Chapter-II
Performance Audits

Chapter II: Performance Audit

PUBLIC HEALTH AND FAMILY WELFARE DEPARTMENT

2.1 Performance Audit on National Rural Health Mission

Executive Summary

Introduction

National Rural Health Mission (NRHM) was launched on 12 April 2005 to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It aimed to reduce infant mortality, maternal mortality and total fertility rates and prevent and reduce mortality and morbidity from communicable and non-communicable diseases. In this process, NRHM was expected to help achieve goals set under the Millennium Development Goals (MDG) 2015 of reducing Infant Mortality Rate (IMR) to 27/1,000 live births and Maternal Mortality Rate (MMR) to 109/1,00,000 live births.

The resource for the programme was shared between Centre and State Governments. During the years 2011-12 to 2015-16, ₹ 5,588.76 crore was incurred against approved outlay of ₹ 6,247.01 crore for Reproductive and Child Health (RCH), immunisation programme and Mission flexi pool. A Performance Audit to assess the impact of NRHM on improving Reproductive and Child Health in the State for the period 2011-12 to 2015-16 revealed the following:

Achievement of NRHM in attaining demographic goals

- State could not attain the goals for IMR, MMR and Total Fertility Rate (TFR) and it was lagging far behind the achievements of other States. The IMR of the State was 51 per 1,000 live births as against the target of 27 per 1,000 live births under MDG. Madhya Pradesh stands at 27th place out of 28 States in IMR. Similarly, the State could reduce MMR to 221 per 1,00,000 live births against the MDG target of 109 per 1,00,000 live births. In MMR, the State was at 13th place out of 18 States.

- The status of TFR improved since 2012, as it reduced from 2.9 (March 2012) to 2.3 (March 2016). However, State could not achieve the target fixed under NRHM Framework of Implementation (2012-17) to reduce TFR to 2.1. The shortfalls in providing maternal, child and reproductive health care services resulted in failure of State in achieving targets for IMR, MMR and TFR.

(Paragraph 2.1.6)

Status of Maternal, Child and Reproductive Health Care Services

- Out of 93.72 lakh pregnant women registered for Antenatal Care (ANC) during 2011-16, only 52.51 lakh (56 *per cent*) could be registered within 1st trimester of pregnancies and 19.44 lakh (21 *per cent*) could not

receive three ANC check-ups. Human Immuno-deficiency Virus (HIV) testing of 47.27 lakh and Venereal Disease Research Laboratory (VDRL) testing of 60.34 lakh pregnant women were not conducted.

(Paragraph 2.1.7.1)

- Institutional delivery was 87 *per cent* of the total deliveries in the State during 2011-16. Forty-eight hours stay at health centres was to be promoted in view of more likelihood of obstetric complications and maternal deaths during delivery and within 48 hours after child birth. However, 28 *per cent* women were discharged within 48 hours of delivery in public institutions. Further, only 35.21 lakh (55 *per cent*) mothers received postpartum check-up between 48 hours to 14 days after delivery due to apathetic attitude of service providers (Staff Nurse and Auxiliary Nurse Mid-Wife (ANMs)) and lack of referral transports.

(Paragraph 2.1.7.2)

- There was large difference of 23.89 lakh between total ANC registered (93.72 lakh) and total delivery (69.83 lakh) during 2011-16. The case of missing delivery may have impact on skewed sex ratio of 52:48 at birth.

(Paragraph 2.1.7.4)

- Targets set for child immunization against seven vaccine preventable disease could not be achieved during 2011-16 and the range of shortfall was 16 to 21 *per cent*. Besides a dose 'Hepatitis B Zero' was to be provided up to 48 hours of birth. However, Out of 69.25 lakh live births, only 39.30 lakh (57 *per cent*) infants were provided 'Hepatitis B Zero' due to unavailability of storage facility of vaccine at health centres, besides failure to provide the dose in case of home deliveries.

(Paragraph 2.1.8.2)

- *Eight per cent* maternal deaths in India are attributed to unsafe abortions. However, Medical Termination of Pregnancy (MTP) services were not provided in 25 sub-district level Hospital (out of 63), 136 Community Health Centres (CHCs) (out of 334) and 380 (out of 531) 24x7 Primary Health Centres (PHCs).

(Paragraph 2.1.9.1)

- TFR could not be reduced due to low performance in family planning programme. Against 3.03 lakh vasectomy planned during the year 2011-16, only 0.83 lakh (27 *per cent*) male sterilization could be performed. The achievement of female sterilization was 43 and 22 *per cent* against planned for minilap and post-partum sterilization respectively. There was shortfall of 42 *per cent* and 49 *per cent* in distribution of contraceptive oral pills and condoms, respectively.

(Paragraph 2.1.9.2)

Planning and Budgeting

- District Health Action Plans (DHAPs) were not prepared after aggregating Block Health Action Plans (BHAPs). Inter-sectoral convergence

with the line departments was not included in annual Programme Implementation Plan (PIP) and DHAPs. Further, State PIPs were submitted to GoI with a delay ranging from 69 to 196 days during 2011-12 to 2015-16. Consequently, the approval of PIPs from GoI was received with a delay ranging from 72 to 223 days.

(Paragraphs 2.1.10.1, 2.1.10.2 and 2.1.10.3)

- During the year 2011-16, GoI approved PIP for ₹ 6,247.01 crore against which only ₹ 5,269.70 crore was made available for implementation of NRHM in the State. Thus, Government could not ensure sufficient fund for implementation of the scheme, despite the dismal performance of State on health indicators.

(Paragraph 2.1.10.4)

Shortage of Rural Health Centres

- The State had failed critically in creating sufficient rural health centres. There was shortfall of 2588 Sub-Centres (SCs) (22 *per cent*), 828 PHCs (41 *per cent*) and 153 CHCs (31 *per cent*) as against the population norms under NRHM. Out of total 9,192 SCs in the State, only 241 were providing delivery services. Upgradation of PHCs as 24x7 was one of the goals of NRHM. However, only 638 out of 1,172 PHCs were functioning 24x7. First Referral Unit (FRU) services were being provided at only 30 out of 334 CHCs in the State. Audit noticed lack of infrastructure in terms of wards, labour rooms, operation theatres, electric supply and toilets, etc.

(Paragraph 2.1.11)

- **Shortage of Health Care Professionals**

Out of 1,172 PHCs in the State, 503 PHCs were functioning without doctors as of April 2016. Further, Laboratory Technician and Pharmacist were not posted in 525 and 312 PHCs respectively. In 96 CHCs of sampled districts, only 13 specialists were available against sanctioned 346 specialists. Further, 58,730 Accredited Social Health Activists (ASHAs) were engaged in the State as of April 2016 against the requirement of 62,206 ASHAs.

(Paragraph 2.1.12)

- **Availability of essential drugs and laboratory services**

Under *Madhya Pradesh Swasthya Seva Guarantee Yojana*, Government was committed to provide minimum essential drugs and laboratory services for all types of health facility centres. However, none of the test-checked health facilities had all the listed drugs and laboratory services categorised under *Madhya Pradesh Swasthya Seva Guarantee Yojana*.

(Paragraphs 2.1.13 and 2.1.15)

Quality Assurance

- State quality assurance committee and district quality assurance committees did not meet at prescribed intervals. Patient satisfaction survey

was not conducted in 10 out of 13 test checked District Hospitals (DHs). Quality assurance programme was not implemented at CHC and PHC levels.

(Paragraph 2.1.18)

Data collection, management and reporting

- There were gaps in capturing of data related to ANC, child care and immunization services provided in private health institutions. Further, entire data of delivery of pregnant women conducted in private health institutions and at home were also not reflected in Health Management Information System (HMIS).

(Paragraph 2.1.20)

2.1.1 Introduction

2.1.1.1 Background

National Rural Health Mission (NRHM) was launched by Government of India in April 2005 to provide accessible, affordable and quality health care to the rural population. A special focus was on 18 States, including Madhya Pradesh, having weak public health indicators and/or weak infrastructure. It aimed to reduce infant mortality, maternal mortality and total fertility rate[1] (TFR) for population stabilisation, and prevent and reduce mortality and morbidity from communicable and non-communicable diseases. The expected outcomes of implementation of NRHM were as detailed in ***Appendix-2.1.1***. In this process, NRHM was expected to help achieve goals set under the Millennium Development Goals 2015 of reducing Infant Mortality Rate (IMR) to 27/1,000 live births and Maternal Mortality Rate (MMR) to 109/1,00,000 live births.

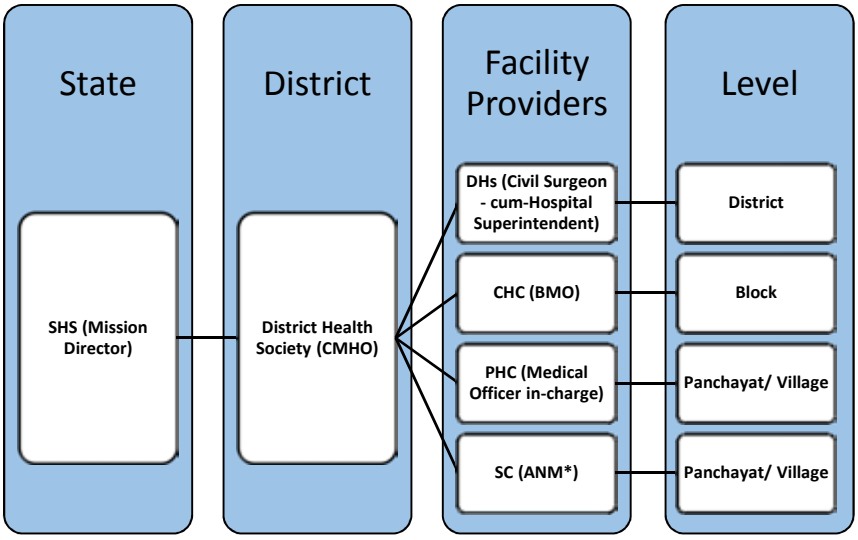
2.1.1.2 Organisational structure

At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. NRHM is a mission mode programme carried out by State Health Society (SHS). Every district has a District Health Societies (DHS) headed by District Collector. Chief Medical and Health Officer (CMHO) acts as the Secretary of DHS. Block Medical Officers (BMOs) are responsible for implementation of the programme at block and village level.

Health care facilities in rural areas of the State are provided through a network of District Hospitals (DHs), Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub-Centres (SCs). The details of various agencies involved are represented in chart below:

[1] The TFR is defined as the average number of children that would be born to a woman over her reproductive life span.

Chart 2.1.1: Various agencies involved in providing rural health care facilities

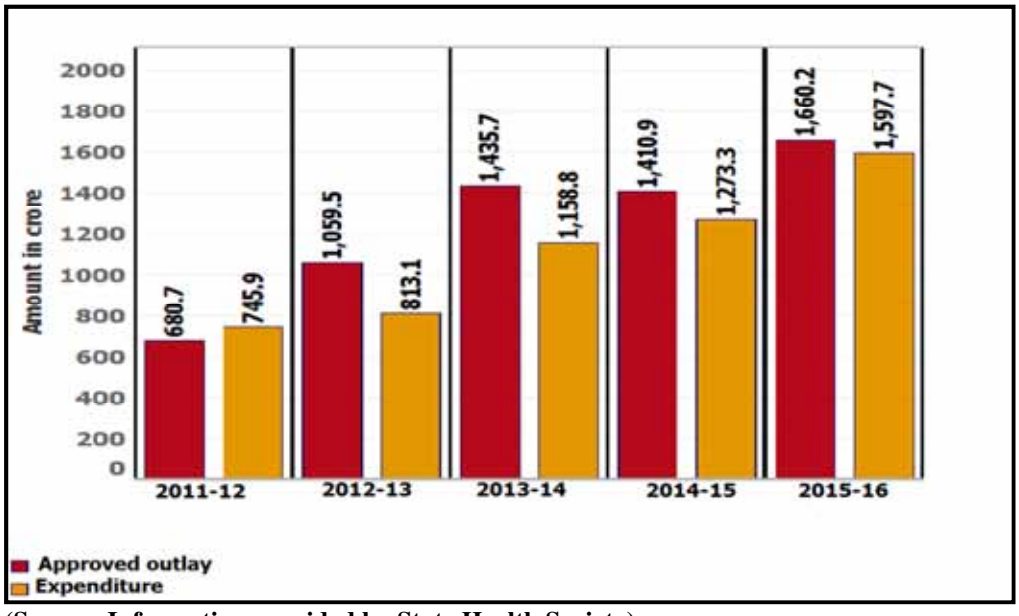


*** Auxiliary Nurse Mid-wife (ANM) is a female health worker posted at Sub-Centre**

2.1.1.3 Fund allocation and expenditure

NRHM is an umbrella programme with various programmes under it with different budgetary requirements. The approved outlay and expenditure under the components - Reproductive Child Health (RCH), immunisation programme and NRHM Mission flexi pool[2], which primarily relates to health indices IMR, MMR and TFR, was as depicted in **Chart 2.1.2**. During the years 2011-12 to 2015-16, ₹ 5,588.76 crore was incurred against approved outlay of ₹ 6,247.01 crore for RCH, immunisation programme and NRHM Mission flexi pool under programme implementation plan (PIP) of NRHM.

Chart 2.1.2: Approved outlay and expenditure on RCH, immunisation programme and NRHM Mission flexi pool during 2011-12 and 2015-16



(Source: Information provided by State Health Society)

[2] Any additional activities which are essential for health system improvement but cannot be funded from any other programme are funded from this pool.

2.1.2 Audit objectives

The audit objectives of the performance audit were to:

- assess the impact of NRHM on improving Reproductive and Child Health in the State by test check of the:
  - extent of availability of physical infrastructure;
  - extent of availability of health care professionals; and,
  - quality of health care provided
- assess the mechanism of data collection, management and reporting which serves as indicators of performance.

2.1.3 Scope and methodology of the Performance Audit

The performance audit was conducted during March 2016 to July 2016 covering the period from 2011-12 to 2015-16. Since NRHM has an intense rural orientation, 43 districts (with predominantly rural population) out of 51 districts of the State were stratified into three categories, *viz*., low, medium and high performing based on their ranking on a Health Index[3]. Four low performing districts (**Anuppur**, **Dhar**, **Dindori** and **Tikamgarh**), five medium performing districts (**Betul**, **Khandwa**, **Mandla**, **Panna** and **Ratlam**) and four high performing districts (**Khargone**, **Neemuch**, **Raisen** and **Rajgarh**) were selected for the performance audit using simple random sampling without replacement (SRSWOR) method.

Within these sampled 13 districts, 27 CHCs, 52 PHCs and 149 SCs were selected (***Appendix-2.1.2***) by SRSWOR method. The records of State Health Society, District Health Societies and District Hospitals of sampled districts and sampled CHCs/PHCs/SCs were scrutinised. The response to a questionnaire from 1,386 *Janani Suraksha Yojana* beneficiaries and 416 Accredited Social Health Activists[4] (ASHAs) of the sampled SCs were also collected.

An entry conference was held on 11 March 2016 to discuss the audit objectives and methodologies with the Commissioner Health, Public Health and Family Welfare Department. The draft report of the performance audit was issued to State Government in August 2016. The reply of the Government was received in October 2016. The audit findings were also discussed in an exit conference held with the Principal Secretary, Public Health and Family Welfare Department on 14 October 2016. The replies of State Government and views expressed during the exit conference have been suitably incorporated in the report.

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[3] Stratification of districts was based on four health indices – infrastructure, health personnel, health services and data reporting.

[4] ASHAs are interface between the community and the public health system to promote health care at household level, who works on incentive basis.

2.1.4 Audit criteria

The following are the sources of audit criteria:

- NRHM Framework for Implementation (2005-12 and 2012-17);
- NRHM Operational Guidelines for Financial Management;
- Indian Public Health Standards (IPHS) – Guidelines (Revised 2012);
- Operational guidelines for Quality Assurance in public health facilities 2013.

2.1.5 Previous audit findings on implementation of the scheme

Performance audit of NRHM for the period 2005-06 to 2008-09 was conducted earlier between April to November 2009 and the audit findings were reported to State Legislature (July 2010) in Audit Report (Civil) for the year ended 31 March 2009. Major shortcomings and the replies submitted by the Government to the Public Account Committee (PAC) are given in **Table 2.1.1**:

Table 2.1.1: Major shortcomings pointed out in previous Audit Report and replies submitted by the Government to the PAC

Sl. No.	Shortcomings pointed out in previous audit report	Government's reply to PAC
(1)	(2)	(3)
1.	Shortage of rural health centres	Due to limited financial resources, the required health centres could not be established. However, the status had been improved and the Government was committed to establish new health centres.
2.	Delays in construction of CHC/PHC/SC buildings	The incomplete works had been completed and the possession of completed buildings had been taken over.
3.	CHC and PHC declared as 24x7 and FRUs were not functional.	The situation had been improved with reference to 24x7 health centres and FRUs.
4.	Shortage of basic infrastructure and health facilities in test checked CHCs and PHCs.	Required services could not be provided due to shortage of Medical Officers and Staff Nurse. However, laboratory and Operation Theatre services had been established in all the CHCs and blood storage units were also established in 53 CHCs.
5.	Huge shortage of medical and para-medical staff	Even after constant efforts to fill the posts of specialists and medical officers, the required manpower could not be filled. However, there was increase in availability of manpower during the last five to six years.
6.	Alarmingly high post-delivery mortality	Reasons of MMR were being flagged out and necessary steps were being taken at State and district level.

(1)	(2)	(3)
7.	Failure to achieve targets for IMR and immunisation of vaccine preventable diseases	Due to combined efforts and rigorous monitoring Polio has been eradicated in the State. Further, complete immunisation of infants was included in the Health Guarantee Scheme in the State.
8.	Monitoring committees were not functional	The quality assurance committees have been formed at district and block level.

Performance Audit of NRHM for the period 2011-12 to 2015-16 revealed that most of the deficiencies as pointed out in earlier CAG's Audit Report were still persisting, as discussed in succeeding paragraphs.

Audit findings

2.1.6 Attainment of demographic goals

State could not attain the goals for IMR, MMR and TFR due to scheme implementation weaknesses.

Improving maternal and child health and their survival are central to the achievement of national health goals. Poor maternal health results in low birth weight and delivery of pre-mature babies. NRHM aimed to reduce infant mortality rate (IMR), maternal mortality rate (MMR) and total fertility rate (TFR). In this process, NRHM was expected to help achieve related goals set under the Millennium Development Goals (MDG) 2015. The status of attainment of these performance indicators was as indicated in **Table 2.1.2**.

Table 2.1.2: Status of target and achievement of IMR, MMR and TFR

Performance Indicators	NRHM Framework of Implementation (2005-12)		NRHM Framework of Implementation (2012-17)		Millennium Development Goals (2015)	
	Target	Achievement by 2012	Target	Status at the end of March 2016	Target	Achievement at the end of March 2016
IMR (Infant Mortality Rate)	30 per 1,000 live births	56	25 per 1,000 live births	51	27 per 1,000 live births	51
MMR (Maternal Mortality Rate)	100 per 1,00,000 live births	230	100 per 1,00,000 live births	221	109 per 1,00,000 live births	221
TFR (Total Fertility Rate)	Reduce to 2.1	2.9	Reduce to 2.1	2.3	No target for TFR were fixed under MDG.	

(Source: State Health Society)

The status of IMR, MMR and TFR was improved since the year 2012. However, the performance of State was still not close to the targets fixed for these performance indicators under NRHM frameworks for implementation and MDG. Further, rural areas had higher IMR (54) and TFR (2.5) in the year 2016 as compared to State average of IMR (51) and TFR (2.3).

As per Annual Health Survey 2012-13, the status of IMR was better in Indore (37), Gwalior (48) and Bhopal (48) districts, whereas it was very high in Panna (85), Satna (83) and Guna (75) districts. The MMR in Indore, Dhar and Barwani districts were 164, whereas Umaria, Shahdol and Dindori districts had MMR of 361. TFR was better in Bhopal (2.0), Gwalior (2.1) and Indore (2.2) and was worse in Panna (4.1), Shivpuri (4.0) and Barwani (3.9).

The status of IMR and MMR in Madhya Pradesh with reference to other States are depicted in table below.

Table 2.1.3: Comparison of IMR and MMR with other States and National average

Comparison of data	*IMR*	*MMR*
Jharkhand	*37*	*219*
Bihar	*42*	*219*
West Bengal	*31*	*117*
Maharashtra	*24*	*87*
Kerala	*12*	*66*
Madhya Pradesh	*51*	*221*
India	*40*	*178*

(Source: www.nrhm.gov.in)

As per information available in the web portal 'nrhm.gov.in', Madhya Pradesh stands at 27th place out of 28 States in IMR, 13th place out of 18 States in MMR and 17th place out of 19 States in TFR. Thus, Madhya Pradesh has a long way to go for improving IMR, MMR and TFR, though these indicators showed some improvement over the years.

The status of maternal and infant/child death in the State during the year 2011-16 is detailed in **charts 2.1.3 and 2.1.4**.

Chart 2.1.3: Maternal deaths in the State

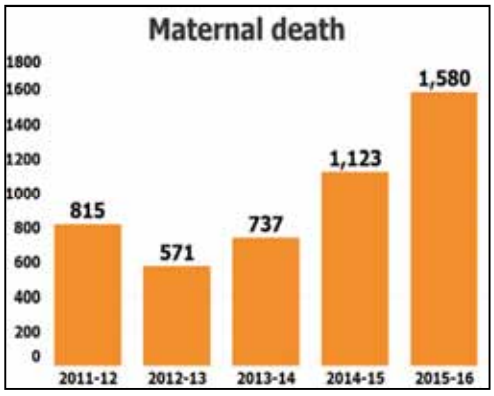
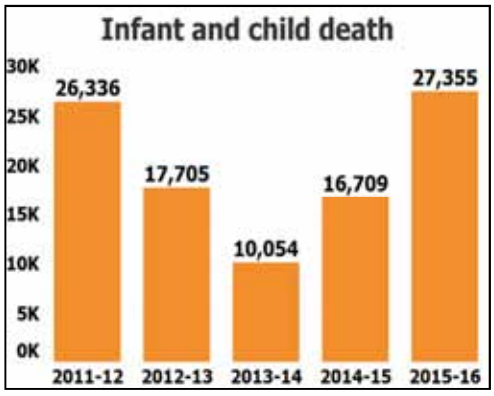


Chart 2.1.4: Infant and child deaths in the State



(Source: State Health Society, HMIS[5])

Thus, the maternal deaths in the State showed an increasing trend during 2012-13 to 2015-16 and in comparison to 815 maternal deaths reported in 2011-12, 1,580 maternal deaths were reported in 2015-16. Similarly, the infant/child death also had an increasing trend during 2013-14 to 2015-16.

[5] Health Management Information System (HMIS) is a web based data entry application for health facilities at all levels.

In the exit conference (October 2016), Principal Secretary stated that the reduction of MMR was one of the priorities of the State Government. Madhya Pradesh was showing steady trend of decline in the MMR, which was evident from various survey data. The MMR of State was 230 in 2010-12 and now it was 221.

Although the performance indicators (IMR, MMR and TFR) have improved during the years 2011-16, the State was still lagging far behind the demographic goals set under the scheme. There was significant increase in the maternal, child and infant death in the State during 2011-12 to 2015-16. The audit findings in the succeeding paragraphs of the report highlight the key areas of concerns, which need to be addressed if the goals of NRHM are to be achieved.

2.1.7 Maternal Health Care

The important services for ensuring maternal health care included antenatal care, delivery care and post-natal care. The maternal health care package was a crucial component of NRHM to reduce maternal morbidity and it aimed to reduce maternal mortality to 100/1,00,000 live births by 2017.

2.1.7.1 Antenatal care (ANC)

As per RMNCH+A[6] guidelines, ANC links the woman with the formal health system, to monitor the progress of foetal growth and to ascertain the well being of the mother. Women who reaches the health care facilities initially with a delay, has more risk of complications during deliveries. ANC package included two doses of Tetanus Toxoid (TT) vaccine and adequate amount of iron-folic acid (IFA) tablets or syrup. The position of ANC registration and services provided during 2011-16 was as detailed in **Table 2.1.4**.

Table 2.1.4: Position of ANC services

Year	Total pregnant women registered for ANC (public and private institutions)	Registered within 1st trimester (12 weeks)	Received 3 ANC check-up during pregnancy	Given TT1 during current pregnancy	Given TT2 or booster during current pregnancy	Pregnant women given 100 IFA tablets
2011-12	1944683	960572	1488982	1448312	1621404	1656340
2012-13	1788353	931286	1410767	1362982	1483072	1655601
2013-14	1885518	1009274	1449706	1383017	1469956	1882222
2014-15	1900801	1166827	1533235	1459858	1510765	1926551
2015-16	1853051	1183408	1545268	1412285	1504292	1875522
Total	**9372406**	**5251367 (56%)**	**7427958 (79%)**	**7066454 (75%)**	**7589489 (81%)**	**8996236 (96%)**

(Source: State Health Society, HMIS)

State Government failed to provide all ANC and associated services to pregnant women.

[6] Reproductive Maternal Newborn, Child and Adolescent Health.

Thus, only 56 *per cent* of 93.72 lakh pregnant women registered for ANC could be registered within 1st trimester of pregnancies. Further, 19.44 lakh (21 *per cent*) could not receive three ANC check-ups during the gestational period. The shortfall in immunisation for TT was 17.83 lakh (19 *per cent*). Similar trend was noticed in test-checked 13 districts, as detailed in ***Appendix -2.1.3***.

Regarding low registration of pregnancies in the 1st trimester and the shortfall in three ANC check-ups, SHS informed (April 2016) that ANC services could not reach remote villages and urban slums due to less competency and accountability of ASHA and ANMs at village level.

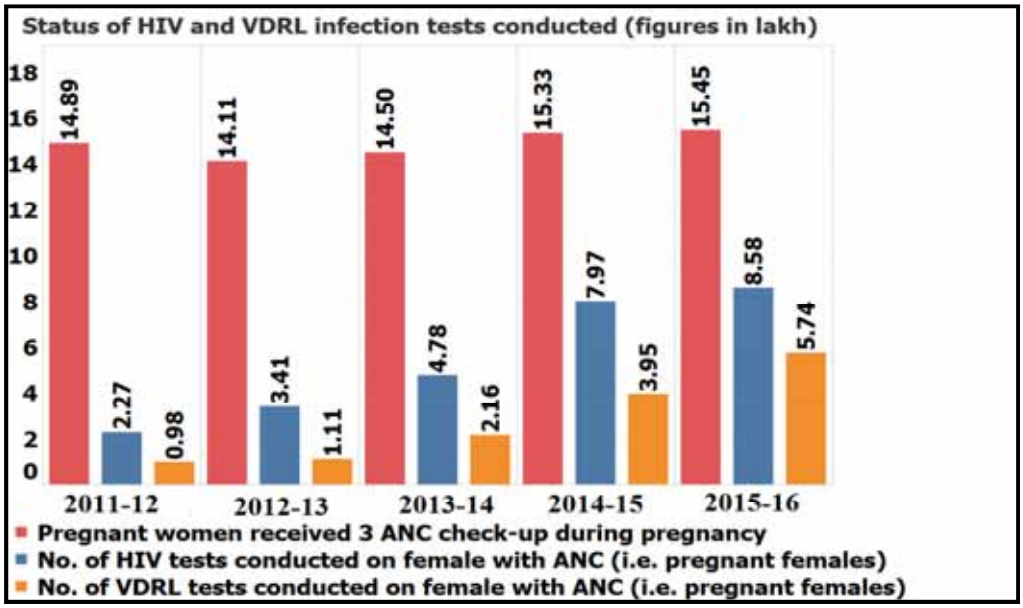
In the exit conference, Principal Secretary stated that there were concerns about 1st trimester registration of pregnancies and receiving three ANC check-ups over last five years. However, efforts were being made to focus on tracking of high pregnancy through Mother and Child Tracking System (MCTS), skill enhancement of services providers etc.

- **Testing of pregnant women for HIV and STI infections**

Parent-to-child transmission of Human Immuno-deficiency Virus (HIV) is a major route of HIV infections in children. According to RMNCH+A guidelines, universal confidential HIV screening should be included as an integral component of routine antenatal check-up. Sexually transmitted infections (STIs) and reproductive tract infections (RTIs) are associated with a number of adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. STI/RTI management must be linked to pregnancy care. These services are to be provided at all CHCs, First Referral Units (FRUs) and at 24x7 PHCs.

The status of HIV and VDRL[7] (for STIs/RTIs infection) tests of pregnant women registered for ANC during 2011-16 was as depicted in the chart 2.1.5.

Chart 2.1.5: Status of HIV/VDRL testing of pregnant women registered for ANC



(Source: State Health Society, HMIS)

Pregnant women registered for ANC were not tested for HIV and VDRL in 64 and 81 *per cent* cases respectively.

[7] Venereal Disease Research Laboratory.

Thus, out of total 74.28 lakh pregnant women received three ANC check-ups, HIV testing of 47.27 lakh (64 *per cent*) women and VDRL testing of 60.34 lakh (81 *per cent*) pregnant women were not conducted for management of adverse pregnancy outcomes in case of infected mothers.

Further, there was discrepancy in the figures related to HIV tests conducted. The services of HIV testing were provided in Integrated Counselling and Testing Centres situated at DH and CHC level under National AIDS Control Programme. As reported by Madhya Pradesh State AIDS Control Society (MPSACS), 16.69 lakh pregnant women were tested for HIV during 2011-12 to 2014-15. However, the report of HMIS furnished by SHS indicated HIV tests of 18.43 lakh during the same period. Thus, there was excess reporting of achievement of HIV test in HMIS.

In the exit conference, Principal Secretary stated that HIV/Syphilis testing of ANCs increased exponentially. However, the gap was still big. To overcome the gaps, process for rate contract of 'point of care rapid testing kit' was in progress, so that testing services might be provided to the health institutes where laboratory technicians were unavailable.

Thus, antenatal care under NRHM suffered due to low registration in the first trimester, huge shortfalls in providing three ANC check-ups and immunisation for TT during gestational period and testing of significantly less number of pregnant women for HIV and STI, which increased the risk of delivery complications.

2.1.7.2 Delivery Care

Janani Suraksha Yojana (JSY), a centrally sponsored scheme, is a safe motherhood intervention under NRHM. The scheme was launched in April 2005 with the objective of reducing maternal and infant mortality by promoting institutional delivery among pregnant women. The status of institutional and home deliveries during 2011-12 to 2015-16 under NRHM was as detailed in ***Appendix-2.1.4,*** which revealed the following:

- **Shortfall in institutional delivery:** Out of 69.83 lakh total deliveries in the State during 2011-16, 60.87 lakh (87 *per cent*) were institutional deliveries, comprising of 55.38 lakh deliveries in public institutions and 5.49 lakh deliveries in private institutions. The number of home deliveries in the State reduced from 2.07 lakh during 2011-12 to 1.43 lakh during 2015-16. However, the objective of promoting institutional delivery suffered due to failure of local health workers (ASHAs and ANMs) to motivate pregnant women to give birth in a health facility and lack of referral transport on time.

- **Shortfall in providing JSY incentive**: Under JSY, pregnant women were entitled for cash assistance (₹ 1,400 in rural and ₹ 1,000 in urban areas) for giving birth in a government institution through e-transfer to their bank accounts. However, out of total 55.38 lakh deliveries in public institutions in the State, JSY incentive was paid to only 49.72 lakh beneficiaries. The shortfall in providing JSY incentive was attributed to unavailability of bank accounts of beneficiaries and paucity of funds.

- **Home based deliveries not attended by trained health professional:** In case of women residing in hard to reach areas or not interested to deliver at

Out of total home deliveries 74 *per cent* were not attended by SBA trained health professional.

health centres, home based deliveries under hygienic conditions and under the supervision of Skilled Birth Attendant (SBA) trained health professionals (ANMs/Nurse) was to be provided in order to reduce maternal and infant mortality. However, out of 8.96 lakh home deliveries in the State during the period 2011-16, 6.65 lakh (74 *per cent*) were not attended by SBA trained health professionals and 3.16 lakh (35 *per cent*) newborns were not visited by health professionals within 24 hours of delivery. Thus, the safe and hygienic condition for home deliveries was not ensured.

- **Deficient postpartum care**: As obstetric complications and maternal deaths occur during delivery and in 48 hours after child birth, 48-hour stay at the health facility was to be promoted in cases of institutional delivery. However, out of 55.38 lakh deliveries in public institutions during 2011-16, 15.26 lakh (28 *per cent*) mothers were discharged within 48 hours of delivery. Further, the postpartum visits were to be made by health care workers, irrespective of the place of delivery. However, only 35.21 lakh (55 *per cent*) mothers received postpartum check-up between 48 hours to 14 days after delivery.

