programme. Monitoring has to be a continuous process with both programme implementation and outcome indicators required to be monitored on a regular basis. The deficiencies in the monitoring and supervision aspects are detailed in the succeeding paragraphs.

1.2.10.1 State Advisory Committee

In exercise of the powers conferred by Section 34 of the RTE Act 2009 read with Rule 26 of the MRCFCE Rules 2011, the GoM constituted the State Advisory Council (March 2012) to advise the State Government on implementation of the provisions of the Act in an effective manner. The deficiencies in formation and functioning of the SAC are detailed below:

i. As per the RTE Act, the number of members of SAC should not exceed 15. Contrary to the norm, the SAC was re-constituted in March 2015 with 26 members.

ii. As per the provisions of the MRCFCE Rules 2011, 50 *per cent* of the SAC members should be females. Contrary to the provision of the Rules, the SAC constituted in March 2012 had only 4 female members (27 *per cent*) and re-constituted SAC of March 2015 had only 5 female members (19 *per cent*).

iii. The MRCFCE Rules provides that three months should not intervene between the last and the next meeting of the SAC. The SAC however, met only once (27 November 2012) since its constitution in March 2012 till the date of audit (July 2016).

Thus, the composition of the SAC was not in conformity with the norms laid down under the RTE Act/MRCFCE Rules. Further, holding of only one meeting between March 2012 and March 2016 indicated that the effectiveness of the SAC in advising the State Government on implementation of the provisions of the Act was virtually non-existent.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that the matter was under process.

1.2.10.2 Shortfall in inspections

Under the RTE Act, inspections of the schools are basically done by the Community Resource Personnel (CRPs), Block Resource Personnel (BRPs) and District Co-ordinators. Further, every district was to submit Quarterly Quality Monitoring Format which served as a tool for inspection.

Scrutiny of the records however, revealed that four out of seven districts were not submitting these reports. Out of the three selected districts, only East Khasi Hills district was submitting these reports regularly.

The position of inspections carried out by the CRPs, BRPs and the District Co-ordinators in three selected districts observed during the physical verification of selected schools is shown below:

Table-1.2.26 - Inspection in selected schools

Name of the District	Period	No. of schools visited	No. of times schools were inspected by the CRPs, BRPs and District Co-ordinators					No. of schools not yet inspected (%)
			1-5 times	5-10 times	10-15 times	15-22 times	>22 times	
East Khasi Hills	2010-16	51	34	10	2	3	Nil	2 (4)
West Garo Hills		50	21	6	2	Nil	Nil	21 (42)
Jaintia Hills		51	3	13	15	8	11	1 (2)
Total		**152**[27]						

Source: Questionnaire filled by the selected schools

As is evident from the above table, the inspection of schools in West Garo Hills was low as compared to the East Khasi and Jaintia Hills district since 42 *per cent* of the schools were not inspected even once during 2010-16.

SEMAM had not prescribed any standard for inspection of schools by the CRPs, Block Resource Personnel (BRPs) and District Co-ordinators. Hence, majority of the schools (68 *per cent* in EKH and 42 *per cent* in WGH) were inspected 1-5 times during 2010-16 while 67 *per cent* of the schools of Jaintia Hills district were inspected more than 10 times during the same period. This showed that inspections were carried out in haphazard and *ad hoc* manner.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that corrective measures would be undertaken.

1.2.10.3 Monitoring by the MSCPCR

In exercise of the powers conferred by Section 36 of the Commission for Protection of Child Rights Act, 2005, the State Government notified the Meghalaya State Commission for Protection of Child Rights Rules, 2013 (MSCPCR) on 10 July 2013. The Chairperson was appointed in February 2014 and the Commission commenced functioning from May 2014. The different aspects of functioning of the MSCPCR with respect to the RTE Act are detailed below:

i. Shortfall in holding meetings

As per MSCPCR Rules 2013, the Commission shall meet regularly, but three months shall not intervene between its last meeting and the next meeting. Contrary to the above provisions, the MSCPCR met only twice (06 February 2015 and 30 September 2016) during 2014-16.

[27] Actual number of schools physically verified was 90. But schools having both primary and upper primary classes were counted as separate schools (totalling 152) in order to align it with the method of counting of schools adopted by SEMAM.

ii. Fund not released by SEMAM

PAB approved ₹ 5.00 lakh and ₹ 5.60 lakh for MSCPCR during 2014-15 and 2015-16 respectively. These funds had however, not been released to the MSCPCR till the date of audit (July 2016).

iii. Absence of Child helpline

As per the Meghalaya Right of Children to Free and Compulsory Education Rules 2011, the SCPCR shall set up a child helpline accessible by SMS, telephone and letter, which would act as a forum for aggrieved child/guardian to register complaint regarding violation of rights under the Act.

Contrary to the above provisions, the MSCPCR had not set up a child helpline number to provide accessibility through SMS and telephone. The Education Department however, accepted written and verbal complaints under the RTE Act.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) in his reply that audit observations were noted for future compliance.

