Chapter-II
Performance Audit

This Chapter presents the Performance Audits of 'National Rural Health Mission' and 'Implementation of Right of Children to Free and Compulsory Education Act, 2009'.

Department of Medical, Health and Family Welfare

2.1 National Rural Health Mission

Executive summary

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005 throughout the country with special focus on 18 states including Rajasthan. The Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to poor and the vulnerable section of the population.

The Department did not follow the "Bottom up approach" for planning in accordance with the NRHM framework. Baseline Survey comprising Household Survey and Annual Facility Survey was not conducted during 2011-16. Annual State Programme Implementation Plans were submitted with delays and consequently approvals of GoI were also delayed, resulting in cascading delays in the implementation of the programme at various levels.

State Government could not provide all the basic infrastructural facilities in 75.77 *per cent* of Rural Health Centres. Health Centres were constructed at inaccessible and uninhabited locations and contracts for construction of buildings were awarded to contractors without ensuring the availability of land. Emphasis on providing all essential equipment in Rural Health Centres was not given as they had more shortages of essential equipment as compared to District Hospitals. Furthermore, equipment were lying unutilised in the Health Centres due to non-availability of trained staff to operate them. There were shortages in the availability of essential drugs particularly at CHCs and PHCs.

There was 62.93 *per cent* shortage of manpower in Health Centres located in rural areas while District Hospitals catering mostly the urban population had to excess manpower of 35.46 *per cent*. The gap in availability of manpower was not even filled up with engagement of medical and para medical manpower on contractual basis.

The percentage of women registered in first trimester of the pregnancy, increased from 46.59 *per cent* to 60 *per cent* during 2011-16, yet 26.93 *per cent* to 31.02 *per cent* pregnant women did not get all three mandatory checkups. Only 67.77 *per cent* pregnant women were given IFA tablets inspite

of widely prevalent anaemia in the State. Further, 26.23 to 34.15 *per cent* newborns delivered at home were not visited by the doctors/ANMs/Nurses within 24 hours of delivery.

There was low coverage in administering vaccines viz. Measles, OPV booster, DPT booster and TT 10/16 to infants (0 to 1 year) and children (1 to 16 years). The achievement against the target of sterilisation was only 54.48 *per cent* and the involvement of men in the family planning process continued to be abysmally low.

Though the State Government projected the requirement of ₹ 8,645.98 crore during 2011-16, ₹ 6,762.38 crore (78.21 *per cent*) were released to State Health Society, who utilised only ₹ 6,494.75 crore (75.11 *per cent*) of the funds. Huge unadjusted advances were outstanding against Rajasthan Medical Services Corporation Limited, State Institute of Health and Family Welfare, Blocks, CHCs and PHCs.

State Health Mission did not hold any meeting during 2011-16 and only two meetings (against stipulated seven) of Governing Body were held, which pointed to weaknesses in the apex monitoring process. Further at the district level, only 14 *per cent* of the prescribed meetings of District Health Mission could be held.

The State continues to lag behind the All India Averages and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th (out of 20) in Total Fertility Rate.

2.1.1 Introduction

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005 throughout the country with special focus on 18 states including Rajasthan. The Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to the poor and the vulnerable section of the population. Period for first phase of the NRHM programme was 2005-06 to 2011-12 and the programme was extended for second phase from 2012-13 to 2016-17.

2.1.2 Organisational set up

The NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The Governing Body (GB) of the State Health Society (SHS) is headed by the Chief Secretary of the State. Its Executive Committee (EC) is headed by the Principal Secretary, Medical and Health Department. A State Programme Management Support Unit (SPMSU) headed by the Mission Director, acts as the secretariat to SHS.

At the district level, every district has a District Health Society (DHS) headed by District Collector and its Executive Committee is headed by the Chief Medical and Health Officer (CMHO). District Hospitals (DHs) at the district level, Community Health Centres (CHCs) at block level, Primary Health

Centres (PHCs) and Sub Centres (SCs) at village level deliver healthcare services to the community.

During 2011-16, the GoI approved State Programme Implementation Plans (PIPs) for ₹ 8,645.98 crore under NRHM, against which ₹ 6,762.38 crore[1] was released and ₹ 6,494.75 crore was utilised in the State.

2.1.3 Objectives of the Programme

The main objectives of the Mission were as under:

- Reduction in child and maternal mortality;
- Universal access to public healthcare services with emphasis on services addressing women's and children's health and universal immunisation;
- Prevention and control of communicable and non-communicable diseases including local endemic diseases;
- Access to integrated comprehensive primary healthcare;
- Population stabilisation, gender and demographic balances;
- Revitalize local health tradition and mainstream AYUSH; and
- Promotion of healthy lifestyles.

2.1.4 Audit Objective

The objectives of Performance Audit were to assess the:

(i) Efficacy of planning in achievement of the objectives of NRHM;

(ii) Availability of adequate physical infrastructure and equipment to meet the requirements of beneficiaries;

(iii) Availability of healthcare professionals as per requirement of the norms;

(iv) Extent and quality of healthcare services provided and impact of NRHM on reducing Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate;

(v) Existence of prudent financial management; and

(vi) Adequacy of the monitoring mechanism.

2.1.5 Audit criteria

The criteria used for the assessment of performance included:

- NRHM Framework for Implementation 2005-12 and 2012-17;
- Operational Guidelines for Financial Management;

1 GoI share: ₹ 4,948.61 crore and State Government share: ₹ 1,813.77 crore.

- Indian Public Health Standards 2012 for Sub Centres, Primary Health Centres, Community Health Centres, Sub-Division Hospitals and District Hospitals;
- Operational Guidelines for Quality Assurance in Public Health Facilities 2013; and
- Audited Annual Financial Statements of SHS.

2.1.6 Scope and methodology

The Performance Audit was carried out during April-July 2016, covering the period 2011-16. The selection of healthcare centres was made at District, Block and Village levels by *'Simple Random Sampling without Replacement'* method.

Seven District Health Societies (DHS) were selected from 28 rural districts[2] along with seven District Hospitals[3] (DHs) and two blocks in each district[4]. Further, 15 CHCs and one Sub Division Hospital (SDH) were selected in these blocks. Two PHCs (making a total of 30 PHCs) under each CHC and three SCs (making a total of 88 SCs[5]) under each PHC were also selected.

Test check of records of the Mission Directorate was also carried out. Apart from examination of documents, joint physical inspections, interview of the beneficiaries and cross verifications of records at various levels were also undertaken.

An Entry Conference was held with Principal Secretary, Medical and Health Department along with Mission Director on 11 April 2016. Audit Findings and the Audit Recommendations were also discussed with Principal Secretary in the Exit Conference held on 15 November 2016.

2.1.7 Audit Findings

Efficacy of planning

Audit Objective 1: To assess the efficacy of planning in achievement of the objectives of NRHM

2.1.7.1 Planning

NRHM adopts a *"bottom up approach"* for planning. As per paragraphs 78 to 80 of the NRHM framework, the process begins at the village level with the preparation of a "Village Health Action Plan" (VHAP). Village Health Sanitation and Nutrition Committee, which includes an Accredited Social Health Activist (ASHA) and an *Anganwari* Worker plays the critical role of recording people's needs and is also responsible for preparation of VHAP

2 The districts having at least 70 *per cent* rural population were classified as rural.
3 Dausa, Jalore, Jhalawar, Nagaur, Pratapgarh, Rajsamand and Sirohi.
4 Except Nagaur, where three blocks were selected.
5 There is only one SC under PHC Diver (District-Rajsamand).

through consultation. Thereafter a "Block Health Action Plan" (BHAP) is prepared at the Block level based on inputs from the VHAP and after discussions with the implementing units. BHAPs are then aggregated to form an integrated "District Health Action Plan" (DHAP). DHAPs of all districts are compiled and aggregated at the State level for framing the State "Program Implementation Plan" (PIP). Funds under NRHM are allocated activity wise by GoI to the State as per approved State PIP.

2.1.7.2 Baseline Survey

As per paragraph 81 of the NRHM framework, a Baseline Survey consisting of a Household Survey[6] and a facility survey[7] was required to be undertaken by DHS to enable comprehensive district planning. This survey when repeated after a gap would provide the details of improvement which came about due to the investment made under the Mission.

It was observed that household survey and annual facility survey were not conducted in the State during 2011-16 as per NRHM framework. The State Government stated (November 2016) that Household Surveys were conducted in the form of Annual Eligible Couple Surveys by the Auxiliary Nurse Midwives (ANM) and data was compiled in the Reproductive and Child Health Register. Regarding facility survey it was stated that district PIPs were prepared after gap analysis of infrastructure, human resources and equipment within the district.

The reply was not convincing as Annual Eligible Couple survey could not substitute the Household Survey as it was deficient in vital information like complete details of the family members in the household, their economic status, health status and lifestyle.

Further, it was noticed that no document/survey report regarding gap analysis in the facilities, was made available to substantiate the reply by any of the test checked units. Furthermore, the practice adopted by the Department for the survey was also not in consonance with the NRHM framework. In the absence of this, the detailed impact of NRHM on improvements in healthcare in households and health facilities could not be assessed.

2.1.7.3 Village and Block level Health Action Plan

Scrutiny of records of test checked districts revealed that Village Health Action Plans (VHAPs) and Block Health Action Plans (BHAPs) were not prepared by the competent authorities during 2011-16. In the absence of inputs[8] from VHAPs, a village level health mapping exercise could not be done. BHAPs could also not be consolidated on the basis of these VHAPs.

6 Household Survey consists of details of the family members, details of economic status, details of health status and lifestyle etc., of households.

7 Facility Survey consists of details of nearby health centres, hospitals, investigation facilities and medical professionals etc.

8 Inputs like number of households, access to drinking water sources, status of household and village sanitation, nearest health facility for primary healthcare, emergency obstetric care and morbidity pattern.

Finally the DHAPs were made without collecting information flowing from VHAPs and BHAPs. This resulted in district level planning being done without involvement of the beneficiaries at the village and block levels. Further, the very purpose of a *"bottom up approach"* of planning was defeated.

State Government stated (November 2016) that annual PIPs were prepared after incorporating requirements of equipment, civil works and human resources through orientations/discussions with the district and block teams. Further on the basis of gap analysis exercise at block and village level, the state PIP was compiled and finalised at the State level after analysis and discussed several times.

The reply needs to be viewed in the light of the fact that the practice adopted by the department was not in accordance with NRHM framework. Further, no document was made available to verify that all requirements which emanated from the village/block level had been incorporated in the overall plans.

2.1.7.4 Programme Implementation Plan/Perspective Plan

As per paragraph 2.4.4 of the Operational Guideline for Financial Management of NRHM, the DHAPs were to be reviewed in detail at the State level and finalised through extensive meetings and discussions with the district authorities. The requirements for all the districts are combined with the State level budgetary requirements to form a State Programme Implementation Plan (PIP). This annual State PIP helps the State in identifying and quantifying the targets required for programme implementation for the proposed year.

The State PIP is required to be submitted to Ministry of Health and Family Welfare, GoI for approval.

It was observed that all the PIPs submitted by the State during 2011-16 to GoI were delayed ranging from 14 to 143 days, which in turn delayed the approval of GoI to the annual PIPs. This resulted in cascading delays of 56 to 193 days in the implementation of the programme and underutilisation of available funds at various levels.

State Government stated (November 2016) that the delay in submission of PIPs occurred due to changes in the guidelines and schedule of submission of State PIP to GoI every year and it was further assured to follow the '*bottom up approach*' in future.

The reply was not convincing as planning is a regular and time bound process to incorporate requirements and make budgetary projections for the coming year. Therefore, the process needed to be started well in advance so that all procedural requirements could be accommodated before finalisation of PIPs.

It was observed that an amount of ₹ 206.97 crore was allotted to the SHS as per approved PIPs of the State during 2012-16 for organising 157 healthcare activities under NRHM. SHS however, did not carry out any of the projected activities during 2012-16. This indicates that the provisions were made in the PIPs without ascertaining the necessities.

It was further observed that perspective plan to outline the year-wise resource and activity needs of the district as required under the NRHM framework was not prepared at both District and State level in phase-I and phase-II.

State Government, while accepting the facts, stated (November 2016) that perspective plans were not prepared on the assumption that district level health action plans and perspective plans were the same.

The reply was not convincing as the perspective plan was required to be prepared for the Mission period as per the NRHM framework, which was not done.

Planning

Household Survey and annual facility survey were not conducted in the State during 2011-16. The Department did not follow the "Bottom up approach" for preparing District Level Health Plans in accordance with the requirements of the NRHM framework. Annual State Programme Implementation Plans were submitted with delays and consequently approvals of GoI were also delayed. This resulted in the cascading delays in the implementation of the programme at various levels. Perspective plans were not prepared at both District and State level for the period 2005-12 and 2012-17.