In the exit conference, Principal Secretary stated that *Janani Suraksha Yojana* and *Janani evam Shishu Swasthya Karyakram* (JSSK) were implemented for promoting institutional deliveries and ensuring safe delivery at home. The districts with high home delivery were identified and SCs with high home deliveries were being developed as delivery point. For ensuring 48 hours stay in hospital after delivery, cleanliness and security was being ensured, along with free drugs, diet, diagnostics and transport facilities under JSSK.

Principal Secretary further stated that lack of referral transport, poor connectivity of roads, apathetic attitude of service providers (Staff Nurse, ANMs etc.) and not staying of service providers at facilities were main constraints in providing postnatal check-up. However, efforts were being made for reducing out of pocket expenditure, mentoring of service provider on behavioural change and improvement in free transport services through implementation of JSSK.

The fact remains that the health workers/doctors could not advocate the benefits of post-natal care to mothers and their attendants. Further, the benefits of JSY could have been appropriately linked to 48-hour stay in hospital to incentivise the longer hospital stay.

2.1.7.3 Referral services

Free assured transportation from home to health facility, inter facility transfer in case of referral and drop back was an entitlement under *Janani Shishu Suraksha Karyakram* (JSSK). *Janani Express* (JE) ambulance services operated by private service providers were available in all the districts of the State. Call centres were established at district hospitals to receive calls and provide ambulance services to pregnant women and neonatal. Commissioner, Health Service issued instructions (June 2012) that 90 *per cent* pick-up and 70 *per cent* drop-back of total institutional deliveries should be ensured by JE services.

Audit scrutiny of records of 13 test checked districts revealed that out of 8.53 lakh institutional delivery in these districts, pick-up services to 4.91 lakh (57 *per cent*) and drop-back services to 4.09 lakh women (*48 per cent*) could be provided during 2011-12 to 2015-16. JE services were not provided in cases of 13,684 calls for ambulances citing its unavailability due to attending other cases.

Vehicles with provision for advanced life support system for complicated pregnancies and basic life support for normal pregnancies were to be made available to manage emergencies during transit. Physical verification of 48 JE ambulances by audit team in 10 out of 13 test checked districts revealed that the ambulances were not equipped with oxygen cylinder in 39 cases and first-aid-kit in 36 cases. A couple of photographs of physical verification are below:

***Janani Express* vehicle without oxygen cylinder, first-aid box and curtains to maintain the privacy of pregnant women in District Panna.**

Fully equipped *Janani Express* vehicle with oxygen cylinders, curtains, first aid box etc. in District-Tikamgarh

In the exit conference, Principal Secretary stated that the reasons for less drop back was lack of awareness among the beneficiaries. Some beneficiaries were not willing to wait for the ambulance for drop back cases and left from hospitals without intimation. With reference to shortfall in pick-up services, Principal Secretary stated that pregnancy related cases were also transported by 108 ambulances and Department has decided to integrate both services (108 and JE) for effective and optimum utilization of ambulances with centralised call centre monitoring with the help of modern technologies and skilled manpower.

The reply was not acceptable, as audit on '108 ambulance services' revealed that only 31 *per cent* to 46 *per cent* requests from patient could be attended by ambulances, as discussed in paragraph 3.3.5.3 of this report. Further, the fact remains that the offer of pick-up and drop-back services were not advocated appropriately among the beneficiaries in the rural health set-up.

2.1.7.4 Pregnancy outcome and gender inequalities at birth

As per census 2011, sex ratio in the State was 912 female per 1,000 male against the national ratio of 914. The skewed ratio is attributed both to declining sex ratio at birth due to sex-selective abortions and to continued neglect and poor care-seeking for the girl child. NRHM seeks to address this challenge by regulating the pre-conception and pre-natal diagnostic techniques (PCPNDT) misused for sex selection.

Data for pregnancy outcome with respect to male and female live birth in the State for the period 2011-12 to 2015-16 was as detailed in **Table 2.1.5**.

Table 2.1.5: Position of pregnancy outcome and care

Year	Pregnant women registered for ANC	Total deliveries	Total births	Total still births	Total number of live births	No. of male live births	No. of female live births	Sex ratio at birth
2011-12	1944683	1490844	1496274	25311	1470963	759932	711031	52:48
2012-13	1788353	1367001	1374710	24447	1350263	698755	651508	52:48
2013-14	1885518	1358054	1390644	23699	1366945	710287	656658	52:48
2014-15	1900801	1369475	1379946	23591	1356355	704251	652104	52:48
2015-16	1853051	1397663	1405312	24787	1380525	715674	664851	52:48
Total	**9372406**	**6983037**	**7046886**	**121835**	**6925051**	**3588899**	**3336152**	

(Source: State Health Society, HMIS)

Huge difference between total ANC registered and deliveries conducted during 2011-12 to 2015-16

Thus, 33.36 lakh female child births were reported in comparison to 35.89 lakh male child births during 2011-12 to 2015-16. The continued skewed sex ratio at birth was required to be reviewed with reference to large difference of 23.89 lakh between total ANC registered (93.72 lakh) and total delivery (69.83 lakh) during 2011-12 to 2015-16.

In the exit conference, Principal Secretary stated that the State and districts showed considerable improvement in the sex-ratio due to consistent efforts and effective implementation of PCPNDT Act. Principal Secretary further stated that the case of missing delivery was being addressed by strengthening reporting mechanism from private hospitals and deliveries at home through RCH portal.

The reply was not acceptable, as there was no improvement in sex ratio during 2011-12 to 2015-16. This large difference between ANC registered and total delivery cases indicated lack of follow-up and tracking of registered ANCs by ground level health workers and other monitoring authorities.

2.1.8 Child Health

2.1.8.1 Management of New Born

RMNCH+A programme has identified birth weight of new born as an important risk factor for survival, since children with low birth weight (LBW) are more likely to have impaired growth, higher mortality and risk of chronic adult diseases. Scrutiny of information furnished by test-checked 149 sub-centres revealed that there were 177 infant deaths due to premature and low birth weight, out of 1,499 infants born during 2015-16.

The status of new born weighed at the time of birth and breastfed within first hour of birth during 2011-16 as against the total number of live births in the State was as detailed in **Table 2.1.6**.

Table 2.1.6: Position of new born weighed and breast fed

Year	Total number live births	No. of newborn weighed at birth	No. of LBW new born (having weight less than 2.5 kg)	No. of newborn breastfed within one hour of birth
2011-12	1470963	1337058	245081	1281888
2012-13	1350263	1210018	249501	1165829
2013-14	1366945	1270278	189357	1261516
2014-15	1356355	1313407	185941	1285630
2015-16	1380525	1345076	190635	1302059
Total	**6925051**	**6475837**	**1060515**	**6296922**

(Source: State Health Society, HMIS)

- As evident from table 2.1.6, there were 10.61 lakh LBW babies, which was 16 *per* cent of the number of newborns weighed at the time of birth. However, out of 69.25 lakh live births during the year 2011-16, 4.49 lakh new born were not weighed at the time of their birth. The failure of taking birth weight in these cases was fraught with the risk of unattended LBW cases and their further medical requirements.

SHS replied (May 2016) that the weighing of newborns were to be conducted by SBA trained health workers. However, the SBA attended home deliveries were less, which was reflected in gap of number of newborns weighed against live births. It further replied that the data of newborn weighed are reflected in labour room register, but it was not being transferred in HMIS software.

Thus, failure of SHS in ensuring SBA attended home deliveries affected management of newborn. Further, there was no evidence to conclude that the data of newborn weighed were actually reflected in labour room register, but not transferred in HMIS software.

- Promotion of newborn breast feeding within one hour of birth was the main motto of Infant and Young Child Feeding Practices (IYCF) so that resistance is developed among the newborns against neonatal diseases to reach their full growth potential. However, out of 69.25 lakh live births, only 62.97 lakh (91 *per cent*) newborns were breastfed within one hour of delivery.

SHS replied (April 2016) that the shortfall in breastfeeding could be attributed to deliveries during night hours in the absence of doctors and staff nurses, C-section deliveries in which mother often did not breastfeed within one hour and less community awareness regarding importance of initial breast feeding.

The reply of SHS underscores the deficiencies in health infrastructure due to which health care professionals were not available to attend the delivery cases during night hours and counsel the mother of newborns regarding importance of initial breast feeding.

In the exit conference, Principal Secretary agreed that there remained a gap in early initiation of breastfeeding and stated that various efforts to promote early initiation of breastfeeding at birth were being done.

2.1.8.2 Child immunisation

Universal Immunisation Programme (UIP) includes vaccines to prevent seven vaccine preventable diseases (Tuberculosis, Polio, Diphtheria, Pertussis, Tetanus, Measles, Hepatitis B). The targets for child immunization were fixed in the State by extrapolating census population data using decadal growth rate for each district and applying birth rate and IMR for each of the district. The status of target set for seven vaccine preventable diseases during the year 2011-16 and achievement against these was as detailed in ***Appendix-2.1.5***, which revealed the following:

Target set for child immunisation against vaccine preventable diseases were not achieved.

- Targets set for child immunization against seven vaccine preventable disease could not be achieved during 2011-16 and the range of shortfall was 16 to 21 *per cent* in the State. Audit noticed that Alirajpur (94 to 114 *per cent*), Bhopal (92 to 105 *per cent*) and Gwalior (91 to 104 *per cent*) were good performing districts; while Seoni (63 to 67 *per cent*), Katni (63 to 68 *per cent*) and Mandla (64 to 68 *per cent*) were under performing districts during 2011-16.

- Targets were also set for age wise immunization of children categorising targets for immunization up to one year of age, one and half year of age and above five year of age. However, the shortfall in category wise immunisation ranged from 17 to 50 *per cent* as detailed in ***Appendix-2.1.6.***

- Under the UIP, Hepatitis-B Zero dose was to be provided to the infants up to 48 hours of age. In this regard, it was noticed that against 69.25 lakh live births only 39.30 lakh (57 *per cent*) infants could be vaccinated for Hepatitis B Zero dose.

- During the period 2011-12 to 2015-16, 618 cases of Diphtheria, 90 cases of Pertussis, 1,009[8] cases of Tetanus and 14,777 cases of Measles were reported. Under the Adverse Event Following Immunization (AEFI), 33 cases of death, 5,972 cases of abscess and 22,281 cases of complications were reported during 2011-12 to 2015-16.

- Village Health and Nutrition Day (VHND) was to be organised once every month at the Anganwadi centre (AWC) for providing identified services such as immunisation, antenatal care, postnatal care, family planning etc. Audit scrutiny revealed that 39.07 lakh VHNDs could be organised against 40.05 lakh planned. However, ASHAs were not present in 7.71 lakh VHNDs held during 2011-12 to 2015-16, though ASHAs were responsible for mobilising the villagers, especially women and children, to assemble at the nearest AWCs.

In the exit conference, Principal Secretary stated that 'Mission *Indradhanush'* was conducted in high and medium priority districts to close the immunisation gaps during 2015-16 and 2016-17. With reference to less vaccination of Hepatitis-B Zero dose, it was stated that vaccination dose was to be given within 24 hours of birth, which was to be given only in case of institutional deliveries at DH, CH, CHC and PHC which have the facility to store the vaccines, while SCs did not have vaccine storage facility. Vaccination of

[8] Tetanus Neonatarum and other than Neonatarum.

infants which were delivered at private institutions was not included in HMIS reports.

Reply confirms the fact that infants delivered at SCs or homes were deprived of Hepatitis B Zero vaccination. Further, deficiency in HMIS report regarding non-inclusion of data of vaccination at private institutions indicated lack of monitoring mechanism for UIP.

2.1.9 Reproductive Health Care

2.1.9.1 Comprehensive Abortion Care

According to RMNCH+A guidelines, eight *per cent* of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term health complications. Therefore, safe and comprehensive abortion care is an essential component of overall pregnancy care.

Under NRHM, 24x7 PHCs were to provide abortion by Manual Vacuum Aspiration (MVA) facilities and medical methods, whereas comprehensive Medical Termination of Pregnancy (MTP) services were to be available at all District Hospitals and Sub-district level hospitals with priority given to 'delivery points', i.e., CHCs. NRHM seeks to up-gradate CHCs as First Referral Units, which would include facility for MTP.

However, audit scrutiny of information provided by SHS revealed that MTP services were not provided in 25 sub-district level Hospital (out of 63) and 136 CHCs (out of 334). Out of 531 24x7 PHCs, MVA facilities were not available in 380 24x7 PHCs. Thus, the objective to reduce maternal death by providing safe abortion to women was defeated.

In the exit conference, Principal Secretary stated that efforts were being made to provide quality abortion care by posting of skilled manpower, capacity building of medical officers, procurement of MVA kits and strengthening of IEC activities.

2.1.9.2 Family planning programme

One of the key indicators of good reproductive health of the community is the Total Fertility Rate (TFR). The TFR is defined as the average number of children that would be born to a woman over her reproductive life span. As TFR decreases, maternal mortality rate also declines. Further, low TFR impacts child survival by bringing optimum spacing between successive pregnancies. NRHM framework has targeted to reduce TFR to 2.1.

Shortfall in service for sterilisation and spacing methods was noticed.

- **Limiting methods:** Limiting methods of family planning consist of vasectomy for male and tubectomy for female. Total target of 30.25 lakh by the State for male and female sterilisation against which achievement was 22.11 lakh during 2011-16, as detailed in ***Appendix-2.1.7***. As against 3.03 lakh vasectomy planned during the year 2011-16, only 0.83 lakh (27 *per cent*) male sterilization could be performed. The achievement of female sterilizations was 43 and 22 *per cent* against planned for minilap and post-partum sterilization respectively. However, 15.89 lakh laproscopic

female sterilisations were carried out during 2011-12 to 2015-16, which was 105 *per cent* of target.

In case of tubectomy, 69 deaths and 8,860 failure cases were reported during the year 2011-12 to 2015-16 and compensation of ₹ 2.09 crore in 2014-15 and ₹ 2.87 crore in 2015-16 was made.

- **Contraceptives and spacing methods:** SHS fixed targets for insertion of 25 lakh IUCD[9], eight lakh PPIUCD[10], and distribution of 43 lakh oral pills and 74 lakh condoms during 2011-16. However, there was shortfall in achievement of 36 *per cent* IUCD, 56 *per cent* PPIUCD, 42 *per cent* oral pills and 49 *per cent* condoms as detailed in ***Appendix 2.1.8***.

In the exit conference, Principal Secretary stated that there were two primary reasons for poor achievement - (i) the family welfare programme was not effectively managed with co-ordination of other department, (ii) the many-faceted population programme which was impacted by women's literacy, status, empowerment, age at marriage, etc. was not implemented and monitored effectively, due to lack of inter-departmental co-operation. Principal Secretary further stated efforts were being made to reach TFR of 2.1.

The fact remains that the targets of TFR could not be achieved due to low performance in family planning programme.

2.1.10 Planning and Budgeting

Under NRHM, a detailed planning and budgeting exercise was to be taken up every year to fix the annual targets for programme implementation and required budget for them. Each implementing agency was required to prepare an annual plan of action, which would indicate the physical targets and budgetary estimates in accordance with the approved pattern of assistance under NRHM.

2.1.10.1 Preparation of State Programme Implementation Plan

As per the NRHM operational guidelines for financial management, bottom up approach for planning and budgeting was to be followed. The process envisaged to begin at the block level by preparing the "Block Health Action Plan" (BHAP) based on inputs/discussions with the implementing units (CHCs, PHCs and Sub-centres). The BHAPs would then aggregate to form a District Health Action Plan (DHAP), which would be sent to the SHS for approval. State Programme Implementation Plan (SPIP) was then to be prepared by aggregating the DHAPs.

Bottom-up approach was not adopted at district level during planning process.

SHS informed (May 2016) that bottom up approach was adopted at district level for preparation of DHAPs. However, out of 13 test checked DHSs, seven DHS[11] informed that they have not adopted bottom up approach. Though six other DHSs informed that they were adopting bottom up approach in the planning process, no supporting records were produced during audit.

[9] Intra Uterine Contraceptive Device.
[10] Post-Partum Intra Uterine Contraceptive Device.
[11] Anuppur, Betul, Mandla, Neemuch, Panna, Rajgarh and Ratlam.

In the exit conference, Principal Secretary stated that the DHAPs in the districts were prepared after integration of the BHAPs of all the blocks of the districts. However, documentation of block plans had been poor. Instructions had been issued (September 2016) to the districts to properly document the block and village plans.

The reply was not acceptable, as seven DHSs had accepted that bottom-up approach was not followed.

2.1.10.2 Delays in preparation of PIPs

NRHM Operational Guidelines for Financial Management provides that the State PIP has to be submitted to GoI by 31st December, which will approve the same by 28th February. Similarly, DHAPs are to be submitted to SHS before 31st October and approved before 15th of March every year by the SHS.

Delay in finalization of PIPs resulted into delay in release of funds at all level.

Audit noticed that State PIPs were submitted to GoI with a delay ranging from 69 to 196 days during 2011-12 to 2015-16. Consequently, the approval of PIPs from GoI was received with a delay ranging from 72 to 223 days ***(Appendix-2.1.9)***. Similarly, there were delays in submission of DHAP by 13 test-checked DHSs, which ranged from two to seven months ***(Appendix-2.1.10).***

In the exit conference, Principal Secretary stated that there was some delay in submission and approval of the State PIP. GoI had developed a software application for the planning process, the State was using the application to expedite the planning process.

Thus, delays in planning process at all levels resulted in delayed release of funds to districts, rush of expenditure at the end of financial years and shortfall in achievement of targets under various programmes/ activities.

2.1.10.3 Inter-sectoral convergence

The guideline for preparation of State PIPs and DHAPs provides for the inter-sectoral convergence with other line departments. However, scrutiny of records revealed that State PIPs and DHAPs were prepared without including activities of inter-sectoral convergence with the line departments. Further, only eight out of 13 test-checked districts informed participation of other line departments in the planning process of DHAPs. In the absence of any plan for inter-sectoral convergence, its achievement during programme implementation could not be ascertained in audit.

In the exit conference, Principal Secretary stated that intersectoral convergence with line departments were organised at the district level before finalising the DHAP. However, instructions had been issued (September 2016) to the districts to invite the line departments in the planning workshops. At the State level, the State PIP was approved by the SHS prior to submission to GoI by organising a meeting of the Governing Body for the purpose and were attended by the Principal Secretaries of concerned line departments.

Reply was not acceptable, as there was absence of any documented inter-sectoral convergence plan under NRHM at State level as well as at test-checked district levels. Further, five test checked districts intimated that officials from line departments did not participate in the planning process.

2.1.10.4 Management of financial resources

The resources allocated to a particular State under NRHM (Resource Envelope) for a financial year consists of: (a) unspent balance, (b) approved GoI releases, and (c) State share contribution due for the year. Cost sharing under NRHM between Central and State Government was 85:15 in 2011-12, 75:25 during 2012-13 to 2014-15 and 60:40 from the year 2015-16. Grants were directly released from GoI to SHS during 2011-14 and through State Treasury System from 2014-15 onwards. SHS disbursed funds to DHSs for onward transmission to DHs at district level, CHCs at block level and PHCs and SCs at village level.

NRHM is a comprehensive healthcare scheme which encompasses several programmes of GoI. However, as the RCH related indices (IMR, MMR and TFR) were selected for analysis in this report, the fund management of RCH, NRHM Mission flexi pool and Immunisation programme, which primarily relates to these three health indicators were only covered in the performance audit. The position of grants received and expenditure incurred by SHS during the year 2011-16 are detailed in **Table 2.1.7**.

Table 2.1.7: Total allocation, expenditure and unutilised balances

(₹ in crore)

Year	Opening balance	Fund received during the year		Bank interest	Total available fund (2+3+4+5)	Expenditure incurred during the year	Closing balance (6-7)	Percentage of unspent balance
		Central share	State share					
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2011-12	156.96	625.42	232.11	7.64	1022.13	745.94	276.19	27%
2012-13	276.19	500.84	422.32	12.02	1211.37	813.09	398.28	33%
2013-14	398.28	600.16	286.43	20.08	1304.95	1158.78	146.17	11%
2014-15	146.17	726.47	324.82	6.80	1204.26	1273.26	-69.00	-
2015-16	-69.00	801.90	749.23	7.11	1489.24	1597.69	-108.45	
Total		**3254.79**	**2014.91**	**53.65**	**5480.31**[12]	**5,588.76**		

(Source: State Health Society)

Audit analysis of the fund allocation and expenditure under NRHM revealed the following:

- **Short release of funds against approved PIP:** During the year 2011-16, GoI approved PIP for ₹ 6,247.01 crore against which only ₹ 5,269.70 crore was made available for implementation of NRHM in the State. Thus, there was shortfall of ₹ 977.31 crore in augmentation of fund for implementation of APIP. In view of the fact that the State had dismal performance in achieving targeted health indicators, the short release of fund as compared to approved PIP would have worsen the health services to rural population.

The status of fund released by GoI and State Government during 2011-16 was as detailed in **Table 2.1.8.**

[12] ₹ 5,480.31 (₹ 156.96 + ₹ 3,254.79 + ₹ 2,014.91 + ₹ 53.65).

Table 2.1.8: Status of GoI and State share received against the approved PIP

(₹in crore)

Year	PIP approved by GoI			Release of fund		
	Total PIP	Proportion of Central share	Proportion of State share	Total funds received	Central share	State share
2011-12	680.69	578.59	102.10	857.53	625.42	232.11
2012-13	1059.46	794.59	264.87	923.16	500.84	422.32
2013-14	1435.72	1076.79	358.93	886.59	600.16	286.43
2014-15	1410.90	1058.18	352.72	1051.29	726.47	324.82
2015-16	1660.24	996.14	664.10	1551.13	801.90	749.23
Total	**6247.01**	**4504.29**	**1742.72**	**5269.70**	**3254.79**	**2014.91**

(Source: State Health Society)

Thus, funds amounting to ₹ 1,249.50 crore were short released by GoI during 2011-16. However, even after availability of sufficient funds during 2011-14, less utilisation of available fund ranging from 11 *per cent* to 33 *per cent* was noticed.

Delay in submission of UCs resulted into delay in release of funds and rush of expenditure in the last quarter of the financial year.

- As envisaged in guidelines the funds would be provided to State by GoI in two tranches (April/May and September/October). Audit noticed that GoI released funds in five to nine tranches instead of two tranches during 2011-12 to 2015-16. This could be due to delay in submission and approval of PIP of State and districts, as well as delay in submission of utilisation certificates (one to five months) to GoI by SHS. Further, GoI released 54 *per cent* of total funds to SHS in last quarter of financial year in 2012-13. The rush of expenditure by SHS/DHS, ranging from 36 to 56 *per cent* was also noticed in the last quarter of the financial year during 2011-12 to 2015-16.

- The excess expenditure of ₹ 177.45 crore against the available funds during 2014-15 and 2015-16 was funded by diverting resources from National Urban Health Mission.

- As envisaged in the NRHM framework 10 *per cent* of NRHM funds were to be utilised at State level, 20 *per cent* at the district level and at least 70 *per cent* at block and below level. However, no mechanism was available at the SHS level to ensure the ratio of expenditure incurred at district and block level, which was a structural defect in the scheme. In the absence of this data, it was entirely possible that NRHM could become lopsided and thereby was sub-optimal.

In the exit conference, Principal Secretary stated that expenditure incurred under program was as per approved PIP. However the actual budget received from GoI was less than the approved PIP. In FMIS[13] software, there was a facility to monitor the funds utilization at all levels. The delay in release of funds to DHS was due to delayed release of funds from GoI.

[13] Financial Management Information System.

Reply was not acceptable, as the expenditure incurred for the programme was ₹ 658.25 crore less expenditure during 2011-16 as compared to approved PIP. Further, there was no mechanism in the FMIS to ensure utilisation of funds in the defined ratio at district and below level. The delay in release/short release of fund together with less utilisation of funds resulted in shortfall in achieving planned targets.

2.1.11 Availability of Rural Health Centres

NRHM is a programme for providing affordable and quality health care for the rural population. The health care infrastructure in rural areas was developed under NRHM as a three tier system, as indicated in **Table 2.1.9**:

Table 2.1.9: Norms for establishment of health centres

Name of Centre	Population Norms	
	Plain Area	Hilly/ Tribal/ Difficult Area
Sub-centre	5000	3000
Primary Health Centre	30000	20000
Community Health Centre	120000	80000

(Source: NRHM framework for implementation)

Audit scrutiny revealed that there were substantial gaps in the available rural health infrastructure in the State as on 31st March 2016. A comparison of the available infrastructure of Sub-Centres/PHCs/CHCs and required health centres in State in view of norms under NRHM framework for implementation was as detailed in **Table 2.1.10**.

Table 2.1.10: Status of available health centres in rural area of the State as on 31 March 2016

Name of Centre	Required health centres, as per population norms (Census 2011)	Number of health centres available	Shortage
Sub-centres	11780	9192	2588 (22%)
PHCs	2000	1172	828 (41%)
CHCs	487	334	153 (31%)

(Source: State Health Society)

There was substantial gaps in required rural health centres and actual available SCs/ PHCs/CHCs.

Thus, there was shortfall of 2,588 SCs (22 *per cent*), 828 PHCs (41 *per cent*) and 153 CHCs (31 *per cent*) as against the required rural health centres in view of population norms. While the neighbouring States viz. Gujarat and Rajasthan have sufficient number of rural health facility against the population norms. The availability of SCs, PHCs and CHCs was more than that required as per population norms in Rajasthan. Gujarat had shortfall of three *per cent* and one *per cent* of PHCs and CHCs respectively, while sufficient number of SCs were available. Further, the State was also lagging behind the national average of availability of health infrastructure, as the shortfalls in SCs and PHCs at national level was only 14 *per cent* and 26 *per cent* in case of CHCs.

Scrutiny of district wise availability of rural health centres revealed availability of adequate number of CHCs in Raisen, Harda and Narsinghpur districts. In Rajgarh, Jhabua and Sheopur districts shortage of CHCs ranged from 50 to 55 *per cent*. PHCs were adequate in Mandsaur and Chhindwara districts; however there was shortfall of PHCs in Shivpuri, Agar Malwa and

Morena districts which ranged from 65 to 73 *per cent*. Further, only Raisen district had adequate number of SCs, whereas shortage of SCs ranging from 35 to 40 *per cent* were noticed in Khargone, Guna and Rajgarh districts.

Adequate funds for establishment of health centres were not allocated, despite substantial gaps in rural health.

Despite substantial shortages of SCs/PHCs/CHCs in most of the districts, SHS did not allocate adequate funds for establishment of rural health centres. NRHM Framework (2012-17) provided for utilisation of up to 33 *per cent* of total resource envelops[14] on construction of new buildings and renovations of health centres. However, the allocation of fund for construction/renovation works was ₹ 397.98 crore during 2011-12 to 2015-16, which was only five *per cent* of total resource envelops of ₹ 7,604.98 crore during this period. SHS could utilise ₹ 364.88 crore on construction/renovation works during 2011-16.

In the exit conference, Principal Secretary stated that although there was a provision of planning of funds to the tune of 33 *per cent* of resource envelope, but considering the huge gap in human resource, the infrastructure development was synchronised with functionality of facility. In 2015-16, creation of 2000 new SCs has been planned and the gap of CHC and PHC would be addressed in coming years in a phased manner.

The reply was not acceptable, as State Government had not prepared any perspective plan to bridge the gap in availability of rural health centres. Further, despite Madhya Pradesh being high focus State under NRHM, State Government did not give adequate priority to Health sector as the expenditure on Health sector was less as compared to General Category States' Average during 2011-15, which were reported under paragraph 1.7.1 of CAG's Audit Reports on State Finances for the year ended March 2014 and March 2015 respectively.

2.1.11.1 Construction of health infrastructure

As envisaged in the RMNCH+A guidelines, the new construction of up to the CHC level should be completed in a maximum of two years and of a District Hospital should be completed in a maximum period of three years. Renovation/repair initiated for any health facility should be completed within a year.

In the State, State Health Society carried out construction works through its Civil Wing at SHS level and DHS level. The major works were entrusted to Public Works Department as deposit works. During the period 2011-16, SHS incurred an expenditure of ₹ 242.58 crore on construction activities. The status of construction works proposed during 2011-12 to 2015-16 was as detailed in **Table 2.1.11**.

[14] The resources allocated to a particular state for any given financial year is termed as the "Resource Envelope". The resource envelope for a Financial Year consists of Uncommitted Unspent Balance, GoI releases proposed for the year and State Share Contribution due for the year.

Table 2.1.11: Status of construction works as on 31 March 2016

Name of Agency	Total works proposed and executed	Total cost as per administrative approval (₹ in crore)	Status of works			
			Cancelled	Not started	Under progress	Complete
Civil wing (SHS level)	1098	409.61	22	13	549	513
State PWD	17	116.05	0	3	10	4
Total	**1115**	**525.66**	**22**	**16**	**559**	**517**

(Source: State Health Society)

Audit scrutiny revealed the following:

- ***Cancelled works:*** SHS cancelled 22 works in 16 districts during 2011-16. These works were construction of new SCs, strengthening/upgradation of PHCs and SCs, construction of ANM training schools and hostels, as detailed in ***Appendix-2.1.11***. The cancellation of these works were attributed to availability of other health facilities near the construction sites, unavailability of land and shifting of proposed health facility to another location. Thus, requirement of health facility and availability of land was not properly assessed prior to the proposal of construction.

Significant number of construction works were either cancelled or were not started.

Further, in three[15] out of 13 test-checked districts, four construction works were cancelled, as detailed in ***Appendix-2.1.12***. Out of these, unfruitful expenditure of ₹ 24.05 lakh was incurred on two works (construction of SC Neempaani and Construction of laundry in Khairi), which were cancelled due to wrong selection of site.

- ***Construction works not started:*** 16 works sanctioned at State level at the cost of ₹ 46.93 crore could not be started due to wrong site selection, unavailability of land, widening of National Highway, etc. as detailed in ***Appendix-2.1.13.*** Similarly, in eight out of 13 test-checked districts, 16 works sanctioned by DHS could not be started despite issuing work orders to the contractor during 2013-16, as detailed in ***Appendix-2.1.14***.

- ***Incomplete construction works:*** At State level, out of total 559 incomplete works, 434 works on which expenditure of ₹ 231.46 crore was incurred up to 31 March 2016, could not be completed even after lapse of their scheduled completion date. The delays were mainly attributed to delayed finalisation of drawing/layout, unavailability of land, disputed land and site situated in forest areas.

Similarly, in 10 out 13 test-checked districts, it was noticed that 17 construction/upgradation works in DHs, 13 works in CHCs, 23 works in PHCs and 125 works in SCs were incomplete even after lapse of period ranging from two to 110 months after their scheduled completion date. An expenditure of ₹ 25.41 crore was incurred on these works as detailed in ***Appendix-2.1.15.***

- ***Delay in taking over completed buildings:*** The construction works which were completed should be immediately taken over so that it could be

[15] Betul, Mandla and Ratlam.

utilized for the purpose for which they were built. Audit scrutiny revealed that 33 completed construction/upgradation works of DHs, CHCs, PHCs and SCs were not taken over by the concerned health institutions even after lapse of 12 to 16 months after their completion at cost of ₹ 3.36 crore, as detailed in ***Appendix-2.1.16***. Two construction works, SC Gopalpur in Dindori district and laundry building in Rajgarh district, were completed (cost of ₹ 0.48 crore) and taken over, but were lying unutilised.

SHS replied (May 2016) that the department was taking concrete steps in fulfilling the gaps of health institutions within the limits of available human resource and perspective strategies for enhancing the human resource at rural areas. However, no timelines or concrete plan of action were furnished to Audit.

2.1.11.2 Upgradation of health infrastructure

As envisaged under NRHM, the public health institutions in rural areas were to be upgraded from its present level to 'Indian Public Health Standards' (IPHS). The IPHS were the benchmark for quality expected from various components of public healthcare institutions and may be used for assessing performance of health delivery system.

SHS informed (July 2016) that State was not providing human resource and infrastructure to the health facilities as per IPHS norms. It further stated that budget was also not provided by the GoI according to IPHS norms. State had implemented National Quality Assurance Standards (NQAS) in 2014 and facilities are being upgraded as per NQAS.

2.1.11.3 Quality of health infrastructure at Sub-Centres

Sub-centres are vital peripheral institutions and first point of contact between the primary health care system and the community. Sub-centres were categorised into two types. Type-A SCs provide all recommended services except delivery services. Type-B SCs are declared as delivery points.