1.2.10.4 Internal Audit

Internal Audit is a control that functions by examining and evaluating the adequacy and effectiveness of other controls throughout the organisation. The responsibilities of the internal auditor should include reporting on the adequacy of internal controls, the accuracy and propriety of transactions, the extent to which assets are accounted for and safeguarded, and the level of compliance with SSA financial norms and State Government procedures.

Deficiencies observed in the internal audit of the SEMAM are detailed below:

i) The post of Senior Audit Officer (SAO) and Financial Consultant (FC) of the SPD, SEMAM was being held by the same person on dual charge basis. This is against the propriety of independence of audit from the finance wing.

ii) Two sanctioned posts of Senior Auditor had been lying vacant during 2010-14. One Senior Auditor was only appointed during 2014-15. As such, one post of Senior Auditor was lying vacant till the date of audit (July 2016).

iii) Though the office of the SEMAM was having Senior Audit Officer, Internal Audit Officer and Senior Auditor, SEMAM hired Chartered Accountant Firms every year for conducting internal audit. Reasons though called for (October 2016) were not furnished.

The Special & Nodal Officer, RTE, DSEL-SSA stated (August 2016) that:

i. The Financial Consultant in position recently resigned from his post and Sr. Audit Officer was given charge till the competent person fit for the post was appointed.

ii. Audit observation noted for future compliance.

iii. The GoI allows the State to hire Chartered Accountants till the time In-house Audit is strengthened.

1.2.11 Joint physical verification of schools

Physical verification of 152 schools[28] was undertaken by the officers of SEMAM (BMCs) and the audit team to assess the actual implementation of RTE Act at the school level. The deficiencies observed during the verification are detailed below:

1.2.11.1 Qualification of teachers

The qualification of teachers in selected schools of three districts is detailed below:

Table-1.2.27-Qualification of teachers in selected schools

Name of the District	No. of schools	Total No. of teachers	Qualification of teachers (%)				
			XII Pass	Graduate	Masters	Diploma in Elementary Education	Bachelor of Education
East Khasi Hills	51	176	54 (31)	82 (47)	10 (6)	15 (8)	15 (8)
West Garo Hills	50	148	92 (62)	38 (26)	01 (1)	05 (3)	12 (8)
Jaintia Hills	51	168	56 (33)	87 (52)	07 (4)	08 (5)	10 (6)
Total		**492**	**202 (41)**	**207 (42)**	**18 (4)**	**28 (6)**	**37 (7)**

As is evident from above table, only 13 *per cent* (D.EL.ED: 6 *per cent* and B.ED: 7 *per cent*) of the teachers in selected schools were having qualifications as prescribed by the NCTE while 83 *per cent* had not acquired the requisite qualification. This situation was alarming and needs immediate attention of the Education Department.

1.2.11.2 Untrained teachers

In three selected districts, the proportion of untrained teachers was as detailed below:

Table-1.2.28-Untrained teachers

Name of the District	Total No. of schools visited[29]	Total No. of teachers	No. of untrained teachers (%)
East Khasi Hills	51	176	114 (65)
West Garo Hills	50	148	111 (75)
Jaintia Hills	51	168	102 (61)

As is evident from table above, the position of untrained teachers in the three selected districts was alarming with 60 *per cent* to 77 *per cent* of the teachers being untrained till the date of audit (July 2016).

1.2.11.3 Absence of science and maths teacher

Contrary to the provisions of the FMP Manual, there was absence of science and maths teachers in upper primary schools in three selected districts as detailed below:

[28] Actual number of schools physically verified was 90. But schools having both primary and upper primary classes were counted as separate schools in order to align it with the method of counting of schools adopted by SEMAM.

[29] Schools having both Primary and Upper Primary sections are treated as separate schools having different school codes

Table-1.2.29 - Availability of science and maths teacher

Name of the District	No. of Upper Primary Schools visited	Schools having no science and maths teacher (%)
East Khasi Hills	25	6 (24)
West Garo Hills	21	10 (45)
Jaintia Hills	22	5 (23)

As is evident from the table above, 23 *per cent* to 45 *per cent* of the selected upper primary schools in three selected districts were not having science and maths teacher.

1.2.11.4 Infrastructure in schools

The position of infrastructure in selected schools of three districts was as detailed below:

Table-1.2.30 - Infrastructure facilities in selected schools

Name of the District	No. of schools visited	No. of schools not having (% in brackets)						
		One classroom for every teacher and Office cum-Head teacher's room	Barrier Free Access	Separate toilet for Girls and boys	Safe and adequate drinking water	Kitchen for MDM	Play-ground	Boun-dary wall
East Khasi Hills	51	29 (57)	24 (47)	16(31)	25 (49)	12 (24)	35 (69)	38 (75)
West Garo Hills	50	38 (76)	27 (54)	19 (38)	31 (62)	05(10)	28 (56)	47 (94)
Jaintia Hills	51	26 (51)	26 (51)	24 (47)	38 (74)	6 (12)	30 (59)	35 (69)

As is evident from above table, infrastructure facilities in all the three selected districts were deficient especially in terms of one classroom for every teacher and Office-cum-Head Teacher's room, barrier free access, availability of safe drinking water, playground and boundary wall facilities.