Recommendations:

1. *Baseline survey including Household Survey and Annual Facility Survey should be conducted by the State Health Mission for assessment of improvement in the available healthcare facilities.*

2. *Perspective plan should be prepared to outline the year wise resource and activity needs of the district. State Government should follow the "Bottom up approach" while preparing District Level Health Plans as outlined in the NRHM framework to ascertain the actual requirements of the rural population.*

2.1.8 Infrastructure and equipment

Audit Objective 2: To assess the availability of adequate physical infrastructure and equipment to meet the requirement of beneficiaries.

2.1.8.1 Physical Infrastructure

NRHM aimed to bridge the gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revitalisation of the existing physical infrastructure such as health centres and new constructions or renovation wherever required.

GoI prescribed (January-February 2007) a set of uniform Indian Public Health (IPH) Standards for planning and upgradation of public healthcare infrastructure (like SCs, PHCs, CHCs, Sub-Divisonal Hospitals and District

Hospitals) in the country. The NRHM framework for implementation, further provided that upgradation of public healthcare infrastructure to the IPH Standards would be one of the core objectives of NRHM.

The Civil construction wing was set up by the State Government for constructions and renovation of health infrastructure facilities under NRHM and it functions under the Mission Director. There was overall projection of ₹ 1417.06 crore during 2011-16 as per approved PIPs for construction and renovation of health infrastructure facilities. During 2011-16, against allocation of ₹ 1107.22 crore, ₹ 892.85 crore was released out of which expenditure of ₹ 888.88 crore (99.55 *per cent*) was incurred.

Instances of creation of lesser number of facilities in tribal areas than the norms, delayed/non-completion of construction works, construction of facilities in remote and unpopulated areas and non-utilisation of infrastructure were noticed during test check, which are discussed in succeeding paragraphs:

2.1.8.2 Availability of Health Centres against IPH Standards

The position of requirement of health infrastructure facilities, as per IPH Standards for rural population and their availability as on 31 March 2016, is given in **Table 2.1**.

Table 2.1

(Position as on 31 March 2016)

Health Infrastructure Facilities	Number of Health Infrastructure Facilities								
	CHCs			PHCs			SCs		
	Non- Tribal Areas	Tribal Areas	Total	Non- Tribal Areas	Tribal Areas	Total	Non- Tribal Areas	Tribal Areas	Total
Requirement as per IPH Standards[9]	384	67	451	1,536	269	1,805	9,220	1,795	11,015
Availability	512	59	571	1,899	181	2,080	12,971	1,437	14,408
Excess(+)/ Shortage(-) (*Per cent*)	(+)128 (33.33)	(-)8 (11.94)	(+)120 (26.60)	(+)363 (23.63)	(-)88 (32.71)	(+)275 (15.24)	(+)3,751 (40.68)	(-)358 (19.94)	(+)3,393 (30.80)

Source: Census 2011.

From the above table, it is seen that as per IPH Standards, the non-tribal areas had excess health facilities, whereas there were deficiencies of eight CHCs (11.94 *per cent*), 88 PHCs (32.71 *per cent*) and 358 SCs (19.94 *per cent*) in tribal areas. Further, two test checked districts (Pratapgarh and Sirohi) had deficiency of one CHC, 14 PHCs and 53 SCs in tribal areas[10]. This indicated that emphasis was not given on establishment of health facilities in the tribal areas.

State Government stated (November 2016) that the IPH Standards are general and not practical to follow in the State of large geographical area and diversity like Rajasthan.

9 The total rural population of Rajasthan was 5,15,00,352 (Non-Tribal Area: 4,61,07,191 (89.53 *per cent*) and Tribal Area: 53,93,161 (10.47 *per cent*). The requirement is based on district-wise rural population as per Census 2011.

10 Pratapgarh has four tribal blocks (Arnod, Dhariawad, Pipalkhunt and Pratapgarh) and Sirohi has one tribal block (Abu Road).

The reply was not convincing as there were inequities in the availability of health infrastructure facilities in tribal areas as compared to non tribal areas. Further, as regards applicability of IPH Standards, SHS confirmed (September 2016) that the IPH Standards were adopted for implementation of the programme.

2.1.8.3 Location of Health Centre

IPH Standards provided that health centres should be centrally located and easily accessible to people and connected with all weather motorable approach road. Further, GoI while approving PIP for the State, also endorsed (June 2011) the construction of new health facility at a place, accessible to people to avail healthcare services in time and discouraged construction in remote and unpopulated areas. It was, however, observed that many health centres were either constructed in remote or unpopulated areas as discussed below:

- IPH Standards provided that a person should have access to a SC within 30 minutes (three kilometres) walking distance. It was, however, observed that 48 SCs (54.54 *per cent*) out of 88 test checked SCs were located beyond 30 minutes walking distance from the remotest village. Further, 56 SCs (63.63 *per cent*) were not accessible by public transport.

- IPH Standards also provided that a PHC should be centrally located in an easily accessible area and have facility of all weather road communication. It was, however, observed that out of 30 test checked PHCs, three PHCs[11] were located at a distance of more than 30 kilometres (kms) from the remotest village and five PHCs[12] were not accessible by all weather roads whereas, other five PHCs[13] were not accessible by public transport.

- IPH Standards further provided that a CHC should be located at a distance of less than two hours travel time from the farthest village. It was, however, observed that out of 15 test checked CHCs, four CHCs[14] were located at a distance of more than 30 kms from the farthest village.

2.1.8.4 Deficiencies in infrastructure in Health Centres

As per IPH Standards, health centres should have their own building with boundary wall, gate, electricity and water supply. They should also be far away from garbage dumps, cattle shed, water logging area etc., and should have adequate manpower, medical departments, wards, beds, laboratories and equipment.

Scrutiny of information provided by the Mission Director, NRHM revealed that 11,268 (78.20 *per cent* of total 14,408) SCs, 1,320 (63.46 *per cent* of total

11 PHC Deldar(Sirohi): 50 kms; PHC Durgapura (Jhalawar):45 kms and PHC Tantwas (Nagaur): 35 kms.

12 PHC Khinyala and Makodi (Nagaur), PHC Chupana and Salamgarh (Pratapgarh) and PHC Sakroda (Rajsamand).

13 PHC Baant (Sirohi), PHC Durgapura (Jhalawar), PHC Makodi (Nagaur), PHC Mohi (Rajsamand) and PHC Punasa (Jalore).

14 CHC Bandikui (Dausa): 35 kms; CHC Bhim (Rajsamand): 60 kms; CHC Bhinmal (Jalore): 64 kms and CHC Nawacity (Nagaur): 40 kms.

2,080) PHCs and 338 (59.19 *per cent* of total 571) CHCs did not have infrastructural facilities[15] as prescribed in IPH standards, as of 31 March 2016.

Similar deficiencies were also noticed in health centres falling under test checked districts which are discussed in succeeding paragraph 2.1.8.7 (equipment deficiencies), paragraph 2.1.9.1 (shortage of manpower) and paragraph 2.1.10.4 (essential drugs deficiencies). Despite emphasis of GoI on providing adequate infrastructural facilities in all rural health centres (CHCs, PHCs and SCs) since launch of NRHM in 2005-06, the State Government could not provide all infrastructural facilities in 75.77 *per cent* of rural health centres.

2.1.8.5 Delays in construction and taking over of Health Facilities

The physical status as of 31 March 2016 of 3,494 construction works sanctioned during 2011-16, is given in **Table 2.2**.

Table 2.2

(As on 31 March 2016)

Year	Number of works sanctioned	Number of works completed and handed over	Number of works completed but not handed over	Number of works in Progress	Number of works not started due to non availability of land	Number of works not started due to other reasons	Number of works de-sanctioned during October 2015
2011-12*	-	-	-	-	-	-	-
2012-13	1923	1289	51	24	01	05	553
2013-14	88	35	16	26	05	05	01
2014-15	699	251	173	118	114	42	01
2015-16	784	18	51	289	06	408	12
Total	**3,494**	**1,593**	**291**	**457**	**126**	**460**	**567**

*No work was sanctioned during 2011-12.

Source: Monthly Progress Report (MPR) provided by Chief Engineer, NRHM.

It is seen from the table that total 3,494 construction works were sanctioned during 2012-16, of which 457 works (13.08 *per cent*) were not completed as of March 2016. Further, 586 works (16.77 *per cent*) could not be taken up for construction (non availability of land: 126 and other reasons: 460) and 567 works were de-sanctioned in October 2015.

Test check of 113 construction works costing ₹ 80.67 crore, taken up in 141 test checked units, revealed the following irregularities:

(i) Non-utilisation of Health Infrastructure

Scrutiny of records and joint physical inspection (May-June 2016) in seven test checked districts revealed that 17 buildings[16] were constructed under

15 Own building, residential quarters for staff, equipment, laboratory, manpower and drugs etc.

16 Buildings of staff quarters at one CHC (Pipalkhunt) and two PHCs (Ghantali and Roll), renovation work of two PHCs (Chanar and Delder), staff quarters at DH Nagaur, one ANM training institute at Pratapgarh, one Swasthya Bhawan at Pratapgarh, three JSY wards at CHC Bhim, Reodar and Maternal Child Health and Nutrition Centre (MCHN), Jhalawar, three MCHNs at Dausa, Jalore and Pratapgarh, one waiting hall at DH Sirohi, *Janani Suraksha Yojana* ward at PHC Reodar and office building of Block Chief Medical Officer at Kuchaman City.

NRHM (between June 2010 and January 2016) by incurring an expenditure of ₹ 43.22 crore, but these buildings were not put to use even after lapse of two to 70 months after their completion.

The concerned Executive Engineers stated (May-June 2016) that responsibility of utilisation of the completed building rests with the Medical Officer In Charge (MOIC) of the health centre. The MOIC attributed the non-utilisation of these buildings to non-availability of staff, construction of buildings at faraway places, non-availability of water and electricity connection, etc.

20 bedded JSY ward at CHC Reodar (District Sirohi) was unutilised due to shortage of manpower.

50 bedded JSY ward at Medical College Hospital Jhalawar was unutilised due to shortage of manpower.

State Government did not intimate reasons for non-utilisation of 17 buildings constructed under NRHM.

(ii) Delay in completion of MCHN/JSY Wards at District Hospitals

Scrutiny of records and joint physical inspection (May-June 2016) in seven test checked districts revealed that five Maternal Child Health and Nutrition (MCHN) centres[17] and one *Janani Suraksha Yojana* (JSY) ward at Jhalawar were completed by incurring an expenditure of ₹ 40.14 crore, with delays ranging between four to 12 months which resulted in delayed establishment of health infrastructure for vital maternal and child healthcare facilities.

(iii) Award of works without ensuring availability of land

Rule 351 of Public Works Financial and Accounts Rules (PWF&AR) provided that the availability of land should be ensured before awarding the construction work.

It was observed that in seven test checked districts, 20 works (Dausa: three, Nagaur: six, Jalore: eight, Rajsamand: two and Sirohi: one) were sanctioned during 2012-15 (2012-13: 17 and 2014-15: three) and the work orders (total amounting to ₹ 2.47 crore) were issued to the contractors for construction. The contractors, however, could not commence the works because the land for construction was not available. This resulted in the works not starting and subsequently being de-sanctioned (October 2015)**.** Details of the cases have been given in ***Appendix 2.1***.

17 100 bedded MCHN at DH Pratapgarh and Nagaur and 50 bedded MCHN at DH Jalore, Rajsamand and Sirohi.

Further, cost overrun of ₹ 0.30 crore was noticed in two cases[18] of delayed completion of buildings due to non-availability of land at the sites selected for construction of these buildings.

Thus, the works were awarded to the contractors for construction without ensuring the availability of land before awarding them, which subsequently led to the works being de-sanctioned.

State Government stated (November 2016) that in most of the cases the land disputes occurred at time of start of work at site, whereas the MOICs reported availability of dispute free land in the proposal for sanction of the works. This was indicative of the fact that MOICs did not coordinate with land revenue authorities before reporting the status of availability of land.

(iv) Infrastructures created at inaccessible and uninhabited locations

- Construction of Hostel Building at Rajsamand for Auxiliary Nurse Midwife (ANM) trainees was sanctioned during 2010-11 for ₹ 0.52 crore. The work was later withdrawn due to non-availability of land and the work was subsequently allotted (December 2012) to another contractor for construction at another place. The building was completed at an expenditure of ₹ 0.82 crore and handed over in March 2015. It was noticed that the hostel building was not utilised and another building was taken on rent to operate the hostel and an amount of ₹ 0.03 crore was paid on account of rent during April 2015 to July 2016.

The Medical Officer In-Charge stated (May 2016) that the building was constructed close to the National Highway and was unsafe, further it was also insufficient to accommodate all the trainees. The fact of non-utilisation of hostel building was confirmed during joint physical inspection with the departmental representatives on 11 May 2016.

Thus, the hostel building was constructed at an unsuitable location and was not utilised. Besides, additional expenditure of ₹ 0.03 crore was also incurred for operation of the hostel in the rental building, which would increase with the passage of time.