Number of SCs declared as delivery points in the State was negligible (four *per cent*).

Out of total 9,192 SCs in the State, 337 (four *per cent*) were declared as delivery points (Type-B). Thus, the proportion of SCs providing delivery services was negligible. Moreover, only 241 Type-B SCs out of 337 declared Type-B SCs were actually providing delivery services. The remaining 96 SCs could not be upgraded as Type-B SCs due to lack of manpower and required infrastructure.

During visit to 149 SCs (four Type-B and 145 Type-A), Audit noticed 49 SCs were covering population of more than 5,500 and 33 SCs were not visited by a doctor even once in a month. Further, 13 SCs were functioning either in PHC building or building adjoining to PHC, thereby, making their usefulness redundant. Other major deficiency in infrastructure are summarised in **Table 2.1.12**.

Table 2.1.12: Major deficiencies in infrastructure at Sub-Centres

Sl. No.	Deficiencies	No. of Sub-Centres	Percentage
1	No SBA trained ANMs	92	69
2	No electricity supply	60	44
4	No examination table	44	33
5	No functional toilet	55	43
6	No labour table	105	77
7	No compound wall	108	91
8	Garbage collection near SC	96	80
9	ANM quarter not available	75	56

Poor cleanliness - cow dung being dumped adjacent to the SC building Bhopalpura (Dist:Tikamgarh)

Building of SC Himmatgarh, (Dist: Dhar) lying unused, while it was functioning from another building.

In the exit conference, Principal Secretary stated that all type "A" SCs buildings constructed after 2007 in the State fulfilled the norms in view of infrastructure i.e. all SCs have been provided with a labour room and accommodation for one ANM. Further, Type "B" SCs were now being constructed with accommodation for two ANMs as per GoI guidelines and posting of ANMs was being done in identified delivery centres on priority basis.

The reply was not acceptable, as only four *per cent* of SCs could be declared as delivery points and test-checked SCs lacked building infrastructure and facilities.

2.1.11.4 Quality of health infrastructure at Primary Health Centres

Primary Health Centre (PHC) is a first port of call to a qualified doctor of the public sector for the people in rural areas. Upgradation of PHCs as 24x7 PHCs was one of the goals of NRHM.

Audit scrutiny revealed that 745 PHCs out of total 1,172 PHCs in the State, were targeted for 24x7 services. However, only 638 PHCs were functioning 24x7. Further, 461 PHCs were identified for BEmONC[16] services, however, only 405 PHCs were providing these services. The shortfall in providing 24x7

[16] Basic Emergency Obstetric and Neonatal Care.

and BEmONC services in PHCs was due to lack of required infrastructure and manpower.

During visit to 51 PHCs of 13 test checked districts, deficiencies in infrastructure and facilities were noticed as summarised in **Table 2.1.13**.

Table 2.1.13: Poor infrastructure in Primary Health Centres

Sl. No.	Infrastructure/facilities	No. of PHCs	Percentage
1	ANC care not available	**08**	**16**
2	No delivery service	**12**	**24**
3	No PNC care	**07**	**14**
4	No MTP service	**44**	**86**
5	Child care including immunization not available	**07**	**14**
6	No family planning and contraception service	**9**	**18**
7	No laboratory service	**26**	**51**
8	No emergency room	**34**	**67**
9	No separate female and male wards	**38**	**75**

The building of PHC, Satipura (District: Dhar) lying abandoned since last five years. Onions was found stocked during visit of audit team.

PHC, Sakrawad (District: Ratlam) had good building and infrastructure but no doctor was posted. Only one Pharmacist posted there was attending patients.

In the exit conference, Principal Secretary stated that the issue pertains to shortfall in HR and shall be sorted out as per availability of the same.

Case study of PHC, Barkhed (Multai Block), Betul district

PHC, Barkhed was linked to four Sub-Centres covering 25,000 population. During years 2014-16, 8,301 patients received OPD services from the PHC. The posts of Doctor, Lab Technician, Compounder, Dresser and Ward Boy were sanctioned for this PHC. During the visit to the PHC, Audit noticed that the PHC was well equipped with required building, staff quarters, infrastructure, drugs and equipment, as can be seen from the photographs:






However, only one ward boy was posted in the PHC and no doctor or other para medical staff were posted. As a result, ward boy was distributing medicines including antibiotics to OPD patients on basis of his assessment of the patient. Thus, the villagers were at risk of health related complications due to wrong medicine and medical negligence, as ward boy was not trained to perform any duty of medical or even para-medical staff. This shows the neglectful attitude towards PHCs.

On being pointed out, CMHO, Betul stated (December 2016) that the posting of medical and para-medical staff against the vacant post was to be carried out by the State Government. However, a Pharmacist on contractual basis had now been posted at PHC, Barkhed.

The fact remains that the investment of government money in the PHC was not utilised for desired, preventive, promotive and curative services as per desired standards.

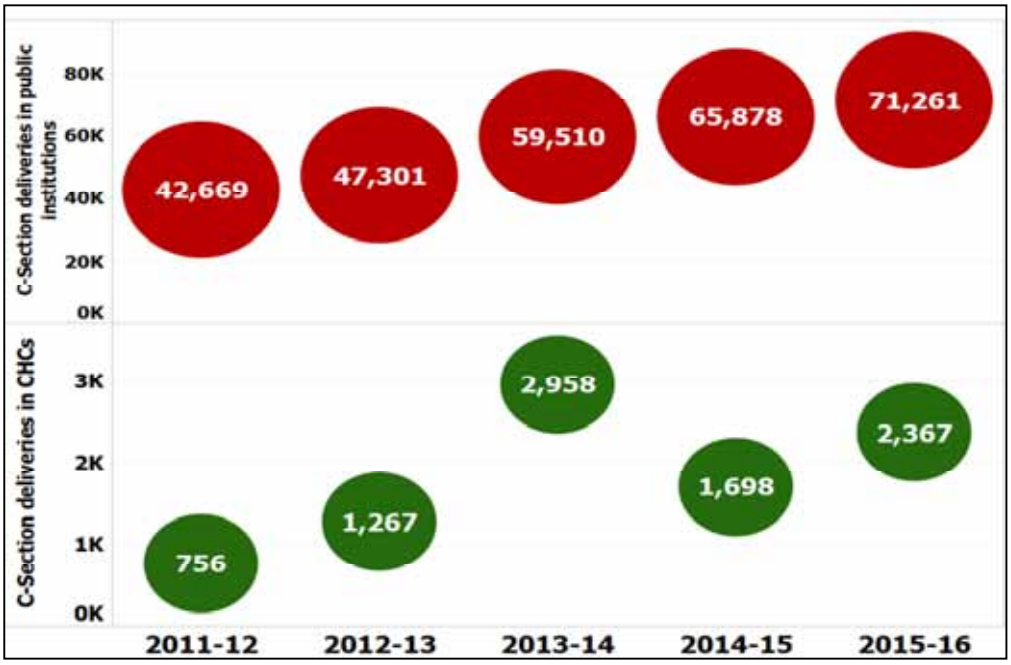
2.1.11.5 Quality of health infrastructure at Community Health Centres

Community Health Centres (CHC) is the secondary level of health care, designed to provide referral as well as specialist health care to the rural population. NRHM seeks to up-gradate CHCs as FRUs, which would provide facilities for comprehensive management of all obstetric emergencies, caesarean sections and other surgical interventions, blood bank/storage center and management of all sick newborns.

Out of 334 CHCs, 30 CHCs were upgraded as FRUs. Even these upgraded FRUs were not actually functioning as FRUs in four test checked cases.

Audit scrutiny revealed that the CHCs could not be made at par with the IPHS norms. However, SHS had targeted 63 out of 334 CHCs in the State for FRUs and only 30 CHCs could be upgraded as FRUs and remaining could not be upgraded due to lack of manpower and infrastructure. As a result, out of total 2.87 lakh C-Section deliveries in the public institutions, only 9,046 (three *per cent*) were conducted in the CHCs during 2011-12 to 2015-16, as depicted in chart 2.1.6.

Chart-2.1.6: Position of C-Section deliveries



(Source: State Health Society, HMIS)

CHCs could not be made at par with the IPHS.

Further scrutiny in the test checked districts revealed that three[17] CHC in district Dhar and one[18] CHC in district Mandla were not functioning as FRU, though declared as FRU by SHS. These CHCs were not performing C-section deliveries, which was essential to be performed by FRUs.

During the visit of 27 CHCs in 13 test checked districts lack of infrastructure and facilities were noticed as required by the IPHS norms as summarised in **Table 2.1.14**.

[17] CHC- Badnawar, Kukshi and Manawar.

[18] CHC-Nainpur.

Table 2.1.14: Poor infrastructure in Community Health Centres

Sl. No.	Infrastructure/facility attributed	No. of CHCs	Percentage
1.	Facility of surgery not available	24	89
2.	Services of obstetrics and gynaecology not available	23	85
3.	No emergency services	20	74
4.	Safe abortion services not available	14	52
5.	No functional toilets	10	37
6.	No separate wards	08	30
7.	No operation theatre	03	11
8.	No New born stabilization unit	17	63
9.	No ultrasound facility	26	96
10.	No blood storage facility	25	93

In the exit conference, Principal Secretary stated that efforts were being made to upgrade CHCs to FRUs by hiring services of Gynaecologist and Anaesthetist from private sector.

2.1.11.6 Quality of health infrastructure at District Hospitals

District Hospital (DH) is a secondary referral level for health care. All the 51 DHs of the State were functioning as FRUs for all health purposes. However, during visit to 13 District Hospitals in the 13 test-checked districts, audit noticed lack of facilities in operation theatres (4 DHs), ANC ward (1 DH) and other infrastructure as detailed in ***Appendix-2.1.17*** and in photograph below:

Stray animals, water logging and waste was found dumped within the premises of the District Hospital, Panna

Rag pickers picking the bio-medical waste being dumped in the premises of District Hospital, Panna

In the exit conference, Principal Secretary stated that strengthening of DHs was prioritised and steps were being taken to adopt the modern trends in hospital infrastructure and technology like provision of modular OTs, Lifts, CT scan machines etc.

2.1.11.7 Availability of staff quarters

To make all the health facilities fully functional, availability of residential quarters near vicinity of health facility was vital. The status of availability of

staff quarters in test-checked 11 DHs, 27 CHCs and 52 PHCs of 13 test checked districts as against the IPHS norms were as indicated in **Table 2.1.15**.

Table 2.1.15: Status of staff quarters for Medical and Para Medical staff in test checked DH/CHC/PHC

Name of Health Facility	Medical			Staff Nurse/ANM/ Para Medical		
	Required	Available	Shortage	Required	Available	Shortage
DH	374	73	301	1452	133	1319
CHC	282	158	124	168	71	97
PHC	52	30	22	260	46	214
Total	**708**	**261**	**447**	**1880**	**250**	**1630**

(Source: Information collected from Health facilities during audit)

Shortage of staff quarters were noticed at all level of health facilities.

Thus, there was shortage of 447 (63 *per cent*) staff quarter for medical officer and 1,630 (87 *per cent*) staff quarters for para medical staff. Further scrutiny in test-checked districts revealed that only two staff quarters were available in DH, Mandla against the requirement of 166 staff quarters. However, eight staff quarters of doctors and five staff quarters for para-medical were lying vacant in CHC, Kotma (Anuppur). Similarly, in PHCs Barach (Panna) and Kakarhati (Panna), doctors were not residing in staff quarter. All available four staff quarters were lying vacant in PHC Simra (Tikamgarh) on the ground that the PHC was located in isolated place.

Block Medical Officer, CHC Kotma stated (April 2016) that the staff quarter was lying vacant as it was far away from the city. The reply was not acceptable, as the Directorate of Health Services directed (June 2013) to all CMHOs to ensure that doctors and other staffs were residing in the place Hqrs. of their posting.

Staff quarters in dilapidated condition in PHC, Baravhi (Betul).

In the exit conference, Principal Secretary stated that the status of shortage of staff quarters was being addressed and currently the status of all functional delivery points was taken up on priority basis and the financial projections would be submitted to State Government at the earliest.

2.1.12 Availability of Health Care Professionals

Improvement in the health outcomes in the rural areas was directly related to the availability of the trained human resources. The Mission aims to increase the availability of trained human resources at all levels. SHS was required to

maintain the data on status of existing human resource at health centres for identification of existing gaps. State Government was responsible to provide the human resources at the rural health centres. NRHM provided for contractual appointment to a facility for filling short term gaps.

Scrutiny of records revealed that SHS had only overall data of human resources in rural health facilities of the State. The status of available human resource, both regular and contractual, at individual facility level was not available. As a result, SHS was not in a position to identify the existing gaps at a particular health facility.

2.1.12.1 Sub-Centre

As per IPHS and State Government norms there was provision of one ANM and one MPW (male) each at the SCs. As against this, ANMs were posted in all 9,192 sub-centres in the State. However, only 5,302 MPW (male) were posted in the State, hence there was shortage of 3,890 MPW (male). The status of deployment of ANM and MPW (Male) in 2,571 SCs of 13 test checked districts was as in **Table 2.1.16**.

Table 2.1.16: Status of manpower at SCs of sampled districts as of 31 March 2016

Name of posts	Required as per State and IPHS norms	Sanctioned Strength	Persons-in-position	Vacant as per sanctioned posts	Shortage as per norms
ANM and MPW (Male)	5142	4360	3593	767	1549

(Source-District Health Societies)

Thus, the sanctioned strength of ANM and MPW (Male) in 2,571 SCs of 13 sampled districts were less by 15 *per cent* than the IPHS norms for deployment of these personnel in SCs. Further, there was 767 vacant posts (18 *per cent*) of ANM and MPW (Male) against the sanctioned posts. The shortage had adverse effect on delivery of health services to rural population, as ANMs and MPWs (Male) were crucial service providers at the grass root level.

2.1.12.2 Primary Health Centre

Scarcity of man power at all level of health facilities was noticed.

As per IPHS and State Government norms one Doctor was to be posted at the PHC. As per information provided by SHS, out of 1,172 PHCs in the State, 503 PHCs were functioning without doctors as of April 2016. Further, Laboratory Technician and Pharmacist were not posted in 525 and 312 PHCs respectively.

The status of deployment of MOs and Para-Medical staff in 359 PHCs of 13 sampled districts was as detailed in **Table 2.1.17**.

Table 2.1.17: Status of manpower at PHCs of sampled districts

Name of posts	Essential as per IPHS norms	Sanctioned strength	Persons-in-position	Vacant as per sanctioned posts	Shortage as per IPHS norms
Medical Officer	359	472	215	257	144
Para-Medical	2872	1504	975	529	1897
Total	**3231**	**1976**	**1190**	**786**	**2041**

(Source-District Health Societies)

Thus, there was shortfall of 257 doctors in 359 PHCs against the sanctioned strength. Further, 168 PHCs out of 359 were functioning without doctors, though as per deployment norms one doctor was to be posted in each PHC. Three[19] PHCs which were declared as Basic Emergency Obstetric and Neonatal Care (BEmONC) institution were functioning without doctors.

2.1.12.3 Community Health Centre

Availability of specialist, medical officer and para-medical staff in 96 CHCs of 13 sampled districts was as in **Table 2.1.18**.

Table 2.1.18: Status of manpower at CHCs of sampled districts

Name of posts	Essential as per IPHS norms	Sanctioned as per State Government norms	Men-in-position	Vacant as per sanctioned posts	Shortage as per IPHS norms
Specialist	480	346	13	333	467
Medical Officer (MO)	384	254	215	39	169
Para-Medical	2016	1639	1229	410	787
Total	**2880**	**2239**	**1457**	**782**	**1423**

(Source-District Health Societies)

Thus, there was shortage of Specialists, Medical Officers and Para-Medical staff in all CHCs against the sanctioned strength as well as IPHS norms. Except for seven[20] CHCs, no Specialists (Surgeon, Gynaecologist, Paediatrician and Anaesthetic) were posted in remaining 89 CHCs. Further in comparison to IPHS norms, fewer Medical and Para-Medical Staffs were sanctioned by the State Government.

2.1.12.4 District Hospital

In 13 test-checked district hospitals, the status of Specialists, Medical Officer and para-medical staff was as in **Table 2.1.19**.

Table No.2.1.19: Status of manpower at DHs of sampled districts

Name of posts	Essential as per IPHS norms	Sanctioned as per State Government norms	Men-in-position	Vacant as per sanctioned posts	Shortage as per IPHS norms
Specialist	330	375	145	230	185
Medical Officer	240	288	258	30	-18
Para-Medical	2271	1684	1273	411	998
Total	**2841**	**2347**	**1676**	**671**	**1165**

(Source-District Health Societies)

[19] PHCs-Kamkomohaniya (Dindori), Kandia and Ringnod (Ratlam).

[20] One surgeon in CHC-Dhamnod, one Gynaecologist each in CHC-Kukshi (Dhar), CHC-Maheshwar (Khargone) and CHC-Mandideep (Raisen), one anaesthetic in CHC-Bajna (Ratlam), one paediatric each in CHC- Kukshi (Dhar), CHC-Khalwa (Khandwa), CHC-Bajna (Ratlam) and CHC-Niwari (Tikamgarh).

Thus, the availability of specialist and para-medical staff was not ensured in DHs as per IPHS as well as State Government norms. Further, in three DHs (Anuppur, Dhar, Khandwa), the post of surgeon was lying vacant and in two DHs (Dhar and Tikamgarh) posts of Obstetric and Gynaecologist were lying vacant. The Paediatric was not posted in DHs, Dindori and Rajgarh and the post of Anaesthetic was lying vacant in Betul and Dhar.

In the exit conference, Principal Secretary stated that advertisement had been issued for filling of the posts of Medical Officers through Madhya Pradesh Public Service Commission and counselling of contract doctors was under process.

2.1.12.5 Accredited Social Health Activist (ASHAs)

ASHA works as an interface between the community and the public health system to promote health care at household level. ASHAs would reinforce community action for universal immunisation, safe delivery, newborn care and prevention of waterborne and other communicable diseases. ASHAs would also provide immediate and easy access for the rural population to essential health supplies like, ORS, contraceptives and a set of ten basic drugs for villagers.

Audit scrutiny revealed that 58,730 ASHAs were engaged in the State as of April 2016 against the requirement of 62,206 ASHAs. Hence, there was shortfall of 3,476 ASHAs.

As per information provided by SHS, drug kits were distributed to all the 58,730 ASHAs. However, verification of drug kits of 129 ASHAs in 13 test checked districts revealed that only six ASHAs had fully equipped kits containing all 16 drugs/items in the kit. The availability of drugs/items in remaining 123 ASHAs ranged from seven to 15. Significant items/drugs which were not found in the kit were thermometer, contraceptive pills, disposal delivery kit, etc. The important results of survey of 416 ASHAs revealed the following:

- **Training:** Under JSY, ASHAs were to be trained for normal delivery in case of emergency situations. However, 304 ASHAs surveyed were not trained for emergencies and did not have necessary equipment to conduct a normal delivery. This constrained them from effectively delivering the health care service.

- **Usage of kits:** 365 ASHAs did not have disposable delivery kits. Out of 41 ASHAs possessing the disposal delivery kits, eight did not know how to use it. Further, 268 ASHAs had blood pressure monitor, out of which 96 did not know how to use it. Likewise, 21, 7 and 30 ASHAs did not possess paracetamol tablets, iron pills and deworming pills respectively. This reduced the effectiveness of ASHA in delivering the mandated health services.

- **Receipt of incentives:** Under JSY, ASHAs should be paid incentives for each activity such as ANC, institutional delivery, PNC etc. Audit survey revealed that 113 ASHAs were paid incentives on time, 135 ASHAs got incentives usually in time, 97 ASHAs got incentives some times, five ASHAs got incentives rarely and four ASHAs never got incentives. 62 ASHAs did not

give any specific response in this regard. This may demotivate the ASHAs in performing their duties diligently.

In the exit conference Principal Secretary stated that selection and training of ASHAs was a continuous process. The process of selection and recommendation of ASHAs begins at the level of Gram Panchayat, which meets only four times in a year, hence required ASHAs could not be selected.

The reply was not acceptable, as there was ASHAs who were not adequately trained to take reading of thermometer, blood pressure monitor and conduct normal delivery in case of emergencies.

2.1.13 Availability of essential drugs in health centres

Realizing the need to improve the availability of drugs in the Government health facilities, the *Sardar Vallabh Bhai Patel Nishulk Aushadhi Vitaran Yojana* (Free Drug for All scheme) was launched in the State in November 2012. The main objective of the scheme was to guarantee the availability of minimum essential drugs free of cost to all patients across all the public health facilities of the state. During 2013-14 to 2015-16, an amount of ₹ 280.92 crore was allocated for procurement of drugs after inception of scheme 'Free Drug for All scheme' under NRHM, against which ₹ 244.28 crore was utilized.

IPHS has defined essential drugs list for each level of health facility. State Government has also issued its own essential drugs' list for SCs, PHCs, CHCs and DHs under Madhya Pradesh *Swasthya Sewa Guarantee Yojana*. The status of availability of drugs in test checked 25 CHCs, 51 PHCs, 134 SCs and 13 DHs of 13 sampled districts was as summarised in **Table 2.1.20**.

Table 2.1.20: Status of drugs available as per IPHS and State Government norms

Name of health centre facility	Essential drugs as per IPHS norms			Essential drugs as per State Government norms		
	Required	Available (Min./Max.)	Not Available (Min./Max.)	Required	Available (Min./Max.)	Not Available (Min./Max.)
SC	43	11/39	04/32	24	02/20	04/22
PHC	148	24/128	20/124	71	15/70	01/56
CHC	176	54/162	14/122	107	42/104	3/65
DH	493	160/351	142/333	147	82/135	12/65

(Source-Test check of sampled health facilities)

Essential drugs were not available according to prescribed norms.

Thus, essential drugs were not available in test checked health centres. Some of the essential drugs which were not found available in the test checked health facilities as per IPHS and State Government norms were Inj. Adrenaline, Inj. Ampicillin, Tab. Aminophylline, Tab. Cetrizine, Tab. Calcium etc.

During visit to health facilities, improper disposal of drugs were also noticed as depicted in the photographs below:

Unexpired drugs being dumped in the pit in the PHC, Khedikort (District: Betul)

Unused drugs thrown adjacent to the SC, Mangrol (Dist: Ratlam)

In the exit conference, Principal Secretary stated that all districts had been instructed to procure medicines and ensure continuous availability of medicines as per the Minimum Drug List in all the Government health facilities. However, some gaps existed in the past regarding availability of some drugs in various hospitals due to pseudo stock outs, stocks in pipeline, delay in supply and availability of alternative drugs.

The fact remains that the Chief Medical and Health Officers and the Civil Surgeons failed to ensure the availability of essential drugs at health facility centres.

2.1.14 Availability of essential equipment in health centre

IPHS and State Government had defined list of essential equipment for each level of health facility. During 2013-14 to 2015-16, State Government allocated an amount of ₹ 57.85 crore for procurement of equipment against which ₹ 33.76 crore was utilized.

The status of availability of essential equipment in test checked eight CHCs, 14 PHCs, 41 SCs and 12 DHs was as summarised in **Table 2.1.21**.

Table 2.1.21: Status of equipment available as per IPHS and State Government norms

Name of health centre facility	Equipment as per IPHS norms			Equipment as per State Government norms		
	Required	Available (Min./Max.)	Not Available (Min./Max.)	Required	Available (Min./Max.)	Not Available (Min./Max.)
SC	67	11/63	04/56	Norms were not fixed		
PHC	92	03/78	14/89	52	03/46	06/49
CHC	265	44/207	58/221	85	34/85	0/51
DH	288	52/145	143/236	169	98/159	10/71

(Source-Test check of sampled health facilities)

Thus, none of the test-checked health facility centres had all essential equipment either as per IPHS or State Government norms. Some of the essential equipment not available in these centres were ECG machine, Neonatal Laryngoscope, Incubator, Colorimeter, phototherapy unit, etc.

In the exit conference Principal Secretary stated that State Government had prepared vital, essential and desirable equipment lists and efforts were being made to ensure availability of all vital equipment at all health facilities.

However, State Government had not fixed timelines for providing the vital and essential equipments in the health facility centres.

2.1.15 Availability of laboratory services in health centres

IPHS has defined laboratory services for each level of health centres. Further State Government has also issued its own list of laboratory services for SC, PHC, CHC and DH under Madhya Pradesh *Swasthya Sewa Guarantee Yojana*. These services were to be available at these centres all the time.

The status of laboratory services in 13 DHs, 24 CHCs, 52 PHCs and 149 SCs test checked health centres were as detailed in **Table 2.1.22**.

Table 2.1.22: Position of laboratory services available as per IPHS and State Government norms

Name of health centre facility	Laboratory services as per IPHS norms			Laboratory services as per State Government norms		
	Required	Available (Min./Max)	Not Available (Min./Max.)	Required	Available (Min./Max)	Not Available (Min./Max)
SC	04	01/04	0/3	05	3/5	0/2
PHC	21	01/21	0/20	16	0/16	0/16
CHC	36	12/31	05/24	28	16/28	0/12
DH	97	37/66	31/60	48	31/46	2/17

(Source-Test check of sampled health facilities)

Thus, any of the test-checked health facility centres were not providing all laboratory services either as per IPHS norms or as per State norms. Further scrutiny of 52 test-checked PHCs revealed that eight[21] PHCs were not providing any laboratory services.

In the exit conference, Principal Secretary stated that efforts were being made for all laboratory testing at the health centres. Diagnostic test counts in the districts were being monitored, which were under active surveillance.

2.1.16 Mobile Medical Units

The objective of Mobile Medical Units (MMUs) was to take health care to the door step of the public in the underserved, rural and hard to reach areas. MMUs were operated through service providers selected by SHS as per mutually agreed terms and conditions.

Services of MMUs could not be provided up to the targeted level.

During the year 2011-12 to 2015-16, against the allocated funds of ₹ 103.65 crore funds for operation of MMU, only ₹ 57.03 crore could be utilized due to which MMU services could not be provided in all identified

[21] PHC-Khandanbujurg, Satipura, (Dhar), Barud (Khandwa), Bisalwaskala, Bordiyakala (Neemuch), Barach (Panna), Goghatpur and Sonwaria (Rajgarh).

areas. The status of coverage of MMU services in the State was as detailed in **Table 2.1.23**.

Table 2.1.23: Status of MMUs coverage

Year	Target for coverage		Actual coverage	
	No. of districts targeted for coverage	Total no. of blocks targeted for coverage in the district	No. of district actually covered	No. of Blocks actually covered
2011-12	33	123	33	123
2012-13	35	131	31	109
2013-14	35	131	30	108
2014-15	35	131	27	84
2015-16	35	131	25	78

(Source: State Health Society)

Thus, the coverage of MMU services was showing a decreasing trend and against the target of 35 districts and 131 blocks only 25 districts and 78 blocks were being covered in 2015-16.

Out of 13 sampled districts, MMU services were operated in nine districts and was later discontinued in six[22] districts and tender was in process for selecting new service providers. Test check of four MMUs in three districts revealed inadequacy of drugs, equipments and lab test facility against the standards fixed by the SHS, as detailed in ***Appendix-2.1.18.***

In the exit conference, Principal Secretary stated that MMU services were discontinued either by service provider or by department due to some operational issues during the past years. However, MMU services were now being integrated with *Sanjivani*-108 and *Janani Express* under the centralized call center operated by a single agency. MMU services would be made operational in the next two to three months.

2.1.17 Training

NRHM aims to increase the availability of trained human resources at all levels. The capacity of all staff caring for maternal, new born and children at the District Hospitals, FRUs and 24x7 PHCs was to be enhanced. With regards to training following deficiencies were noticed during audit:

- **Inadequate training to health professionals**

During the period 2011-12 to 2015-16 against the available funds of ₹ 99.86 crore, only ₹ 46.80 crore (47 *per cent*) of the funds were utilised under training component. The less utilisation of available funds led to shortfall in target set for capacity building through training as detailed in **Table 2.1.24**.

[22] Anuppur, Dhar, Dindori, Khargone, Mandla and Tikamgarh.

Table 2.1.24: Position of trainings held in various components and shortfall during 2011-12 to 2015-16

Even after availability of sufficient funds targeted training could not be imparted.

Name of component	No. of training/ batches planned	No. of participants/ trainees	No. of training/ batches achieved	No. participant/ trainees trained	Shortfall	
					Batches	Trainees
Maternal Health	2541	42462	1111	10837	1430	31625
Child Health	1585	36004	832	20010	753	15994
Family Planning	1291	9846	690	5721	601	4125
Immunisation	1746	76643	1511	71435	235	5208
ASHA	13759	528255	10666	390306	3093	137949
Community Participation	22330	630278	9634	242001	12696	388277
HMIS	2676	88754	2193	80420	483	8334
Total	**45928**	**1412242**	**26637**	**820730**	**19291 (42%)**	**591512 (42%)**

(Source: State Health Society)

Thus, training could not be imparted as planned resulting in 42 *per cent* shortfall in number of batches as well as participant/trainees. Further scrutiny revealed that training need analysis was done only in 2015-16 for Medical Officers in four (out of 51) districts. The training need analysis was not done during 2011-15 in remaining cases to ascertain the gaps and required training programme.

The shortfall in training was mainly noticed in activities, such as training of MOs in EMOC/BEmONC/LSAS[23] under Maternal Health, training of MOs/SNs in IMNCI, training of ANMs/AWW on Infant Child Feeding Practices (IYCF), *Navjaat Shishu Suraksha Karyakram* (NSSK) training of MOs under Child Health; training of MOs in Vasectomy/Tubectomy and training of SNs/ANMs/LHVs in IUD insertions etc.

- **Inadequate training to ASHAs**

ASHAs were provided a composite training comprising of the induction and module training to acquire the required knowledge, skill and confidence in performing her assigned roles effectively. In addition to this, to develop specific competency in healthcare for mothers and children, training in module sixth and seventh were provided to ASHA.

Audit scrutiny revealed that 57,730 out of 58,730 ASHAs were trained up to fifth module and only 9,409 ASHAs were trained in sixth module. Thus, 49,321 ASHAs (84 *per cent*) were not trained in module sixth and seventh to develop specific competency in healthcare for mothers and children.

In the exit conference, Principal Secretary stated that it was difficult to nominate doctors for EMOC and LSAS trainings as these were four and six

[23] EMOC-Emergency Obstetric Care, BEmONC-Basis Emergency Obstetric and Newborn Care, LSAS-Life Saving Anesthesia Skills.

months duration trainings. Refresher training for ANMs commenced late during 2015-16 as there was issue regarding budget distribution per batch. Further, there was difficulty in collection and compilation of training data, hence, there was need of training MIS.

Thus, the capacity building of medical and para-medical staff could not be done through training and orientation programme to enhance the service delivery at health facility level, even after availability of adequate funds.

2.1.18 Quality Assurance

Quality Assurance (QA) standards under NRHM are prescribed in Operational Guidelines for Quality Assurance in Public Health Facilities 2013. As per the guidelines for strengthening the QA activities, organisation arrangements are to be ensured through State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC) and District Quality Team (DQT) at respective levels with defined roles and responsibilities.

SHS intimated that in the light of Guidelines for Quality Assurance received from GoI, MoHFW in September 2014, SQAC, DQAC and DQT were re-constituted in September 2014. During 2013-14 to 2015-16, against allocated funds of ₹ 6.85 crore for QA activities, only ₹ 0.60 crore (nine *per cent*) was utilised. Audit noticed that less utilisation of funds resulted in poor implementation of QA as discussed below:

Quality Assurance could not be implemented in the State as prescribed in the guidelines.

- As per guidelines, the SQAC and DQAC would meet at least once in six months and three months respectively. During the year 2014-15, only one meeting and in 2015-16 two meetings of SQAC were held. Further, in 13 test-checked districts, against required 52 DQAC meetings in each year, only 26, 40 and 48 meetings were reported to be held in 2013-14, 2014-15 and 2015-16 respectively. However, copies of minutes of meetings were not furnished to audit.

- To ensure QA at field level, no criteria were prescribed for the field visits by SQAC. However, 41 field visits were conducted in 2015-16. Similarly, regular field visits by DQAC were conducted in eight districts only during 2013-16.

During 2013-14 and 2014-15, no orientation/training programme was planned or conducted in 13 test-checked districts, except Tikamgarh and Raisen. Further, in 2015-16 these were conducted in Anuppur, Raisen, Rajgarh, Ratlam and Tikamgarh districts only.