1.2.11.5 School Management Committee meetings

As per the provisions of the MRCFCE Rules 2011, the School Management Committees were to meet at least once in a month.

The position of School Management Committee meetings in the selected schools of three districts during 2011-16 is detailed below:

Table-1.2.31-School Management Committee (SMC) meetings in selected schools

Name of the District	No. of schools visited	Number of SMC meetings held during last 5 years				
		1-5 times	5-10 times	10-15 times	15-20 times	>20 times
East Khasi Hills	51	6	13	4	4	3
West Garo Hills	50	20	10	4	3	0
Jaintia Hills	51	3	12	9	8	2

As is evident from above table, there was severe shortfall in number of School Management Committee meetings as against the requirement of holding 60 School Management Committee meetings during 2011-16.

1.2.12 Impact analysis of the Scheme

With a view to analysing the impact on implementation of the RTE Act, the retention trend of the students in government schools[30] was assessed during the performance audit. The class wise enrolment in primary and upper primary schools in the State and their retention trend during 2010-16 are analysed in the table below:

Table-1.2.32-Retention of enrolled children in the State

Year	Class								Total
	I	II	III	IV	V	VI	VII	VIII	
2010-11	97076	89646	80275	63489	64334	48709	31244	9164	483937
2011-12	101377	89907	80079	65451	53993	56833	35767	16046	499453
2012-13	96569	87263	78723	65366	51553	50508	34802	15195	479979
2013-14	89324	84513	79434	66883	55128	52923	34924	16293	479422
2014-15	80617	84716	80306	70363	57125	53678	34294	16364	477463
2015-16	77404	82624	81134	71997	60094	54978	35209	15468	478908

Source: DSEL, Shillong

From the table, it would be clear that only 54,978 out of 97,076 children (highlighted in table) enrolled in class I could be retained in Class VI after six years. Drop out of 42,098 (43 *per cent*) children during 2010-16 indicated decline in retention rate in spite of implementation on the RTE Act over six years.

On enquiring about the reason for the decline in the retention rate, the State Project Director, SEMAM stated (January 2017) in his reply that the reasons for decline in the retention rate was under investigation.

1.2.13 Conclusion

Though the RTE Act envisages to achieve elementary education for all children between ages 6-14 years by March 2013, the State had not fully achieved the desired objective. Considering that the State already had a high enrolment of 96 *per cent* during 2011-12 itself, failure to universalise the elementary education indicated lacklustre performance of the Department in implementing the RTE Act 2009. In the State, Annual Plans were being prepared without having perspective plan and without adopting participatory approach at the village/habitation level. Education for OOSC and CWSN did not receive special care and attention. The State failed to contain the existing dropout rates. High proportion of untrained and unqualified teachers, shortage of teachers in primary schools, lack of basic infrastructure, shortages in uniform grant, non-availability of free textbooks, shortages in grant of transport allowance were the factors which hindered the State in achieving the objective of universalisation of elementary education. The fund allocated to the State was not being utilised efficiently as ₹ 908.46 crore was not released by the GoI/GoM due to under-utilisation of funds. Expenditure of ₹ 483.88 crore on incomplete civil works were lying unfruitful for a period of three to six years. Provision of reserving 25 *per cent* of the strength of the class in unaided schools for children belonging to weaker sections and disadvantaged

[30] Government, Government Aided and SSA schools

groups was not being implemented. Monitoring and supervision of the scheme in terms of constitution, composition and meetings of the State Advisory Committee, constitution and functioning of the State Commission for Protection of Child Rights, inspections and internal audit was not very satisfactory.

1.2.14 Recommendations

On the basis of the shortcomings and deficiencies pointed out in the foregoing paragraphs, the following recommendations are made for improving the effectiveness of the working of the SEMAM for implementation of the RTE Act, 2009:

- *perspective plan should be prepared and annual plans should adopt a participatory approach and draw its targets from the perspective plan;*
- *enrolment of children and universalisation of elementary education by covering all the eligible children should be ensured and the dropout rates be contained;*
- *focus should be laid on training the untrained teachers and reducing the shortage of teachers in primary schools;*
- *infrastructure and basic facilities should be provided in schools;*
- *funds should be effectively utilised in time;*
- *functioning of the SAC, MSCPCR and internal audit should be improved. Inspections should be carried out in a planned manner and vigorously followed up.*

HEALTH AND FAMILY WELFARE DEPARTMENT

1.3 National Rural Health Mission

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

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

Highlights:

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

(Paragraphs 1.3.9.1 & 1.3.9.2)

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

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

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

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

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

(Paragraphs 1.3.9.11 & 1.3.9.12)

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

(Paragraphs 1.3.10.1 & 1.3.10.2)