ANM hostel building at Rajsamand was constructed and was not utilised.

18 ANM trainees hostel building at Rajsamand (₹ 0.21 crore) and staff quarters at CHC Pipalkhunt (₹ 0.09 crore).

- Staff quarters at CHC Bhim were constructed at an expenditure of ₹ 0.63 crore[19] and handed over in January 2012. It was observed that the staff quarters were lying vacant and not utilised. The MOIC, CHC, Bhim informed (May 2016) that staff quarters were constructed in an uninhabitable area and 2.5 kms away from the CHC building. The fact of non-utilisation of staff quarters was also confirmed during joint physical inspection with the departmental representatives on 12 May 2016.

Unutilised Staff quarters at CHC Bhim, which were constructed 2.5 kms away from CHC building in an uninhabitable area.

State Government (November 2016) did not offer specific comments on these cases of construction of facilities at unsuitable locations.

2.1.8.6 Non-utilisation of staff quarters

In Rajasthan, out of 17,059 rural health centres (CHCs-571, PHCs-2,080 and SCs-14,408) only 8,430 (49.42 *per cent*) health centres (CHCs-392, PHCs-1,244 and SCs-6,794) had residential quarters for doctors and staff, of which quarters at 421 (4.99 *per cent*) health centres were lying vacant as of March 2016.

Test check of 133 selected health centres (CHCs-15, PHCs-30 and SCs-88) revealed that out of 182 quarters available at these health centres, 26 *(*14.28 *per cent)* residential quarters were lying vacant due to the reasons like buildings requiring repair/ maintenance (16), non-availability of water/ electricity connections (six) and shortage of staff (four).

State Government, while accepting the facts, stated (November 2016) that these quarters were constructed on land, which was generally available at places located far away from populated area, schools and markets.

2.1.8.7 Non-availability of equipment in health centres

The IPH Standards have prescribed two categories of equipment as essential (minimum assured services) and desirable (the ideal level of services) for health centres (DHs, SDHs, CHCs, PHCs and SCs).

Availability of essential equipment in 141 test checked health centres (DHs: seven, SDH: One; CHCs: 15, PHCs: 30 and SCs: 88) and their shortfall are enumerated in the **Table 2.3**.

19 Including boundary wall constructed later during 2015-16 at an expenditure of ₹ 0.12 crore.

Table 2.3

S. No.	Equipment	Status of availability
District Hospitals: Seven		
1.	2 D Eco Machine	Not available in all seven selected district hospitals.
2.	Ultrasound facility	Available in all seven selected districts but non- functional in Sirohi DH.
Community Health Centres: 15		
1.	Operation Theatre Table	Not available in three CHCs (Basni, Bhandarej and Pipalkhunt) and non functional in CHC Arnod.
2.	Bedside screen	Not available in two CHCs (Ahore and Bhandarej).
3.	ECG facilities	Not available in three CHCs (Bhandarej, Kankroli and Roll) and non-functional in three CHCs (Bakani, Bhim and Jhalrapatan).
4.	X-ray facility	Not available in three CHCs (Bhandarej, Kankroli and Roll) non-functional in one CHC (Reodar).
5.	Sterlisation Instruments	Not available in one CHC (Bhandarej).
Primary Health Centres: 30		
1.	Delivery table	Not available in one PHC (Ghana) and non-functional in one PHC (Chupana).
2.	Operation Theatre Table	Available and functional in six PHCs[20] and in one PHC (Sarda) it was available but not functional.
3.	Bed side screen	Not available in six PHCs[21].
4.	Sterilisation instruments	Not available in 14 PHC[22]s and non-functional in one PHC (Salamgarh).
5.	IUD Insertion Kit	Not available in one PHC (Ghana).
6.	Normal delivery kit	Not available in one PHC (Ghana) and non functional in two PHCs (Aloonda and Bhagwanpura).
7.	Vaccine carrier	Not available in three PHCs (Aloonda, Bali-Jassakheda and Chupana).
Sub Centre: 88		
1.	Examination table	Not available in 14 SCs[23], and non-functional in seven SCs (Bhanskheri, Bori, Girwar, Kachotya, Lodham, Manpura and Nandi- Kheda).
2.	Labour table	Labour Table was not available in 38 SCs[24] and non-usable in 12 SCs[25].
3.	Weighing machine	Not available in 14 selected SCs[26] and non-functional in four SCs (Bijapura, Kaloda, Nogava and Thaneta).
4.	Disposable delivery kit	Available and functional in only 13 selected SCs[27] and in four SCs (Jaitpura, Kalota, Maharajpura and Mahikheda) kits were available but not functional.

Source: Information provided by the Healthcare Facilities.

20 Arniya, Badikhatu, Chanar, Chupana, Durgapura and Minda.
21 Aloonda, Bali-Jassakheda, Ghana, Makodi, Minda and Panchola.
22 Aloonda, Baant, Bali-Jassakheda, Chupana, Diver, Donda, Ghana, Khinyala, Makodi, Nosra, Panchola, Punasa, Sanwara and Tantwas.
23 Bakli, Bas-Bewai, Dahikhera, Daytra, Devaldi, Dhani-Nimbodi, Ghanliyawas, Ghatiyad, Kaliswar, Khinyawas, Liliya, Moikala, Padaliya and Thikarya.
24 Asawa, Badayala, Bakli, Bas-Bewai, Bhanskheri, Bhanwarsa, Bheboli, Bori, Dahikhera, Devaldi, Dhani-Nimbodi, Dhanoda, Digariya-Tappa, Gangliyawas, Ghatiyad, Govindpura, Gudha-Ashiqpura, Hajya-ka-Vas, Jaitpura, Jetawara, Kaliswar, Khinyawas, Ladli-Ka-Bas, Liliya, Kalota, Mahuakhoh, Moheda, Moikala, Mundghosoi, Padaliya, Rajod, Raipur-Jangal, Salotiya, Sirsi, Thikariya, Thikariya-Khurd, Udwaria and Viyo-Ka-Gholiya.
25 Bijapura, Lodhan, Mahikheda, Malgaon, Manpura, Matasen, Nandikheda, Nogava, Panchola, Pilanwasi, Thenchala and Tongi.
26 Bhanskheri, Dahikhera, Dhani-Nimbodi, Devaldi, Ghatiyad, Giriwar, Kaliswar, Khinyawas, Liliya, Lodhan, Manpura, Moheda, Moikala and Padaliya.
27 Balwa, Batoli, Dantiwas, Datina, Doyeba, Gagron, Gudha-Ashiqpura, Khedli-khurd, Nakli, Pindya, Rajawas, Raipur-jungle and Ruchiyar.

It is seen from the table that health centres catering to rural population (CHCs, PHCs and SCs) were having shortage of more equipment as compared to DHs. This indicated that emphasis on providing all essential equipment in rural health centres was not given.

Thus, in absence of essential equipment, the minimum assured services could not be provided to the targeted rural population as envisaged under NRHM.

State Government accepted the facts and stated (November 2016) that due to non-availability of staff to operate the equipment and proper space/building to install them, the equipment were non-functional. Further, remedial steps are being initiated to provide the equipment at health centres.

2.1.8.8 Utilisation of equipment

Scrutiny of 141 test checked health centres revealed that apart from the essential equipment, in following instances equipment for blood bank, ophthalmic, cardiac and life saving Intensive Care Unit (ICU) could not be utilised because of shortage/non-availability of staff to operate them indicating that equipment were supplied without any proper plan as discussed below:

- Five ventilators (costing ₹ 0.61 crore) received in October 2013-April 2015 in DH, Nagaur were not installed and lying unutilised due to delay in completion and taking over of the hospital building.

- One ventilator (costing ₹ 0.07 crore) received in December 2009 in DH, Jalore was not installed and lying unutilised.

- Various equipment like ventilator, Multi Para-monitor, Cardic Monitor, ICU Bed, Operation Theatre (OT) Table, Suction Table etc., costing ₹ 0.35 crore for ICU ward in DH, Dausa were not utilised due to shortage of staff.

- A blood bank refrigerator (60 bags capacity) with printer and real time clock (purchased during November 2006) was lying unutilised in CHC Bakani, since its receipt due to non-deployment of a trained operator. It was also noticed that license to establish blood bank was also not obtained by MOIC. Further, cardiac equipment (Biphasic Defibrillator 400-200 Jules) was also lying unutilised since its purchase in February 2010, due to non appointment of Junior Specialist.

- Ophthalmic equipment (purchased during May 2006) and Tread Mill Test (TMT) machine (purchased during July 2010) costing ₹ 0.03 crore were lying unutilised since their purchase in CHC, Bhinmal due to non-availability of specialists.

- Cardiac equipment (Cardiac Monitor: February 2006, Pulse Monitor: April 2007 and Biphasic Defibrillator 400-200 Jules: February 2010) costing ₹ 0.03 crore were lying unutilised since their purchase in CHC, Ahore.

To address the problem of non-functioning of equipment in the health centres, the State Government stated (November 2016) that a new Equipment Management and Maintenance System (e-Upkaran) had been launched.

2.1.8.9 Payment to supplier without installation of equipment

Rajasthan Medical Services Corporation Limited (RMSCL) issued (November 2014) supply orders to M/s Schiller Healthcare India Private Limited, for procurement and installation of life saving equipment (viz. Ventilator, Multi Para-Monitor, Cardiac Monitor and Fetal monitor) in 22 Maternal Child Health and Nutrition (MCHN) Centres at the cost ₹ 7.52 crore. As per condition of supply order, 70 *per cent* payment was to be made on receipt of equipment and remaining 30 *per cent* after their installation subject to the condition that supplier would be responsible for installation of the equipment on intimation of readiness of site by the health centre.

It was, however, observed that full and final payment of ₹ 2.39 crore was made (March 2015 to January 2016) to the supplier for supply and installation of equipment in nine[28] MCHN centres even though the sites were not ready for installation. Further in case of 10 ventilators (cost: ₹ 1.26 crore), installation certificates were issued by five DHs[29] though the site was not ready.

Thus, the supplier was paid ₹ 0.72 crore (30 *per cent* of ₹ 2.39 crore) without installation of equipment, which was irregular.

State Government accepted the facts and stated (November 2016) that the payment was released on the request of the supplier.

The reply was not acceptable as contrary to the condition of the supply orders, the payment of ₹ 0.72 crore (30 *per cent* amount) was made without installation of the equipment.

Infrastructure and equipment

NRHM aimed to bridge the gaps in the existing capacity of the rural health infrastructure and GoI has prescribed Indian Public Health Standards for availability of public healthcare infrastructure. As per these Standards, lesser number of health centres was provided in the tribal areas as compared to non-tribal areas.

State Government could not provide all the basic infrastructural facilities in 75.77 per cent of rural health centres. Health centres were constructed at inaccessible and uninhabited locations and contracts for construction of buildings were awarded to the contractors without ensuring availability of the land.

There was 50.58 per cent shortage in staff quarters. Further, even the constructed staff quarters and Health Centres were not utilised due to shortage of staff.

Emphasis on providing all essential equipment in rural health centres (CHCs, PHCs and SCs) was not given as they were having more shortages of essential equipment as compared to District Hospitals. Further, equipment were lying unutilized in health centres due to non-availability of trained staff to operate them.

28 Sites were not ready for installation as construction of three MCHN centres (Bhilwara, Dungarpur and Sikar) was under progress and possession of other six MCHN centres (Banswara, Baran, Beawar, Karauli, Nagaur and Udaipur) were not taken over by the hospital authorities as of August 2016.

29 Banswara, Bhilwara, Dungarpur, Nagaur and Udaipur.

Recommendations:

3. *State Government should follow the IPH Standards to provide adequate number of accessible health centres and infrastructure in the rural areas.*
4. *Availability of adequate number of functional equipment and operating manpower in Rural Health Centres should be ensured by the State Health Mission so that the rural people do not migrate to urban areas for medical services.*

2.1.9 Manpower Management

Audit objective-3: To assess the availability of healthcare professionals as per requirement of the norms.

2.1.9.1 The mission aimed at increasing the availability of manpower as per IPH Standards. GoI also extended assistance to the State Government for filling up the existing vacancies on contractual appointments.

The position of deployment of manpower required *vis a vis* IPH Standards in health centres (DHs, SDHs, CHCs, PHCs and SCs) and sanctioned by the State Government is given in **Table 2.4**.

Table 2.4

Health Facilities	Number of Health Centres	Manpower required as per IPH Standards for each centre	Total Man power required as per IPH Standards	Number of Sanctioned Posts by the State Government	Men in position	Shortage(-) /Excess(+) as per IPH Standard *(per cent)*	Shortage(-) /Excess(+) *vis a vis* sanctioned post *(per cent)*
DHs	34	123	4,182	6,963	5,665	(+) 1,483 *(35.46)*	(-)1,298 (*18.64*)
SDHs	19	86	1,634	2,754	1,637	(+) 3 *(0.18)*	(-)1,117 (*40.56*)
CHCs	571	46	26,266	13,542	8,493	(-) 17,773 *(67.67)*	(-)5,049 (*37.28*)
PHCs	2,080	13	27,040	16,398	11,856	(-) 15,184 (*56.15*)	(-)4,542 (*27.70*)
SCs	14,408	3	43,224	21,554	15,430	(-) 27,794 (*64.30*)	(-)6,124 (*28.41*)
Total	**17,112**		**1,02,346**	**61,211**	**43,081**	**(-) 59265 (*57.91*)**	(-)**18,130 (*29.62*)**

Source: Data provided by the Department.