- Guidelines prescribed reporting and review of key performance indicators[24] (KPI) to assess overall quality care performed by various departments of the health facility. However, only eight DHs in 2014-15 and 26 DHs in 2015-16 were reporting the data on key performance. The negligible reporting of KPIs indicates that quality assurance programme could not be implemented at all level.

[24] Critical data for assessment and monitoring of performance indicators of all the departments in the health facility.

SHS intimated that no public health care facility in the State qualified for State and National level certification in terms of quality assurance. However, audit noticed that DH Khandwa has been awarded State (*Kayakalp*) and National level certification for promoting cleanliness, hygiene and infection control in 2015-16.

In the exit conference, Principal Secretary stated that the SQAC and DQAC were reconstituted in September 2014, hence less number of meetings was held. Further, staff of hospitals needs to be trained in KPI reporting.

2.1.18.1 Quality Assurance in District Hospital (DH)

Quality Assurance has 70 standards categorized into eight broad areas of concern i.e. Service Provision, Patient Rights, Input, Support Services, Clinical Care, Infection Control, Quality Management and Outcome. Audit scrutiny in 13 DHs revealed the following shortcomings:

- Internal Quality Team (IQT) was formed during December 2015 to July 2016 in all 13 DHs except Dhar. However, Standard Operating Procedure (SOPs) and QA guidelines was not available in DH, Anuppur, Dhar, Neemuch and Khargone. Orientation/training of staff for quality standards/SOPs was not conducted in DH, Anuppur, Dhar, Khargone and Tikamgarh.

- DQT should meet once every month. However, no meeting was conducted in 2013-14 and 2014-15, except in DH-Ratlam. Further, against required 156 meetings of DQT in 13 test-checked DHs in 2015-16, only 27 meetings were held.

- Internal assessment of DH was not conducted in 2013-14. In 2014-15, only two internal assessments were conducted, one at DH, Rajgarh and one at DH, Ratlam. In the year 2015-16, DH, Dhar, Panna and Tikamgarh did not conduct any internal assessment. Remaining 10 DHs conducted 24 internal assessments of which reports of only 20 were available.

- Patient satisfaction survey was not conducted in any test checked DH during 2013-14 and 2014-15. In 2015-16, patient satisfaction survey was conducted only in DHs Anuppur, Dindori and Neemuch.

- KPI were not prepared in DH Anuppur, Dhar and Dindori. In remaining 10 DHs, preparation and reporting of KPIs to SQAC/DQAC started from December 2015 to April 2016.

- Periodic assessment of DHs by DQAC and SQAC was not conducted in 2013-14 and 2014-15 in any of the 13 DHs test checked. In 2015-16, DQAC assessed five[25] DHs and SQAC assessed five[26] DHs.

In the exit conference, Principal Secretary stated that instructions had been issued to all districts for constitution of DQT. SOPs had been sent to the districts and instructed the districts to impart training on SOP for its implementation.

[25] Khandwa, Neemuch, Panna, Rajgarh and Ratlam.

[26] Khandwa, Panna, Rajgarh, Ratlam and Tikamgarh.

2.1.18.2 Quality Assurance in CHC

The shortcomings noticed during audit of implementation of QA at test-checked 27 CHCs was as follows:

- Internal Quality Team was not formed in 19 out of 27 CHCs. During 2013-16, meeting of IQTs were held only in five[27] CHCs and minutes were recorded only in two[28] CHCs. Further, SOPs were not available in 14 CHCs and QA guidelines were not available in 17 CHCs. Orientation of staff for Quality Standards was not carried out in 18 CHCs.

- Periodic internal assessment was reportedly conducted only in nine[29] CHCs. However, they did not furnish any record in support of reply. Further, patient satisfaction survey was conducted only in two[30] CHCs.

- KPIs were not measured and monitored in 15 CHCs out of 27 CHCs. Further, out of 10 CHCs, only eight CHCs were reporting the KPIs to DQAC and SQAC.

- During 2013-16, out of 27 CHCs, six[31] CHCs were assessed by DQAU and three[32] CHCs were assessed by SQAU.

A couple of photographs of CHC in view of quality being followed at the health centres are as below:

	
Used gloves being again put-up for reuse in CHC-Sailana, Ratlam, district.	**Soiled linen found used on the patient bed in CHC-Sailana, Ratlam district.**

2.1.18.3 Quality Assurance in PHC

- IQT was formed only in five[33] PHCs out of 52 test-checked PHCs. Meetings of IQT were held only in two[34] PHCs during 2013-16. Further, QA guideline was available only in three PHC[35] and SOPs were available in seven PHCs[36].

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27 CHC-Ajaygarh, Bamhani Banjar, Jaithari, Prithvipur and Jeerapur.
28 CHC-Ajaygarh and Jeerapur.
29 CHC-Ajaygarh, Bamhani Banjar, Gogawa, Jathari, Khalwa, Khilchipur, Narainganj, Prithvipur and Sehra.
30 CHC-Ajaygarh and Chegaon Makhan.
31 CHC-Bajag, Bamhani Banjar, Gogawa, Jaithari, Karanjia and Kasrawad.
32 CHC- Bajag, Bamhani Banjar and Karanjia.
33 PHC-Babliya Bazaar, Chondi Pondi, Gorakhpur, Mohaniya Patpara and Singhora
34 PHC-Mohaniya Patpara and Singhora.
35 PHC-Lapta, Gadasarai and Babliya Bazar.
36 PHC- Babliya Bazar, Dhangaon, Gadasarai, Gorakhpur, Hridyanagar, Lapta and Singhora.

- Periodic internal assessment was reportedly conducted in two[37] PHCs. However, no records were available in support of the same. Further, patient satisfaction survey was not conducted in any of the 52 test-checked PHCs.

- KPIs were measured only in three[38] PHCs and reported only in one PHC-Sendhwal, out 52 test-checked PHCs. However, no records were furnished in this regard.

In the exit conference, Principal Secretary stated that guidebook for quality assurance for DH and CHC/PHC was released by GoI in the year 2014 and 2015 respectively. State QA cell instructed the districts to conduct periodic assessment. Implementation of QA Programme at CHC and PHC level would be done in year 2017-18. Reporting of KPIs was an integral part of QA programme, therefore, KPIs from CHC and PHC would be captured only after the training of service providers.

2.1.19 Beneficiary Survey

In 13 test checked districts out of 1,386 beneficiaries surveyed audit noticed:

- **Registration of pregnancy**: Of the 1,386 beneficiaries surveyed, 1,314 (95 *per cent*) were registered in time, 51 (4 *per cent*) beneficiaries were registered between four to six months of their pregnancies and 14 (1 *per cent*) were registered between six to nine months and seven beneficiaries did not know about registration of their pregnancies.

- **Knowledge about due date:** 1,271 beneficiaries knew about due date of their delivery, whereas 115 (8 *per cent*) beneficiaries did not know about their due date of delivery.

- **Ante-Natal Care (ANC):** Pregnant women are required to visit the facilities at least four time for ANCs. In the beneficiary survey audit found that seven beneficiaries visited health centre or hospital just once, 73 (5 *per cent*) beneficiaries visited the health centre or hospital twice and 345 (25 *per cent*) beneficiaries visited the health centre or hospital thrice and 956 beneficiaries visited health centre or hospital four times or more. Five beneficiaries did not visit any health centre or hospital.

- Under the scheme guidelines, ASHAs are required to visit beneficiary homes at least thrice during pregnancy period. ASHAs visits to beneficiary homes in the sample, during pregnancy period was once for three pregnant women, twice for 48 (3 *per cent*) pregnant women, thrice for 132 (10 *per cent*) pregnant women and four and above times for 1,163 (84 *per cent*) pregnant women. 40 beneficiaries were not aware whether ASHAs visited them. Thus, the required visits were not ensured.

- NRHM is being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. 1,259 (91 *per cent*) beneficiaries delivered at health facilities (DH-444 beneficiaries, CHC-309 beneficiaries, PHC-479 beneficiaries, SC-27 beneficiaries), 47 beneficiaries delivered at private hospitals, 77 beneficiaries

[37] PHC- Chanda and Singhora.

[38] PHC- Chanda, Kukdeshwar and Sendhwal.

delivered at home and three delivered in transit. Beneficiaries, who did not deliver in the institution stated that the family did not allow and some stated that they were not interested/not necessary to deliver at institution. Thus, the ANMs/ASHAs failed to advocate the benefits of institutional deliveries in the rural areas.

- **Ambulance availability:** As per Janani Express Yojana, referral transport facility should be made available free of cost to pregnant women. It was noticed that out of 1,386 beneficiaries, 1,065 (77 *per cent*) beneficiaries called the ambulances, whereas 321 (23 *per cent*) beneficiaries did not call the ambulance. Further, ambulances arrived in time in 1,026 (96 *per cent*) cases and did not arrive in time in 39 (4 *per cent*) cases.

- **Stay in health facility:** As per *Janani Suraksha Yojana*, beneficiaries are to stay in the hospital facility for at least 48 hours after delivery. Audit survey revealed that out of 1,386 beneficiaries, 1,309 were institutional deliveries, wherein 43 (3 *per cent*) beneficiaries stayed in the health facility after delivery up to 12 hours, 246 (19 *per cent*) beneficiaries stayed in the health institutions after delivery for 12-24 hours, 194 (15 *per cent*) beneficiaries stayed in the health institution after delivery for 24-48 hours and 820 (63 *per cent*) beneficiaries stayed more than 48 hours after delivery. Six beneficiaries did not remember/did know how long they stayed at the health facility. Thus, provision of the guidelines were not adhered to in 483 cases (37 *per cent)* cases.

- 1,112 beneficiaries were provided food in health institutions free of cost, whereas nine beneficiaries had to pay for the food provided and no food was provided to 59 (4 *per cent*) beneficiaries. 21 beneficiaries did not remember whether they got food for free or they paid for it. 108 beneficiaries did not give any specific response in this regard.

- **JSY cash incentive:** Under JSY, every women is entitled for cash incentive of ₹ 1,400 in rural areas and ₹ 1,000 in urban areas immediately after her institutional delivery. Audit survey revealed that 1,017 beneficiaries were paid incentives, while 369 beneficiaries were not paid incentives under JSY. Out of 1,017 beneficiaries, 748 women received JSY benefits with delay of one to 30 days, 269 women received with delay of 30 to 90 days.

- **Post natal care (PNC):** Under the guidelines, new mothers are required to visit health facilities at least four times within 42 days of delivery for PNCs. Audit survey revealed that 88 beneficiaries visited the medical facilities only once for PNC, 246 beneficiaries visited the medical facilities twice, 527 beneficiaries visited the medical facilities three times and 501 visited the health facilities for four or more times. 24 beneficiaries did not visit any health facilities for PNC. Thus, Medical Officers, ANMs and ASHAs failed to promote and mobilise the beneficiaries of the benefits of post natal care.

- Under the guidelines, health workers are to visit beneficiary's home at least twice within seven days from the date of delivery. In 1,233 cases health worker visited beneficiaries home within two-seven days, in 144 (10 *per cent*) cases health worker did not visit the beneficiaries home within seven days to

check the mother and baby and in nine cases beneficiaries did know about the visit requirement of health workers.

- 1,362 beneficiaries received Vitamin-A dose, 16 beneficiaries did not receive Vitamin-A dose and eight beneficiaries were not aware of this service.

- Gender balance was one of objectives of the Mission. However, gender inequalities were seen, where in view of pregnancy outcome, against birth of 771 male children, 595 female births were noticed among the surveyed beneficiaries.

- Though the target was to minimise the TFR rate up to 2.1, however, it was noticed that 332 women were having three or more children and 37 women were having more than five children among the surveyed beneficiaries.

- 378 women gave birth by normal delivery at District Hospitals, ignoring the PHC/CHC which existed in the vicinity of their residence, which shows that the PHCs and CHCs could not instil the confidence of the quality of the health care services being provided by them.

In the exit conference, Principal Secretary stated that number of deliveries in DHs was more as compared to rural health institutions, as DHs had full comprehensive obstetric and neonatal care facility. Close monitoring of deliveries at sub district level delivery points was being ensured and gaps in terms of human resources, civil works, equipment and capacity building were being addressed.

2.1.20 Data collection, management and reporting

2.1.20.1 Health Management Information System

The HMIS is a web based data entry application designed by Ministry of Health and Family Welfare for capturing of data, which helps in gathering, aggregating, analysing and then using the information for taking actions to improve performance of health systems at all levels.

As per HMIS operational manual SC, PHC and CHC would report their data on monthly basis to the Block in the format prescribed for their facility on 5th of following month at the Block level, further the Block would consolidate these data to prepare the 'Block Consolidated Report' and the same would be submitted to the district.

Two copies of the data set would be prepared by health facilities, one copy should be transmitted and the one would be filed in the facility records after being duly signed by the authority. At the Block or District level where the facility data sets are received, it should be ensured that these are duly signed and verified, before the data entry for these are undertaken. A paper copy of the generated report must be verified (signed and stamped) and maintained at the district level and other copy should be sent to the State.

SHS informed (July 2016) that each health facility prepared HMIS data in two copies in the prescribed format and reported timely, one copy was transmitted to the Block Programme Management Unit (BPMU) and one was kept in the

facility records. However, this fact was not found correct during test-check of the health facilities, as detailed in **Table 2.1.25**.

Table 2.1.25: Status of data reporting at health facilities

Name of the health facility	No. of health facility test-checked	Duplicate authenticated copy retained		Figures of data reported tallied with base records		Frequency of date on which data reported
		Yes	No	Yes	No	
SCs	83	28	55	14	14	15th to 14th, 16th to 14th, 26th to 25th, 1st to 26th, 21st to 20th, 22nd to 21st of each month
PHC	30	01	29	00	01	NA
CHC	15	01	14	01	00	Monthly

(Source: Data collected from test-checked health facilities)

- Out of 83 test-checked SCs, duplicate copy of data reported was not found maintained in 55 SCs. Thus, accuracy of data reported by these SCs could not be ensured by audit. Further, test-check of data reported by remaining 28 SCs, revealed mismatch of data reported from the available records in 14 SCs. Further, it was also noticed that the periods for which data reported were not uniform in 16 SCs.

- Out of test checked 30 PHCs and 15 CHCs duplicate copy of data reported was not found maintained in 29 PHCs and 14 CHCs. On being asked for duplicate copies they stated that data was reported to higher authorities in soft copy and hard copy was not available.

Further, scrutiny of HMIS data reported to GoI during 2011-12 to 2015-16 by SHS revealed that accuracy and authenticity of reported data was not ensured, as the number of FRUs reported ranged from 979 in 2011-12 to 3,082 in 2015-16, whereas only 148 FRUs were functional in 2015-16; further it was reported in HMIS that the number of 24x7 PHCs functioning with at least three staff nurses ranged from 4,628 in 2011-12 to 4,778 in 2015-16, whereas only 68 24x7 PHCs were functioning in 2015-16. Similarly, number of functional SNCUs reported ranged from 1,160 in 2011-12 to 2,566 in 2015-16, whereas only 54 SNCUs were functioning in the State in 2015-16.

In the exit conference, Principal Secretary stated that instructions were issued to keep a month-wise copy of reported HMIS information at each health facility. There was need for improvement in current reporting system as per HMIS operational manual, efforts are being made to strengthen the same. Further, it intimated that the same instruction has been reiterated (September 2016) and from 2015-16 State, district and block level functionaries would be personally accountable for the quality of reporting in the HMIS.

Thus, the veracity of reported data was not ensured and the protocols of HMIS guidelines were not followed.

2.1.20.2 Physical and Financial Progress Reports (PFMR)

Physical and Financial Progress Report against Plan provides component-wise utilization against the budget allocated. It is also supposed to include physical progress against the target.

Scrutiny of reports for the year 2011-12 to 2015-16 revealed several discrepancies in figures reported as detailed in **Table 2.1.26**.

Table 2.1.26: Status of PFMR

(₹in crore)

Year	No. of activities where 'nil' physical achievement is shown but expenditure has been incurred		No. of activities where physical planned and budget planned is 'nil' however achievement is shown under physical and expenditure shown in budget achieved	
	No. of activities	Amount involved	No. of activities	Amount involved
2011-12	33	17.24	22	14.38
2012-13	71	30.38	04	5.91
2013-14	144	26.99	24	17.98
2014-15	50	21.82	75	134.55
2015-16	149	25.45	04	1.60

(Source: State Health Society)

Thus, due to above discrepancies true and fair picture of co-related physical and financial progress was not exhibited from PFMR and this report did not fulfil the purpose for which it was prepared.

In the exit conference, Principal Secretary stated that there are differences in the reported figures of physical and financial. However efforts are being made at State level for reconciliation and improvement of progress data.

2.1.21 Conclusion and recommendations

State could not attain the goals for IMR, MMR and Total Fertility Rate (TFR) and it was lagging far behind the achievements of other States. The IMR of the State was 51 per 1,000 live births as against the target of 27 per 1,000 live births under MDG. Madhya Pradesh stands at 27th place out of 28 States in IMR. Similarly, the State could reduce MMR to 221 per 1,00,000 live births against the MDG target of 109 per 1,00,000 live births. In MMR, the State was at 13th place out of 18 States.

The status of TFR improved since 2012, as it reduced from 2.9 (March 2012) to 2.3 (March 2016). However, State could not achieve the target fixed under NRHM Framework of Implementation (2012-17) to reduce TFR to 2.1. The shortfalls in providing maternal, child and reproductive health care services resulted in failure of State in achieving targets for IMR, MMR and TFR.

All out efforts should be made to improve the situation of IMR and MMR in the State.

Only 56 *per cent* of 93.72 lakh pregnant women registered for ANC could be registered within 1st trimester of pregnancies. Further, 19.44 lakh (21 *per cent*) could not receive three ANC check-ups during the gestational period. The shortfall in immunisation for TT was 17.83 lakh (19 *per cent*).

Targeted couple may be tracked for early registration of pregnancies and registered pregnant women may be followed-up for complete ante-natal care. Government has accepted the audit recommendation.

Out of total 74.28 lakh pregnant women received three ANC check-ups, HIV testing of 47.27 lakh (64 *per cent*) women and VDRL testing of 60.34 lakh (81 *per cent*) pregnant women were not conducted for management of adverse pregnancy outcomes in case of infected mothers.

Screening of pregnant women for HIV and VDRL tests may be enhanced at point of care. Government has accepted the audit recommendation.

Institutional delivery was 87 *per cent* of the total deliveries in the State during 2011-16. However, only 49.72 lakh beneficiaries out of 55.38 lakh deliveries in public institutions were paid JSY incentive. Further, 8.96 lakh were total home deliveries in the State during 2011-16, out of which 6.65 lakh (74 *per cent*) were not attended by SBA trained health professionals. Out of 55.38 lakh deliveries in public institutions during 2011-16, 15.26 lakh (28 *per cent*) were discharged within 48 hours of delivery and only 35.21 lakh (55 *per cent*) mothers received postpartum check-up between 48 hours to 14 days after delivery.

Districts and blocks with high home delivery and less institutional delivery may be earmarked for promotion of institutional delivery through awareness programme, social mobilization and assured referral transport services.

In the 13 test checked districts, it was noticed that out of 8.53 lakh institutional delivery in these districts, pick-up services to 4.91 lakh (57 *per cent*) and drop-back services to 4.09 lakh women (*48 per cent*) could be provided during 2011-12 to 2015-16.

The offer of free pick-up and drop-back may be given wide publicity, so that the facilities are utilised by the rural population.

Female sex ratio at birth still needs improvement, wherein 33.36 lakh female births were reported in comparison to 35.89 lakh male birth during 2011-16. Moreover, the proportion of missing cases of deliveries was very high wherein 69.83 lakh total deliveries were reported against the total 93.72 lakh ANC registered.

System of follow-up and tracking of registered ANCs both in public and private health institutions may be strengthened. Government has accepted the audit recommendation.

Out of total 69.25 lakh live births in the State, 10.61 lakh babies were reported as low birth weight. However, 4.49 lakh babies were not weighed at the time of birth during 2011-16. Further, only 62.97 lakh newborns were breast fed within one hour of delivery.

All live births may be weighed after birth so that in case of LBW necessary steps could be taken in view of health requirement. Government has accepted the audit recommendation.

Targets set for child immunization against seven vaccine preventable disease could not be achieved during 2011-16 and the range of shortfall was 16 to 21 *per cent* in the State. Besides, Hepatitis-B Zero dose was to be provided to the infants up to 48 hours of age. However, against 69.25 lakh live births, only 39.30 lakh (57 *per cent*) infants could be vaccinated for Hepatitis B Zero dose.

Gaps of immunization may be identified and full immunization of all infants and children may be ensured.

Under comprehensive abortion care, MTP services were not provided in 25 sub-district level Hospital (out of 63) and 136 CHCs (out of 334). Out of 531 24x7 PHCs, MVA facilities were not available in 380 24x7 PHCs. Against 3.03 lakh vasectomy planned during the year 2011-16, only 0.83 lakh (27 *per cent*) male sterilization could be performed. Further, the achievement of female sterilization was 43 and 22 *per cent* against planned for minilap and post-partum sterilization respectively.

PHCs and CHCs may be strengthened to provide comprehensive abortion care and the proportion of male sterilisation should be enhanced through awarensss programme and social mobilisation. Government has accepted the audit recommendation.

During the period 2011-16, bottom-up approach was not adopted in preparation of DHAPs. State PIPs and DHAPs were prepared without including activities of inter-sectoral convergence with the line department. State PIPs to GoI and DHAPs to SHS were neither submitted nor approved within the prescribed time limit.

Timely submission and approval of PIPs and DHAPs may be ensured by including activities of inter-sectoral convergence. Government has accepted the audit recommendation.

District Health Action Plans (DHAPs) was not prepared after aggregating Block Health Action Plans (BHAPs). Inter-sectoral convergence with the line department was not included in annual Programme Implementation Plan (PIP). Further, State PIPs were submitted to GoI with a delay ranging from 69 to 196 days during 2011-12 to 2015-16. Consequently, the approval of PIPs from GoI was received with a delay ranging from 72 to 223 days.

During the year 2011-16, GoI approved PIP for ₹ 6,247.01 crore against which only ₹ 5,269.70 crore was made available for implementation of NRHM in the State. Thus, Government could not ensure sufficient fund for implementation of the scheme, despite the dismal performance of State on health indicators.

Efforts should be made to receive the entire amount of PIPs approved by GoI and optimum utilisation of funds should be ensured and funds may be released in time so that all the activities planned in the PIP could be completed within stipulated time. Government has accepted the audit recommendation.

The State had failed critically in creating sufficient rural health centres. There was shortfall of 2588 Sub-Centres (SCs) (22 *per cent*), 828 PHCs (41 *per cent*) and 153 CHCs (31 *per cent*) as against the population norms under NRHM. Out of total 9,192 SCs in the State, only 241 were providing delivery services. Upgradation of PHCs as 24x7 was one of the goals of NRHM. However, only 638 out of 1,172 PHCs were functioning 24x7. First Referral Unit (FRU) services were being provided at only 30 out of 334 CHCs in the State. Audit noticed lack of infrastructure in terms of wards, labour rooms, operation theatres, electric supply and toilets, etc.

Concerted efforts may be made to upgrade CHCs to FRUs and gaps in availability of health facility infrastructure may be filled in accordance with

population norms, with co-relation to availability of human resource in a phased manner. Government has accepted the audit recommendation.

Out of 1,172 PHCs in the State, 503 PHCs were functioning without doctors as of April 2016. Further, Laboratory Technician and Pharmacist were not posted in 525 and 312 PHCs respectively. In 96 CHCs of sampled districts, only 13 specialists were available against sanctioned 346 specialists. Further, 58,730 Accredited Social Health Activists (ASHAs) were engaged in the State as of April 2016 against the requirement of 62,206 ASHAs.

Priority in engagement of health personnel may be ensured, so that manpower could be made available at all level of health facilities. Government has accepted the audit recommendation.

Under *Madhya Pradesh Swasthya Seva Guarantee Yojana*, Government was committed to provide minimum essential drugs and laboratory services for all types of health facility centres. However, none of the test-checked health facilities had all the listed drugs and laboratory services categorised under *Madhya Pradesh Swasthya Seva Guarantee Yojana*.

Minimum essential drugs and all prescribed laboratory services may be ensured at all types of health centres.

The coverage of Mobile Medical Unit services was showing a decreasing trend and against the target of 35 districts and 131 blocks, only 25 districts and 78 blocks were being covered in 2015-16.

MMUs may be made fully functional in all the targeted districts as per requirement utilising the available funds.

NRHM aims to increase the availability of trained human resources at all level. However, training could not be imparted as planned resulting in 42 *per cent* shortfall in number of batches as well as trainees during 2011-16. Further, 57,730 out of 58,730 ASHAs were trained up to fifth module and only 9,409 ASHAs were trained in sixth module. Thus, 49,321 ASHAs (84 *per cent*) were not trained in module sixth and seventh to develop specific competency in healthcare for mothers and children.

Training programme as planned in the PIP may be imparted in order to make health personnel capable enough to deliver all the required health services.

Quality assurance programme could not be implemented up to satisfactory level. State quality assurance committee and district quality assurance committees did not meet at prescribed intervals. Patient satisfaction survey was not conducted in 10 out of 13 test checked District Hospitals (DHs). Quality assurance programme was not implemented at CHC and PHC levels.

Quality assurance activities may be implemented at all levels of health facilities.

There were gaps in capturing of data related to ANC, child care and immunization services provided in private health institutions. Further, entire data of delivery of pregnant women conducted in private health institutions and at home were also not reflected in HMIS.

HMIS should be strengthened in order to capture data of all health services done at all levels in the State.

Home Department

2.2 Modernisation of Madhya Pradesh Police Force

Executive Summary

'Police' is a State subject and it is primarily the responsibility of the State to modernise and adequately equip the police forces. The Modernisation of Police Forces (MPF) scheme was launched by Ministry of Home Affairs (MHA), Government of India (GoI) in 1969 to effectively face the emerging challenges to internal security. The scheme was revised during 2000-01 and extended for a period of five years from 2012-13. The major components covered in the scheme are: police housing and building, mobility, weaponry, forensic science, communication and other infrastructure.

A Performance Audit of 'Modernisation of Madhya Pradesh Police Force' for the period 2011-12 to 2015-16 revealed the following:

Planning

The scheme guidelines provided for identification of resource envelop for the State and include joint resource planning to avoid duplication of efforts. During 2011-16, other Central and State schemes contributed ₹ 999.93 crore for infrastructure development of the State police. However, Annual Action Plan (AAP) of the State did not include joint resource planning to optimise utilisation of fund. Further, there were inordinate delays ranging from 55 to 102 days in submission of AAPs to the MHA during 2011-16, which resulted in consequential delays in approval of AAPs. Thus, there was little time left to implement the scheme as per plan and utilise the funds during the same year.

(Paragraph 2.2.7)

Financial Management

During 2011-16, expenditure in the State on MPF was ₹ 316.47 crore against total available fund of ₹ 349.53 crore. However, the progress of expenditure against available funds was slow and improved largely during 2015-16 in which ₹ 163.65 crore (52 *per cent* of total ₹ 316.47 crore) was incurred. Slow progress of expenditure led to short release of ₹ 92.79 crore of Central share for implementation of MPF in the State. For the period 2015-16, Central share of ₹ 23.42 crore released by MHA to GoMP as well as the State Share of ₹ 17.87 crore was not released to the Department even till the end of March 2016.

(Paragraph 2.2.8)

Impact of the scheme in filling up identified gaps

Bureau of Police Research and Development (BPRD) Study Report on 'Modernisation and upgradation of Police Infrastructure: A Five Year Projection' published in March 2000 highlighted the gap for various police infrastructure in each State and projected item wise requirement of funds for five years. Audit scrutiny of present status of the required and available police infrastructure in Madhya Pradesh showed that there was still substantial shortfall in police buildings, rest rooms/toilets for women police, houses, vehicles and weaponry.

(Paragraph 2.2.9)

Police housing and building

Construction of well secured police station buildings and houses for police personnel closer to the police stations is one of the thrust areas of the scheme. Out of ₹ 160.10 crore released under this component during 2011-16, the expenditure of ₹ 75.85 crore were incurred. Due to delays in construction, availability of police housing and buildings was lagging far behind the actual requirement.

More than two thirds of subordinate police personnel could not be provided government accommodation, as there was a shortfall of 69,978 houses for police personnel. In selected 13 districts, police personnel had occupied 683 condemned and 582 dilapidated houses. Similarly, there was shortage of 718 buildings, including police station, outposts, district police office, district police line, control rooms. Basic amenities such as toilet and rest rooms for women personnel were lacking in Police Stations/Outposts. During interview, 122 out of 150 police personnel, who were working in dilapidated buildings, cited problem of seepage of water, lack of space, inconvenience and danger to life of person. Thus, police force's own security was in jeopardy.

(Paragraph 2.2.10)

Mobility

There was large shortage of vehicles, especially motorcycle, in the Department. In selected 39 Police Stations (PSs)/Outposts (OPs), there were no motorcycle in six PSs and two OPs. Further, 102 cars valuing ₹ 5.88 crore were procured, which were prohibited for procurement under MPF.

(Paragraph 2.2.11)

Weaponry

The scheme offers to replace out dated and unserviceable weapons with sophisticated weapons. Audit noticed that there was a gap of 23,955 modern weapons as of December 2016. Thus, the department was dependent on old weapons affecting the striking capacity of police force.

(Paragraph 2.2.12)

Procurement of equipment

Inordinate delays noticed in procurement of equipment related to Forensic Science Laboratories (FSLs), Telecommunication, Intelligence and CID wing, which affected the modernisation programme of police forces.

(Paragraphs 2.2.13, 2.2.14, 2.2.15 and 2.2.16)

Human Resource Management

There was overall vacancy of 16,751 personnel in police force as of June 2016. Posts of Scientific Officers and Lab Technician were lying vacant in FSLs leading to large pendency in forensic examinations. Training of police personnel affected due to short availability of trained teachers. In interview of 150 police personnel in selected districts, only 26 *per cent* were satisfied with available resources and 45 *per cent* were satisfied with career progression.

(Paragraphs 2.2.13.1 and 2.2.17)

Crime Scenario

During 2011-15, the number of Indian Penal Code crimes in State increased gradually from 2.17 lakh to 2.69 lakh and pendency of investigations also increased from 12,582 to 23,380. Therefore, effective steps were required for strengthening of police force with adequate manpower, improvement in living condition of personnel, enhanced mobility, weaponry and other related infrastructure.

(Paragraph 2.2.19)

2.2.1 Introduction

'Police' and 'law and order' is a State subject and it is primarily the responsibility of the State Government to modernise and adequately equip their police forces for meeting the challenges to 'law and order' and 'internal security'. The Modernisation of Police Forces (MPF) scheme was launched by the Ministry of Home Affairs (MHA), Government of India (GoI) in 1969 for modernizing the police forces to effectively face the emerging challenges to internal security. The scheme was revised during 2000-01 and extended for a period of ten years, to make good the deficiencies in basic police infrastructure as identified by the Bureau of Police Research and Development (BPRD). The major components covered in the scheme are: police housing and building, mobility, weaponry, forensic science, communication and other infrastructure. The Scheme was first extended for two years i.e. 2010-11 to 2011-12 and further for five years from 2012-13.

2.2.2 Organisational Structure

The Additional Chief Secretary (Home) (ACS) assisted by Secretary (Home) is the Head of the Department at Government level. Director General of Police (DGP) is Head of the Police Force. The State Level Empowered Committee (SLEC) headed by the Chief Secretary and comprising of four other members, viz., ACS (Home), Director General of Police (DGP), Secretary (Finance) and Additional Secretary (Home) is the apex body for implementation of the scheme.

The Additional DGP (Provisioning) is the Nodal Officer for implementation of the Scheme, who is assisted by Inspector General of Police (Provisioning). The Scheme is implemented by Police Headquarters (PHQ) in consultation with Superintendents of Police (SP) of districts. The housing activities were executed through Madhya Pradesh Police Housing Corporation (MPPHC).There are 11 police zones, 15 ranges, 51 district SPs, 1061 police stations and 576 out posts in the State.

Map showing Madhya Pradesh Police Zone, Range and Districts

Name	Index	Number
Zone I.G.		11
Range D.I.G.		15
District S.P.	•	51

2.2.3 Audit objectives

Performance Audit was taken up with the objectives to ascertain that:

- proper and adequate long term and short term plans were prepared to achieve the objectives of the Scheme;
- financial management was efficient and effective;
- various components of the Scheme were implemented economically and efficiently and the targets for each component were achieved;
- human resource management and capacity building was adequate;
- system of monitoring and evaluation of implementation of the Scheme was in place and effective.