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

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

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

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

1.3.1 Introduction

Background

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

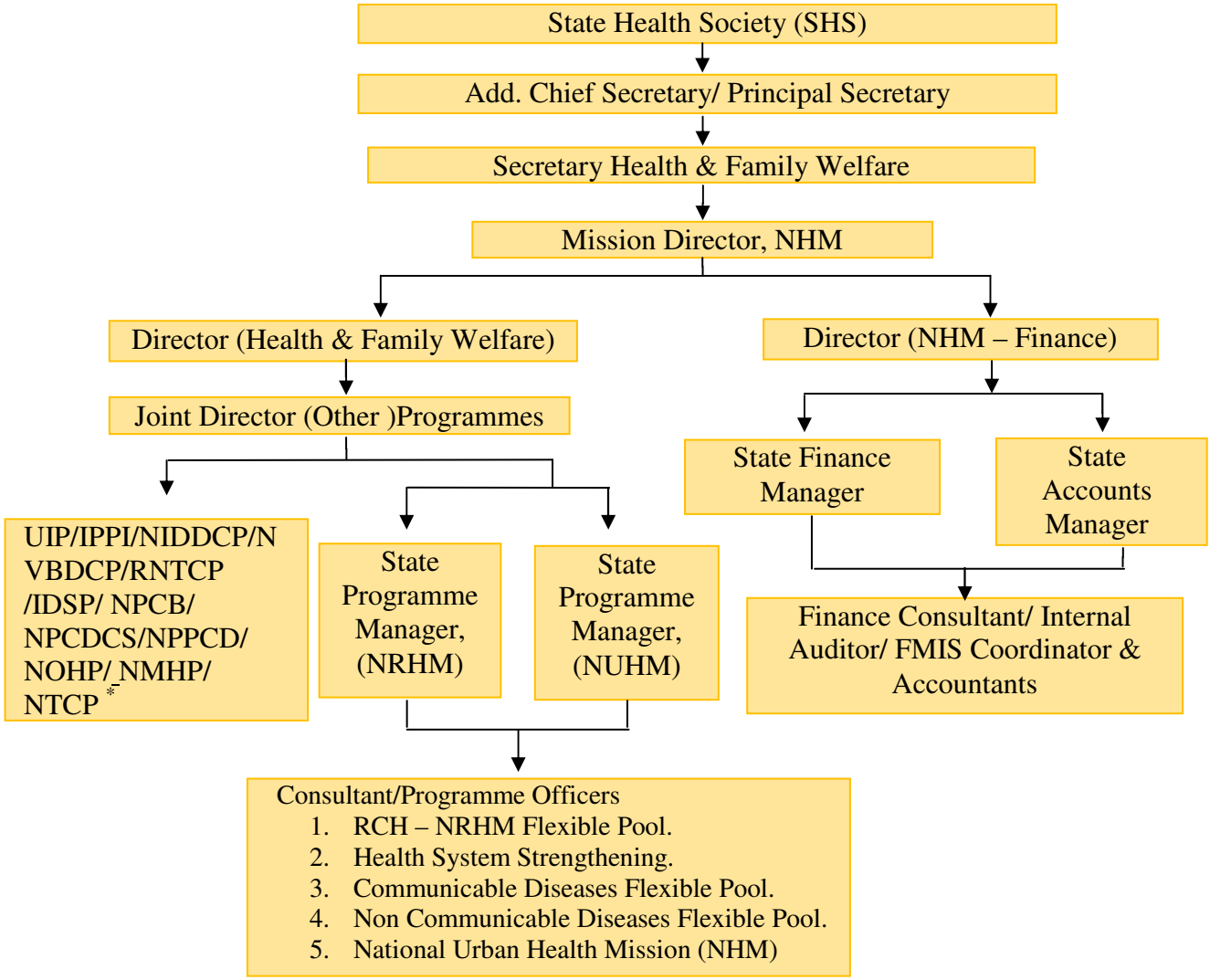
On 15 May 2013, the NRHM was subsumed as a sub mission of an over arching National Health Mission (NHM). The objectives of NRHM were to reduce child and maternal mortality; provide universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health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

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

Organisational Structure

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

Organisational Structure of NHM



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

1.3.2 Financial inputs and fund flow arrangements

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

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

b) Contribution by the State Government

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

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

Table 1.3.1: Financial position

(₹ in crore)

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

(Source: SHS)