The above table shows an overall shortage of 62.93 *per cent* of manpower in rural areas (CHCs; 67.67 *per cent*, PHCs; 56.15 *per cent* and SCs; 64.30 *per cent*). DHs, catering mostly urban population however, had excess of 1,483 manpower (35.46 *per cent*) as compared to IPH Standards.

Further, when compared to sanctioned posts, it was noticed that there was shortage of manpower at all levels i.e. at DHs (18.64 *per cent*), SDHs (40.56 *per cent*), CHCs (37.28 *per cent*), PHCs (27.70 *per cent*) and SCs (28.41 *per cent*).

The comparison of posts sanctioned by the State Government with IPH Standards also indicates that less posts were sanctioned for rural health centres (CHCs, PHCs and SCs) than for urban health centres at DHs.

Deployment of manpower was also checked in 141 selected health centres in seven rural districts and deficiencies noticed are discussed below:

(i) District Hospitals

The requirement of medical professionals[30] and para medical manpower as per IPH Standards, post sanctioned by the State Government and men in position in seven test checked DHs as on 31 March 2016 is given in **Table 2.5**.

Table 2.5

Name of DH	Manpower required as per IPH Standards		Posts sanctioned by the State Government		Men in position		Variation over parameters (+) excess; (-) shortage			
	Medical profe-ssional	Nurses and para medical staff	Medical profe-ssional	Nurses and para medical staff	Medical profe-ssional	Nurses and para medical staff	Medical professional		Nurses and para medical staff	
							As per IPH Stan-dards	As per sancti-oned posts	As per IPH Stan-dards	As per sancti-oned posts
Dausa	29	76	48	113	43	93	(+)14	(-)5	(+)17	(-)20
Jhalawar	29	76	53	138	23	122	(-)6	(-)30	(+)46	(-)16
Jalore	29	76	39	87	14	65	(-)15	(-)25	(-)11	(-)22
Nagaur	29	76	60	91	41	85	(+)12	(-)19	(+)9	(-)6
Pratapgarh	29	76	46	130	12	83	(-)17	(-)34	(+)7	(-)47
Rajsamand	29	76	42	113	15	73	(-)14	(-)27	(-)3	(-)40
Sirohi	29	76	41	112	16	48	(-)13	(-)25	(-)28	(-)64
	203	**532**	**329**	**784**	**164**	**569**	**(-)39**	**(-)165**	**(+)37**	**(-)215**

Source: Data provided by the respective Health Centres.

It is seen from the above table that:

Medical professionals: As per IPH Standards, 203 medical professionals were required in seven test checked DHs and the State Government sanctioned 329 posts. But only 164 medical professionals were deployed there. Thus there was a shortage of 165 medical professionals (50.15 *per cent*) in these seven test checked DHs.

Further, disproportionate deployment of medical professionals was also observed in DH, Dausa and Nagaur, where 26 medical professionals were deployed in excess of IPH Standards whereas, in the other five test checked DHs, there was shortage of 65 medical professionals.

Para medical manpower: As per IPH Standards, 532 para medical staff was required in seven test checked DHs and the State Government sanctioned 784 posts. But only 569 para medical staff were deployed there. Thus there was a shortage of 215 para medical staff (27.42 *per cent*) in these seven test checked DHs.

30 Medical professional includes Doctors such as Anaesthesiologists, Dentists, General practitioners, Gynaecologists, Obstetricians, Ophthalmologists, Orthopaedists, Paediatricians, Surgeons etc.

Further, disproportionate deployment of para medical staff was also observed in DH, Dausa and Jhalawar, where 63 para medical staff was deployed in excess of IPH Standards whereas, in DH, Sirohi there was shortage of 28 para medical staff.

Furthermore, against the requirement of one ECG Technician in each DH, no ECG Technician was posted in any of test checked DHs.

State Government stated (November 2016) that the posts of ECG technician at DHs were not yet created and now it has been proposed. Further, the advertisement has been published by Rajasthan Subordinates and Ministerial Service Board for the post of Lab Technician, Assistant Radiographer, Ophthalmic Assistant and Dental Technician.

(ii) Community Health Centres

Medical professionals: Test check of 15 CHCs in seven districts revealed that against the requirement of 165 medical professionals only 68 medical professionals (41.21 *per cent*) were posted there, as of March 2016. Thus, there was a shortage of 97 medical professionals[31] in these 15 CHCs. Further, Medical Officer-AYUSH were not posted in any of the test checked CHCs, as out of 1013 sanctioned posts, 907 posts (89.54 *per cent*) were vacant in the State as of March 2016.

Para medical manpower: Against the total requirement of 375 para-medical staff as per IPH Standards, only 215 para medical staff (57.33 *per cent)* were deployed.

(iii) Primary Health Centres

Medical professionals: One doctor (Medical Officer) was required in each PHC, as per IPH Standards**.** It was, however, observed that in three test checked PHCs (Ghana, Baant and Sanwara) Medical Officers were not posted whereas two Medical Officers were posted in five other test checked PHCs (Khatukalan, Bhagwanpura, Salamgarh, Chanar and Deldar). This indicated disproportionate deployment of medical professionals in PHCs.

Para medical manpower: IPH Standards provided deployment of 12 para-medical staff in each PHC. The State Government sanctioned 213 posts of para-medical staff against the requirement of 360 in 30 test checked PHCs, and against this, only 139 (38.61 *per cent)* were posted. Further out of 30 test checked PHCs, 29 were functioning without Pharmacists.

State Government stated (November 2016) that the Department has since appointed 589 Pharmacists during 2016-17.

(iv) Sub Centres

IPH Standards provided for appointment of one ANM (Female), one Health Worker (Male) and one *Safai Karamchari* in each SC. It was, however,

31 Anesthetist (13), Dental Surgeon (eight), General Medical Officer (7), General Surgeon (10), Obstetrician & Gynecologist (11), Pediatrician (12), Physician (eight), Public Health Nurse (13) and Public Health Specialist (15).

observed that ANMs were not posted in the 12 out of 88 test checked SCs. Further, Health Workers (Male) and *Safai Karamchari* were not posted in any of the 88 test checked SCs.

State Government stated (November 2016) that instructions have been issued to fill the vacant post of Women Health Worker by relocating the Women Health Workers from other health facilities where more than one were working.

The fact however remains that any mismatch between availability of medical professionals, para medical staff, skilled technicians and availability of buildings/equipment will not serve the purpose of providing healthcare facilities to rural people.

2.1.9.2 Accredited Social Health Activist

NRHM Framework for Implementation provided for appointment of Accredited Social Health Activist (ASHA) to forge the linkage of hamlet to hospital for curative services, empowerment of women and universalisation of child development services for every 1000 population/large isolated habitations. Payments to the ASHAs are made on the basis of services rendered by them. Further, the State Government prescribed (October 2009) that a woman in the age group of 21-45 years and possessing formal education[32] could be appointed as ASHA.

It was observed that against the sanction of 54,915 ASHAs, only 47,927 ASHAs (87.27 *per cent*) were working as of March 2016. In seven test checked districts, 9,681 ASHAs were sanctioned and against which 8,154 (84.22 *per cent*) were working as of March 2016.

State Government, while accepting the facts, stated (November 2016) that selection of ASHAs could not be completed due to non-availability of women of prescribed qualification. Further, to fulfil the backlog of ASHAs, the matter had been taken up with the Rural Development and Panchayati Raj Department.

In addition, drug kits containing, Oral Rehydration Solution, contraceptives and a set of ten basic drugs were required to be provided to ASHAs for immediate and easy access to the rural population. Analysis of feedback obtained from 180 ASHAs in 88 test checked SCs revealed that drug kits of 90 ASHAs (50 *per cent*) were replenished within 10 days while drug kits of other ASHAs were replenished after 10 days {i.e. 18 ASHAs (10 *per cent*) between 10 days and three weeks and 72 ASHAs (40 *per cent*) after three weeks time}.

State Government stated (November 2016) that the drugs had been replenished as per demand of the ASHAs.

The reply needs to be viewed in the light of the fact that ASHAs were required to provide immediate and easy access to the rural population to essential health supplies and any delays in replenishment of the kits would adversely affect these response provided.

32 Minimum of VIII standard.

Good Practice

ASHA Soft is an online system launched in 2014 which facilitates the department to capture beneficiary wise details of services given by ASHA to the community, online payment to ASHA into their bank account and generate various reports to monitor the progress of the programme. Rajasthan is the first State in the country to start online payments to ASHAs in all the districts.

2.1.9.3 Training to ASHAs

GoI prescribed two levels of training for ASHAs, *viz*. Induction training (in module I to V, of 23 days over 12 months) and capacity building (in module VI to VII, in four rounds of five days each).

It was observed that during 2011-16, against the target of providing induction training (module I to V) to 27,800 ASHAs, only 11,926 ASHAs (42.90 *per cent*) were imparted induction training.

Further, out of 47,927 working ASHAs, only 5,143 ASHAs (10.73 *per cent*) could complete all four rounds of the capacity building training. Thus the capacity building training was not provided to the remaining 42,784 working ASHAs as of March 2016.

Analysis of feedback obtained from 180 ASHAs revealed that 157 ASHAs in 88 test checked SCs were not trained and did not have necessary equipment to perform a normal delivery.

State Government accepted the facts and stated (November 2016) that the achievement of target of induction training was not possible due to non selection of eligible ASHAs. It was further stated that capacity building training was not provided to ASHAs, as the trainers were not selected.

2.1.9.4 Appointment of Contractual Staff

NRHM provides for engagement of medical and para medical manpower on contractual basis to fill the gaps in availability of manpower and provide additional manpower for the delivery of healthcare services. NRHM Framework for Implementation further provided that GoI would provide financial support to fill up all new contractual posts.

Accordingly, the provision for appointment of 21,245 persons during 2014-15 and 22,773 persons during 2015-16, on contractual basis was approved by GoI in the State PIP. It was, however, observed that only 13,752 (64.73 *per cent*) persons during 2014-15 and 13,311 (58.45 *per cent*) persons during 2015-16 were appointed on contractual basis.

State Government stated (November 2016) that Finance Department stopped (June 2011) the recruitment on contractual post therefore most of the contractual post could not be filled. Subsequently Finance Department permitted (June 2014) for recruitment and 575 persons were recruited on

contractual posts of different cadres at State/District and Block level during 2015-16.

The fact remains that despite priority on filling the gaps in availability of manpower by GoI and approval of the proposal of the State Government in the State PIP, persons were not appointed on contractual basis for the delivery of healthcare services.

Manpower management

The mission aimed at increasing the availability of manpower as per IPH Standards. There was a 62.93 per cent shortage of manpower in health centres located in rural areas while District Hospitals catering mostly the urban population had excess manpower of 35.46 per cent as compared to IPH Standards.

Though ASHAs had a pivotal role in providing healthcare support services at the village level, empowerment of women and universalisation of child development services, there was shortage of 12.73 per cent ASHAs in the State. Further, only 42.90 per cent of ASHAs could be imparted induction training.

Though GoI emphasised on filling up the gaps in availability of manpower by engagement of medical and para medical manpower on contractual basis, yet only 64.73 and 58.45 per cent persons were appointed on contractual basis during 2014-15 and 2015-16 respectively against the provision approved in annual PIP.

Recommendation:

5. State Government should endeavor to provide the sufficient manpower as per standards at the rural health centres and also rationalise the posting of existing staff from surplus centres to deficit centres.

2.1.10 Quality of Healthcare services

Audit Objective 4: To assess the extent and quality of healthcare services provided and impact of NRHM on reducing Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate.

2.1.10.1 Maternal healthcare services

(i) Ante Natal Care

Ante Natal care (ANC) is the healthcare received by a woman during her pregnancy and starts with recording the history of the patient followed by examination of the woman[33], guidance for nutritional diet, regular antenatal

33 As per the ANM guidelines, this includes recording of weight and height, blood test for anaemia, blood pressure measurement and regular abdominal examination etc.

checkups and counseling for family planning. She is also immunised with Tetanus Toxoid (TT) and provided Iron Folic Acid (IFA) tablets. Every pregnant woman should be registered during the first trimester (first 12 weeks) of her pregnancy and undergo three checkups during the pregnancy, at prescribed intervals for proper ANC.

Table 2.6 below depicts the status of total number of pregnant women registered for ANC and their follow up during 2011-16.