2.2.4 Audit Criteria

Following criteria were used to assess the implementation of the Scheme in the State:

- Scheme Guidelines, instructions and circulars issued by GoI and State Government from time to time;
- Annual Action Plans, Allotment orders of PHQ;
- Norms and Scales prescribed by GoI and State Government for manpower and vehicles.

2.2.5 Scope and methodology

The performance audit was conducted during March 2016 to July 2016 covering the period 2011-16. Audit covered PHQ, 10[39] State level offices and 13[40] (25 *per cent)* out of 51 police districts of the State. The districts were selected on the basis of Simple Random Sampling without Replacement method and suggestions made by the Department during the entry conference. 30 Police Stations (PSs) and nine Outposts (OPs) were selected (three PSs/OPs from each District) on random basis. Information on status of modernisation of Central Arms Repair Workshop, Bhopal was also collected through ADG (Provisioning). Audit methodologies adopted were test check of records, collection of information through questionnaires, interview of Police personnel, joint physical inspections with departmental officers and photographs of assets.

The Entry Conference was held with ACS (Home) and DGP on 15 February 2016 to discuss the audit methodology, scope, objectives and criteria. The exit conference was held on 8 November 2016 with the ACS and DGP to discuss the Audit findings. The replies of the department have been suitably incorporated.

2.2.6 Lessons learnt and sensitivity to error signals

Performance Audit of the implementation of Modernisation of Police Force Scheme in the State during the period 2000-01 to 2005-06 was conducted earlier and the audit findings were reported in para 3.5 of Comptroller and Auditor General's Report for the year 2005-06 (Civil). The para-wise replies of Home Department were furnished to the Public Accounts Committee (PAC) in October 2010. The performance audit report was discussed by PAC in July 2011. Recommendations of the PAC were awaited (November 2016).

The present Performance Audit of the scheme for the period 2011-12 to 2015-16 revealed that the deficiencies pointed out in earlier CAG's report, such as shortfall in utilisation of funds, delays in construction of buildings, insufficient number of drivers, delayed response time and pendency in analysis of samples by Forensic Laboratories, were still persisting, as discussed in succeeding paragraphs.

Audit findings

2.2.7 Planning

2.2.7.1 Preparation of Strategic Plan

MPF Guidelines envisages preparation and submission of a Strategic Plan to GoI incorporating an equipment acquisition perspective plan for five years

[39] ADG (Planning), ADG (Provisioning), SpDG (Intelligence), ADG (Criminal Investigation Department), ADG (State Crime Record Bureau), ADG (Telecommunication), SpDG (Training), State Forensic Science Laboratory, Sagar, DG (Home Guard) and Madhya Pradesh Police Housing Corporation.

[40] Balaghat, Betul, Bhopal, Chhatarpur, Chhindwara, Dindori, Gwalior, Indore, Jabalpur, Khargone, Panna, Rewa and Sagar.

identifying and analysing the gaps in various components under MPF and in conjunction with the BPRD norms to arrive at a requirement for the State. MHA directed (December 2010) to submit the Strategic Plan for the period 2011-16 by 27 December 2010.

Audit scrutiny revealed that Strategic Plan for the period 2011-16 was submitted to MHA on 18 July 2011. However, the strategic plan was not prepared in the prescribed template and it did not include SWOT[41] analysis, situation analysis, strategies, activities and evaluation.

In the exit conference (November 2016), ACS stated proper preparation of strategic plan was not possible as the Department was not conversant with the funds allotted in the Plan years and the Plans were prepared to fill the gap of priority items. However, a perspective plan was now being prepared for future requirements.

2.2.7.2 Preparation of Annual Action Plans

According to MPF Guidelines, Annual Action Plan (AAP) were to provide the description of program actions or activities necessary to achieve strategic goals and objectives and evaluation criteria for determining success in achieving goals and the difference made by the activities. Audit scrutiny revealed the following:

- AAPs for the period 2011-16 were prepared without indicating pre-documented goals and objectives as these were not identified in the Strategic Plan 2011-16. Gap analysis for various Police equipment such as Intelligence, Training, Telecommunications, Railway, CID and FSL was not found to be done, hence the yearly action plan was a wish list of items for procurement to that extent.

In the exit conference (November 2016), ACS stated that the Department was aware of its requirements, items of immediate priority were proposed in AAPs in accordance to change in respect of social, economic, political scenario of the State, law and order and crime pattern.

Fact remains that Department did not conduct gap analysis for procurement of various police equipment.

AAPs did not include joint resource planning to optimise available funds from other Schemes.

- The funds provided by GoI under the Scheme were intended to supplement the resources of the State for modernisation of police. Therefore, AAPs was to include joint resource planning indicating component wise requirements of funds and source wise availability of the required funds in a prescribed format. During 2011-16, other Central and State schemes contributed ₹ 999.93 crore (***Appendix 2.2.1***) for training, housing, forensic science, vehicles, equipment and weapons, out of which ₹ 712.48 (71 *per cent*) crore was incurred. However, AAPs of the MPF did not include joint resource planning to optimise utilisation of fund out of available resource envelope[42].

In the exit conference (November 2016), ACS stated that as gap between requirement and availability was wide, funds received from various sources

41 Strength, weakness, opportunities and threats.

42 Funds available in the State from various sources for the modernisation of police force.

were utilised to fill in the gap and there was further need of improvement in satisfaction level.

Department inordinately delayed submission of AAPs by up to 102 days, resulting in consequential delays in release of fund by MHA.

The reply was not acceptable, as the guidelines of MPF provided for identification of resource envelop for the State and include joint resource planning for optimum use of resources and avoidance of duplication of efforts.

- There were inordinate delays ranging from 55 to 102 days in submission of AAPs to the MHA against the stipulated dates (***Appendix 2.2.2***), which resulted in consequent delays in approval of AAPs by MHA and release of funds to implementing agencies. Thus, there was little time left to implement the scheme as per plan and utilise the funds during the same year.

In the exit conference (November 2016), ACS stated that delays in holding meeting due to engagements of SLEC Committee members was the reason of the delays in submission of the AAPs to MHA. Efforts would be made to submit the AAPs as soon as possible in future.

2.2.8 Financial Management

During 2011-12, the fund sharing between Centre and State under MPF Scheme was 75:25, which was revised to 60:40 during 2012-16. After approval of the Annual Action Plans of the State, MHA sanctioned the Central share of funds and released it to the State Government as well as directly to Ordnance Factories Board (OFB) for supply of weapons. GoMP provided State shares for supply of weapons to OFB, while funds were released for other components to DGP through budgetary mechanism.

BPRD Study Report on 'Modernisation and upgradation of Police Infrastructure: A Five Year Projection' published in March 2000 estimated requirement of ₹ 1824.14 crore for Madhya Pradesh on various items under building, housing, vehicle, arms, manpower and training. As against this, only ₹ 1103.47 crore was incurred on implementation of scheme during 2000-2016. During the period of 2000-16, total sanctioned Central share under MPF was ₹ 879.22 crore, out of which ₹ 745.96 crore was released to State Government and the expenditure ₹ 713.17 crore was incurred. Analysis of sanctioned and released Central share during 2000-05, 2005-10 and 2010-15 revealed that sanctioned amount increased gradually from ₹ 249.13 crore (2000-05) to ₹ 338.97 crore (2010-15). However, the released amount decreased from ₹ 249.13 crore (2000-05) to ₹ 242.67 crore (2010-15), as depicted in **Chart-2.2.1** and **Chart-2.2.2**.

Chart-2.2.1

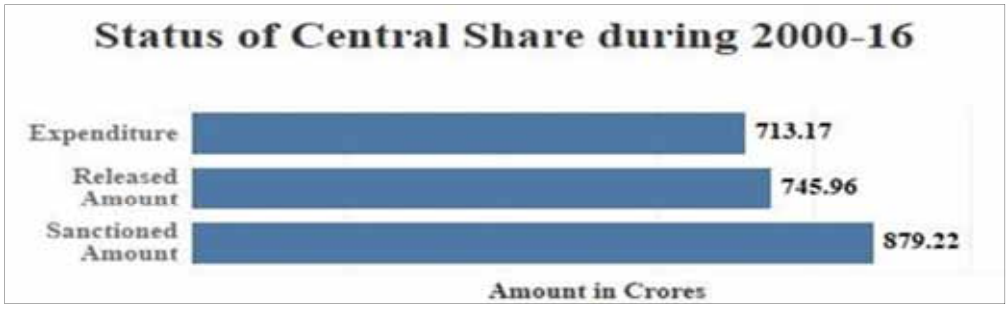


Chart-2.2.2

(Source: Information furnished by the Nodal Officer)

Further scrutiny of records for the period 2011-16 revealed the following:

2.2.8.1 Availability and utilisation of funds

MHA from time to time highlighted the position of unspent balances and stated that the release against sanctioned amount would depend on position of unspent balances and the balance amount would be deducted from the future releases.

Status of unspent balances, release and expenditure under Central and State Shares as per Utilisation Certificates (UCs) for the period 2011-16 was as detailed in **Table-2.2.1**.

Table 2.2.1: Release and expenditure of Central and State Shares under MPF

(₹in crore)

Sl. No.	Year	Central Share					State Share				
		Previous Balance	Amount released	Total	Expen-diture	Closing Balance	Previous Balance	Amount released	Total	Expen-diture	Closing Balance
1	2011-12	56.62	37.54	94.16	56.80	37.36	24.94	12.31	37.25	9.71	27.54
2	2012-13	37.36	13.78	51.14	28.72	22.42	27.54	9.19	36.73	23.17	13.56
3	2013-14	22.42	61.37	83.79	13.04	70.75	13.56	38.26	51.82	7.44	44.38
4	2014-15	70.75	57.57	128.32	7.28	121.04	44.38	11.15	55.53	6.66	48.87
5	2015-16	121.04	26.80	147.84	117.54	30.30	48.87	0.00	48.87	46.11	2.76
Total			**197.06**		**223.38**			**70.91**		**93.09**	

(Source: Sanctions of MHA and GoMP and Utilisation Certificates submitted by Department)

Slow progress of expenditure led to short release of ₹ 92.79 crore of Central Share

It was evident from the above table that during 2011-16, expenditure was ₹ 316.47[43] crore against total available fund of ₹ 349.53[44] crore. Progress of expenditure against available funds was slow and improved largely during 2015-16 in which ₹ 163.65 crore (52 *per cent* of total ₹ 316.47 crore) was

[43] Central Share expenditure ₹ 223.38 crore + State Share expenditure ₹ 93.09 crore.

[44] Previous balances (₹56.62 crore + ₹ 24.94 crore) and releases (₹ 197.06 crore + ₹ 70.91 crore).

incurred. Further, ₹ 33.06 crore (Central and State Share) was still unutilised as on March 2016.

Audit noticed that unutilised fund even pertained to 2010-11. Failure to spend the funds even after six years indicated poor financial and procurement management by the department and resulted in decrease in release of Central Share by MHA. Central assistance of ₹ 197.06 crore was released out of sanctioned assistance of ₹ 289.85 crore. Thus, the scheme of modernising the Police Force was deprived of funds to the tune of ₹ 92.79 crore as well as proportionate State share.

In the exit conference (November 2016), ACS stated that short utilisation of funds was due to delays in release of funds, tendering and procurement process. Action would be taken after taking this into consideration in future.

2.2.8.2 Delays and shortfall in amount released by GoMP

GoMP did not release ₹ 23.42 crore of Central Share and ₹ 47.75 crore of State Share to Home Department.

Status of demand, Central Share sanctioned and subsequent release by MHA and GoMP are shown in ***Appendix 2.2.3***. Audit observed that during 2011-15, GoMP released State share with delays ranging from one to 27 months from the date of release by MHA. Further, State share of ₹ 29.88 crore were not released during 2011-15. For the period 2015-16, Central share of ₹ 23.42 crore released by MHA to GoMP as well as the State Share of ₹ 17.87 crore was not released to the Department (March 2016).

In the exit conference (November 2016), ACS stated that action would be taken after taking this into consideration in future.

2.2.8.3 Incorrect financial reporting due to submission of inaccurate utilisation certificate

Audit observed from the UC (as on March 2016) that the Department reported utilisation of ₹ 228.83 crore to MHA against the allotment of ₹ 244.56 crore during 2011-16. However, the examination of records revealed that only ₹ 144.00 crore was spent. Thus, the UCs furnished by the Nodal Officer was inflated by ₹ 84.83 crore.

Further scrutiny revealed that ₹ 84.25 crore were lying unspent (March 2016) with MPPHC against total release of ₹ 160.10 crore. During 2011-16, MPPHC did not furnish UC to the Nodal Officer and the Department furnished UCs to MHA on the basis of amount released/paid to the MPPHC. This inaccurate capture of utilised amount at the level of the Department was indicative of the poor accounting controls.

In the exit conference (November 2016), ACS stated that the amount provided in advance to OFB/ MPPHC were shown as utilised as per practice adopted earlier by Department. However, the audit observation would be taken in consideration in future.

2.2.8.4 Utilisation of Interest earned from Bank account for MPF funds

According to para 7.11 of MPF Guidelines, funds released to MPPHC shall be kept in an exclusive saving bank account and the interest accrued from the

account be used for the furtherance of objectives of the Scheme after approval by the SLEC.

Interest of ₹ 1.10 crore earned on outstanding fund with MPPHC not utilised for furtherance of scheme objective.

Audit observed that ₹ 160.10 crore in six instances were paid to MPPHC during 2011-16. MPPHC opened exclusive savings account for ₹ 19.39 crore, ₹ 6.48 crore and ₹ 6.40 crore released by MHA during 2011-12 to 2013-14 and remaining ₹ 127.83 crore were deposited in other prevailing accounts. However, funds received from other schemes/sources were also deposited in the exclusive bank accounts for MPF. As a result, the interest earned/accrued from the funds received under MPF was not worked out correctly.

In reply, MPPHC intimated interest of ₹ 1.10 crore on the basis of outstanding balance as on March 2016. However, the interest accrued from time to time was neither reported to MHA/Nodal Officer nor was it utilised for the purpose of furtherance of the objectives.

In the exit conference (November 2016), ACS stated that MPPHC was furnishing the details to MHA team, who visit half yearly basis for audit as well as to Planning branch of PHQ. Interest earned/accrued upto 2008-09 had already been intimated. The scheme wise interest was being worked out and utilisation of the interest earned/accrued during the period of audit would be done with the approval of SLEC. Scheme wise separate account would be maintained in future.

2.2.9 Achievement in filling the gaps highlighted in BPRD Study Report

Bureau of Police Research and Development (BPRD) Study Report on 'Modernisation and upgradation of Police Infrastructure: A Five Year Projection' published in March 2000 highlighted the gap for various police infrastructure in each State and projected item wise requirement of funds for five years. Scrutiny of present status of the required and available police infrastructure showed that there was still substantial shortfall in PS/OP buildings, rest rooms/toilets for women police, houses, vehicles and arms. Deficiencies noticed in implementation of major components of MPF in the State are discussed in succeeding paragraphs.

2.2.10 Police housing and building

Construction of well secured police station buildings and houses for police personnel closer to the police stations is one of the thrust areas of the scheme. Audit noticed that there was more than 50 *per cent* of the allocation during 2011-16 for this component of the Scheme. MPPHC, a limited company of GoMP, was executing agency for construction of residential and administrative buildings under MPF. During 2011-16, MPPHC incurred ₹ 75.85 crore out of ₹ 160.10 crore released to it by MHA and GoMP.

Audit scrutiny revealed that the availability of housing and administrative buildings was lagging far behind the actual requirement. The gap under housing and administrative buildings was as mentioned in **Table 2.2.2**.

Table-2.2.2: Comparative status of requirement of houses and buildings

Item	Gap as on January 1998 (Units required)	Gap as reported by PHQ in December 2016 (Units required)
(1)	(2)	(3)
Police Station Buildings	121	254
Out Post buildings	124	199
Extension of old PSs	644	805
District Police lines	16	19
Control Rooms	43	17
Official buildings: SP's Office	16	26
Official buildings: Range DIG	0	3
Official buildings: Zonal IG	1	3
Official buildings: SDOPs Office	118	61
Rest Rooms/Toilets for Women Police	1457	805
Housing: Lower Subordinate	44243	55455
Housing: Upper Subordinate	7496	14523

(Source: BPRD study report 2000 and ADG (Planning))

Thus, there was substantial gap in requirement and availability of housing and administrative building even after implementation of MPF since last 16 years.

2.2.10.1 Shortage of staff quarter

National Police Commission had recommended 100 *per cent* accommodation for all police personnel. Home Department provides housing for Lower (Constable and Head Constable) subordinates and Upper (Inspector, sub-Inspector and Assistant Sub Inspector) subordinates.

Available houses were categorised as good[45], dilapidated and condemned. The availability of houses during the period 2011-16 is given in **Table - 2.2.3**.

Table - 2.2.3: Availability of houses and deficiency

Sl. No.	Year	Required	Houses available		Deficiency	Houses per 100 personnel
			Good	Condemned		
1.	2011-12	85473	28968	3828	56505	34
2.	2012-13	93897	34209	6275	59688	36
3.	2013-14	99642	36723	6331	62919	37
4.	2014-15	99642	29880	7936	69762	30
5.	2015-16	102772	32794	8076	69978	32

(Source: Information provided by ADG (Planning))

More than two-thirds of subordinate police personnel could not be provided government accommodation.

Thus, more than two thirds of subordinate police personnel could not be provided government accommodation. The availability of good houses had

[45] Houses which were considered suitable for residential purpose.

increased from 28,968 (2011-12) to 32,794 (2015-16). However, this increase was not commensurate with increase in requirement. As a result, the availability of houses per 100 personnel decreased from 34 to 32.

According to information provided by ADG (Planning), there were no condemned houses in the stock. However, audit scrutiny in selected districts revealed that police personnel had occupied 683 condemned houses and 582 dilapidated houses. In selected 39 PS/OPs, only 403 good houses were available against the requirement of 1,616 houses and there was a shortfall of 1213 good houses (75 *per cent*). A couple of photographs taken during joint inspections shows poor conditions of residential houses in Betul and Sagar Districts:

Dilapidated Houses in Kotwali Police Station, Betul

Dilapidated houses in Police Line, Sagar

In the exit conference (November 2016), ACS agreed to the scarcity of houses and stated that prior to implementation of the MPF Scheme, budget for construction activities was very low and many houses had been declared as unserviceable. However, the construction of 10,500 houses under HUDCO loan Scheme were in progress and a proposal for construction of 25,000 houses was pending for approval with the Government.

2.2.10.2 Shortage of Administrative buildings

Buildings, i.e., police station, outposts, district police office, district police line, control rooms etc., are the most important infrastructure of the Police and provide proper place to work and safety to police personnel, arrested person, arms and other police infrastructure. The status of availability of buildings for the period 2011-16 is given in **Table2.2.4**.

Table-2.2.4: Availability of buildings and deficiency

Sl. No.	Year	Required	Buildings available			Deficiency	Percentage of good condition buildings
			Good condition	Dilapidated	Condemned		
1.	2011-12	1806	1318	48	53	488	73
2.	2012-13	1852	1334	50	40	518	72
3.	2013-14	2002	1305	55	59	697	65
4.	2014-15	2052	1287	53	59	765	63
5.	2015-16	2049	1331	152	18	718	65

(Source: Information provided by ADG (Planning))

Percentage of availability of good buildings decreased from 73 to 65.

Thus, availability of good buildings had increased marginally from 1,318 to 1,331 during 2011-16, while requirement increased from 1,806 to 2,049. As a result, the percentage of availability of good buildings decreased from 73 to 65. SPs, in selected 13 district stated that dilapidated/condemned building caused problem like unsafe records/office equipment and person, lack of space, inconvenience and seepage of water.

During interview, 122 out of 150 police personnel who were working in dilapidated buildings cited problem of seepage of water, lack of space, inconvenience and danger to life of person.Thus, police force's own security was in jeopardy. Photographs taken during joint inspections showed poor condition of administrative buildings in Bhopal and Gwalior Districts:

Condemned building of MLA Rest House Out Post, Bhopal

Poor condition of Hall of Barrack in Police Line, Gwalior

Poor condition of Barrack in Police Line, Gwalior

Poor condition of toilets of Barrack in Police Line, Gwalior

In the exit conference (November 2016), ACS stated that planning was done keeping in view the future demand and availability of funds. However, the fact remains that the Department had a shortage of almost one thirds administrative buildings affecting adversely to working environment and safety.

2.2.10.3 Lack of basic amenities for women police personnel

Basic amenities such as toilet and rest rooms for women personnel were lacking in PS/OP.

MHA, directed (May 2014) that a provision be made for suitable toilet facilities for women police personnel in police stations, out posts and barracks as well as a rest room in every police station. Audit observed from Model design of Urban, Semi-urban and Rural Police Stations as approved by DGP that provision for separate toilet facilities for women police personnel was made. However, the provision for a women rest room was made only for urban Police Station from 2014-15.

Out of 365 PSs and 189 OPs of selected districts, separate retiring rooms for women police personnel were available in 162 PSs, while separate toilets were

available in 170 PS/OPs. During interview, 48 out of 50 women police personnel cited problem of inconvenience, adverse impact in work and insecurity due to unavailability of separate toilets and/or separate retiring rooms. Thus, the Department failed to provide basic amenities for women police personnel.

In the exit conference (November 2016), ACS stated that provision for separate toilets was made for buildings during 2011-16. In compliance to the direction of GoMP (September 2016), a detailed project report for separate room for women complainants in each PS was being prepared and these rooms would also be used for women police. Provision for separate toilet and room would be made in all new PSs in future.

2.2.10.4 Construction of new buildings

The status as on March 2016 of works sanctioned, commenced, completed and handed over by MPPHC to the State police during 2011-16 is given in **Table-2.2.5**.

Table-2.2.5: Progress of works and handing over of Houses and Buildings

Year	Houses/ Buildings	Total sanctioned	Not commenced	In progress	Completed	Handed over
2011-12	Building	36	0	0	36	36
	Houses	116	0	0	116	116
2013-14	Building	154	59	28	67	45
2014-15	Building	81	43	38	0	0
Total		387	102	66	219	197

(Source: MPPHC)

102 buildings works out of 235 sanctioned during 2013-15 were not commenced.

Fund for this component was not sanctioned under MPF during 2012-13 and 2015-16. Out of 235 buildings sanctioned during 2013-14 and 2014-15, 102 buildings (43 *per cent*) had not commenced as on March 2016. MPPHC attributed the delay in commencement of work to – (i) land not being available in four cases of 2013-14, (ii) late receipt of list of works from PHQ in 14 cases, (iii) delay in receipt of documents relating to land/possession and land not being provided in four cases of works sanctioned in 2014-15. This indicated poor programme management by the Department due to which only 57 *per cent* of sanctioned houses/buildings during 2011-16 were completed.

In the exit conference (November 2016), ACS attributed the delays in commencement of works to disputed land, unavailability of land and time taken by Revenue Department in allotment process. It was further informed that the number of uncommenced works had been reduced to 26. However, effective coordination with State police and better programme management would be adopted by MPPHC in future.

- **Delays in handing over of completed building**

Inordinate delays in handing over of completed buildings/houses reduced the effective defect liability period.

As per standard agreement clause the defect liability period (repair on cost of the contractor) was two years from date of completion of works. Out of 219 houses/buildings completed, date of handing over of buildings/houses were provided to Audit in 197 cases. Of these 197 cases, time taken in handing over of buildings/houses after their completion was more than one to two months in

91 cases, more than three to four months in 52 cases and more than five months in five cases. Delay in handing over of buildings/houses resulted in effectively reduced defect liability period to that extent.

In the exit conference (November 2016), ACS attributed the delays in handing over of the works to preoccupancy of staff with law and order, election and other pressing engagements. It was further stated that a time bound well defined mechanism was being prescribed to avoid delays in handing over of the completed works in future.

- **Deficiencies in quality control mechanism in construction projects**

Quality control is necessary for safety, reliability and durability of all structures and also for optimum use of building and scarce materials. Audit noticed that various tests such as concrete cubes, TMT Steel bar, metal, sand cement etc. were conducted by certified test laboratories, but the source of sample was not recorded in test reports in eight out of 15 test checked cases. Further, test reports submitted by various laboratories revealed that details of methods followed for adjudging the quality were not mentioned in 13 out of 15 test checked cases. Grade designation of cement concrete cubes, which refers to the specified compressive strength of 150 mm size cube at 28 days and determines group (ordinary, standard and high strength) of concrete, was also not mentioned in four out of six laboratory test reports test checked. Thus, the quality control mechanism in the construction projects of MPPHC was deficient.

In the exit conference (November 2016), ACS stated that a provision had been incorporated (August 2016) in the standard Notice Inviting Tender (NIT) for carrying out at least 50 *per cent* of tests from NABL[46] accredited laboratories for the works costing over ₹ 50 lakh and a separate quality control mobile unit would be established soon.

2.2.11 Mobility

Mobility of police forces is essential for enhancing its operational efficiency, in tackling law and order situations as well as for prevention and detection of crimes and ensuring security and surveillance. In a well-equipped police force the mobility deficiency is nil. Increased mobility reduces response time and enhances operational efficiency of police forces.

Gap under Mobility as per BPRD in its study report 2000 and status as on December 2016 was as detailed in **Table 2.2.6**.

Table-2.2.6: Comparative status of requirement of vehicles

Item	Gap as on January 1998 (Units required)	Gap as reported by PHQ on December 2016 (Units required)
Heavy Vehicles	820	720
Medium Vehicles	0	636
Light Vehicles	2180	826
Motor Cycle	4564	14107

(Source: BPRD study report 2000 and information provided by ADG (Provisioning))

[46] National Accreditation Board for Testing and Calibration Laboratories.

Thus, the gap has widened in medium vehicle and motor cycles. However, the gap analysis of PHQ for requirement of vehicle was fluctuating and did not tally with the year wise status provided (May 2016) for requirement of vehicles, as given in **Table-2.2.7**.

Table-2.2.7: Status of vehicles required, available and shortfall in Department

Sl. No.	Year	Required		Available		Shortfall	
		Four Wheeler	Motor Cycle	Four Wheeler	Motor Cycle	Four Wheeler	Motor Cycle
1.	2011-12	5749	5730	4681	2682	1068 (19%)	3048 (53%)
2.	2012-13	5904	9291	4836	2928	1068 (18%)	6363 (68%)
3.	2013-14	6439	10490	4855	2954	1584 (25%)	7536 (72%)
4.	2014-15	6442	10595	4994	2915	1448(22%)	7680 (72%)
5.	2015-16	6442	10595	5060	3062	1382 (21%)	7533 (71%)

(Source: ADG (Provisioning))

Large short fall of motor cycle affected mobility of police personnel.

As evident from **Table 2.2.6** and **Table 2.2.7**, there was large shortfall of motor cycles as availability did not improve in proportion to increase in requirement. Motor cycles were to be used for beat duty, night patrolling, traffic control and *dak* duty etc. by the cadre of Inspectors and below which form the frontline of the police law and order control and investigative machinery. In their absence, the mobility of such personnel was affected.

BPRD norms provided for two light motor vehicles and three motor cycles for PS, two motor cycles for OP and seven heavy, 17 medium, 14 light vehicles and seven motor cycles for District Police Line. However, in 13 selected districts, there was discrepancy in distribution of vehicles between PSs, OPs and police line of districts against the norms fixed by BPRD, as shown in **Table-2.2.8**.

Table-2.2.8: Status of availability and distribution of vehicles in selected Districts

Name of Unit	No.	Requirement as per norms				Actual available				Shortfall (+)/ Excess (-)			
		Heavy	Medium	Light	Motorcycle	Heavy	Medium	Light	Motorcycle	Heavy	Medium	Light	Motorcycle
Police Station	365	0	0	730	1095	2	24	377	650	- 2	- 24	353	445
Out Posts	189	0	0	0	378	0	7	22	129	0	- 7	- 22	249
Police Line	13	91	221	182	91	107	156	484	509	- 16	65	- 302	- 418

(Source: ADG (Provisioning))

Thus, there was shortfall of 445 motorcycles and 353 light vehicles in 365 PS of 13 districts, whereas there was excess of 418 motorcycles and 302 light vehicles in 13 Police lines.

In the exit conference (November 2016), ACS stated that due to the shortage, vehicles were allotted to districts in proportion to the gap. SPs allotted the vehicles among PS/OP/Police Lines looking into law and order situation of

districts. However, the issue of discrepancy in allotment of vehicles would be reviewed and addressed.

2.2.11.1 Procurement of vehicle

Audit observed that ₹ 26.08 crore was utilised against allocation of ₹ 26.22 crore under mobility component of MPF during 2011-16. Fund for this component was not released under MPF during 2013-14 and 2015-16. The procurement of vehicles against allocation is given in **Table 2.2.9**.

Table-2.2.9: Procurement of vehicles against allocation under MPF

Sl. No.	Vehicle	2011-12		2012-13		2014-15	
		Approved	Procured	Approved	Procured	Approved	Procured
1	Light Vehicle	149	167	80	80	129	137
2	Motor Cycle	215	258	120	148	221	98
3	32/52 Seater Bus	2	2	0	0	6	0
4	Troop Carrier	2	2	0	0	0	0
Total		368	429	200	228	356	235

(Source: Records of ADG (Provisioning))

Thus, 892 vehicles were procured against 924 approved in allocation orders. However, 52 motor cycles were short procured while 26 light vehicles were procured in excess. In selected 39 PS/OPs, there were no motorcycle in six PSs (Matgunwa, Bijawar, Garhi Malahra, Karnjiya, Devendra Nagar and Women PS, Rewa) and two OPs (Sihora and Anand Nagar). Had the vehicles been procured rationally, it could have been distributed at needful places.

In the exit conference (November 2016), ACS stated that short purchase of motor cycles during 2014-15 was due to increase in rates of vehicle. However reason was not cited regarding procurement of excess number of light vehicles.

- **Irregular procurement of cars under MPF**

Under MPF Scheme, only operational vehicles like jeep, motorcycle, medium/ heavy vehicles have been allowed for procurement. It prohibited the procurement of vehicles such as cars.

102 sedan and hatchback cars valuing ₹ 5.88 crore were procured in violation of scheme guidelines.

Audit observed from records of ADG (Provisioning) that during 2011-16, out of total 384 light vehicles procured, 102 vehicles valuing ₹ 5.88 crore were sedan and hatchback cars which was not in accordance with the provisions of the MPF guidelines according to which vehicle like jeeps were to be procured.

In the exit conference (November 2016), ACS stated that vehicles were provided to various level of officers for quick mobility for various departmental activities. However, provision of the Guidelines relating to procurement of vehicles would be followed in future.

2.2.11.2 Shortage of drivers

In selected districts, there was shortage of 626 drivers against available 1302 vehicles.

In selected districts, there was shortage of 626 (48 *per cent*) drivers against available 1,302 four wheeler vehicles. This indicated that AAPs were not formulated rationally and further procurement without availability of drivers

would lead to idle vehicles. This was a constraint in achieving optimum mobility.

In the exit conference (November 2016), ACS agreed to the facts and stated that efforts were being made to address the shortage of drivers and new constables were being imparted driving training in Police Training Schools to reduce the shortfall of drivers in future. The department further stated (January 2017) that 1,371 drivers were recruited between 2011 and 2013 and recruitment of 992 drivers was in progress.

2.2.11.3 Response time

Quick response to crime and law and order not only helps to preserve the lives of people but also ensures that guilty is brought to justice. PHQ directed (July 2009, October 2009 and January 2013) that response time for arrival of police/vehicle in urban and rural Police Stations should be monitored through a register. Each month Zonal Inspector General would review the response time and intimate the average response time of Zone and name of PS with highest and lowest average response time to PHQ.

Response time was not monitored adequately.

Audit noticed that average response time was not monitored in PHQ. Due to lack of flow of response time data to PHQ, good and poor performance could not be analysed at State level. Scrutiny of response time in test checked districts revealed that SPs Rewa, Betuland Chhindwaradid not monitor response time of PS. SP, Rewa and Betul stated that instructions had not been received from PHQ while SP, Chhindwara stated that the information would be received from the PSs. SP, Dindori could furnish data for 2015-16 only.

Further scrutiny of response time in selected districts (***Appendix 2.2.4***) during 2011-16 revealed that response time decreased in five[47] districts, increased in Balaghat, remained same in two[48] districts. In Gwalior district, it decreased in rural PSs and increased in urban PSs. In selected 30 PSs of 13 districts, registers for response time were maintained only in 10 PSs of six[49] districts.