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

1.3.3 Audit Objectives

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

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

   i. extent of availability of physical infrastructure

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

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

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

1.3.4 Audit criteria

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

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

1.3.5 Audit Sampling

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

1.3.6 Scope and coverage of audit

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

1.3.7 Audit methodology

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

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

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

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

1.3.8 Acknowledgement

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

Audit Findings

1.3.9 Availability of physical infrastructure

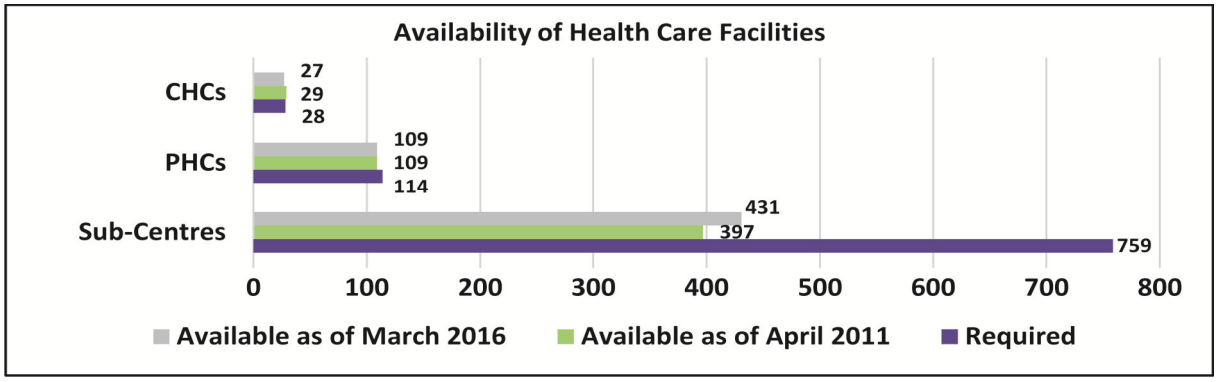
NRHM aims to bridge gaps in existing capacity of rural health infrastructure by establishing functional health facilities such as DHs, CHCs, PHCs and SCs through revitalisation of existing physical infrastructure and fresh construction or renovation wherever required.

1.3.9.1 Availability of Health Centres against the requirement

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

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

Chart 1.3.9.1 – Availability of CHCs/PHCs and SCs



(Source: Information furnished by SHS)

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

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

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

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

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

1.3.9.2 Shortage of First Referral Units

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

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

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

1.3.9.3 Health facility not operationalised.

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

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

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

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

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

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

1.3.9.4 Non upgradation of infrastructure

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

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

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

1.3.9.5 Poor infrastructure in the selected five district hospitals

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

The main issues noticed in the five selected DHs were:

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

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

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

1.3.9.6 Poor infrastructure in the three selected CHCs

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

The issues noticed in the three selected CHCs were:

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

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

Rusted labour table in Riangdo CHC

Toilet outside female ward in Riangdo CHC used for storage

Flooding in Bhoirymbong CHC during rain due to faulty system

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

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

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

Seepage of water in staff quarter of Umsning CHC

1.3.9.7 Poor infrastructure in the 12 selected PHCs

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

The issues noticed in the 12 selected PHCs were:

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

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

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

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

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

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

1.3.9.8 Poor infrastructure in the 36 selected SCs

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

The issues noticed in the 36 selected SCs were:

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

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

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

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

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

1.3.9.9 Shortfall in availability of staff quarters

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

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

Table 1.3.2 - Availability of staff quarters

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

(Source: information furnished by the health centres)

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

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

1.3.9.10 Medicines and equipment

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

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

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

(i) Improper assessment and procurement of medicines

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

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

Table 1.3.3 – Excess procurement of drugs

(₹ in crore)

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

(Source: Replies furnished by SHS)

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

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

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

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

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

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

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

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

Source: Records maintained at health facilities

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

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

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

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

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

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

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

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

(iv) Procurement of equipment

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

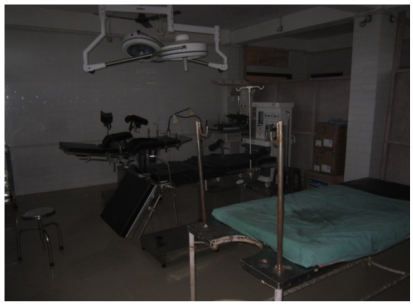
Table 1.3.5 – Funds utilised for procurement of equipment

(₹ in crore)

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

(Source: Information furnished by SHS)

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



OT in Riangdo CHC lying unutilised

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

Table top incinerator lying idle in Nongstoin DH

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

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

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

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

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

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

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

Table 1.3.6 Availability of equipment in five DHs and three CHCs

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

(Source: Replies furnished by facilities)

From the above, it can be seen that:

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

(vi) Equipment lying idle/ non functional

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

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

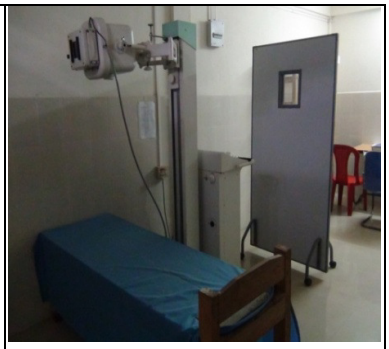
- OT in Nongstoin and Nongpoh DHs were lying idle and were not utilised because of lack of specialist doctors. In reply (December 2016), the Secretary, Health Department stated that the OT in Nongpoh was used for sterilisation cases. But the fact remained that the OT was not used for cases other than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