Table 2.6

Year	Total Number of pregnant women registered	Number of pregnant women registered under ANC in first trimester (*per cent*)	Three checkups (*per cent*)	Number of pregnant women provided TT (*per cent*)	Number of pregnant women given IFA tablets (*per cent*)
2011-12	18,51,453	8,62,679 (*46.59*)	13,41,543 (*72.46*)	15,15,772 (*81.87*)	11,75,154 (*63.47*)
2012-13	19,14,624	9,49,018 (*49.57*)	13,82,822 (*72.22*)	15,92,126 (*83.16*)	14,46,784 (*75.56*)
2013-14	19,38,528	10,57,498 (*54.55*)	14,16,481 (*73.07*)	16,39,231 (*84.56*)	13,28,552 (*68.53*)
2014-15	19,21,561	11,24,015 (*58.49*)	13,97,211 (*72.71*)	16,04,367 (*83.49*)	13,09,710 (*68.16*)
2015-16	19,04,886	11,43,116 (*60.00*)	13,14,084 (*68.98*)	15,49,442 (*81.34*)	11,98,592 (*62.92*)
Total	**95,31,052**	**51,36,326 (*53.89*)**	**68,52,141 (*71.89*)**	**79,00,938 (*82.90*)**	**64,58,792 (*67.77*)**

Source: Information provided by SHS and extracted from the Demographic Report for the respective year.

It is seen from the above table that:

- Though the percentage of women registered in first trimester increased from 46.59 *per cent* to 60 *per cent* during 2011-16, yet 26.93 *per cent* to 31.02 *per cent* pregnant women did not get all three checkups.

- 15.44 to 18.66 *per cent* women were not immunised during their pregnancy, with both doses (TT-1 and TT-2) of TT vaccine.

- Anaemia in pregnancy is associated with high maternal morbidity and mortality[34] in the State for last three decades and persistence of anaemia during the second trimester is associated with preterm (premature) birth. To prevent/cure anaemia, IFA tablets (100 mg iron with 0.5 mg folic acid) are given once daily for 100 days after the first trimester of pregnancy.

In this regard, it was observed that only 64.59 lakh (67.77 *per cent)* out of 95.31 lakh pregnant women registered in the State, were given IFA tablets. Thus, despite the fact that a large percentage of pregnant women of the State were suffering from anaemia for three decades, the problem was not adequately addressed under NRHM.

34 Mortality is a measure of deaths within a population or geographic area whereas morbidity is a measure of sickness or disease within a geographic area. Further, mortality is being susceptible to death while morbidity is having diseases to cause death later on.

Scrutiny of ANC provided to 14.14 lakh pregnant women registered for ANC in seven test checked districts revealed the followings deficiencies:

- Only 10.50 lakh (74.25 *per cent*) pregnant women were given three mandatory checkups during their pregnancy. Further, only Jalore and Pratapgarh districts maintained records of first and second checkups and rest of test checked districts did not maintain the records of first and second checkups of pregnant women.

- Distribution of IFA tablets to the pregnant women ranged between 60.27 to 77.76 *per cent* during 2011-16.

- Further, 39.05 to 44.97 *per cent* women were not immunized with TT during their pregnancy.

State Government accepted the fact and stated (November 2016) that efforts were being made to improve three ANC checkups, distribution of IFA tablets and providing TT to pregnant women against total ANC registration.

(ii) Institutional Delivery

NRHM encouraged institutional deliveries for improving maternal healthcare through creating awareness among people. *Janani Suraksha Yojana* (JSY) was launched (April 2005) by modifying the National Maternity Benefit Scheme (NMBS) to promote institutional deliveries and reduce Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). Status of the institutional deliveries conducted in the State and in seven test checked districts during 2011-16 is given in **Table 2.7**.

Table 2.7

Year	State level				Seven test checked district			
	Registered for Ante Natal Care	Targets for institutional delivery	Total Institutional deliveries *(per cent)*	Home Delivery	Registered for Ante Natal Care	Targets for institutional delivery	Total Institutional deliveries *(per cent)*	Home Delivery
2011-12	18,51,453	16,54,148	12,79,264 (*77.34*)	1,31,732	2,99,149	2,59,744	2,13,093 (*82.04*)	19,027
2012-13	19,14,624	17,22,136	13,46,810 (*78.20*)	1,21,065	2,85,932	2,57,544	2,29,902 (*89.27*)	17,441
2013-14	19,38,528	17,64,959	13,73,512 (*77.82*)	1,03,072	2,74,656	2,86,673	2,35,135 (*82.02*)	14,394
2014-15	19,21,561	17,86,892	13,50,242 (*75.56*)	86,639	2,76,473	2,90,378	2,26,181 (*77.89*)	10,833
2015-16	19,04,886	17,90,050	13,53,622 (*75.62*)	65,515	2,77,397	2,90,591	2,26,402 (*77.91*)	6,168
Total	**95,31,052**	**87,18,185**	**67,03,450 (*76.89*)**	**5,08,023**	**14,13,607**	**13,84,930**	**11,30,713 (*81.64*)**	**67,863**

Source: information provided by the Department.

Analysis of data relating to pregnant women registered for ANC revealed that:

- Against the targets of 87.18 lakh institutional deliveries in the State, the achievement was only 67.03 lakh (76.89 *per cent*) during 2011-16, leading to shortfalls during 2011-12 (22.66 *per cent*), 2012-13 (21.80 *per cent*),

2013-14 (22.18 *per cent*), 2014-15 (24.44 *per cent*) and 2015-16 (24.38 *per cent*) in achieving targets of institutional deliveries.

State Government stated (November 2016) that institutional deliveries were gradually rising in the State.

The reply was not convincing as the year-wise data of institutional deliveries was stagnant between 75 to 78 *per cent* during 2011-16.

- The total number of pregnant women registered in the State during 2011-16 was 95.31 lakh. As per data furnished by the Department, there were 67.03 lakh institutional deliveries and 5.08 lakh home deliveries leaving a balance of 23.20 lakh pregnant women, for which no information was available.

State Government, while accepting (November 2016) the facts, attributed the reasons for gap in total ANC registration and institutional deliveries to possible loss of pregnancy due to abortion, miscarriage & medical termination of pregnancy and non reporting of deliveries in urban areas due to lack of manpower.

The fact however remains that no authentic information was available about the type of delivery for 24.34 *per cent* of the pregnant women. There is an urgent need to keep a track of these pregnant women considering the high MMR and IMR in the State.

- Out of total home deliveries during 2011-15, deliveries ranging between 40.84 to 60.95 *per cent* were carried out by *dais*[35]/relatives/others and 34.15 to 26.23 *per cent* newborns were not visited by a Doctor/ANM/Nurse within 24 hours of delivery as required under the norms. Thus, the directions of guidelines to reduce IMR by providing healthcare to newborns within 24 hours of birth were not adhered to.

State Government accepted the fact and stated (November 2016) that still there are areas in the State where people prefer the traditional method of delivery conducted by *dais*.

There is, however, a need to increase awareness about the advantages of institutional deliveries so that the MMR and IMR in the State is reduced.

- In seven test checked districts, institutional deliveries decreased from 89.27 *per cent* in 2012-13 to 77.91 *per cent* in 2015-16.

Further, test check of 88 SCs revealed that out of 2,104 deliveries conducted at home during 2011-16, 70.48 *per cent* home deliveries (1,483) were not attended by Doctor/skilled birth attendant Nurse/ANM and 45.01 *per cent* newborns (947) were not visited by health worker within 24 hours of home delivery.

35 Untrained midwives.

Thus, the objectives of NRHM to encourage institutional deliveries for improving maternal health could not be achieved as the number of institutional deliveries did not increase during 2011-16.

(iii) Non-availability of maternal healthcare services in rural health centres

Assessment of availability of maternal healthcare services in rural health centres (15 CHCs) revealed the following:

- Post partum sterilisation service was available in only eight CHCs[36],
- Caesarean section service was available in only two CHCs[37],
- Ultra Sonography service was available in only three CHCs[38],
- Comprehensive obstetric service was available in only seven CHCs[39] and
- Round the clock blood storage service was available in only two CHCs[40].

This indicates that a large number of CHCs were not able to provide essential maternal healthcare services and facility of institutional delivery to cater the demand of rural community.

State Government, while accepting the facts, stated (November 2016) that only District Hospitals were initially covered and instructions have been issued to CMHOs for improvement in facilities at CHC and PHC level.

(iv) Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) was launched to promote institutional deliveries and reduce MMR and IMR. JSY awards cash assistance[41] for post-delivery care at the time of discharge. ASHA has significant role in encouraging the pregnant women to institutional deliveries. Both the pregnant woman and ASHA receive the cash benefits under JSY.

Non-payment of incentive to beneficiaries

- In the State, out of total 55.50 lakh institutional deliveries[42] under JSY, cash incentive was paid to 52.73 lakh women, depriving benefit to 2.77 lakh women (4.99 *per cent*) during 2011-16. Further, only 25.35 *per cent* JSY beneficiaries were assisted by ASHAs.
- In seven test checked districts, out of 10.48 lakh institutional deliveries under JSY, 1.09 lakh (10.40 *per cent*) women were deprived of cash

36 Abu Road, Bakani, Bandikui, Basni, Bhandarej, Kankroli, Pipalkhunt and Reodar.
37 Abu Road and Bhim.
38 Abu Road, Ahore and Bakani.
39 Abu Road, Arnod, Bakani, Bandikui, Basni, Bhandarej and Jhalrapatan.
40 Abu Road and Bakani.
41 ₹ 1,400 in rural area and ₹ 1,000 in urban area were provided to the beneficiaries at the time of discharge.
42 This exclude 11.53 lakh deliveries performed in private hospitals.

incentive during 2011-16 and only 13.64 *per cent* JSY beneficiaries were assisted by an ASHA.

State Government accepted the facts and stated (November 2016) that due to non-submission of required documents in health centres, discharge before 48 hours and non-providing of KYC of the beneficiary's bank account, the cash benefits could not be disbursed to the beneficiaries. It was, further, stated that efforts were being made to record the bank account number of the beneficiary in the early time of ANC.

Good Practice

State Government has started (August 2015) an Online JSY and Shubhlaxmi payment system (OJAS) wherein cash incentives for institutional deliveries are directly deposited into the bank accounts of the beneficiaries. Currently cash incentives for 75 per cent of the institutional deliveries in the State are being transferred through OJAS.

Post Natal Care

According to JSY, as part of Post Natal Care (PNC), a pregnant woman has to stay for minimum 48 hours after her delivery. Scrutiny of records of SHS revealed that during 2011-16, out of 67.03 lakh Institutional deliveries conducted in the State, 9.19 lakh (13.71 *per cent*) women were discharged within 48 hours of delivery. This resulted in the eligible beneficiaries being deprived of JSY incentives and facing PNC complications.

In seven test check districts it was observed that:

- During 2011-16, out of 11.31 lakh institutional deliveries conducted, 2.44 lakh (21.57 *per cent*) women were discharged within 48 hours of delivery.

- Out of total 8.11 lakh women who availed PNC facility, 3.62 *per cent* to 7.18 *per cent* women had PNC complications during 2011-16. In Jalore district, the situation of PNC complications was highest and it ranged between 8.37 to 24.11 *per cent* during 2011-16.

State Government stated (November 2016) that pregnant women were discharged before 48 hours due to non availability of proper arrangement of stay in outreach areas/over crowding and non/under availability of healthcare staff. It was further assured that efforts are being made to increase the stay of women up to 48 hours after delivery.

(v) Beneficiary Survey

To assess the impact of quality of services provided by the State Government, a survey was conducted (during April-June 2016) with a random sample of 880 beneficiaries in 88 SCs by Audit, in which response of beneficiaries was obtained on a predefined set of questions. The survey revealed that:

- 330 beneficiaries (37.50 *per cent*) out of 880 did not register themselves within three months of their pregnancy.

- 483 beneficiaries (54.89 *per cent*) did not visit the health centres for follow ups against prescribed four medical check up during their pregnancy.

Thus, the survey further substantiated the fact that the main objective of NRHM to provide ANC to all pregnant women was not achieved.

State Government stated (November 2016) that nearly 91.07 *per cent* beneficiaries were getting ANC services before six months of pregnancy and 96.02 *per cent* beneficiaries visited hospitals/health centres during pregnancy once or more than once.

The position stated by the Department was contrary to the NRHM framework which required at least four checkups during the pregnancy period.

2.1.10.2 Immunisation

Routine immunisation is an important strategy for child survival, focusing on preventive care to reduce morbidity against six preventable diseases. Accordingly, vaccinations for tuberculosis, diphtheria, pertussis, tetanus, polio and measles are to be given in seven stages to the age group of 0-1 years. Vaccines like Bacille Calmette Guerians (BCG), Oral Polio Vaccine (OPV), Tetanus Toxoid (TT), Diphtheria Pertussis and Tetanus (DPT), Diphtheria and Tetanus (DT) and Measles were provided under universal immunisation programme. Pulse Polio immunisation campaigns were also taken up for eradication of polio.