In the exit conference (November 2016), ACS stated that looking to number of vehicles in the State, SPs and Zonal IGs were monitoring the response time. Response time of Police has improved in the State due to important Scheme of 'Dial 100'.

The reply was not acceptable, as inadequate record maintenance at PSs and monitoring of response time at district level do not substantiate the reply.

2.2.12 Weaponry

To meet the challenges of terrorists and criminals, equipped with high tech and latest weapons, upgradation of weaponry was of paramount importance for the police force. Against allocation of ₹ 26.76 crore during 2011-16, ₹ 23.38 crore was utilised (March 2016). State Police received 3,631 Rifles and 1,150 Pistols from OFB during 2011-15.

47 Chhatarpur, Indore (two years data; 2014-15 and 2015-16 furnished), Jabalpur, Khargone and Sagar.

48 Bhopal (up to 2014-15) and Panna.

49 Bhopal, Panna, Khargone, Gwalior, Balaghat and Indore.

Audit noticed that 385 Rifles and 386 Pistols, which were to be supplied by OFB against central release of ₹ 3.38 crore in 2015-16 (August 2015 and March 2016) were not received by Police as of June 2016. In the exit conference (November 2016), ACS stated that against central release in 2015-16, Rifles had been collected in full numbers while Pistols were being collected shortly.

2.2.12.1 Availability of weapons with State Police

Assessment of weapons was done according to authorisation in Musketry Regulations, 1957 which was not revised despite changes in organisational structure and introduction of modern weapons. BPRD Report reported the gap of weapons as 34,838 (January 1998).

The Department contemplated to phase out old weapons, such as Point 410 Musket, Point 303 and 7.62 mm BA Rifles along with Point 38 and Point 455 revolvers with modern weapons such as 7.62 SLR, 7.62 LMG, AK 47, 5.56 INSAS Rifles, Glock Pistol and 9 mm Pistol etc. Old weapons are less effective as they are heavy, their magazine capacity is less and chances of misfire is high, whereas modern weapons are light weighted, convenient and have better striking capacity.

The department possessed 53,084 old weapons. Out of these, 8,233 Point 410 Musket Rifles and 581 Point 455 revolvers had become unserviceable as Ordinance factories have stopped manufacturing their spare parts and ammunition while rest of 44,268 weapons were in use.

Audit noticed that there was a gap of 23,955 modern weapons as of December 2016. The year wise position of authorisation, availability and shortfall of modern weapons with Police force during 2011-16 is shown in **Table 2.2.10**.

Table-2.2.10: Status of availability and shortfall of modern weapons

Sl. No.	Year	Authorisation	Available	Deficiency	Percentage of deficiency
1.	2011-12	66826	38465	28361	42
2.	2012-13	66826	40557	26269	39
3.	2013-14	81314	55977	25337	31
4.	2014-15	92818	71401	21417	23
5.	2015-16	99396	74166	25230	25

(Source: ADG (Provisioning))

There was deficiency of 25 *per cent* modern weapons, which led to dependency on outdated weapons.

During 2011-16, availability of modern weapons had increased by 35,701 (93 *per cent*) due to funding under MPF and State Schemes. The deficiency of modern weapons reduced by 17 *per cent*, due to increase in requirement by 32,570 modern weapons. Therefore, the deficiency remained 25 *per cent* in 2015-16.

The deficiency of modern weapon indicated that the Department had not procured sufficient number of modern weapons and the department was also dependent on old weapons affecting the striking capacity of police force.

In selected 39 PS/OPs authorisation of weapons increased from 1,531 to 1,616 and availability increased from 1,035 to 1,103. Therefore, shortfall of weapons remained almost at the same level (496 and 513), while percentage of old

weapons was 49 *per cent*. Further, it was also noticed that weapons were not provided to women PS Rewa.

In the exit conference (November 2016), ACS stated that availability of arms had improved but due to increase in manpower satisfaction level had decreased. Regarding weapons to Women PS, it was stated that most women PSs were situated near other PSs of cities, support including weapons were provided from these PSs.

Fact remains that one of the main objectives of MPF scheme of equipping police with modern weapons for bringing improvement in preparedness and striking capability of force was largely not achieved.

2.2.12.2 Repair of weapons

Machines used in Arms Workshop for repair of weapons were outdated and were not fit for repair of modern weapons.

Adequate and timely repair and maintenance of weapon is as important as its possession. Audit observed that the machines used in Arms Workshop, Bhopal such as welding transformer, power hammer, lathe, shaper, drill etc. were purchased between 1965 and 1987. ADG (Provisioning) informed (April 2016) that these machines had lost quality as well as accuracy and were not fit to repair modern weapons.

Audit observed in 12 selected districts that during 2011-16, 1,457 weapons were sent to the Arms workshop, Bhopal for repair. These were returned after one to 15 months. The delays indicated that weapon repair management was not adequate and the workshop required upgradation.

In the exit conference (November 2016), ACS stated that weapons were being repaired from existing machines, especial attention would be given for corrective action.

2.2.13 Forensic Science Laboratories

State had one State Forensic Laboratory (FSL), four Regional Forensic Science Laboratories (RFSL) and 50 District Scene of Crime Units (March 2016) for forensic analysis. FSL works under the Administrative control of ADG (CID).

FSLs could not procure equipment despite availability of fund.

The details of allotment for Forensic Science component under the MPF and status of expenditure during 2011-16 are given in **Table 2.2.11**. Fund for this component was not released under MPF during 2013-14 and 2015-16

Table-2.2.11: Allotment and expenditure under Forensic Science Laboratory

(₹ in crore)

Year	Allocation		Expenditure	
	No. of equipments	Amount	No. of equipments	Amount
2011-12	4	0.55	5	0.55
2012-13	11	1.16	5	0.30
2014-15	28	3.69	0	0
Total	43	5.40	10	0.85

(Source: Director (FSL))

Thus, Department could incur only ₹ 85 lakh (16 *per cent*) out of allotted ₹ 5.40 crore, as a result only 23 *per cent* physical targets were achieved. Department could not complete the legal formalities for procurement of incinerator, which was approved for procurement under AAP 2012-13. Further, Department took *ad hoc* approval for procurement of Microwave digester under AAP 2012-13. The need analysis for Microwave digester was done after its approval of AAP and it was decided to not procure the equipment. Further, the approval for procurement under AAP 2014-15 was awaited from ADG (CID) (April 2016).

FSL procured Binoculars Research Microscope (BRM) for ₹ 16.17 lakh out of the allotment for 2012-13. However, BRM was not an approved item in the AAP and the approval of SLEC for procurement of BRM was awaited (April 2016).

The delays in procurement and utilisation of only 16 *per cent* of allocation indicated poor procurement management, which affected the process of modernisation of FSL.

In the exit conference (November 2016), ACS agreed with the audit conclusion and stated that the delays were due to time taken in finalisation of specification, tendering process etc. The procurements were in progress and the problems would be addressed.

2.2.13.1 Shortage of manpower in FSL

AAP 2011-12 envisaged for filling up of vacant posts in FSLs. However, there was consistent shortage of manpower in FSLs. The status of manpower in various posts as on March 2016 is given in **Table 2.2.12.**

Table-2.2.12: Status of manpower in FSLs as on March 2016

Sl. No.	Post	SS	PIP	Vacancy
1	Director	1	0	1
2	Sr. Joint Director	1	0	1
3	Joint Director	13	6	7
4	Sr. Scientific Officer	84	45	39
5	Scientific Officer	167	111	56
6	Lab Technician	52	27	25
7	Lab Assistant	76	25	51
8	Lab Attendant	54	21	33

(Source: Director (FSL))

Posts of Scientific Officers and Lab Technician were lying vacant in FSLs leading to pendency in forensic examinations.

Thus, the posts of Director and Senior Joint Director was vacant. Further, there was vacancy of 46 *per cent* in Senior Scientific Officers, 34 *per cent* in Scientific Officers, 48 *per cent* in Lab Technicians, 67 *per cent* in Lab Assistant and 61 *per cent* in Lab Attendants. All sanctioned posts were lying vacant in RFSL in Jabalpur (March 2016).

Audit noticed that the shortage of manpower had effected the output of FSL. During 2011-16, cases received for examination increased from 19,235 to 24,155, but disposal of cases deceased from 26,656 to 23,780 (***Appendix 2.2.5***). As on March 2016, 4,806 cases were pending, out of which 1,372 cases were pending for over two months, 1,056 were pending for over three months, 302 for over six months and 267 for more than 12 months.

In the exit conference (November 2016), ACS stated that the pendency was due to shortage of working strength and increase in number of cases received. Higher officers had directed FSL from time to time and supervised the position to reduce the pendency. Recruitment and promotions were in progress from June 2015 and 91 Scientific Officers have been appointed in 2015-16 and pending cases would be disposed of shortly.

2.2.14 Telecommunication

Details of amount allotted to telecommunication wing under the MPF and status of expenditure during 2011-13 are given in **Table 2.2.13**. Fund for this component was not released under MPF during 2013-16.

Table-2.2.13: Status of allotment and expenditure under MPF

(₹ in crore)

Year	Allocation		Expenditure	
	Item	Amount	Item	Amount
2011-12	Solar Power UPS 2.5 KW (65)	3.19	No expenditure incurred	00
2012-13	HF Digital Set (50) EPBX System (1)	2.00	Radio Sets/Hand Free Kit (1985) EPBX System (1)	2.00
Total		**5.19**		**2.00**

(Source: ADG (Telecommunication))

The Solar Power Uninterrupted Power Supply (UPS) approved under AAP for 2011-12 could not be procured despite four tenders between January 2012 and January 2013 due to inadequate participation of bidders and the suppliers did not produce certificates from authorised test laboratory. Afterwards, the fund was transferred to *Madhya Pradesh Urja Vikas Nigam* in October 2013 to supplement the project of ₹ 31.10 crore for installation of 681 2KW UPS in various PSs.

Electronic Private Automatic Branch Exchange (EPABX) system and 50 High Frequency digital sets were approved against AAP 2012-13. However, one EPABX and 1985 Radio Sets/Hand Free Kit were procured with substantial delays between February 2014 and March 2015.

In reply, SP (Telecommunication) stated (April 2016) that EPABX was procured and installed after completion of new PHQ Building, while Radio Sets/Hand Free Kits were procured after approval of SLEC in July 2014.

In the exit conference (November 2016), ACS stated that the work of installation of UPS was in progress as the matter was *sub-judice* and UC was awaited.

2.2.15 Intelligence (Special Branch)

Details of amount allotted to Special Branch under the MPF and status of expenditure thereon during 2011-16 is given in **Table 2.2.14**. Fund for this component was not released under MPF during 2013-14 and 2015-16

Table-2.2.14: Status of allotment and expenditure under Intelligence Component

(₹in crore)

Year	Allocation		Expenditure	
	No. of equipments	Amount	No. of equipments	Amount
2011-12	22	2.01	21	1.77
2012-13	32	6.33	28	6.31
2014-15[50]	22	3.76	1	0.83
Total	76	12.10	50	8.91

(Source: Information provided by SpDG (Intelligence))

Inordinate delays were noticed in procurement of intelligence equipment.

It is evident from the **Table 2.2.14** that Intelligence wing did not utilise 26 *per cent* of the funds against allocation. Audit observed that for procurement of items under AAP 2011-12, tenders were invited between February 2012 and September 2014 with delays up to 35 months from the date of finalisation of specifications. For procurement of items under AAP 2012-13, technical committee was constituted in July 2012 which finalised specification after 11 months. There were further delay up to 14 months in issuing tenders, which consequently led to delay in procurements. Against AAP 2014-15, only 'Thermal Imaging' was procured and nearly 78 *per cent* allotment for the year remained unutilised.

Special DG (Intelligence) attributed delay in finalisation of specifications to other engagement of committee members, such as law and order and VIP security. The delays in acquisition of the equipment indicated inefficient procurement management and affected adversely modernisation of police force.

In the exit conference (November 2016), ACS stated that total expenditure for Intelligence is ₹ 9.05 crores and procurement of rest of the items was under process. Further, two items of 2011-12 plan and four items of 2012-13 plan were not procured as these were not found useful in present scenario and changing technology. Procurement of five items for 2012-13 was cancelled due to lack of participation of bidders/ higher rates and non-supply of material against purchase order. Procurement of equipment was in progress and available budget would be utilised soon.

The reply underscores that adequate planning and need analysis was not done before inclusion of procurement proposals in AAP.

[50] Includes ₹ 19.45 lakh for three Railway equipments.

2.2.16 Crime Investigation Department

Investigation equipment play pivotal role in scientific investigation of cases. Position of allotment to CID and expenditure under MPF Scheme during 2011-16 is given in **Table 2.2.15**.

Table-2.2.15: Allotment and expenditure to CID

(₹in crore)

Sl. No.	Year	Allotment		Expenditure	
		No. of items	Amount	No. of items	Amount
1.	2011-12[51]	11	0.34	11	0.33
2.	2012-13[52]	5	0.79	1	0.65
3.	2014-15[53]	11	0.99	0	00
Total		**27**	**2.12**	**12**	**0.98**

(Source: ADG (CID))

Only 46 *per cent* funds provided for modernisation of CID wing was utilised.

Thus, only ₹ 98 lakh (46 *per cent*) out of ₹ 2.12 crore allotted to CID wing were utilised against AAPs for 2011-12 to 2014-15. PHQ allotted (March 2013) an amount of ₹ 11.25 lakh to ADG (CID) against AAP 2012-13 for procurement of Railway equipments. Audit observed that Railway Police wing communicated (November 2013) technical specifications of the equipment to CID wing, but the procurement was still under process (March 2016). Audit also observed that against the sanction of ₹ 98.90 lakh under AAP 2014-15, only Technical Committee could be constituted (March 2016) by CID wing.

Due to delay in procurement of investigation equipment under MPF, Department was deprived of the benefit of modern equipment for CID wing.

In the exit conference (November 2016), ACS stated that the delay in finalisation of specification was due to transfer of the committee members. The process of procurement was in progress in CID wing and would be completed soon.

2.2.17 Human Resource Management

2.2.17.1 Deficiencies in man power management

Without availability of adequate manpower and sufficient training, infrastructure created under various schemes cannot be optimally utilized for the purpose for which it was created. Audit scrutiny revealed that Home Department fixed (November 2010) minimum manpower norms as 75 for urban PSs, 50 for *Nagar Panchayat* PSs, 35 for rural police stations and 45 for Naxal effected Rural PSs. Norms of 15, 11 and 35 personnel were also fixed for urban, rural and naxal effected OPs respectively. It was stipulated that police force would be increased considering the factors such as increase in population and crime rate etc. Audit, however, observed that the norms for

[51] Includes ₹ 31.50 lakh for nine Railway equipments.
[52] Includes ₹ 11.25 lakh for Railway equipments.
[53] Including ₹ 20.70 lakh for Railway equipments.

other constituents of Police Force, such as, District Reserve Police, Special Armed Force and Traffic Police, were not fixed.

During 2011-16, sanctioned strength of total police force increased from 87,291 to 1,12,027. However, there was overall vacancy of 16,751 personnel in police force as of June 2016.

Audit noticed that total sanctioned strength of police force in the selected districts increased from 24,436 to 29,564 during the years 2011-16. While available manpower increased from 21,602 to 25,004, the shortfall of personnel also increased from 2,834 to 4,560. As of March 2016, 34 *per cent* post of Inspector/Reserve Inspector, 27 *per cent* post of Sub-Inspector/*Subedar*, 17 *per cent* post of Constable and 29 *per cent* Ministerial post were vacant. In interview of 150 police personnel in selected districts, only 5 *per cent* were satisfied with availability of police force.

Thus, there was significant shortage of manpower in the police force, which was crucial in view of rising crime and pendency in investigation, as discussed in **paragraph 2.2.19**.

In reply, ADG (Planning) stated (June 2016) that filling up of vacancies through recruitment and promotion was in process. In the exit conference (November 2016), ACS accepted the observations and stated that man power position had improved but further improvement was required. Further, GoMP had accorded in-principle sanction of 6000 new posts, the order would be issued soon.

Facts remains that there remained substantial shortfall in police personnel in all cadres, which had increased over the years in test checked districts. Thus, the Department was required to fill up of the vacancy in all cadres in a planned manner.

2.2.17.2 Deficiencies in training programmes

Following deficiencies were noticed in management of training programmes:

There was deficiency in providing in-service training in modern weaponry.

- Audit noticed that training calendars were not prepared for training which indicated that phased planning of training was not done. Only basic foundation courses were offered in six Police Training Schools[54] (PTS) and two[55] Academies during 2011-16. Further, 17,785 personnel were imparted in basic course in the PTSs and pass percentage of the trainees reduced from 84 *per cent* in 2011-12 to 69 *per cent* in 2015-16. Pass percentage of trainees had decreased due to short availability of trained teachers. The PTSs had 495 vacant posts (29 *per cent*) and the vacancy in Academies were 141 (32 *per cent*) as of March 2016.
- In selected districts, training was imparted to only 136 personnel in modern weapons, 248 personnel in safety equipment, 137 personnel in cyber, 565 personnel in use of databank and 74 personnel in forensic

[54] Indore, Sagar, Pachmadhi, Rewa, Tigra (Gwalior) and Umaria.

[55] Jawahar Lal Nehru Police Academy, Sagar and Madhya Pradesh Police Academy, Bhauri.

during 2011-16. Thus, there was lack of sufficient training for police personnel to raise the overall proficiency.

In the exit conference (November 2016), ACS stated that from 2010 police personnel were recruited in high numbers, as five thousand to six thousand new posts were sanctioned every year. Due to this, in-service courses were stopped to provide basic courses to new recruits so that they may be posted for field duties. However, in-service courses were conducted in supervision of Range IGs. Training to police personnel on modern weapons, data analysis and Cyber-crime were provided through 35-40 courses during the period in Rustam Ji Arms Police Training Collage, Indore, special units (such as ATS and Hawk Force etc.) and Police Radio Training School, Indore respectively. It was further stated that more attention would be paid towards training.

The Department, however, did not provide the number of personnel imparted in-service training courses. Further, the number of personnel imparted training in the Districts during 2011-16 indicated that the number of in-service training was minuscule and training courses was required to be enhanced substantially, especially in view of procurement of modern weapons under MPF.

2.2.17.3 Other Human Resource Management aspects

Human Resource aspect, such as, improvement in career advancement, improvement in living conditions, rewards systems, kind of training imparted in the improved/new training institutions including gender sensitization, custodial sensitivities, stress management, team building apart from weapon training, forensic and cyber training for specialised branches, use of data bank etc. would largely improve efficiency of police force.

Audit observed that the scheme guidelines for MPF did not provide for these aspects. However, there was a provision for preparation of strategic five year plan under the scheme, which was an opportunity to strategize such human resource aspects in larger goal of enhancing efficiency of police force. However, Audit noticed that strategic plan for the period 2011-16 did not cover aforesaid human resource aspects.

In interview of 150 police personnel in selected districts, only 26 *per cent* were satisfied with available resources and 45 *per cent* were satisfied with career progression. However, 85 *per cent* personnel stated that they are motivated to meet the challenges of various departmental tasks and 81 *per cent* were satisfied with the reward system.

In the exit conference (November 2016), ACS stated that training need analysis based courses, including the subjects of gender sensitisation, stress management, arms, law and cyber, had been prepared for posts of Constable to Deputy SP. Further, 55 officers had been imparted training in 'Quality of Training', 8995 Officers in 'PS management', 77 in 'Best Practice and Innovative' and 53 Officers in 'Leadership Programme' in various Institutes. In future, police officers would also be imparted training in new fields to make them professionally efficient.

The fact remains that the satisfaction level of police personnel about human resource aspect was not very affirmative and concerted efforts were required to address it.

2.2.18 Monitoring and internal control

2.2.18.1 Inadequate monitoring

GoI directed (February 2001) to constitute a State Level Empowered Committee (SLEC) under the chairmanship of Chief Secretary of State to monitor the implementation of the project. GoMP constituted (June 2001) SLEC comprising of the Chief Secretary, Principal Secretary/Home, DGP, Secretary (Finance) and Additional Secretary (Home) for monitoring of the Scheme.

Audit observed that meetings of SLEC were held for approval of AAPs and there was no evidence on whether monitoring of the implementation of the project was done by SLEC or not. The department did not provide information on total number of meetings held by SLEC during 2011-16.

In the exit conference (November 2016), ACS stated that proposal of the Department was approved by the committee after being fully satisfied and utilisation of funds was being monitored by PHQ from time to time.

Reply was not acceptable, as Department SLEC was mandated for monitoring at the top level, whereas SLEC did not monitor the implementation of scheme after approving AAP.

2.2.18.2 Inadequate internal control over assets created under the Scheme

According to MPF guidelines, annual verification of assets would be carried out by a team of designated officers of the Police Directorate and necessary entry made in the assets registers. The procedure for physical verification included generating a list of assets from assets register, physical verification of the fixed assets at its location, enquiry of discrepancies noticed, etc.

Department did not conduct the annual verification of assets created out of MPF scheme.

Audit noticed that Officers were not designated by PHQ during 2011-16 to carry out the annual verification of assets. In selected 13 districts, registers of assets were maintained for Arms and Vehicle. However, no register was maintained for equipment. Further, registers of assets for Houses and Buildings were maintained by only two SPs (Sagar and Chhatarpur). This indicated poor inventory management and lack of internal control over assets created under the scheme.

In the exit conference (November 2016), ACS stated that a Computerised Inventory Management System would be initiated for adequate control over assets.

2.2.18.3 Impact Assessment of Modernisation of Police Force

Exercise to assess the overall impact of funds utilised for Modernisation was not carried out.

The Scheme was being implemented from 2000 in the State. Impact assessment of the funds utilised for Modernisation of the Police Force was vital to assess the success and midterm corrections.

Audit noticed that department assessed the impact of Mobility, Arms and Housing/ Buildings on the basis of requirement and availability but there was no evidence to suggest that any exercise to assess the overall impact of funds utilised for Modernisation was carried out by the Department itself or through third party.

In the exit conference (November 2016), ACS stated that impact assessment by any third party was not carried out but the utilisation of Scheme fund had been helpful in filling in the gaps of infrastructure, boosted morale of the force, improved equipment for various activities and as a result the state police had been able to achieve success in various aspects of policing. The reply however is not corroborated by any documentary evidence.

The reply was, however, silent about the exercise carried out by Department to assess the overall impact of funds utilized under MPF.

2.2.18.4 Effectiveness of Concurrent Audit

System of Concurrent Audit was not utilised for improvement in working.

MHA has instituted a system of Concurrent Audit and its follow up through Action Taken Report (ATR). Audit noticed from information furnished by the Nodal Officer that nine concurrent audits were conducted during 2011-16, three Concurrent Audit Reports (CAR) were received and ATRs were sent in two cases and ATR for the period October 2014 to March 2015 was yet to be sent (June 2016). Audit noticed from the CAR made available that deficiencies such as delay in release of funds, unspent balances, delay in execution of works, were highlighted, but were still persisting. Thus Department did not utilise the system of concurrent audit to improve the mechanism to implement the Scheme.

In the exit conference (November 2016), ACS confirmed the facts and stated that in two cases ATRs have been sent while in one case ATRs was yet to be sent. The reply, however, was silent on the issue of not utilising the system of concurrent audit to improve the mechanism to implement the Scheme.

2.2.19 Crime Scenario

Trend of crime and status of investigation is an indicator of preparedness and operational efficiency of Police force. Scrutiny of data furnished by State Crime Record Bureau regarding status of crime cases and pace of investigation for the period 2011-16 revealed increasing trend of crime and low pace of investigation as indicated below:

Number of Crime cases and pendency in investigation increased in the State.

During 2011-2015, the number of Indian Penal Code crimes in the State gradually increased from 2.17 lakh to 2.69 lakh (24 *per cent*). Audit also observed that the pendency in investigation also increased from 12,582 to 23,380 (86 *per cent*), though the number of charge sheets also increased from 2.14 lakh to 2.66 lakh (24 *per cent*) during the same period. This indicated that pace of investigation of the crime was not in congruence with the pace of increase in crime. Details are shown in ***Chart 2.2.3***.

Chart-2.2.3

(Source: State Crime Record Bureau)

Increase in criminal cases and pendency in investigation revealed that the improvement in the efficiency of State police force was not discernible, despite increase in availability of resources such as vehicles, arms and equipments.

The SPs of selected districts attributed the increase in crime and pendency in investigation to population increase, engagement of police in other duties such as VVIPs security and court proceedings, changing economic and social scenario, increasing public awareness, etc. It was also stated that there was shortfall of police force in comparison to increase in population and crime.

Department informed (January 2017) that efforts were made for motivating the police force, which comprised:

- Training module included dimensions of personality development, such as self-development, stress management and motivational techniques.
- Various schemes such as 15 *per cent* reservation for Constables with excellent service record in appointment to Sub-Inspectors and rewards.
- Welfare activities such as scholarship for studying children, co-operative stores, Scheme for cashless treatment.

In the exit conference (November 2016), ACS stated that out of total increase of 24 *per cent* in registration during 2011-16, almost 10 *per cent* cases have increased because FIRs were mandatory to be lodged in cases of missing child under instruction of Honorable Supreme Court (May 2013). Police force had not increased in comparison to increase in registered crime. Investigation of cases also suffered due to engagements of the force in election and VVIPs duties, etc. It was also stated that year wise analysis of registered and disposed of cases showed that pendency has decreased from 3,177 to 2,629 for the years from 2011 to 2015.

The reply was not acceptable, as pendency in the number of investigation increased during 2011 to 2016. Therefore, effective steps was required to be taken for strengthening of police force with adequate manpower, enhanced mobility, weaponry, improvement in living condition and other related infrastructure, as discussed in the preceding paragraphs of the performance audit.

2.2.20 Conclusion

- Strategic planning was done without vision, mission, goals, objectives and evaluation plan. Gap analysis for various police equipment relating to intelligence, training, telecommunications, railway, CID and FSL was not done in AAPs. There were inordinate delays in submission of AAPs to the MHA during 2011-16, which resulted in consequential delays in approval of AAPs. Thus, there was little time left to implement the scheme as per plan and utilise the funds during the same year. Further, AAP were not prepared after including joint resource planning to optimise utilisation of fund available to the State from MPF and other related schemes.

- The progress of expenditure against available funds was slow, which improved largely during 2015-16 in which ₹ 163.65 crore (52 *per cent* of total ₹ 316.47 crore) was incurred. Slow progress of expenditure led to short release of ₹ 92.79 crore of Central share for implementation of MPF in the State. For the period 2015-16, Central share of ₹ 23.42 crore released by MHA to GoMP as well as the State Share of ₹ 17.87 crore was not released to the Department. Inaccurate utilization certificate were furnished to GoI. MPPHC did not work out interest in outstanding fund of the scheme, therefore it could not be utilised for furtherance of the objectives of the Scheme.
- Due to delays in construction, availability of police housing and buildings was lagging far behind the actual requirement. Substantial number of buildings works did not commence and completed works were handed over with delay to Department by MPPHC. Inconsistency was noticed in application of quality control norms for building works. There was lack of coordination between MPPHC and the Department.
- Availability of buildings as well as houses per 100 personnel decreased. More than two thirds of subordinate police personnel could not be provided government accommodation, as there was a shortfall of 69978 houses for police personnel. Similarly, there was shortage of 718 buildings, including police station, outposts, district police office, district police line, control rooms. Basic amenities such as toilet and rest rooms for women personnel were lacking in PS/OP. Police personnel were residing and working in condemned and dilapidated houses/buildings. Thus, police force's own security was in jeopardy.
- Response time was not monitored adequately. There was deficiency of vehicles, especially motorcycle, in the Department. There was shortage of modern weapons and Arm Workshop required upgradation. There were delays in completing procurement process. Number of Indian Penal Code crimes in State increased gradually and pace of investigation was not in congruence with the pace of increase in crime.
- There was large vacancy in Police Force. Posts of Scientific Officers and Technical Officers were lying vacant in FSL leading to pendency in sending test reports. Imparting of Training for modern and sophisticated weapons and equipment to Police Force was not adequate.
- Monitoring of implementation of scheme was not adequate. Internal control over assets created under the scheme was inadequate. Exercise to assess the overall impact of funds utilised for Modernisation was not carried out and system of Concurrent Audit was not utilised for improvement in working.

2.2.21 Recommendations

- *Strategic Plan for Modernisation of Police Force may be prepared after proper assessment of deficiencies under each component, adherence to provisions of the Guidelines and time limit should be ensured in submission of AAPs.*

- *GoMP should ensure timely release of all due funds under MPF and interest amount* should *be utilised for furtherance of the objectives of the MPF scheme.*
- *Reasons for bottlenecks in implementation of various components of MPF may be identified and rectified. There is a need for further financial support for Modernisation of Police Force in view of increasing manpower of Police Force.*
- *Shortage of manpower at various level should be addressed in phase wise manner and overall skill development, training including use of modern weapons and equipments should be accorded top priority.*
- *Periodical and regular monitoring and impact assessment mechanism may be evolved at Government level for timely implementation of programmes and midterm corrections.*

The Department accepted the recommendations.

WOMAN AND CHILD DEVELOPMENT DEPARTMENT

2.3 Performance Audit on Supplementary Nutrition Programme under Integrated Child Development Services

Executive Summery

Integrated Child Development Services (ICDS) is India's response to the challenge of breaking a vicious cycle of malnutrition, impaired development, morbidity and mortality in young children. Supplementary Nutrition Programme (SNP) under ICDS is primarily designed to bridge the gap between the recommendatory dietary allowance and average daily intake. Every beneficiary of SNP is provided supplementary nutrition (SN) for 300 days in a year, which is supplied by the Anganwadi Centres (AWCs) in the form of cooked meals and Take Home Ration (THR).

In Madhya Pradesh, ₹ 5012.17 crore was incurred on implementation of SNP during 2011-12 to 2015-16. A performance audit of the implementation of ICDS (Supplementary Nutrition Programme) in Madhya Pradesh during the period 2011-16 revealed the following:

Financial Management

State Government provided allocated food grains to District Programme Officers (DPOs) through Madhya Pradesh State Civil Supplies Corporation (MPSCSC) for release under SNP. Audit scrutiny revealed that DPOs did not adhere to Central Issue Price (CIP) of wheat and rice and payments were made to MPSCSC at higher rates. This resulted in excess payment of ₹ 40.87 crore to MPSCSC during 2012-13 to 2014-15. Further, unreconciled advance of ₹ 13.81 crore was lying with MPSCSC on account of short lifted food grains by DPOs.

(Paragraphs 2.3.6.1 and 2.3.6.3)

Madhya Pradesh State Agro Industrial Development Corporation Ltd. (MP Agro), which was the agency for supply of THR packets, utilised excess wheat and rice as compared to quantity of food grains required for THR packets actually supplied by it. Department did not reconcile the reasons for excess utilised food grains, which resulted in undue financial benefits of ₹ 15.57 crore to MP Agro.

(Paragraph 2.3.6.2)

Short coverage of beneficiary

ICDS was to be extended to all children upto the age of six years and all pregnant and lactating mothers. During 2011-16, 20.94 lakh registered children in the age group of six months to three years, 57.02 lakh registered children in age group of three years to six years and 7.99 lakh registered pregnant and lactating mothers were not provided SN. The shortfall was due to deficient infrastructure at AWCs, preparation of less quantity of SN or at times no supply of SN and long distances of AWCs, which acted as disincentives to enrolled beneficiaries affecting their attendance at AWCs.

(Paragraph 2.3.7.2)

Disruption in delivery of services

In 14 test-checked Project Offices, SN was not supplied during various months (ranged from one day to 120 days) during 2011-12 to 2015-16 in 983 AWCs having 37,079 registered beneficiaries.

(Paragraph 2.3.9.1)

Distribution of cooked meal

There was a shortfall of 24432.05 MT wheat and 3592.06 MT rice in distribution to Self Help Groups (SHGs) engaged in preparation of cooked meal during year 2011-16, which affected the distribution of cooked meal to beneficiaries.

(Paragraph 2.3.9.2)

Shortage of AWCs in the State

There was shortage of 18604 AWCs and 3400 Mini-AWCs in the State as of March 2016 as per population norms laid down by Government of India. Out of total 61755 villages/wards in the State, 11156 villages/wards covering 53.84 lakh population were without AWCs. GOI sanctioned 4305 (November 2014), however, these AWCs were not opened.

(Paragraph 2.3.10)

Growth monitoring and nutritional status of children

As per National Family Health Survey (2015-16), there were 9.2 *per cent* of severely malnourished children in the State. Thus, State could not achieve target for reducing severely malnourished children from 12.6 *per cent* to 5 *per cent*. Similarly, State was lagging behind the targets set for reducing percentage of underweight children and under-5 mortality rate.