OT in Nongstoin DH lying unutilised

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

Anaesthetist machine lying idle in Nongpoh DH

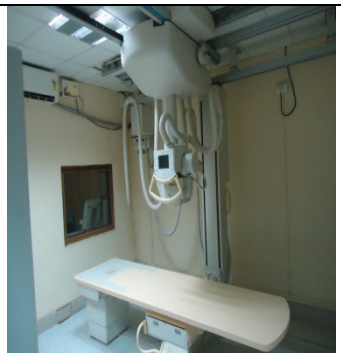
Non functional 500 MA X-Ray Nongpoh DH



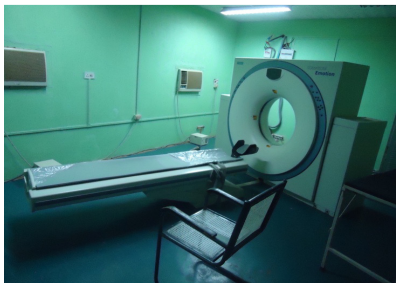
Functional X-Ray machine lying unutilised in Bhoirymbong CHC

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

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

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

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



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

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

1.3.9.11 Mobile Medical Units

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

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

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

[51] Recorded in the RoP of 2015-16

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

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

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

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

1.3.9.12 Ambulance Service

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

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

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

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

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

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

1.3.10 Availability of health care professionals

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

1.3.10.1 Shortfall in availability of manpower at District Hospital

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

Table 1.3.7 – Manpower position of DHs

(In numbers)

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

(Source: Information furnished by SHS)

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

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

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

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

Table 1.3.8 – Manpower position of selected DHs

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

(Source: Information furnished by the five selected DHs)

From the above, Audit observed as follows:

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

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

1.3.10.2 Shortfall in availability of manpower at CHCs

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

Table 1.3.9 – Manpower position of CHCs

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

(Source: Information furnished by SHS)

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

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

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

Table 1.3.10 – Manpower position of selected CHCs

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

(Source: Information furnished by three selected CHCs)

From the above, Audit observed as follows:

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

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

1.3.10.3 Shortfall in availability of manpower at PHCs

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

Table 1.3.11 – Manpower position of PHCs

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

(Source: Information furnished by SHS)

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

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

Table 1.3.12 – Manpower position of selected PHCs

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

(Source: Information furnished by 12 selected PHCs)

From the above, Audit observed as follows:

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

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

1.3.10.4 Human resources at Sub Centres

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

Table 1.3.13 – Manpower position of selected SCs

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

(Source: Information furnished by 36 selected SCs)

From the above, Audit observed that:

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

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

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

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

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

1.3.11 Quality of health care provided

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

1.3.11.1 Antenatal care

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

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

Table 1.3.14 - Pregnant women registered and receiving ANC services

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

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

(Source: information furnished by SHS)

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

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

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

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

1.3.11.2 Shortfall in institutional deliveries

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

Table 1.3.15 - Target and achievement of institutional deliveries

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

[61] Targets for ID was furnished only for JSY

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

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

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

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

Table 1.3.16 - Achievement of institutional deliveries

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

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

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

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

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

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

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

1.3.11.3 Post natal care

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

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

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

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

(Source: information furnished by districts)

It is seen from the table above that:

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

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

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

1.3.11.4 Payment of JSY incentive

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

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

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

Table 1.3.18 – Target and actual payment made for JSY

(₹ in lakh)

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

(Source: Information furnished by SHS)

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

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

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

Table 1.3.19 - JSY beneficiaries who did not receive financial incentives

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

(Source: Information furnished by SHS & districts)

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

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

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

1.3.11.5 Immunisation of infants and children

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

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

Table 1.3.20 - Shortfall in immunising children

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

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

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

Table No 1.3.21 - Trend of Infant Diseases

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

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

1.3.11.6 Family Planning

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

(i) Target and achievement of sterilisation – terminal method

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

Table 1.3.22 - Target and achievement of terminal methods of sterilisation

(Figures in numbers)

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

(Source: Information furnished by SHS)

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

(ii) Target and achievement of sterilisation – spacing method

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

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

Table 1.3.23 - Target and achievement of IUD insertion

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

(Source: Information furnished by SHS & districts)

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

[64] T – Target , A - Achievement

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

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

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

1.3.11.7 Quality Assurance

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

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

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

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

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

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

1.3.12 Indicators of performance

1.3.12.1 Data collection and reporting system

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

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

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

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

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

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

1.3.12.2 Data quality and reliability

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

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

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

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

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

1.3.12.3 Information, Education & Communication

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

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

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

Table 1.3.24 – Funds allocation and expenditure on IEC

(₹ in lakh)

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

(Source: Information furnished by SHS)