Achievement of Target for immunisation

(i) In the State, achievements against the targets of full immunisation for 0-1 year infants, DPT Booster I, OPV Booster and Measles for 01-02 years children, during 2011-16 are given in the **Table 2.8**.

Table 2.8

Year	Target for full immunisation of infants (0-1 year)	Achievement *(per cent)*	Target for immunisation (1-2 year)	Achievements		
				DPT Booster I *(per cent)*	OPV Booster *(per cent)*	Measles *(per cent)*
2011-12	15,70,602	13,36,402 (*85.09*)	14,86,153	7,76,950 (*52.28*)	7,64,057 (*51.41*)	3,42,826 (*23.07*)
2012-13	16,35,882	13,36,841 (*81.72*)	15,32,811	8,56,361 (*55.87*)	8,45,138 (*55.14*)	1,46,544 (*9.56*)
2013-14	16,64,485	13,80,291 (*82.93*)	15,23,444	9,96,275 (*65.40*)	9,92,761 (*65.17*)	5,76,767 (*37.86*)
2014-15	16,80,133	13,62,148 (*81.07*)	16,50,587	10,67,818 (*64.69*)	10,63,030 (*64.40*)	9,52,315 (*57.70*)
2015-16	16,91,597	13,62,794 (*80.56*)	16,62,177	11,42,992 (*68.76*)	11,43,106 (*68.77*)	11,30,880 (*68.03*)

Source: Information provided by the Department.

It is seen from the table that:

- During 2011-16, the achievement in number of immunisations of infants (0 to 1 year) was decreasing from 85.09 to 80.56 *per cent*.

- Further, target for 1-2 year children for DPT Booster-I, OPV Booster and Measles were not fully achieved during 2011-16 though there were improvements in coverage of the number of children. In seven test checked

districts, it was also noticed that 16.12 to 19.14 *per cent* infants were not fully immunised during 2011-16.

State Government stated (November 2016) that the targets were set for quantities to be indented to GoI and not based on head count, further lack of awareness among parents/guardians (illiteracy) and fear of adverse events following immunisation were the reasons for short achievement of targets.

The reply was not acceptable as quantity targets should have been set on the basis of eligible infants and children. This also highlights the need for a more effective "*Bottom up approach*" for planning.

(ii) Similarly, in the State, achievements against the targets of DPT Booster II upto 5 year children, TT 10 for 10 years children and TT 16 for 16 years children during 2011-16 are given in the **Table 2.9**.

Table 2.9

Year	Target for DPT Booster II	Achievements *(per cent)*	Target for TT 10	Achievements *(per cent)*	Target for TT 16	Achievements *(per cent)*
2011-12	14,44,485	3,69,617 (*25.59*)	15,34,765	4,63,136 (*30.18*)	15,69,489	4,29,631 (*27.37*)
2012-13	14,90,967	4,15,944 (*27.90*)	15,86,897	4,85,899 (*30.62*)	16,18,530	4,58,460 (*28.33*)
2013-14	14,81,460	6,17,131 (*41.66*)	15,77,424	9,72,389 (*61.64*)	16,08,415	8,63,933 (*53.71*)
2014-15	15,03,000	7,35,404 (*48.93*)	16,00,000	9,16,123 (*57.26*)	16,32,000	8,18,059 (*50.13*)
2015-16	15,24,000	8,35,269 (*54.80*)	16,22,000	8,36,494 (*51.57*)	16,55,000	7,32,608 (*44.27*)

Source: Information provided by the Department.

It is seen from the table that against the targets, achievement of immunisation through DPT Booster-II (45.20 to 74.41 *per cent*), TT 10 (38.36 to 69.82 *per cent*) and TT 16 (46.29 to 72.63 *per cent*) were not fully achieved for children of 5-16 years during 2011-16. This indicates the dismal performance in immunisation in the State, particularly for children above five years of age.

State Government, while accepting the facts, stated (November 2016) that many schools, including private schools did not cooperate for vaccinations. This indicated lack of coordination and awareness of community.

Providing Vitamin 'A' supplements to children

As envisaged in the guidelines, all children of the age of nine months to five years were required to be administered Vitamin 'A' dose. Against the targets of 82.43 lakh for administration of five doses of vitamin 'A', first dose was administrated to 59.78 lakh (72.52 *per cent*), second dose was administrated to 33.51 lakh (40.66 *per cent*) and third, fourth and fifth doses were administrated to 26.30 lakh (31.91 *per cent*) children only.

In seven test checked districts it was observed that 5.76 to 10.96 *per cent*, 38.67 to 51.58 *per cent* and 60.40 to 67.14 *per cent* children were not given Vitamin 'A' first dose, second dose and third to fifth doses respectively

during 2011-16, which reflected dismal performance of administering vitamin 'A' doses.

State Government accepted (November 2016) that vitamin A dose was not administered to children as per plan.

2.1.10.3 Family Planning

Objective of the family planning programme was to reduce the Total Fertility Rate (TFR) and improve the health status of people particularly, women by encouraging adoption of appropriate family planning methods. Male involvement in family planning including male sterilisation would also be promoted. Vasectomy for male and tubectomy for female are family limiting methods and oral pills, condoms and Intra Uterine Device (IUD) insertion are the methods for family spacing, to reduce TFR.

Achievements *vis. a vis.* targets of sterilisation for the State during 2011-16 are discussed in **Table 2.10**.

Table 2.10

Year	Target for sterilisation	Achievement			Shortfall *(per cent)*
		Tubectomy cases *(per cent)*	Vasectomy cases *(per cent)*	Total cases	
2011-12	**6,86,210**	3,09,426 (*98.25*)	5,528 (*1.75*)	3,14,954	3,71,256 (*54.10*)
2012-13	**6,98,604**	3,11,539 (*98.44*)	4,949 (*1.56*)	3,16,488	3,82,116 (*54.69*)
2013-14	**5,01,170**	2,98,898 (*98.75*)	3,769 (*1.25*)	3,02,667	1,98,503 (*39.60*)
2014-15	**4,62,304**	2,99,302 (*98.58*)	4,304 (*1.42*)	3,03,606	1,58,698 (*34.33*)
2015-16 (Provisional)	**4,50,000**	2,81,927 (*98.34*)	4,748 (*1.66*)	2,86,675	1,63,325 (*36.29*)
	27,98,288	**15,01,092 (*98.47*)**	**23,298 (*1.53*)**	**15,24,390 (*54.48*)**	**12,73,898 (*45.52*)**

Source: Information provided by the Department.

It is seen from the above table that:

- Against the target of 27.98 lakh sterilisation for the State, only 15.24 lakh (54.48 *per cent*) sterilisation were done during 2011-16, leading a shortfall ranged between 34.33 to 54.69 *per cent.*

- Further, the percentage of vasectomy operations in the State was only 1.53 *per cent* of the total sterilisation operations.

- In seven test checked districts, shortfall in sterilisation ranged between 53.91 and 65.26 *per cent*. Further the percentage of vasectomy operations to total sterilisation operations was abysmally low (2.05 *per cent)*.

Thus, despite instructions in the NRHM framework for promoting male involvement in family planning, male sterilisations continued to be low.

State Government stated (November 2016) that the eligible couples are counselled to adopt family planning practices and they select the method of their choice. Further, trainings were imparted to service providers and male sterilisation camps were planned in each district.

However, the fact remains that the participation of male in the sterilisation process was very low and needed concerted efforts to improve the same.

2.1.10.4 Other healthcare services

(i) Non-availability of essential drugs

State Government following the IPH Standards, issued Essential Drugs List (EDL) of 522 drugs for DH, 445 drugs for CHC, 236 drugs for PHC and 32 drugs for SC. RMSCL, is responsible for distribution and management of essential drugs in all the health centres. Audit scrutiny revealed that the position of distribution of drugs in DHs, CHCs, PHCs and SCs in the entire State was not maintained.

Audit scrutiny of seven test checked districts revealed that:

There were shortages in the availability of essential drugs, as only 320 to 409 drugs were available in six DHs (except Jhalawar), 125 to 324 essential drugs in all CHCs, four to 100 drugs in 12 PHCs[43] and eight to 20 drugs in 21 SCs[44].

It was also noticed that essential obstetric care drug kit was not available in four CHCs (Abu Road, Ahore, Bandikui and Reodar) and further Reproductive Transmitted Infection/Sexual Transmitted Infection drugs were not found available in four CHCs (Abu Road, Ahore, Bhinmal and Kankroli).

State Government did not provide the reasons for non-availability of essential drugs in test checked districts. This also highlights the need for a more effective "*Bottom up approach*" for planning which would have thrown up such shortages in essential medicines.

(ii) Mobile Medical Units

The objective of having Mobile Medical Units (MMU) was to take healthcare to the doorsteps of the public in the rural areas, especially in underserved areas and in urban slums. As per IPH Standards, 20 camps per month per MMU were required to be organised.

There were 52 MMUs deployed in 31 districts in the State, which organized only 33,879 camps (54.29 *per cent*), against stipulated 62,400 camps during 2011-16.

In seven test checked districts, eight MMUs were deployed, which organised camps ranging from 1,128 (67.14 *per cent*) to 1,136 (67.62 *per cent*) during

43 Arniya, Bali-Jassakhera, Bhagwanpura, Donda, Ghana, Ghantali, Khinyala, Nausara, Panchola, Sarda, Suhagpura and Tantwas.

44 Balwa, Bijapura, Dantina, Dantiwas, Dhani-Nimbodi, Digariya-Tappa, Guda-Ahiqpura, Hajya-Ka-Vas, Jaitpura, Kalota, Karwa, Khedala-Khurd, Khinyawas, Kotra, Ladli-Ka-Bas, Panchola, Rajod, Sindhipura, Sirsi, Sugli-Jodha and Thikriya.

2013-15, against the target of 1,680 camps per annum. Further, no MMU camp was organised in Rajsamand district during 2011-15.

State Government, while accepting the facts, stated (November 2016) that IPH standard could not be achieved due to poor and damaged conditions of MMUs and expiry of contract period with service provider.

2.1.10.5 Quality Assurance Programme

GoI has prescribed 70 Quality Assurance Standards for public health which have been categorised into eight broad areas of Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management and Outcome.

The State level Quality Assurance Committee (SQAC), State Quality Assurance Unit (SQAU) along with District level Quality Assurance Committee (DQAC) and District level Quality Assurance unit (DQAU) in all 33 districts was constituted (February 2015) to oversee the quality assurance activities across the State and also to ensure regular and accurate reporting of the various key indicators. Further, every DQAU was required to submit monthly report on the performance indicators to SQAU.

It was observed that against prescribed four meetings during 2015-16, SQAU convened only one meeting (March 2016). Further, during 2015-16 though SQAC visited all 34 DHs to assess the qualities of services provided by the DHs, but it did not visit any rural health facilities (SDH/CHC/PHC).

It was further observed in test checked units (30 PHCs, 15 CHCs and seven DHs) that:

- None of the DQAUs submitted the monthly report on the performance indicators to SQAU.

- Key outcome indicators pertaining to Reproductive Maternal Newborn Child Health (RMNCH) were not measured and monitored in 27 PHCs[45], 13 CHCs[46] and three DHs (Nagaur, Pratapgarh and Sirohi).

State Government, while accepting the facts, stated (November 2016) that instructions had been issued to all districts for patient satisfaction survey/patient feedback, conducting regular meeting and sending returns on scheduled dates.

The fact remains that the implementation of Quality Assurance Programme, which was intended to enhance the satisfaction level among the users of the Government health facilities, was in a nascent stage in the State and needed improvement.

45 Aluda, Arniya, Baant, Bali-Jassakheda, Bhagwanpura, Bivai, Chupana, Daspa, Deldar, Diver, Durgapura, Ghana, Ghantali, Khinyala, Kundal, Makodi, Minda, Mohi, Nosara, Panchola, Punasa, Salmgarh, Sankroda, Sanwara, Sarda, Suhagpura and Tantwas

46 Aburoad, Ahore, Arnod, Bandikui, Basni, Bhandarej, Bhim, Bhinmal, Kankroli, Nawacity, Pipalkhunt, Reodar and Roll.

2.1.10.6 Impact of NRHM on IMR, MMR and TFR

Maternal Mortality Ratio (MMR) measures the number of women of reproductive age (15–49 years) dying due to maternal causes per 1,00,000 live births and is a sensitive indicator of the quality of the healthcare system for women. Infant Mortality Ratio (IMR), a measurement of death of children before the age of one year per 1,000 live births, is a sensitive indicator of the health and nutritional status of population of children. Further, Total Fertility Rate (TFR) is a measure of number of children born to a woman during her entire reproductive age. Due to early marriage, close spacing of births, high unmet need and lack of skilled contraceptive services, high fertility remains a problem.