(Paragraph 2.3.11)

Monitoring of the scheme

Meeting of State Level Monitoring and Review Committee was not held. Monitoring and Review Committee was not constituted at District and Block level for proper monitoring and supervision.

(Paragraphs 2.3.12.3 and 2.3.12.4)

2.3.1 Introduction

The Integrated Child Development Services (ICDS) scheme was launched in October 1975 by Government of India as a Centrally Sponsored Scheme. The Scheme aims at holistic development of children in the age group of zero to six years, pregnant and lactating mothers. The ICDS scheme is a package of six services, viz., Supplementary Nutrition Programme, Immunization, Health check-up, Referral Services, Pre School Education (PSE) and Nutrition and Health Education.

The Supplementary Nutrition Programme (SNP) is primarily designed to bridge the gap between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI). Every beneficiary under SNP is to be provided supplementary nutrition for 300 days of a year, which is delivered by the Anganwadi Centres (AWCs) at village level. The types of SN provided in Madhya Pradesh are shown in the **Table 2.3.1.**

Table- 2.3.1: Types of Supplementary Nutrition under ICDS

Target Group	Type of SN	Menu	Days for food provided in a year	Frequency
Six months to three years children	Take Home Ration (THR) {packed food material}	*Halwa, BalAahar* and *Khichadi*	THR for five days per week and Cooked food on Tuesday.	Every Tuesday for a week
lactating and pregnant mothers		*Soya Barfi, AataBesanLaddu* and *Khichadi*		
Three years to six years children	Cooked Food	As per day to day menu decided by State Government	300 days (six days per week)	Two times a day for all children and additional third meal for malnourished children

2.3.2 Organisational Setup

The organizational structure along with functions and responsibilities at various levels for implementation of ICDS in the State are shown in **Chart 2.3.1**.

Chart 2.3.1: Organisational Structure

2.3.3 Audit Objectives

The audit objectives of the Performance Audit were to ascertain whether:

- funds provided by the Central and State Government for supplementary nutrition under the ICDS were utilised efficiently and economically;
- the services of the ICDS (SNP) were being implemented effectively so as to achieve its objective of improving the nutritional status of beneficiaries.
- required infrastructure facilities were adequate in AWCs for efficient and smooth delivery of ICDS (SNP); and
- monitoring system was adequate to ensure effective implementation of the ICDS (SNP).

2.3.4 Audit Criteria

The Audit criteria for the Performance Audit were drawn from:

- Scheme guidelines of ICDS (SNP) of GOI and State Government.
- Instructions issued by the GOI and State Government.
- Prescribed monitoring and evaluation mechanism.

2.3.5 Scope of Audit and Audit Methodology

The Performance Audit covers implementation of Supplementary Nutrition Programme under ICDS during 2011-12 to 2015-16. For the performance audit, 14 Districts[56] and three Project Offices in each of these districts have been selected on the basis of Simple Random Sampling without Replacement (SRSWOR) method. Ten AWCs in each selected Project Office were selected on random basis.

The implementation of ICDS (Supplementary Nutrition Programme) was reviewed through a test check of the records of the Commissioner, ICDS at State level, 14 sampled district level offices of District Programme Officers (DPOs), 42 sampled Project level offices of Child Development Project Officers (CDPOs) and 420 sampled AWCs. Records of Madhya Pradesh State Agro Industrial Development Corporation Ltd. (MP Agro) relating to supply of THR and Madhya Pradesh State Civil Supplies Corporation (MPSCSC) relating to supply of food grains for ICDS were also test checked.

Joint physical inspection of 210 AWCs and 57 SHGs and joint beneficiary survey of 2080 beneficiaries, including parents (either mother or father) of children in the age group of six month to six years, and pregnant and lactating mothers were carried out with departmental officers.

An entry conference was held on 11 March 2016 with the Principal Secretary of Department of Women and Child Development (WCD) to discuss the audit objectives and audit criteria. The draft report was issued to WCD in August 2016. The audit findings were also discussed in an exit conference with the Commissioner on behalf of Principal Secretary, WCD held on 14 October

[56] Alirajpur, Balaghat, Bhopal, Chhindwara, Dhar, Indore, Khandwa, Khargone, Panna, Rajgarh, Ratlam, Satna, Seoni and Vidisha.

2016. The replies of Government and views expressed during exit conference have been suitably incorporated in the review.

Audit Findings

2.3.6 Financial Management

ICDS is a Centrally Sponsored Scheme funded on cost sharing basis between Government of India (GoI) and State Government. The funds are provided for implementation of the scheme under two heads:

- ICDS (General), for meeting operational costs under which cost sharing between GoI and State Government is 90:10; and,
- Supplementary Nutrition, under which cost sharing between GoI and State Government is 50:50.

During 2011-12 to 2015-16, Department incurred ₹ 5012.17 crore on implementation of SNP. The details of actual amount received and expenditure incurred on SNP during 2011-12 to 2015-16 are as given in **Table 2.3.2:**

Table 2.3.2: Fund received and expenditure incurred on Supplementary Nutrition Programme

(₹ in crore)

Year	Central Share			State Share		
	Actual Received	Expen-diture	Excess (+)/ short (-) received	Actual received	Expen-diture	Excess/ short received
2011-12	523.23	446.83	76.40	451.00	446.83	4.17
2012-13	575.74	521.13	54.61	523.68	521.13	2.55
2013-14	423.86	447.40	(-)23.54	489.73	494.57	(-) 4.84
2014-15	484.62	485.63	(-)1.01	574.99	485.63	89.36
2015-16	423.82	581.51	(-) 157.69	600.78	581.51	19.27
Total	**2431.27**	**2482.50**	**(-) 51.23**	**2640.18**	**2529.67**	**110.51**

(Source: Data provided by Directorate)

Thus, the fund of Central share was short received to the tune of ₹ 51.23 crore during the year 2011-12 to 2015-16. Further, audit observed that expenditure of ₹ 191.76 crore (19.75 *per cent*) was excess incurred during year 2015-16 in comparison with expenditure of year 2014-15, whereas the increase in the benefited beneficiaries was only 9.34 *per cent*.

On being pointed out, Commissioner replied that number of benefitted beneficiaries under SN was given through Management Information System (MIS), which was not 100 *per cent* accurate. Expenditure figures under SN were taken on the basis of actual expenditure. Further, annual expenditure differed due to ban imposed by Finance Department on drawal of bills at the end of financial year and bills not received from SHGs in time.

In the exit conference (October 2016), the Commissioner replied that in case of short receipt from Central share, expenditure was met out from the State share in anticipation of Central share.

Fund was also given for construction of Anganwadi buildings separately under various schemes viz; 13th Finance Commission, Additional Central Assistance, as detailed in ***Appendix 2.3.1.*** The details of budget allotment and expenditure incurred on the construction of AWCs during 2011-12 to 2015-16 are given in **Table 2.3.3**.

Table-2.3.3: Budget allotment and expenditure of construction of AWCs

(₹ in crore)

Year	Original budget	Supplementary budget	Re-appropriation / surrender	Total available budget	Expenditure incurred	Unspent amount
2011-12	100.01	0	0	100.01	100.01	0
2012-13	100.00	50.00	0	150.00	0	150.00
2013-14	108.38	103.00	(-) 4.13	207.25	104.17	103.08
2014-15	185.25	64.75	0	250.00	87.44	162.56
2015-16	11.00	83.16	(-) 2.00	92.16	57.01	35.15
Total	**504.64**	**300.91**	**(-) 6.13**	**799.42**	**348.63**	**450.79**

(Source: Data provided by Directorate)

Out of ₹ 799.42 crore available for construction of AWCs, ₹450.79 crore remained unspent.

Thus, out of a total budget of ₹ 799.42 crore for construction of AWCs, ₹ 450.79 crore (56 *per cent*) remained unspent. In the exit conference (October 2016), the Commissioner replied that construction of AWCs sanctioned under various schemes were carried out by various executing agencies selected at the district level. The progress of construction works were slow due to disputed land, site selection and delay in construction by the executing body.

2.3.6.1 Excess payment of food grains to MPSCSC

GoI annually released foods grains (wheat/rice) on Below Poverty Line (BPL) rates under Wheat Based Nutrition Programme (WBNP) to States for use in SNP. The purpose was to reduce the procurement cost of the SN and ensure the availability of more food grains for the beneficiaries. During the year 2011-16, the Central Issue Price (CIP) of wheat for BPLwas ₹ 415 per quintal and of rice for BPL was ₹ 565 per quintal, which was payable by the State to the Food Corporation of India.

GoI had allowed Government of Madhya Pradesh to draw its allocation from the Decentralised Procurement (DCP) stocks procured under decentralised procurement system. Accordingly, State Government provided allocated food grains to Districts through MPSCSC and from there it would be sent to Fair Price Shop under Public Distribution System for release under SNP. The payment for food grains was to be made by DPOs to MPSCSC.

Excess payment of ₹ 40.87 crore was made to MPSCSC.

Audit scrutiny revealed that the DPOs did not adhere to the CIP of wheat and rice for BPL at the time of releasing payments to MPSCSC. The payments were made to MPSCSC at higher rates, as detailed in **Table 2.3.4**, which resulted in excess payment of ₹ 40.87 crore to MPSCSC.

Table 2.3.4: Details of food-grains lifted in the State and amount paid during 2012-15

(₹in crore)

Year	Food grains lifted (in MT)		Amount actually paid to MPSCSC		Amount that should have been paid to MPSCSC @ CIP of rice and wheat for BPL		Excess Payment to MPSCSC
	Wheat	Rice	Wheat	Rice	Wheat	Rice	
2012-13	137117.431	55804.900	65.69	38.94	56.90	31.53	16.20
2013-14	139947.571	56325.439	63.79	38.99	58.08	31.82	12.88
2014-15	125277.050	50305.873	55.74	36.46	51.99	28.42	11.79
Total							**40.87**

(Source: Data provided by MPSCSC)

In the exit conference (October 2016), the Commissioner replied that transportation/storage charges in addition to basic rate of wheat ₹ 415 per quintal and rice ₹ 565 per quintal was paid to MPSCSC for providing food grains to SHGs. Therefore, payment was not made to MPSCSC at higher rate.

The reply was not acceptable, as the payment to MPSCSC was to be released on the basis of CIP rates of wheat and rice for BPL as notified by GoI. Further, Directorate had issued (October 2013) instruction to DPOs that MPSCSC should be paid for BPL food grains under WBNP at Central rates. MPSCSC had also issued instruction (May 2012) to its District Managers for release of food grains under SNP after receiving payment for food grains at the rate of CIP of wheat for BPL (₹ 415 per quintal) and of rice for BPL (₹ 565 per quintal). Therefore, the excess payment of ₹ 40.87 crore was required to be recovered from MPSCSC.

2.3.6.2 Excess utilisation of food grains for THR

THR consists of packed food material, viz., *Halwa, Bal Aahar, Soya Barfi, Aata Besan Laddu* and *Khichadi*. For the preparation and supply of THR, Department had entered into agreement with (June 2008 and December 2011) Madhya Pradesh State Agro Industrial Development Corporation Ltd. (MP Agro). As per the agreement, Department was responsible to make available BPL wheat/rice to MP Agro from FCI. Department had also prescribed norms for food grains to be utilised in THR. The requirement of wheat and rice in view of these norms were as detailed in **Table 2.3.5:**

Table 2.3.5: Norms for consumption of Wheat and Rice for preparation of THR

Sl. No.	Name of THR	Quantity of packet (in gram)	Name of food grains	Percentage of composition
1	Halwa	600	Wheat	42
			Rice	03
2	BalAahar	600	Wheat	56
3	Khichadi (for children)	625	Rice	58
4	Soya Barfi	750	Wheat	40
5	*AataBesan*Laddu	750	Wheat	47.50
6	Khichadi (for pregnant and lactating mothers)	750	Rice	58

(Source: Data provided by Directorate)

On the basis of supply order received from the Department, THR was supplied by MP Agro to project level godown for further distribution to the beneficiaries through AWCs. Scrutiny of information received from MP Agro revealed that MP Agro had utilised excess quantity of wheat/rice as compared to that required for preparation of THR supplied by MP Agro during 2011-12 to 2015-16. The details are given in **Table 2.3.6**:

Table-2.3.6: Details of wheat/rice required and utilised by MP Agro for preparation of THR

(Quantity in MT)

Year	Food grains required as per norms against supplied THR packets		Food grains reportedly utilised by MP Agro for preparation of THR		Excess utilised	
	Wheat	Rice	Wheat	Rice	Wheat	Rice
2011-12	55005.594	25749.360	60511.321	27269.159	5505.727	1519.799
2012-13	56321.870	26409.451	61821.370	27908.011	5499.500	1498.560
2013-14	52399.018	24571.122	57478.843	25948.397	5079.825	1377.275
2014-15	50602.384	23724.835	55495.629	25049.419	4893.245	1324.584
2015-16	54163.473	26965.262	60640.076	28639.830	6476.603	1674.568
Total					**27454.900**	**7394.786**

(Source: Data provided by MP Agro)

Department extended undue financial benefits of ₹ 15.57 crore to MP Agro.

In view of CIP of wheat for BPL at the rate of ₹ 415 per quintal and of rice for BPL at the rate of ₹ 565 per quintal, the cost of excess utilised wheat and rice was ₹ 11.39 crore and ₹ 4.18 crore respectively. However, Department did not reconcile the reasons for excess utilised food grains for preparing THR packets during 2011-16, which resulted in undue financial benefits of ₹ 15.57 crore to MP Agro.

In the exit conference (October 2016), the Commissioner replied that MP Agro had lifted the entire allocated food grains from MPSCSC. There was no excess allocation of food grains to MP Agro.

The reply was not acceptable, as the allocation and utilisation of food grains to MP Agro was in excess of THR packets actually supplied by MP Agro, as detailed in **Table 2.3.6**. The failure of Department in reconciling the utilisation of food grains with reference to supplied THR packets resulted in excess lifting of food grains worth ₹ 15.57 crore by MP Agro, which was due to be recovered.

2.3.6.3 Unreconciled advance for food grains lying with MPSCSC

As per order (October 2009 and February 2014) of the Department for providing SN to AWCs, DPOs were required to make advance payment to MPSCSC for quarterly food grains allocated to them. The advance payment was to be adjusted after receiving status of actual lifting by SHGs, which was to be compiled by MPSCSC. The status of allotment and actual lifting was to be reconciled by the Department at State and District level.

Audit scrutiny revealed that seven test checked DPOs did not reconcile the status of actual lifting vis-à-vis allotment of food grains. Further scrutiny revealed that due to short lifting of food grains in these districts for which payment was released in advance to MPSCSC, there was unreconciled

advance of ₹ 3.90 crore with MPSCSC. The status of short lifted food grains lying with MPSCSC was as detailed in **Table 2.3.7**:

Table 2.3.7: Details of foodgrains lying with MPSCSC

(₹in crore)

Sl. No.	Level	Food Grains Allotted (in MT)		Food Grains Lifted (in MT)		Food Grains Lying with MPSCSC (in MT)			
		Wheat	Rice	Wheat	Rice	Wheat	Amount	Rice	Amount
1	State	473790.00	163751.47	386871.34	139305.70	86918.66	36.07	24445.77	13.81
2	Seven districts[57]	48594.43	17576.13	42229.94	15343.15	6364.49	2.64	2232.98	1.26

(Source: Data provided by Directorate and Districts)

86,918 MT of wheat (₹ 36.07 crore) and 24445 MT of rice (₹ 13.81 crore) were short lifted by DPOs for which advance payment was released to MPSCSC.

Thus, 86,918 MT of wheat (₹ 36.07 crore) and 24445 MT of rice (₹ 13.81 crore) were short lifted by DPOs for which advance payment were released to MPSCSC. DPOs of seven test checked districts replied that adjustment would be made from MPSCSC after reconciliation of food grains.

In the exit conference (October 2016), the Commissioner replied that food grains were lifted by MP Agro and SHGs in various districts, from godowns of MPSCSC and FPS as per requirement and payment made on the same. Payment was made for such food grains, which was lifted by MP Agro and SHGs and reconciliation of food grains lifted by SHGs was done continuously by DPO. As per allocation of foodgrains by GOI, quantity which was not lifted from MPSCSC, assumed to be lapsed. Foodgrain was not lying with MPSCSC.

The reply was not acceptable, as payments for food grains were released by DPOs in advance to MPSCSC on the basis of allotment. Further, DPOs of test checked districts had accepted that reconciliation were yet to be made.

2.3.7 Programme Implementation

2.3.7.1 Survey of beneficiaries

As envisaged in the User's Manual of ICDS, Family Detail Register comprising details of families, all births and deaths, migration of family was to be maintained at AWC level. This register would be used to make monthly summary of events. Monthly Progress Report (MPR) of AWC was to be prepared by the AWW every month and was to be uploaded on MIS, which was compiled at state level.

AWWs were to conduct house-to-house survey of all families in AWC areas for enrolling eligible beneficiaries for providing services under ICDS. The survey was to be conducted annually in April.

[57] Alirajpur (Wheat 26.12 MT and Rice 7.83 MT, ₹ 1.53 lakh), Dhar (Wheat 171.47 MT and Rice 94.67 MT ₹ 12.46 lakh), Indore(Wheat 26.00 MT, Rice 10 MT, ₹ 1.64 Lakh), Panna (Wheat 1211.209 MT and Rice 619.296 MT, ₹ 85.26 lakh), Rajgarh (Wheat 1983.71 MT and Rice 316.48 MT ₹ 1.00 crore), Ratlam (Wheat 384.18 MT and Rice 97.90 MT ₹ 21.47 lakh) and Satna (2561.80 MT wheat and 1086.80 MT Rice ₹ 1.68 crore).

Out of 42 test-checked Projects, 41 Projects conducted household survey of the families every year. However, 27 Projects did not update family register monthly. Since family registers were not updated and MPR of all functional AWCs/Mini-AWCs was not uploaded on MIS, the State level data in MIS was not realistic.

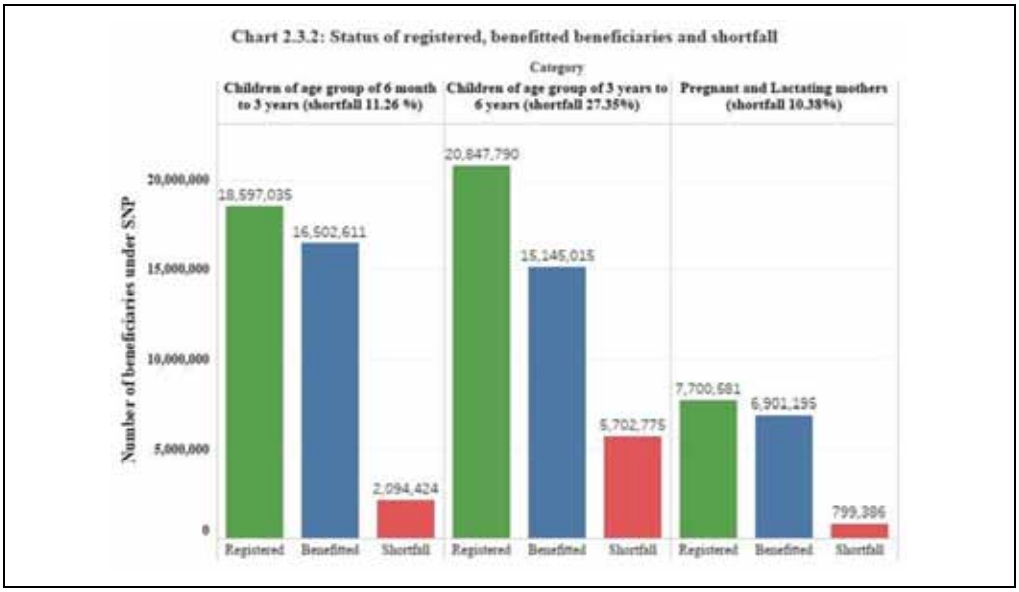
Audit noticed that the number of beneficiaries in the State under ICDS increased from 97.50 lakh in 2011-12 to 105.00 lakh in 2015-16. However, the number of beneficiaries during 2012-13 to 2014-15 was constant at 97.68 lakh. This shows that the number of beneficiaries were not based on actual survey and updated information from AWCs.

In the exit conference (October 2016), the Commissioner replied that survey was conducted each year in the month of April as per GOI instructions, which was recorded in survey register. On the basis of this, MPR was prepared. The number given in Administrative Report was estimated number.

The reply was not acceptable, as test checked projects were not updating family register on monthly basis and updated information was not uploaded on MIS.

2.3.7.2 Short coverage of beneficiaries

ICDS was to be extended to all children upto the age of six years and all pregnant and lactating mothers. However, considerable number of beneficiaries could not be brought under the ambit of SNP. The category-wise position of registered beneficiaries and those benefited at the State level during 2011-16 are listed in **Chart 2.3.2.**



(Source: Data provided by Directorate)

There was huge shortfall in coverage of beneficiaries due to deficient infrastructure of AWCs, no supply of SN and preparation of less quantity of cooked meal.

Thus, 20.94 lakh children of the age group of six months to three years, 57.02 lakh children of age group of three years to six years and 7.99 lakh pregnant and lactating mothers registered under ICDS were deprived of receiving the envisaged benefit of the SNP during 2011-16.

The year wise data of shortfall during the year 2011-12 to 2015-16 in providing benefits to registered beneficiaries at test-checked districts and

projects are given in ***Appendix 2.3.2*** and ***Appendix 2.3.3*** respectively, which was as summarised in **Table 2.3.8**:

Table-2.3.8: Details of shortfall of beneficiaries under SN at selected Districts, Projects and AWCs during 2011-12 to 2015-16.

Sl. No.	Type of beneficiaries	Shortfall at District level	Shortfall at Project level	Shortfall at AWCs
1	Children in the age group of six months to three years	974245 (15.52 %)	219893 (12.79 %)	15577 (12.13 %)
2	Children in the age group of three years to six years	1749187 (26.46 %)	436447 (24.16 %)	34189 (26.85 %)
3	Pregnant and lactating mothers	271718 (10.92 %)	74972 (10.90 %)	5005 (9.47 %)

(Source: Data provided by Districts, Projects and AWCs)

The shortfall in providing supplementary nutrition was due to poor infrastructure of AWCs, failure of AWCs to distribute SN as per menu, preparation of either less quantity of SN or at times no supply of SN at AWCs and long distances of AWCs, as discussed in succeeding paragraphs. These deficiencies acted as disincentives to enrolled beneficiaries affecting their attendance at AWCs.

In the exit conference (October 2016), the Commissioner replied that efforts were being made constantly against shortfall. Instructions had been issued to enroll the uncovered children and to enhance the regular attendance through *Anganwadi Chalo Abhiyan* and monthly review to ensure providing 100 *per cent* benefits. Due to first registration/enrollment of children in the age of three to six years in school, 100 *per cent* target could not be achieved. Further, due to migration of parents/guardian to other places and admission of children of three to six years in school, less number of beneficiaries got SN.

The reply was not acceptable because as per the instructions of GOI, all the beneficiaries should be covered under ICDS. The shortfall has been commented with reference to registered beneficiaries and the migrated parents/guardian would not appear in the enrolment of beneficiaries. Further, State Government could have linked enrolled beneficiaries with Aadhar, so that it could be tracked whether there was indeed migration within the State and whether those people were availing of the benefits at the next place.

In its further reply (December 2016), the Commissioner informed that action for registration of all beneficiaries under Aadhar were being taken.

2.3.8 Take Home Ration

Take Home Ration (THR) consisting of six types of packed food material, namely; *Halwa, Bal Aahar* and *Khichadi* are provided to the children in the age group of six months to three years and *Soya Barfi, Aata Besan Laddu* and *Khichadi* are provided to pregnant and lactating mothers. One packet of THR per beneficiary was distributed on Tuesday for following five days at AWCs. As per the agreement entered into with MP Agro, supply order of THR was given by Directorate to MP Agro. On the basis of supply order, THR was

supplied by MP Agro to project level godown for further distribution to the beneficiaries through AWCs.

- **Excess/short supply of THR**

Audit scrutiny of supplies of THR with reference to the number of beneficiaries during the period 2011-12 to 2015-16 revealed excess as well short supply of THR at State, selected districts and selected project levels, as details shown in **Table 2.3.9:**

Table-2.3.9: Details of excess/short supply of THR at State, selected Districts and Selected Projects level

(Quantity in MT)

Sl. No.	Level	Category of beneficiary	Number of districts/ projects	Excess Supply	Number of districts/ projects	Less Supply
1.	State	Six month to three years		---		13850.63
		Pregnant and lactating mother		8709.65		---
2.	In selected District	Six month to three years	4	2437.62	9	6038.33
		Pregnant and lactating mother	7	4281.90	6	1029.99
3.	In selected Project	Six month to three years	13	1413.51	28	2798.89
		Pregnant and lactating mother	23	1511.51	18	732.13

(Source: Data provided by MP Agro)

Thus, THR were not supplied to Projects during the years 2011-12 to 2015-16 on the basis of enrolled beneficiaries, which had impact on providing SN to infants and lactating mothers.

In the exit conference (October 2016), the Commissioner replied that the requirement of THR was generated on the basis of beneficiaries shown in the MPR of AWCs and accordingly monthly supply order was given to MP Agro. In case of saving of THR, the same was used in following month. That was a continuously running process. The number of beneficiaries shown in MPR was not fixed. There was no excess/short supply of THR.

The reply was not acceptable, as District Programme Officers and Project Officers had informed that they had received either excess or less quantity of THR than requisitioned in MPR.

- **Outdated THR found at Project level godown and AWCs**

As per order issued by Directorate (May 2014), THR must be distributed on First in First out (FIFO) basis. Physical verification of THR godown/AWCs was to be done monthly by the Project Officer/Sector Supervisor. THR of expiry date should never be distributed. THR must be utilised within three months from manufacturing date.

Outdated THR packets were found at Project/ AWCs level.

During the joint inspection on 31.03.2016 of THR godown of Jaora Urban Project of District Ratlam, Audit noticed that 2240 packets of THR

(manufacturing date 31.12.2015 Batch No. NK 188) were lying in the godown, which was received by Project Officer on 01.01.2016. On being pointed out, CDPO replied (April 2016) that THR had been distributed on 01.04.2016. Further, 250 packets of outdated THR were noticed in the joint inspection of eight AWCs[58] during March 2016 to July 2016.

Outdated THR found in Godown of Jaora Urban Project in Ratlam District (Date of Inspection 31.03.2016)

In the exit conference (October 2016), the Commissioner replied that THR found at Project office, Jaora, district Ratlam was distributed before expiry date. Due to late distribution, warning letter had been issued to Store Incharge and Supervisor. Regarding expired THR found at AWCs level, notice was issued to AWW and action for recovery of amount of expired THR was being taken.

2.3.9 Hot cooked food

Hot cooked food is prepared and provided by SHGs to the children in the age group of three years to six years at AWCs as per day to day menu prescribed by State Government.

2.3.9.1 Disruption in delivery of services

In 983 AWCs in 14 Project Offices of seven selected districts SN was not supplied by SHGs. The SN interruption ranged from one to 120 days.

As per the agreements between SHGs and the Project Officers, in cases of interruption in supply of cooked food at the AWCs, the Project Officers were empowered to impose penalties at prescribed rate and could also revoke the agreements and assign other SHGs to supply the items. Monitoring Committee was to be constituted at AWC, Block and District level for monitoring the implementation of SN.

Scrutiny of records of 983 AWCs in 14 Project Offices of seven selected districts[59] revealed that SN was not supplied by 606 SHGs to 37079 beneficiaries of these AWCs during various months in the year from 2011-12

[58] Alirajpur (Katthiwada-3, 11 packets, Mordha 15 packets), Dhar (Kunjda Khodrah of Nalchha project 62 packets), Panna (Lamtara 20 packets), Ratlam (AWCs Ward no. 13A, Parmilaganj, Alot Project 4 packets, Minipura in Jaora urban project 81 packets), Satna (Sonvari 10 of Maihar 01 project 17 packets) and Vidisha (Atarikheda 3 of Gyarashpur project 40 packets).

[59] Bhopal, Chhindwara, Dhar, Khargone, Panna, Rajgarh and Seoni.

to 2015-16, as detailed in ***Appendix 2.3.4.*** The SN interruption ranged from one to 120 days.

In the exit conference (October 2016), the Commissioner replied that inspection of AWCs were being conducted by departmental officers from time to time so that interruption of supplementary nutrition did not happen.

The reply was not acceptable, as respective CDPOs had accepted disruption in delivery of cooked food. Thus, the beneficiaries were deprived of the SN and the intended objective of ICDS was defeated. The following case studies present the cases of nutrition interruption.

Case Study 1: SN was not distributed at AWCs for two years

During inspection (March 2016) of Nevali AWC of Lateri Project in district Vidisha, it was noticed that cooked food was not given to 127 beneficiaries since last two years. In Unheli AWC of Sardarpur 1 Project in district Dhar, breakfast was not given to 96 beneficiaries from 2013-14 to 2015-16.

Audit observed that District Level Monitoring and Review Committee and Block Level Monitoring Committee were not functional in both districts as well as in their projects.

On being pointed out, CDPO, Sardarpur 1 project replied (April 2016) that action would be taken to get rid of discrepancies found at AWCs. In exit conference, the Commissioner replied that that action would be initiated in the case.

Case Study 2: SN was not distributed during summer vacation by *Sanjha Chulha*[60] in Satna District.

SN was not distributed during summer vacation in district Satna.

Audit scrutiny of the records/bills for payment of SN to SHGs of sampled Project Maihar-01, District Satna for the months of summer vacation (May of 2013, 2014 and 2015) revealed that SN was not supplied at 269 AWCs (43 *per cent*) out of 623 rural AWCs by SHGs under *Sanjha Chulha* during May 2013, May 2014 and May 2015.

DPO replied (May 2016) that notices were being issued to SHGs to ensure distribution of SN at AWCs and beneficiaries were distributed THR packets as an alternative arrangement.

In the exit conference (October 2016), the Commissioner replied that the Collector, Satna had issued a letter (June 2013) regarding regular distribution of supplementary nutrition under *Sanjha Chulha* in the summer vacation. Show cause notice had been issued to SHGs who did not supply SN at AWCs.

Reply was not acceptable, as no alternative arrangement was made to provide cooked food at AWCs during summer vacation.

2.3.9.2 Short allotment of food grains to SHG

District wise allotment of foodgrains under SNP was given by Directorate after receiving allocation from GOI. Further, project wise re-allocation of

[60] *Sanjha Chulha* is a scheme for serving hot cooked meal by SHGs to beneficiaries under MDM and SNP.

foodgrains was given by DPOs to CDPOs. Release Order (RO) was issued by Project officers to SHG for lifting of foodgrains from FPS. Cooked food was prepared and provided by SHGs to the beneficiaries of the children in the age group of three years to six years at AWCs level as per prescribed menu.

The lifting of food grains by SHG and quantity of food grains required on the basis of average number of beneficiaries actually benefitted under SNP during year 2011-12 and 2015-16, was as given in **Table 2.3.10**:

Table-2.3.10: Details of food grains required and distributed to SHG at State level

(Quantity in MT)

Year	Food grains required		Food grains allocated and distributed to SHG		Excess(+)/ Short(-) distributed to SHG	
	Wheat	Rice	Wheat	Rice	Wheat	Rice
2011-12*	77840.54	26719.88	78269.30	26124.00	428.76	-595.88
2012-13	96561.53	33179.76	80340.03	30692.90	-16221.50	-2486.86
2013-14	77225.94	26489.99	81697.57	30025.44	4471.63	3535.45
2014-15	75711.76	25954.96	71517.05	26000.87	-4194.71	45.91
2015-16	83359.98	28585.00	74443.75	24485.32	-8916.23	-4090.68
Total					-24432.05	-3592.06

(Source: Data provided by MPSCSC, * Data provided by Directorate)

There was a shortfall of 24432.05 MT wheat and 3592.06 MT rice in distribution to SHGs of all districts during year 2011-16.

Thus, there was a shortfall of 24432.05 MT wheat and 3592.06 MT rice in distribution to SHGs of all districts during year 2011-16. Due to shortage of food grains, distribution of SN to the beneficiaries as per prescribed menu and quantity could not be ensured.

In the exit conference (October 2016), the Commissioner replied that release order (RO) was issued to SHGs on the basis of wheat/rice required for SN. Lifting of food grains as per RO was made by SHGs from godown of MPSCSC and Fair Price Shop.