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

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

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

1.3.12.4 Monitoring and evaluation

(i) Shortfall of meetings at State level

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

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

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

Table 1.3.25 – Details of Meeting held at State level

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

Source: Information furnished by SHS

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

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

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

(ii) Shortfall in formation of VHSNC

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

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

Table 1.3.26 - Position of formation of VHSNCs in three districts

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

Source: Information furnished by districts

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

(iii) Approval of Plans by SHS

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

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

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

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

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

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

1.3.12.5 Beneficiary and ASHA survey

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

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

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

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

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

Table – 1.3.27 - Availability of basic equipment with ASHA

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

1.3.12.6 Assessment of performance

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

Table 1.3.28 - Achievement of key health indicators

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

(Source: Information furnished by SHS)

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

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

Table 1.3.29 – Cases of maternal deaths

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

(Source: Information furnished by SHS)

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

1.3.13 Conclusion

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

1.3.14 Recommendations

The recommendations of Audit are:

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

COMPLIANCE AUDIT PARAGRAPHS

HEALTH AND FAMILY WELFARE DEPARTMENT

1.4 Unfruitful expenditure

Failure of the Health Engineering Wing to make provision for transformer in its estimate and delay in requesting Meghalaya Power Distribution Corporation Limited for installing transformer for the Mawryngkneng PHC had not only rendered the expenditure of ₹ 1.00 crore incurred on the construction unfruitful but the objective to operate from the renovated and extended PHC remained unfulfilled even after three years of the building being completed.

Ministry of Health and Family Welfare, Government of India (GoI) approved the work 'Renovation and extension of Mawryngkneng Primary Health Centre (PHC)' for ₹ 1.00 crore with initial installment of ₹ 0.50 crore for 2012-13 and another ₹ 0.50 crore for 2013-14 under the National Rural Health Mission State Programme Implementation Plans 2012-13 and 2013-14. The estimate for the work was prepared by the Executive Engineer, Health Engineering Wing (EE-HEW), Directorate of Health Services (DHS), Meghalaya on plinth area basis, based on Public Works Department Schedule of Rate (Building) for the year 2010-11. The reason stated for taking up the work was because the existing PHC at Mawryngkneng had become old and some portion of the land in front of the PHC including a portion of the main building would fall on the proposed National Highway.

Notice Inviting Tender for the work was invited (August 2012) by the Department and the work order was issued (October 2012) to the lowest bidder. The work was completed in November 2013 at an expenditure of ₹ 1.00 crore.

Scrutiny (October-November 2016) of records of the Executive Engineer, Health Engineering Wing (EE-HEW), Meghalaya revealed that even though the building was completed in November 2013, the newly constructed PHC building had not been made functional as the load capacity of electricity presently supplied was not capable of catering to the load requirement of the new building and a separate transformer was needed for the whole complex.

Further scrutiny revealed that the estimate for the work did not have the provision for providing transformer to meet the electrical load of the newly renovated PHC and its complex. It was only 16 months after the construction was completed that the EE-HEW (DHS), Meghalaya requested (April 2015) the Meghalaya Power Distribution Corporation Limited (MePDCL) for installation of transformer for the PHC. Even upto September 2015, the HEW (DHS), Meghalaya was meeting the query raised by MePDCL on the status of the existing electrical connections within the PHC complex. During the joint physical verification of the Mawryngkneng PHC conducted on 25 November 2016 by the officers of the HEW and the Audit team, it was seen that the transformers were not installed and electrical supply line had not been provided,

resulting in the completed PHC building lying idle even after three years of its completion.

Thus, failure of the HEW(DHS), Meghalaya to provide for transformer in its estimates, coupled with delay in requesting MePDCL for installing transformer for the PHC had not only rendered the expenditure of ₹ 1.00 crore incurred on the construction unfruitful but the objective to operate from the renovated and extended PHC remained unfulfilled even after three years of the building being completed.

The matter was reported to Government/Department in December 2016; reply was awaited (January 2017).

URBAN AFFAIRS DEPARTMENT

1.5 Unfruitful expenditure

Urban Affairs Department failed to provide shelter to 240 urban slum dwellers of Nongpoh even after a lapse of more than five and half years of the targeted date of completion, rendering the expenditure of ₹ 3.73 crore unfruitful. Besides with the project being executed on a land belonging to the contractor, the expenditure is fraught with the risk of becoming wasteful if the Department fails to acquire the land from the contractor.

The Meghalaya Urban Development Agency (MUDA), the nodal agency under the Urban Affairs Department (UAD) for implementation of schemes under the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) entered into an agreement (March 2007) with Hindustan Prefab Limited (HPL), a Government of India Enterprise, for formulating and executing projects under the sub-missions of JNNURM programme. Accordingly, HPL prepared (February 2009) a detailed project report (DPR) to relocate 240 Economically Weaker Section (EWS) households from slums at Nongpoh under the Integrated Housing and Slum Development Programme (IHSDP), a sub-mission under the JNNURM. The project estimated to cost ₹ 9.18 crore also included ₹19.30 lakh for acquiring 40,173.14 sqm of private land at Pahamsyiem, Nongpoh.