(i) Trend of achievements at State level

A comparison of the State[47] with other states and All India average for IMR, MMR and TFR revealed that:

- During 2009, IMR in the State was 59, which reduced to 47 during 2013 for per 1000 live births, but during the same period All India average of IMR declined from 50 to 40. The State stood at 23rd position among 28 states of the country during 2013.

  Further during 2013, IMR in seven test checked districts[48] was higher than the IMR of the State and ranged between 52 (Nagaur) to 72 (Jalore).

- During 2009, MMR in the State was 318, which reduced to 244 during 2013 for per 1,00,000 live births. However, during the same period All India average of MMR declined from 212 to 167. The State stood at the 25th position among 28 states of the country during 2013.

- During 2009, TFR in the State was 3.3, which reduced to 2.8 during 2013. However, during the same period All India average of TFR was reduced from 2.6 to 2.3. The State stood at 17th position among 20 states in the country during 2013 for which details were available.

  Further, during 2013 TFR in seven test checked districts, was not significantly different in comparison of State average and ranged between 2.7 (Nagaur) to 3.6 (Jalore).

Thus, specific initiatives were needed to focus on districts by providing better infrastructural/services for maternal and child healthcare, where IMR/MMR/ TFR has not been reduced substantially.

47 As per Sample Registration System Statistical Report 2013 published by the Registrar General of India, Ministry of Home Affairs, New Delhi.

48 As per Annual Health Survey 2012-13 published by the Registrar General and Census Commissioner, India, Ministry of Home Affairs, New Delhi.

Quality of Healthcare services

The percentage of women registered in first trimester of the pregnancy increased from 46.59 per cent to 60.00 per cent during 2011-16, yet 26.93 per cent to 31.02 per cent pregnant women did not get all three mandatory checkups. Further only 67.77 per cent pregnant women were given IFA tablets inspite of anaemia being widely prevalent in the State.

There was no significant variation in institutional deliveries in the State during 2011-16. Further 26.23 to 34.15 per cent newborns were not visited by a Doctor/ANM/Nurse within 24 hours of delivery in case of deliveries at home.

The position of immunisation was poor for infants (0 to 1 year) and children (1 to 16 years) as there was low coverage in administering vaccines i.e. Measles, OPV booster, DPT booster and TT 10/16.

The achievement against the target of sterilisation was only 54.48 per cent and the involvement of men in the family planning process continued to be abysmally low. There were also shortages in the availability of essential drugs particularly at CHCs and PHCs.

Thus, inspite of Rajasthan being a special focus State under NRHM, the State continues to lag behind the All India Averages and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th position (out of 20) in Total Fertility Rate.

Recommendations:

6. *To reduce the risk and complications involved during pregnancy, the State Health Mission should ensure that all the pregnant women are mandatorily registered in the first trimester and get three checkups during pregnancy to improve the Maternal Mortality Ratio in the State.*

7. *The State Health Mission should ensure full immunisation of infants and children to improve the Infant Mortality Ratio in the State by introducing awareness programmes and better coordination with schools.*

8. *The State Health Mission should improve the position of sterilisation in the State and make special efforts to increase the involvement of men in the sterilisation process so that the Total Fertility Rate in the State is reduced.*

2.1.11 Adequacy of Financial Management

Audit Objective -5: To assess the existence of prudent financial management.

2.1.11.1 Funding pattern

The Centre and State Governments provided funds for NRHM in the ratio 85:15 during 2011-12. The funding pattern was revised to 75:25 during

2012-15 and further 60:40 during 2015-16. GoI directly released the funds to the bank account of the State Health Society (SHS) upto 2013-14. From 2014-15 onwards all funds were released through treasury route of the State Government.

The details of funds released by the GoI and the State Government and expenditure incurred there against during 2011-16 [49] are shown in the **Table 2.11**.

Table 2.11

(₹ in crore)

Year	Funds approved in State PIP	Opening Balance	Funds released by			Total fund available for the year	Expenditure[50] (*per cent*)	Closing Balance
			GoI	State Govt	Total			
2011-12	1,015.70	213.12[51]	1,029.64	173.21	1,202.85	1,415.97	979.98 (*69.21*)	435.99
2012-13	1,545.60	435.99	800.59	256.71	1,057.30	1,493.29	1,065.33 (*71.34*)	427.96
2013-14	1,796.62	427.96	867.47	278.05	1,145.52	1,573.48	1,315.55 (*83.61*)	257.93
2014-15	1,896.24	285.51[52]	1,031.02	351.08	1,382.10	1,667.61	1,436.22 (*86.12*)	231.39
2015-16 (Provisional)	2,391.82	231.39	1,219.89	754.72	1,974.61	2,206.00	1,697.67 (*76.96*)	508.33
Total	**8,645.98**		**4,948.61**	**1813.77**	**6,762.38**		**6,494.75**	

Source: Data provided by the SHS

It is seen from the above table that during 2011-16, against aggregate approval of ₹ 8,645.98 crore in the State PIPs, funds amounting to ₹ 6,762.38 crore (78.21 *per cent*) were released to SHS and funds of ₹ 6,494.75 crore (75.11 *per cent*) were actually utilised. The utilisation of the available funds by the SHS ranged between 69.21 and 86.12 *per cent* during 2011-16. The State Government was to contribute ₹ 1,832.12 crore as per prescribed ratios, however matching share was short released by ₹ 18.35 crore.

State Government stated (November 2016) that non utilisation of available funds during 2015-16 was due to change in sharing ratio during 2015-16 (December 2015) from 75:25 to 60:40 and delayed release (March 2016) of additional state share to SHS. The reasons for less utilisation of available funds during 2011-15 and for short release of states share to the SHS were not intimated.

The fact however remained that utilisation of funds was consistently low during 2011-16. Further, delay approval of PIPs by GoI was also due to delay in submission of PIPs by the SHS.

2.1.11.2 Delay in release of funds

Paragraph 3.3.1 and 3.3.2 of the Operational Guidelines for Financial Management of NRHM provides that the State Government would release the proportionate share to the SHS within seven days of the release of fund by

49 Final accounts for the period 2015-16 are under finalisation.

50 Amount received through treasury route and fund received/expenditure whichever is less, has been taken as expenditure under NIDDCP and Infrastructure Maintenance.

51 It includes ₹ 119.30 crore, released in 2011-12 but pertains to previous years.

52 Due to inclusion of NPHCE, NTCP and Cancer programmes under umbrella of NRHM the opening balance of ₹ 27.58 crore of these programmes was included.

GoI, who in turn would release the funds to DHSs within 15 days of receipt of the funds.

It was, however, observed that during 2011-16, the State Government released the matching share of ₹ 1,175.69 crore with delays ranging from 31 days to 362 days (average delay of 135 days).

State Government accepted the facts and stated (November 2016) that the amount was transferred /deposited in the bank account of SHS with delay of 40 to 45 days as it entails a long process[53].

Similarly, SHS also delayed the release of ₹ 1,460.94 crore to the DHSs ranging from 31 days to 275 days (average delay of 118 days).

State Government stated (November 2016) that the transfer of funds by SHS to DHS was delayed to control unnecessary accumulation of advances lying at district and lower level. Further, funds were released after analysis of the requirement of district demands and this took time.

2.1.11.3 Diversion of funds

As paragraph 3.3.5 of the Operational Guidelines for Financial Management of NRHM, the funds provided for various programmes should only be used for the intended purpose and not be mixed with other funds. Paragraph 10.3 *ibid* further prohibited the diversion of NRHM funds for another programme, without approval of GoI. In following instances, funds of NRHM were however, diverted:

- An amount of ₹ 257.62 crore (₹ 103.09 crore during 2013-14 and ₹ 154.53 crore during 2014-15) was diverted from *Janani Suraksha Yojana* of NRHM to another State Government Scheme i.e. *Mukhyamantri Subh Lakshmi Yojana*. However, funds of ₹ 247.36 crore (₹ 88 crore during 2013-14 and ₹ 159.36 crore during 2014-15) was later recouped. The remaining amount ₹ 10.26 crore has not been recovered from the State Scheme as of March 2016.

- During 2015-16, an amount of ₹ 3.66 crore was diverted from NRHM to *Mukhyamantri BPL Jeevan Raksha Kosh*, which is a State Government Scheme.

State Government, while accepting the facts, stated (November 2016) that such irregularity would not be repeated in future.

2.1.11.4 Unadjusted advances to various agencies

(a) As per paragraph 6.9.1 of Operational Guidelines for Financial Management, all advances should be duly approved by the Competent Authority and should preferably be settled within a maximum period of 90 days. Consolidated Balance Sheet of SHS exhibited unadjusted advances of

53 Delay attributed to time taken in receiving copy of GoI sanction order, non-uploading of sanction on site, time taken in reconciliation, approval and release of fund, release in administrative sanction etc.

₹ 199.42 crore as of March 2012 at SHS level, which increased to ₹ 605.57 crore by the end of March 2015. In following cases, non-adjustment of advances reflected lack of monitoring:

- All DHSs of the State exhibited (March 2016) total outstanding advances of ₹ 111.09 crore against Blocks, CHCs, PHCs and others. Out of which, a sum of ₹ 11.55 crore was outstanding for more than five years.

- Unadjusted/unspent advances to ₹ 181.87 crore was outstanding against RMSCL as of March 2016, out of which advance of ₹ 24.27 crore was outstanding for more than two years.

- Due to continuous release of advances to State Institute of Health and Family Welfare (SIHFW) without adjustment of previous advances, unadjusted sum of ₹ 16.86 crore had accumulated as of March 2016. Further, an amount of ₹ 2.33 crore was released to SIHFW for providing trainings for 12 activities. SIHFW did not organise the training programmes and refunded back the amount with delays ranging between eight to 23 months.

State Government stated (November 2016) that letters were being issued and meetings were being conducted with the officers of RMSCL/SIHFW on regular basis for settlement of advances.

Thus, huge amount of advances pending for refund/adjustment reflects lack of monitoring.

(b) Against an advance of ₹ 106.25 crore, given to Director, Information, Education and Communication (IEC) during 2011-16, Utilisation Certificates (UCs) for ₹ 46.24 crore were only submitted and an advances of ₹ 60.01 crore were lying unadjusted as of March 2016. Records relating to utilisation of ₹ 46.24 crore though called for by Audit, were not made available and it was intimated (June-September 2016) that all the records relating to this utilised amount were seized by Anti Corruption Bureau. Thus, the entire amount of ₹ 106.25 crore given to Director, IEC could not be vouchsafed by Audit.

Financial Management

Though the State Government projected the requirement of ₹ 8645.98 crore during 2011-16 in the State PIP but only 78.21 per cent funds were released and 75.11 per cent was utilised by SHS. Instances of delay in release of proportionate share by State Government to the SHS were noticed. Funds received for NRHM were diverted for other schemes of the State Government. Huge unadjusted advances were outstanding against Rajasthan Medical Services Corporation Limited, State Institute of Health and Family Welfare, Blocks, CHCs, PHCs and others.

Recommendation:

9. State Government should ensure better financial management by preparing realistic PIPs, better utilisation of available funds and ensure timely adjustment of outstanding advances.

2.1.12 Monitoring Mechanism

Audit Objective 6: To assess the adequacy of the monitoring mechanism.

The NRHM framework envisages intensive accountability structures based on internal monitoring through computer based Health Management Information System (HMIS). Further, Pregnancy, Child Tracking and Health Services Management System (PCTS) was implemented in Rajasthan during September 2009, for online tracking of pregnant women and infant and children, monitoring of immunisation and institutional deliveries etc. Each DHS was to develop a computer based Management Information System under NRHM framework and submit monthly reports to SHS.

2.1.12.1 Discrepancies in data

Scrutiny of data collected from PCTS, HMIS and basic records maintained in health centres related to 27 Reproductive and Child Health activities implemented during 2011-16, revealed the data of the activity was different in all three information systems, which are given in detail in ***Appendix 2.2***. Instances of substantial differences are elaborated below:

(i) Comparison of PCTS data with HMIS data

- Difference in the number of pregnant women to whom IFA tablets were given ranged from 15,217 (7.95 *per cent*) in 2011-12 to 52,431 (26.02 *per cent*) in 2015-16.
- Difference in number of women discharged within 48 hours of deliveries ranged from 13,817 (35.87 *per cent*) in 2014-15 to 56,215 (78.08 *per cent*) in 2012-13.

(ii) Comparison of PCTS data with basic records

- Difference in tubectomy sterilisations ranged from 9,948 (25.19 *per cent*) in 2014-15 to 12,702 (31.42 *per cent*) in 2012-13.
- Difference in 'oral pill cycles' ranged from 22,732 (3.04 *per cent*) in 2013-14 to 1,26,997 (14.11 *per cent*) in 2011-12.

(iii) Comparison of HMIS data with basic record

- Difference in tubectomy sterilisations ranged from 9,772 (24.75 *per cent*) in 2014-15 to 13,179 (40.14 *per cent*) in 2015-16.
- Difference in 'oral pill cycles' ranged from 23,250 (3.11 *per cent*) in 2013-14 to 1,27,383 (14.15 *per cent*) in 2011-12.
- Difference in women discharged within 48 hours of delivery ranged from 20,273 (45.07 *per cent*) in 2014-15 to 54,541 (74.04 *per cent*) in 2012-13.