The reply was not acceptable, as physical verification of kitchen of SHGs revealed preparation of less quantity of SN against requirement of beneficiaries, as detailed in paragraph 2.3.9.5.

2.3.9.3 Engagements of cooks

As per para 5.3 of the guidelines issued (February 2014) by WCD, GOMP regarding providing SN at AWCs/Mini-AWCs, as far as possible, a separate cook for each AWC would be deployed by SHG, which would be paid ₹ 500 per month. Wherever it was not possible, cook of the Mid Day Meal Scheme (MDM) would be deployed. It would be the responsibility of cook to provide food regularly as per required quantity and quality.

- **Shortage of cooks**

Scrutiny of the records of three Districts (Chhindwara, Dhar and Rajgarh) revealed that only one cook had been deployed by SHG to provide breakfast and lunch under SNP to more than one AWCs and remuneration were paid at the rate of ₹ 500 per AWC per month for the number of AWCs. This resulted in irregular payment of ₹ 13.09 lakh on engagement of cooks, as detailed in **Table 2.3.11**:

Table-2.3.11: Details of number of cooks engaged by SHG for AWCs

Sl. No.	Name of District	Name of Project	Number of AWCs	Number of SHG engaged	Number of cook engaged	Period	Payment made to cook
1	Chhindwara	Jamai, Pandhurna Mohkhed, Ghansaur	2 to 10	1	1	June 2014 to October 2015	₹ 5.83 lakh
2	Dhar	Sardarpur 01	25	1	1	September 2014 to May 2015	₹ 1.12 lakh
3	Rajgarh	Khilchipur, Jirapur Sarangpur, Suthalia	2 to 7	1	1	November 2014 to October 2015	₹ 6.14 lakh

(Source: Data provided by districts)

In the exit conference (October 2016), the Commissioner replied that supplementary nutrition was being provided by a SHG to more than one AWC. Therefore, no irregular payment to cook was made.

The reply of the Commissioner was not acceptable, as separate cook for each AWC was required to be deployed by SHG.

- **Undue benefit given to SHG**

Under the scheme, the honorarium to cook would be deposited directly in his bank account by the DPO. During scrutiny of vouchers for payment of SN in Satna district, audit noticed that honorarium of the cook amounting to ₹ 1.67 crore was paid to 588 SHGs during June 2014 to March 2016.

Honorarium of the cook amounting to ₹ 1.67 crore was paid to 588 SHGs during June 2014 to March 2016 in district Satna, instead of depositing directly to his bank account.

In the exit conference (October 2016), the Commissioner replied that due to change of cooks frequently by SHG and the fact that the cooks did not have bank accounts, the honorarium amount was deposited in the bank accounts of the SHGs and honorarium was paid to cook by SHGs.

The reply was not acceptable, as payment of cook's honorarium to SHG was in violation of scheme guidelines. Further, no evidence in support of the fact SHGs had paid the honorarium to the cooks was furnished by the DPO. Fact also remains that without direct transfer of benefits of cooks to their bank accounts, charges of corruption and misappropriation cannot be ruled out.

2.3.9.4 Shortcomings in providing supplementary nutrition by AWCs

GOMP prescribed (October 2009 and February 2014) the menu for breakfast and lunch to be provided under SNP. This menu was to be displayed on display board at AWCs for awareness of public. AWCs were required to provide the utensils for preparation and distribution of SN. AWCs were also required to keep weighing scale to record the weight of children for providing additional meal to malnourished children. As per order issued (July 2015) by GOMP, *Panchnama* for distribution of SN was to be prepared at AWCs consisting of details of quantity of SN and date of distribution duly signed by AWW/AWH, one guardian, ASHA worker, representative of SHG, *Poshan Mitra, Poshan Sahyogini and Panch/Sarpanch*.

Shortcomings in providing supplementary nutrition by AWCs.

On scrutiny of information furnished by 420 selected AWCs, audit noticed that *Panchnamas* in 314 AWCs, Survey register in 15 AWCs, *Poshan Aahar* stock register in 47 AWCs, Monthly and Annual Abstract in 19 AWCs, growth chart in 63 AWCs, Inspection register in 38 and *Bhojan Patrak* in 302 AWC were not prepared.

During inspection of 210 AWCs out of 420 sampled AWCs, audit noticed the following deficiencies:

- On the inspection day, attendance register was not filled in 85 AWCs. Therefore, the number of beneficiaries which attended the AWC on the inspection day vis-à-vis total enrollments could not be ascertained in audit.
- SN was not distributed as per menu in 155 AWCs on the date of inspection. SN was not provided at 11 AWCs on the date of inspection.
- Utensils for distribution of cooked food were not found at 41 AWCs.
- Weighing scale was not found in 10 AWCs. Thus, physical growth/malnutrition of infant/ children could not be measured and recorded.
- Display board for menu in 95 AWCs was not available.
- Two AWCs (Miyapura, Nalchha project, District Dhar and Unida, Berasiya 01 project, District Bhopal) were found closed during the inspection.

In the exit conference (October 2016), the Commissioner replied that instructions had been given to concerned officials from time to time to ensure maintenance of services in prescribed register.

The reply was not acceptable, as the aforementioned shortcomings were noticed despite departmental instructions to Project Officers. Thus, the State Government failed to ensure compliance of its own instruction for providing SN to beneficiaries.

Case Study 3: **Acute shortfall in actual beneficiaries on the day of inspection of AWCs**

During joint inspection of 210 AWCs attendance of shortage of 60 *per cent* beneficiaries were found.

Attendance of children was found less than registered number at all inspected AWCs. During joint inspection of 210 AWCs, audit noticed that 3536 beneficiaries (40 *per cent*) were found present on the day of inspection against 8940 registered children in the age group of three years to six years. As informed by AWCs, the main reasons for lesser attendance were migration of parents, admission of children in schools, poor and less quality of SN, inadequate sitting space at AWC, AWC running at long distance and hot weather.

The shortfall of beneficiaries at inspected AWCs was quite large as compared to figures of shortfall provided by Department, District Programme Offices and Project Offices, which were 27.35 *per cent* of beneficiaries in the age group of three to six years at State level, 26.46 *per cent* at District level and 24.16 *per cent* at Project level during 2011-16.

In the exit conference (October 2016), the Commissioner replied that deficiencies were negligible on the basis of population of State. However, efforts would be made to get rid of shortfall.

The reply was not acceptable, as the data compiled for the number of actual beneficiaries of SNP was higher in test checked cases, which renders the possibility of misreporting and even absent children were being shown as receiving SN.

2.3.9.5 Joint Inspection of SHGs

As per guidelines (February 2014) of GOMP, *Bhojan Patrak* would be given to each SHG monthly, in which AWW would mention quantity and quality of meal at the time of receiving each meal and put her signature with date. As per para 8 of guidelines (October 2009) of GOMP, stock register of BPL wheat/rice/raw materials, cash book/bill vouchers was to be maintained by SHG. SN was to be prepared in kitchen shed.

During joint inspection of 57 SHGs, following shortcomings were noticed:

- Food was prepared in open space by eight SHGs because separate kitchen was not available at AWCs.
- Firewood was used by 50 SHGs for preparation of food instead of LPG stove on the ground of easy availability of firewood.
- SN food was not prepared as per menu by any of the SHGs.
- 54 SHG did not submit *Bhojan Patrak* to AWCs for entry of foods distributed by them. Further audit scrutiny revealed that bills of SHGs were accepted and paid without insisting on filled *Bhojan Patrak.*
- Stock register of food grains, cash book and bill voucher was not maintained by 52, 45 and 49 SHGs respectively.

The Project Officer stated that SHG was a small unit run by rural women, due to which these deficiencies were noticed.

The reply was not acceptable, the deficiencies noticed during the joint inspection were in violation of scheme guidelines and therefore, required to be addressed.

Food preparing by Saraswati SHG, Nunagar at unhygienic space infront of toilet room, Sector Shahnagar 1, District Panna.

SN prepared in temporary open shed by Ganesh SHG, Badnavar 1 project in District Dhar

Short preparation of SN against about 300 beneficiaries by Ganesh SHG, Badnavar 1 project in Dhar District

Temporary open Kitchen shed of Jai MaaVaisnav Devi SHG, Jaswadi, Project Khandava Rural in Khandawa District

In the exit conference (October 2016), the Commissioner replied that instructions had been issued to district officers and SHGs to address these deficiencies. However, efforts would be made to get rid of shortfall.

2.3.9.6 Registration of SHG under Food Safety and Standards Act

As envisaged under section 31(2) of Food Safety and Standards Act 2006 and as per circular (January 2014) of Food and Drug Administration, Madhya Pradesh, food providing institution was required to obtain registration from Food Department. In this regard, Commissioner, ICDS has also issued (July 2015) instructions to all Collectors of Madhya Pradesh to follow the guidelines.

Scrutiny of information received from 39 sampled projects revealed that 2319 (51 *per cent*) SHGs out of 4633 SHGs were not registered from the Department of Food and Drug Administration. Thus, Project Offices failed to ensure that SHGs engaged in providing supplementary nutrition at AWCs had mandatory registration under Food Safety and Standards Act 2006.

In the exit conference (October 2016), the Commissioner replied that action for registration of SHGs was completed by all districts.

The reply was not acceptable, as the verification of the reply of Department in DPO, Rewa (November 2016) revealed that only 10 SHGs out of 3343 SHGs was registered under Food Safety and Standards Act 2006.

2.3.9.7 Quality Assurance

Water used for cooking/drinking was not tested regularly for conforming to quality standards and regular testing of food was not done.

As per para 11 of Chapter 2 of the Operational Guidelines for Food Safety and Hygiene regarding food handling and safety measures for hot cooked meals under ICDS issued by GOI (December 2013), sample of food should be sent for laboratory testing at regular intervals. Water used for cooking/drinking should be regularly tested for conforming to drinking water quality standards as prescribed by the Ministry of Drinking Water and Sanitation.

Scrutiny of records in 42 test checked projects and 210 AWCs physically verified revealed that water used for cooking/drinking was not tested regularly for conforming to drinking water quality standards. Regular testing of food was not found at the 201 AWCs and sample of breakfast and lunch were not maintained at 140 AWCs out of 210 tests checked AWCs.

In the exit conference (October 2016), the Commissioner replied that as per norms of WCD, GOI, testing for quality of cooked food from laboratory was not necessary. There was a provision under *Sanjha Chulha* for testing of quantity and quality of cooked food by members of *Gram Sabha Tadartha Samiti* constituted at local level.

The reply was not acceptable, as the guidelines of ICDS specifically provided for testing of sample of cooked food from laboratory at regular intervals. Further, the provision under *Sanjha Chulha* for testing of quantity and quality of cooked food by members of *Gram Sabha Tadartha Samiti* constituted at local level was also not adhered to.

2.3.10 Infrastructure for project implementation

2.3.10.1 Inadequate manpower at State level

To operationalise the scheme effectively, adequate manpower was required. The position of sanctioned strength and men in position at State level are shown in **Table 2.3.12:**

Table-2.3.12: Position of sanctioned and Men in position at State level as of March 2016

Sl. No.	Name of Post	Sanctioned	Men-in-Position	Vacant
1	DPO	51	39	12
2	CDPO	453	334	119
3	Supervisor	3213	3125	88
4	AWW	92230	91279	951
5	AWH	80160	79021	1139

(Source: Data provided by Directorate)

Thus, there was a considerable shortage of supervisory staff as well as in the cadres of AWW/AWH, which affected the proper implementation of the SNP.

In the exit conference (October 2016), the Commissioner replied that proposal for filling of vacant post of DPO/CDPO and Supervisor was sent to Public Service Commission and *Vyapam* respectively. The provision for filling of vacant post of AWW/AWH before six month had been made by State Government.

2.3.10.2 Establishments of Inadequate Project Offices

According to GOI Guidelines (December 2008), for blocks with more than two lakh population, State could opt for more than one project (@ one per one lakh population) or could opt for one project only. In the latter case, staff could be suitably strengthened based on population or number of AWCs in the block. Similarly, for blocks with population of less than one lakh or so, staffing pattern of CDPO office could be less than that of a normal Block.

Directorate informed that 453 projects at State level were running against the requirement of 701 projects as of March 2016. However, population of five selected Projects[61] were more than 2 lakh so one additional project was to be established in each block.

In the exit conference (October 2016), the Commissioner replied that a proposal for sanction of new projects had been sent to GOI.

2.3.10.3 Shortage of AWCs on the basis of population

According to the revised population norms laid down by Government of India under ICDS (December 2008), one AWC was to be opened for 400-800

[61] Alot (Ratlam) 2.36 lakh, Gunnor (Panna) 2.34 lakh, Maihar 01 (Satna) 2.07 lakh, Nalchha (Dhar) 2.56 lakh and Pandhana (Khandawa) 2.60 lakh.

rural/urban population, thereafter in multiples of one AWC for population of 800.

Requirement of AWCs and Mini-AWCs at State level as per population as on March 2016 is given in **Table 2.3.13:**

Table-2.3.13: Details of requirement and shortage of AWCs and Mini-AWCs at State level

Sl. No.	Area	Anganwadi Centres			Mini-Anganwadi Centres		
		Requirement	Availability	Shortage	Requirement	Availability	Shortage
1	Urban	13067	8278	4789	422	205	217
2	Rural	56056	49098	6958	10580	7950	2630
3	Tribal	29641	22784	6857	4468	3915	553
		98764	80160	18604	15470	12070	3400

(Source: Data provided by Directorate)

There was shortage of AWCs and Mini-AWCs.

Thus, there was shortage of 18604 AWCs and 3400 Mini-AWCs in the State as of March 2016. The shortfall in AWCs had an increasing trend, which was 13226 (March 2012), 13764 (March 2013), 16130 (March 2014) and 17957 (March 2015). Due to shortage of AWCs/Mini-AWCs, the benefit of SN could not be provided adequately to intended beneficiaries.

Audit noticed that proposals for sanction of 1332 AWCs in 2010-11 and 8589 AWCs in 2012-13 were sent to GOI by the State Government. Out of those proposals, sanction for 4305 AWCs (November 2014) were received. However, these 4305 AWCs were not opened, as the approval from the Cabinet was not received.

As per data provided by Directorate (January 2017), out of total 61,755 villages/wards in the State, 11156 villages/wards covering 53.84 lakh population were without AWCs. The beneficiaries under ICDS had to travel one Kilometer (Km) in most of the areas, but in the area having sparse population density the distance was 1.5 to 3 Km to access AWCs. The status of villages/wards in the State during 2011-12 to 2013-14 was not available with the Department. Therefore, the improvement in the coverage of AWCs could not be ascertained in audit.

In the exit conference (October 2016), the Commissioner replied that sanction for 4,305 AWC and 600 Mini-AWC had been given and state government has initiated action for running of aforesaid sanctioned AWC/Mini-AWC. Commissioner further stated (January 2017) that there was no norms for opening AWCs on the basis of distance.

2.3.10.4 Slow Progress in construction of AWCs

Audit scrutiny revealed that 22,693 AWCs in the State were running in rented buildings, as detailed in **Table 2.3.14:**

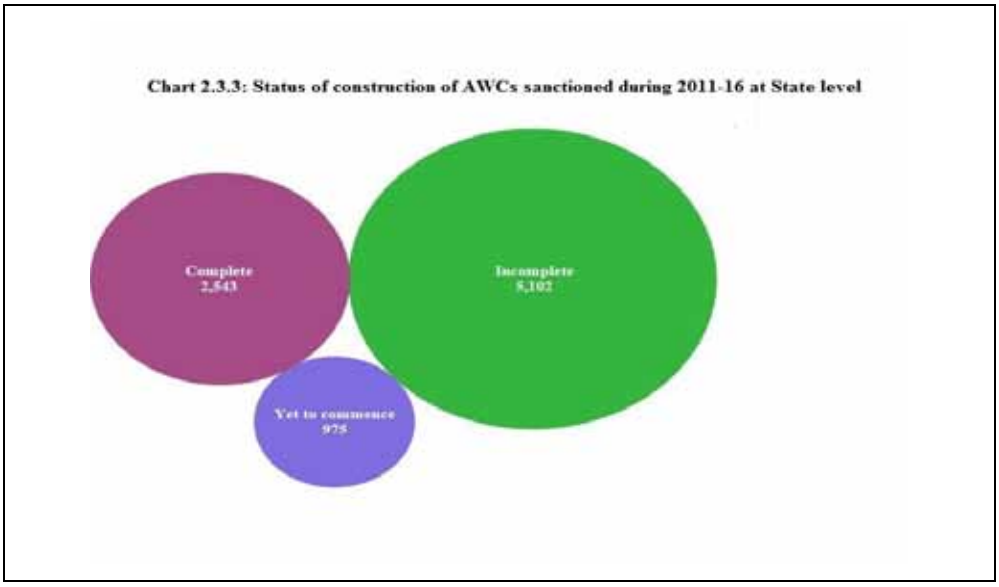
Table 2.3.14: Status of building where AWCs running

Sl. No.	Level	Departmental building	Rented building	Other government building
1	State	56146	22693	1321
2	Selected Districts	11467	9673	9221
3	Selected Projects	3519	3062	2587

(Source: Data provided by Directorate, Districts and Projects)

As per information given by Directorate, out of 11187 AWCs sanctioned before 2011-12, construction of 720 AWCs was incomplete, whereas construction of 489 AWCs was yet to be commenced as on March 2016 at the state level. Scheme wise and year wise details given in ***Appendix 2.3.5*.** However, construction work of 7286 AWCs for ₹ 450.79 crore was not executed. Construction was not completed even after the lapse of one to five years despite deposit of funds and lying with construction agencies.

The status of construction of AWC sanctioned during 2011-16 at the State level are listed in **Chart 2.3.3.**



(Source: Data provided by Directorate)

Further, 1608 AWCs were sanctioned for construction before 2011-12 in two districts[62], out of these 59 AWCs were incomplete. In seven districts[63], an amount of ₹ 56.73 crore was sanctioned for construction of 1578 AWCs, out of which 198 AWCs were incomplete and construction of 29 AWCs is yet to be commenced. An amount of ₹ 15.08 crore was lying unspent.

Audit observed that construction of 1291 AWCs, which was sanctioned during 2011-16 was incomplete and 101 AWCs were yet to commence. An amount of ₹ 116.91 crore remained unutilised with the agencies. Construction was not completed even after the lapse of one to five years despite deposit of funds. The details are given in ***Appendix 2.3.6.***

[62] Balaghat (sanctioned 963, incomplete 16) and Chhindwara (sanctioned 645, incomplete 43).

[63] Bhopal, Dhar, Indore, Khandwa, Khargone, Ratlam and Rajgarh.

The following pictures are showing the status of buildings of selected AWCs:

Kachcha building of Anganwadi Centre, Manaura 3 of Gyaraspur project in Vidisha.

Damaged condition of roof in Aganwadi Ward 7/2, Project Maihar 01, District Satna

Unhygienic surrounding of Aganwadi Centre Ward 6/2, Project Maihar 01, Satna

Cooked food was distributed in open space at AWC Mordha, Katthiwada Project, District Alirajpur

Construction of 5102 AWCs were incomplete and 975 AWCs were yet to be commenced out of 8620 AWCs buildings sanctioned during 2011-16.

In the exit conference (October 2016), the Commissioner replied that efforts would be made to get rid of shortage of amenities in AWCs. Further, replied that construction of AWCs sanctioned under various schemes was carried out by various executing agencies selected at the district level. The construction work was slow due to disputed land, site selection and delay in construction by the executing body. Out of construction of 11187 AWCs buildings sanctioned at State level before 2011-12, construction of 10111 AWCs was completed, 913 AWCs was incomplete and 163 was yet to be commenced. At district level, 1608 AWCs sanctioned before 2011-12, construction of 39 AWCs was incomplete in District Balaghat and Chhindwara. Construction of 8477 AWCs buildings sanctioned during 2011-12 to 2015-16, out of which, 4509 AWCs were incomplete and 471 AWCs were yet to be commenced.

2.3.10.5 Deficient infrastructure facilities at AWCs

As per prescribed GOI norms (March 2011), an AWC was to provide basic facilities like sitting room, a separate room for a kitchen, a store room for storing food items, child friendly toilet, separate space for children to play indoor and outdoor games and safe drinking water facilities. The minimum requirements of covered area of not less than 600 sq. feet was also prescribed for an AWC.

Scrutiny of information provided by 42 test checked CDPOs in respect of 9192 AWCs revealed that AWCs were located in structures with very small spaces with no drinking water facilities in 693 AWCs, no toilets for children in 2734 AWCs, no indoor space for playing in 1457 AWCs, insufficient place for children and women to sit in 770 AWCs and no separate kitchen in 4447 AWCs.

Good Practice: AWC Bhojpura at Bairasiya 01 Project, District Bhopal was found with adequate space to play for children and all other facilities for children

Further, the joint physical verification (March to July 2016) of 210 AWCs of 42 projects in 14 selected districts revealed that:

- Adequate space for playing was not available in 75 AWCs;
- Kitchens were not found in 141 AWCs;
- A store room for storing food items was not found in 66 AWCs;
- Toilets were not found in 88 AWCs;
- Safe drinking water facility was not found in 70 AWCs.

In the exit conference (October 2016), the Commissioner replied that co-ordination with various departments was being made to provide basic amenities at AWCs.

2.3.11 Growth Monitoring and Nutrition Status of Children

Atal Bihari Vajpayee Bal Arogya and *Poshan Mission* (ABM) scheme run by the State Government with the objective to reduce the incidence of mortality and malnutrition as well as to improve the nutritional and health status of children under five years of group. The achievements of ABM as reflected from National Family Health Survey (NFHS)-3 (2005-06) and NFHS-4 (2015-16) was as shown in the **Table 2.3.15:**

State could not achieve target for reducing severely malnourished children from 12.6 *per cent* to 5 *per* cent, even after distribution of third meals to underweight children.

Table-2.3.15: Details of Target of ABM and achievement

Sl. No.	Indicators	Target fixed under ABM by year 2015	Achievement as per NFHS-3 report (2005-06)	Achievement as per NFHS-4 report (2015-16)
1	Under-5 mortality rate	From 94.2 to 60 deaths per 1000 live births	93 deaths per 1000 live births	65 deaths per 1000 live births
2	Percentage of underweight children	From 60 *per cent* to 40 *per cent*	60 *per cent*	42.8 *per cent*
3	Severely malnourished children	from 12.6 *per cent* to 5 *per cent*	12.6 *per cent*	9.2 *per cent*

(Source: ABM guidelines, NFHS-4 report)

Thus, State could not achieve target for reducing severely malnourished children from 12.6 *per cent* to 5 *per cent*, even after distribution of third meals

to underweight children. Similarly, State was lagging behind the targets set for reducing percentage of underweight children and under-5 mortality rate. The shortfall in achievement may be attributed to shortfall in providing SN and lackadaisical approach of AWCs as they were not monitoring growth of children, as detailed in paragraph 2.3.9.4.

In the exit conference (October 2016), the Commissioner replied that status of malnutrition was improving through ABM and continuous efforts was also being made.

2.3.12 Internal Control Mechanism

2.3.12.1 Integrated Child Development Scheme Mission

ICDS Mission was not constituted.

As per GOI guidelines, State ICDS Mission headed by the Chief Minister of the concerned State would be responsible for overseeing child development and nutrition system, consideration of policy matters related to child development and nutrition. The State ICDS Mission would meet at least once in every six months. Every district would have a District ICDS Mission headed by the District Collector of the concerned district.

Audit scrutiny revealed that ICDS Mission was not constituted at State level as well as District level.

In the exit conference (October 2016), the Commissioner replied that as per decision taken by State Government, committee constituted previously under ABM was to be re-established in place of constitution of ICDS Mission. The further action was under process.

Reply was not acceptable, as ICDS Mission was yet to be constituted for implementation of ICDS Programme.

2.3.12.2 Social Audit

As per provision given in guidelines of WCD, GOMP (October 2009), Social Audit of the work of SHG for providing SN would be conducted according to the procedure prescribed for MDM by Panchayat and Rural Development Department.

Social audit was not conducted during 2011-16.

Audit observed that no Social Audit of SHG for SNP was conducted during the period from 2011-12 to 2015-16 in 42 projects of 14 sampled districts.

In the exit conference (October 2016), the Commissioner replied that action for social audit was to be taken by Panchayat and Rural Development Department. A provision for preparation of *Panchnama* during distribution of supplementary nutrition by SHGs was made.

The reply of the Commissioner leads to the conclusion that in the absence of social audit, the participation of the community could not be ensured. Further, *Panchnama* was not prepared at 314 AWCs out of 420 test checked AWCs.

2.3.12.3 Monitoring and Supervision

As per GOI circular (October 2010), the monitoring and supervision schedule stipulated in **Table 2.3.16** was to be ensured for effectiveness in the delivery of services in ICDS.

Table 2.3.16: Details of schedules of Monitoring and Supervision.

Sl. No.	Category of official	Schedule/ proposed requirement
1.	District Programme Officer	All blocks to be covered per quarter. At least three AWCs during each block to be visited to ensure 10 *per cent* AWC coverage in a year equally spreading them across the year.
2.	Child Development Project Officer	At least 20 AWCs per month on a rotational basis and to ensure coverage of 100 *per cent* AWCs in a year.
3.	Supervisors	A minimum of 50 *per cent* of AWCs under the Supervisor's jurisdiction every month.

In selected districts and 40 projects, details of visits made by DPOs to projects and AWCs and by CDPOs and supervisors to AWCs within their jurisdiction to monitor their operations are given in **Table 2.3.17**. However, two projects offices (Lateri and Gyaraspur of district Vidisha) did not furnish the requisite information.

Table 2.3.17: Details of visits by DPOs/CDPOs/Supervisors

Sl. No.	ICDS Officials	Number of Visits of Projects			Number of Visit of AWCs		
		Target[64]	Achievement*	Shortfall	Target	Achievement*	Shortfall
1	DPOs	2724	736	1988 (72.98 *per cent*)	13342	5504	7838 (58.75 *per cent*)
2	CDPOs	--	--	--	43437	19351	24086 (55.45 *per cent)*
3	Supervisors	--	--	--	256476	130818	125658 (48.99 *per cent*)

(Source: *Data provided by Districts/Projects)

DPOs, CDPOs and Supervisors had not undertaken supervision of SNP as per their targets.

As evident from the above table, DPOs, CDPOs and Supervisors had not undertaken supervision of SNP as per their targets.

In the exit conference (October 2016), the Commissioner replied regular inspection of AWCs were conducted by officials of division, district, project and sector of department, for which, monitoring was done through online Management Information System. Further, shortage of inspection was due to work load. The inspection of AWCs/projects was conducted by all competent officers as per roster and oral instructions were issued on the spot for deficiency.

The reply was not acceptable, as the information provided by DPOs and CDPOs indicated shortfall ranging from 49 *per cent* to 73 *per cent* in supervision.

2.3.12.4 Monitoring and Review Committee at various levels

As per GOI Circular (March 2011), Monitoring and Review Committees at various levels were to be constituted (as detailed in **Table 2.3.18**) in the context of universalisation of ICDS with focus on improved quality in delivery of services. The committee would monitor and review the issues related with

[64] Target (DPO – All blocks to be covered per quarter. At least 3 AWCs during each block to be visited to ensure 10 *per cent* AWC coverage in a year, CDPO – 100 *per cent* in a year, Supervisors –A minimum of 50 *per cent* of AWCs under the Supervisors jurisdiction every month).

the overall progress and universalisation of ICDS, convergence with other departments, improving the AWC infrastructure, use of Information, Education and Communication (IEC) in the State.

Table 2.3.18: Details of Monitoring and Review Committee

Sl. No.	Level	Name of Committee	Chairperson	Meeting to be held
1	State	State Level Monitoring and Review Committee (SLMRC)	Chief Secretary	Once in Six month
2	District	District Level Monitoring and Review Committee (DLMRC)	District Magistrate/ Collector	Once in a quarter
3	Block	Block Level Monitoring Committee (BLMC)	Sub Divisional Magistrate	Once in a quarter

(Source: GOI Guidelines March 2011)

Meeting of State Level Monitoring and Review Committee was not held.

Audit observed that the State Government had constituted SLMRC. However, meeting of SLMRC was not held during 2011-12 to 2015-16. Further, DLMRC had been constituted only in one District (Balaghat) out of 14 selected Districts, where only two meetings were held during 2015-16. However, district Alirajpur did not provide the information.

Out of the covered 42 projects of 14 selected districts, BLMC had been formed in nine Projects[65] of five Districts. However, no meeting of BLMC was held except in Phanda (Bhopal). BLMC was not constituted in 33 projects and meetings were not held.

In the exit conference (October 2016), the Commissioner replied that meetings of SLMRC was not conducted. Departmental schemes were reviewed through other committees constituted at State level under chairmanship of Chief Secretary. Monitoring and Review Committee at District, Block and AWC levels had been constituted in all Districts of State and meetings were conducted regularly. Instructions had been issued to the concerned District Collectors where meeting were not being conducted.

The reply was not acceptable, as DLMRC and BLMC were not constituted and meetings were not held regularly in test checked districts and projects.

2.3.13 Conclusion

- SNP was to be extended to all children upto the age of six years and all pregnant and lactating mothers. During 2011-16, 20.94 lakh registered children of the age group of six months to three years, 57.02 lakh registered children of age group of three years to six years and 7.99 lakh registered pregnant and lactating mothers were not provided SN. The shortfall was due to deficient infrastructure at AWCs, preparation of less quantity of SN or at times no supply of SN and long distances of AWCs, which acted as disincentives to enrolled beneficiaries affecting their attendance at AWCs.

[65] Bhopal (Phanda in 2012-13), Chhindwara (Jamai 2 in 2015-16, Pandhurna in 2015-16, Chindwara Rural in 2014-15), Dhar (Badnawar-1 in 2012-13 and Nalchha in 2015-16), Indore (Indore Rural 01 and Urban 07 in 2012-13) and Khargone (Sanawad in 2015-16).

- There was shortage of 18604 AWCs and 3400 Mini-AWCs in the State as of March 2016 as per population norms laid down by Government of India. Out of total 61755 villages/wards in the State, 11156 villages/wards covering 53.84 lakh population were without AWCs. State Government did not open 4305 AWCs, though these AWCs were sanctioned by GoI in November 2014.

- DPOs did not adhere to Central Issue Price (CIP) of wheat and rice and payments were made to MPSCSC at higher rates. This resulted in excess payment of ₹ 40.87 crore to MPSCSC during 2012-13 to 2014-15. Further, unreconciled advance of ₹ 13.81 crore was lying with MPSCSC on account of short lifted food grains by DPOs. Department did not reconcile the reasons for excess utilised food grains by MP Agro, which resulted in undue financial benefits of ₹ 15.57 crore to MP Agro. DPOs irregularly paid ₹1.67 crore to SHGs towards honorarium to cooks instead of paying it directly in the accounts of cooks. Without direct transfer of benefits of cooks to their bank accounts, charges of corruption could not be ruled out.

- In 14 test-checked Project Offices, SN was not supplied during various months (ranged from one day to 120 days) during 2011-12 to 2015-16 in 983 AWCs having 37079 registered beneficiaries. There was a shortfall of 24432.05 MT wheat and 3592.06 MT rice in distribution to SHGs engaged in preparation of cooked meal during year 2011-16, which affected the distribution of cooked meal to beneficiaries.

- As per National Family Health Survey (2015-16), there were 9.2 *per cent* of severely malnourished children in the State. Thus, State could not achieve target for reducing severely malnourished children from 12.6 *per cent* to 5 *per cent*. Similarly, State was lagging behind the targets set for reducing percentage of underweight children and under-5 mortality rate.

- Meeting of State Level Monitoring and Review Committee was not held. Monitoring and Review Committee was not constituted at District and Block level for proper monitoring and supervision.

2.3.14 Recommendations

- *Reconciliation of allotment and lifting of food grains, and its payments should be made periodically.*
- *Efforts should be made to cover all beneficiaries under SNP. Link the beneficiaries with Aadhar Card etc. so that they can be tracked.*
- *The Government should closely monitor the progress of construction of AWCs buildings so as to ensure availability of good quality buildings for the AWCs, fulfilling the prescribed standards for infrastructure and efforts should be made to provide basic amenities like safe drinking water, toilets etc., in all AWCs to ensure healthy environment to the beneficiaries.*
- *ICDS Mission should be constituted for proper and smooth running of scheme.*
- *Inspection of AWCs by DPOs/CDPOs/ Supervisors as prescribed should be ensured for effective implementation of the scheme.*

Government stated that it would endeavor to implement these recommendations.