The Ministry of Housing and Urban Poverty Alleviation, Government of India (GoI) approved (February 2009) the project at a cost of ₹ 9.18 crore with the Central share of the project cost being ₹ 7.10 crore and the State share ₹ 2.08 crore. The project was approved with a condition that the State must furnish confirmation regarding possession of land. The status whether MUDA had submitted the confirmation of possession of land to GoI could not be verified since relevant records were not produced to Audit despite reminder (June and July 2016). For the project, GoI released (July 2009) ₹ 3.55 crore and Government of Meghalaya (GoM) released (February 2011) ₹ 1.04 crore as their matching share.

Scrutiny of records of MUDA (April 2016) regarding implementing the project revealed the following irregularities:

- Prior to preparation of the DPR, Urban Affairs Department (UAD) received an offer (July 2008) from Nongpoh-Pahamsyiem IHSDP Project Committee for sale of 10 acres of *Ri Raid* (Community land), free from all encumbrances, at Pahamsyiem, Nongpoh (site-I) including giving advance possession of the land pending payment of the land compensation. The UAD however, took another 11 months to ascertain the suitability and ownership of the land and only in June 2009, the Director, UAD requested the Deputy Commissioner (DC), Ri Bhoi to initiate the land acquisition proceeding. HPL however, without even ascertaining whether DC, Ri-Bhoi had initiated the land acquisition proceeding, tendered the work (May 2010) and awarded (July 2010) it to M/s Leborlang Lyngdoh, a local contractor, at a tendered value of ₹ 7.79 crore with a stipulation to complete the work within 15 months (October 2011).

  During December 2010, when the contractor went to commence the work, some local people stopped the construction on the ground that the site was a cultivable land. During June 2011, the Nongpoh Town Committee (NTC) submitted an unregistered gift deed to the UAD showing that the '*Dorbar Shnong of Umbada, Mylliem Syiemship*[65]*'* had donated 3,54,300 sqft of land at Umbada, Nongpoh (site–II) for the project, on the condition that the Government compensate for the loss of cultivated crops. UAD however, failed to direct NTC to register the land and subsequently, the project was shifted (July 2011) to site – II. During July 2015, the chairman of the NTC however, wrote to the Director, UAD that based on the verbal request of the UAD, the contractor with the help of NTC had identified the land at site II and purchased it at a cost ₹ 0.36 crore. The chairman also stated that the purchase was duly registered with Sub-Registrar Office at Nongpoh and as on the date of the letter the project stands on the land belonging to the contractor. The chairman then requested the Director, UAD to pay the cost of land to the contractor with little amount of interest so that the contractor transfers the land to the UAD. Despite the different claim to the ownership of the land being reported to UAD, it failed to take any steps to ensure that the Department had a clear title to the ownership of the land at Umbada. Consequently the project being undertaken is fraught with risk of turning wasteful in case the contractor fails to hand over the land to the UAD at a later date. Further despite the delay in ascertaining the suitability and ownership of the land at site-I the Department failed to ascertain the opposition of the public towards the project thus delaying the project with resulted in escalation in the cost of the project.

[65] 'Dorbar Shnong' means the traditional village institution of the village of the Khasis where the prevailing age-old customary and traditional governance and adjudication are carried -out

- The work at site-II commenced during August 2011 and out of a total 240 dwelling units sanctioned, construction of only 128 dwelling units were taken up due to lesser area and topography of the plot at site-II. Subsequently after incurring an expenditure of ₹ 3.73 crore on completion of only 90 *per cent* of 112 dwelling units and 40 *per cent* of 16 dwelling units, HPL expressed (October 2013) its inability to complete the project at the old rates and requested either for a cost escalation or takeover of the project by the State Government on 'as is where is basis'. UAD framed (February 2015) a revised estimate of ₹ 5.15 crore to complete the remaining works of the 128 dwelling units and other basic infrastructure[66]. The estimates had however, not been approved by the Government (August 2016). The incomplete project was taken over from HPL (May 2015) by MUDA on 'as is where is basis' without acquiring the land at site-II. The documents of handing over of the project also recorded the fact that the land was in the name of the contractor and ₹ 0.36 crore was to be paid to the contractor for the land. Till the time of taking over the incomplete project, MUDA had released ₹ 3.55 crore to HPL and had outstanding liability of ₹ 0.18 crore to be paid to HPL and ₹ 0.36 crore to be paid to the contractor for the land at Umbada, Nongpoh.

Thus, failure of the Department to provide shelter to 240 urban slum dwellers even after a lapse of more than five and half years of the stipulated date of completion had not only rendered the expenditure of ₹ 3.73 crore incurred on the project unfruitful, but because of the project being executed on the land purchased by the contractor (site-II), the expenditure is fraught with risk of turning wasteful in case the contractor failed to hand over the land to the UAD at a later date. Besides, delay in ascertaining the suitability and ownership of the land at site-I and failure to ascertain the opposition of the public towards the project also contributed to delaying the project with risk of escalation in cost of the project.

The matter was reported to Government (August 2016); reply had not been received (January 2017).

[66] A community centre, footpath, drains, internal road, external electrification and water supply.