The presence of such huge difference across the activities raises serious concern over utility of data for the purpose of planning and evaluation.

State Government, while accepting the facts, stated (November 2016) that validation error occurred while uploading in few cases. Further, data was not compiled during 2015-16, on the web portal due to technical reasons.

2.1.12.2 Monitoring by State and District Health Missions

NRHM envisaged an intensive accountability framework through a three pronged mechanism of internal monitoring, community based monitoring and external evaluations. The deficiencies noticed in monitoring are discussed below:

(i) As per NRHM guidelines, SHM at State level and DHM in each district were to conduct at least one meeting in every six month interval to discuss issues related to inter-sectoral coordination to promote NRHM. In this regard it was observed that:

- SHM did not hold any meeting during 2011-16, against the requirement of 10 meetings.
- Only two meetings of the Governing Body[54] were convened during 2011-16 against prescribed seven meetings. Similarly, only 22 meetings of the Executive Committee[55] were held during 2011-16 against prescribed 33 meetings.
- All DHMs in the State held only 45 meetings[56] against prescribed 334 meetings.
- In seven test checked districts, only 11 meetings[57] of DHMs were held against prescribed 70 meetings. Further, in Rajsamand district no meeting of DHM was held during 2011-16.
- 33 DHSs of the State held 301 meetings (during 2011-12), 291 meetings (during 2012-13), 236 meetings (during 2013-14), 269 meetings (during 2014-15) and 313 meetings (during 2015-16) against prescribed 396 meetings[58] per year.

State Government, while accepting the facts, stated (November 2016) that though the meeting of SHM was not conducted due to State Legislative Election in 2013, several review meetings were organised under the chairmanship of the Chief Minister.

The reply was not acceptable as the meeting of SHM, GB and EB of SHS, DHM were to be organised at the prescribed intervals for monitoring of the programme.

2.1.12.3 Community based monitoring

(i) Village Health Sanitation and Nutrition Committee (VHSNC), at village level was responsible for preparation of the Village Health Plans, organising public awareness programmes, analysing key issues and problems related to village level health activities etc. It was, however, observed that out

54 Governing Body: Six monthly meeting upto April 2013 and annual meeting from May 2013.

55 Executive Committee: Monthly meetings upto April 2013 and thrice in a year from May 2013.

56 17 meetings in 2011-12, eight meetings in 2012-13, seven meetings in 2013-14, two meeting in 2014-15 and 11 meeting in 2015-16.

57 Dausa-one, Jalore-two, Jhalawar-four, Nagaur-one, Pratapgarh-two, Rajsamand-nil and Sirohi-one.

58 12 monthly meetings for each DHS.

of 45,123 revenue villages in the State, VHSNCs were formed in 43,440 villages as of March 2016.

VHSNCs were not formed in 34 revenue villages of test checked district Jalore as of March 2016.

(ii) *Rogi Kalyan Samiti* (RKS) was to be constituted for day-to-day management of the affairs of the healthcare facilities at the DH, CHC and PHC levels. In State, RKSs was established with the nomenclature of Rajasthan Medicare Relief Society in all DHs. However, RKSs were not formed in 87 (out of 2080) PHCs and 13 (out of 571) CHCs of the State as of March 2016. In seven test checked districts, it was observed that RKS were not formed in nine PHCs of Jalore district as of March 2016.

State Government stated (November 2016) that 43,440 VHSNCs were formed in the State and the revenue villages having population less than 100 persons would be merged with nearby VHSNCs.

The reply was not acceptable as VHSNCs in 1683 villages were not formed and the village level planning was not done in all villages. Reasons for non constitution of RKSs in PHCs and CHCs were not intimated by the Government.

2.1.12.4 External evaluation

NRHM framework provided for external evaluation to track the effectiveness of the various activities for providing quality health services. It was observed that external evaluation of implementation of NRHM by an independent agency was not conducted in the State during 2011-2016.

Monitoring Mechanism

There were differences in data maintained in various databases i.e. Health Management Information System, Pregnancy Child Tracking & Health Services Management System and the original records available at the health centres, leading to huge discrepancies which were not reconciled.

State Health Mission did not hold any meeting during 2011-16 and the only two meetings (against seven) of Governing Body were conducted, which pointed to weaknesses in the apex monitoring process. Further at the district level only 14 per cent of the prescribed meetings of District Health Mission could be held.

Recommendations:

10. State Health Mission should ensure reconciliation and correctness of data so that the planning and decision making process could be based on more realistic inputs.

11. State Government should ensure that the prescribed monitoring system is followed at all levels so that the implementation of NRHM becomes more effective in the State.

2.1.13 Conclusion

The National Rural Health Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to poor and the vulnerable section of the population.

The State Health Mission did not follow the "Bottom up approach" for planning at the village and block level and this resulted in gaps in availability of infrastructure, equipment and manpower in most of the rural areas. Further instances of non-utilisation of staff quarters in health centres, non availability of all essential equipment in rural health centres and equipment lying unutilised, were also noticed. There were also shortages of medical and para medical staff in rural areas as compared to urban areas.

To reduce the risk and complications during pregnancy, all the pregnant women in the State could not be registered in the first trimester of their pregnancy and were also not provided all three mandatory checkups, IFA tablets and prescribed immunisations. Proper Post Natal Care could not be extended in case of home deliveries. The achievement against the target of sterilisation was just above fifty *per cent* and the involvement of men in the family planning process continued to be abysmally low.

The monitoring mechanism was weak as the State Health Mission, Governing Body and District Health Missions did not even hold twenty *per cent* of the required meetings.

The State continues to lag behind the All India Average and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th (out of 20) in Total Fertility Rate.

School Education Department

2.2 Implementation of Right of Children to Free and Compulsory Education Act, 2009

Executive Summary

Government of India (GoI) enacted the Right of Children to Free and Compulsory Education (RTE) Act in August 2009 for providing free and compulsory education to all children in the age group of 6-14 years. The RTE Act became operative in the State with effect from 1 April 2010 and the State Government notified Rajasthan RTE Rules in March 2011, however with delay of one year.

The objective of providing free and compulsory education through proper identification and enrolment was not achieved as Household Survey for identification of children in the age group upto 14 years was not done and 12.40 to 18.74 *per cent* children were not enrolled in schools during 2012-16. The exact requirement of neighbourhood schools could not be properly assessed. Further reduction in number of schools by 14.90 *per cent* and non-distribution of transport allowance to children further led to no significant improvement in increasing accessibility as required under the RTE Act/Rules.

The provisions for admission under 25 *per cent* RTE quota were delayed by two years by the State Government thereby depriving children belonging to weaker section and disadvantaged groups of free education in Non-Government Schools. Also 11,300 Non-Government Schools representing 16.36 *per cent* did not adhere to the provision of 25 *per cent* RTE quota.

The prescribed Pupil Teacher Ratio was not maintained in 30,549 schools which constitute 51.52 *per cent* even after five years of the commencement of the Act. The State Government could not provide basic facilities as required as per the RTE Act within the prescribed period of three years i.e. by March 2013 inspite of availability of the funds. Further even after six years i.e. March 2016, there were huge gaps in infrastructure facilities in the schools.

An amount of ₹ 318.15 crore released for implementation of the RTE Act could not be utilised during 2010-16. Further the State Government did not demand an amount of ₹ 190.84 crore from the GoI towards central share for implementation of the 25 *per cent* RTE quota in Non Government Schools. The monitoring mechanism was weak as the State Advisory Council met only three times against 15 in the last four years.

Thus, the key objective of RTE Act 2009 of universalisation of elementary education encompassing three major aspects of access, enrolment and retention of children in the age group of 6-14 years, was not fully achieved.

2.2.1 Introduction

To provide free and compulsory education to all children in the age group of 6-14 years, Article 21-A was inserted as a Fundamental Right in the Constitution of India through the Constitution (Eighty-Sixth Amendment) Act, 2002. Consequent to that, Government of India (GoI) enacted the Right of Children to Free and Compulsory Education (RTE) Act in August 2009. The RTE Act provides that every child of the age of 6-14 years shall have a right to free and compulsory education in a neighbourhood school till completion of elementary education.

The key objective of RTE Act, 2009 was universalisation of elementary education which encompasses three major aspects i.e. access, enrolment and retention of children in the age group of 6-14 years. *Sarva Shiksha Abhiyan* (SSA) which was the main vehicle for implementing the provisions of the RTE Act, was revised (March 2011) to align with the provisions of the RTE Act.

Though the literacy rate in the State of Rajasthan increased from 60.41 *per cent* in 2001 (Census 2001) to 67.06 *per cent* in 2011 (Census 2011), it was lower than national literacy rate of 74.04 *per cent* (Census 2011). Further, Rajasthan was ranked 33rd out of 35 states[59] including Union Territories (UTs) in literacy rate as per Census 2011 and in terms of female literacy rate, Rajasthan was ranked last among all states and UTs in the country. Thus the effective implementation of the RTE Act was an absolute requirement for improving the dismal situation of literacy in the State.

The RTE Act became operative in the State with effect from 1 April 2010 and the State Government notified (March 2011) Rajasthan RTE Rules (RTE Rules) with delay of one year.

At the State level, the Secretary, School Education Department implements the provisions of the RTE Act. At field level the provisions of the RTE Act are being implemented by Rajasthan Council for Elementary Education (RCEE), a State Implementing Agency of SSA. Director, Elementary Education (DEE) deals with Primary & Upper Primary Schools and Director, Secondary Education (DSE) deals with Secondary and Senior Secondary Schools having Primary/Upper Primary classes for the purpose of RTE Act.

2.2.2 Audit Methodology, Coverage and Criteria

The Performance Audit was carried out for the period 2010-16, during April 2016 to July 2016 which covered School Education Department (Elementary)

59 While the position of Rajasthan decreased from 29th in 2001 to 33rd in 2011, States like Uttar Pradesh and Jharkhand improved their position from 31st to 29th and 34th to 32nd respectively.

of the Government of Rajasthan (GoR), RCEE, DEE, DSE and 192 schools of 24 blocks in six selected districts[60].

These six districts out of 33 were selected by *'Population Proportionate to the Size without Replacement'* method. Twenty four blocks (three rural and one urban block of each district) and 180 schools (30 schools comprising 20 Government and 10 Non-Government) were selected by *'Simple Random Sampling without Replacement'* method. Out of these 180 schools, 102 Primary Schools (PS) & Upper Primary Schools (UPS) and 78 Secondary & Senior Secondary Schools having Primary and/ or Upper Primary classes were selected. Besides this, one Adarsh Secondary/Senior Secondary School and one Non-Government School having highest fee was selected randomly in each selected district. Thus a total of 192 schools were selected.

An Entry Conference with Secretary, School Education Department, GoR, was held on 22 April 2016 wherein Audit objectives, selection of units, Audit methodology and scope of PA were explained. An Exit Conference with Secretary, School Education Department, GoR, was held on 9 November 2016 wherein Audit findings and recommendations were discussed.

The data sources for Audit were District Information System for Education (DISE) and data from departmental authorities.

The Audit criteria were:

- Right of Children to Free and Compulsory Education Act, 2009.
- Rajasthan Right of Children to Free and Compulsory Education Rules, 2011.
- Various orders, notifications, circulars issued by GoI and GoR.
- DISE data[61].

2.2.3 Audit objectives

The objectives of the PA were to verify adherence to the criteria laid down in the RTE Act regarding:

(i) Identification and Enrolment of children in schools,

(ii) Ensuring access to schools and retention in schools till the completion of elementary education,

(iii) Ensuring admission of children in Non-Government Schools under 25 *per cent* RTE quota,

60 Districts Barmer (Baytu, Barmer, Chohtan and Shiv blocks); Jaipur (Amber, Dudu, Jaipur East & West and Phagi blocks); Jhunjhunu (Buhana, Jhunjhunu, Chidawa and Surajgarh blocks); Rajsamand (Bhim, Kumbhalgarh, Rajsamand and Railmagra blocks); Sikar (Dhod, Fatehpur, Laxmangarh and Piprali blocks) and Udaipur (Badgaon, Bhinder, Kotra and Sarada blocks).

61 DISE is an annual school based computerised information system having information on all types of PS/UPSs i.e. Government schools and Non Government schools. Information is collected annually (by 30th September every year) and the information regarding schools in Rajasthan is published annually in the form a booklet.

(iv) Achieving the prescribed Pupil Teacher Ratio within three years,

(v) Ensuring basic infrastructure facilities and qualification of the teachers, and

(vi) Effective financial management and monitoring.

2.2.4 Audit Findings

Identification and Enrolment of Children

Audit objective 1: Whether objectives of RTE Act regarding identification and enrolment of children in schools was adhered to.

2.2.4.1 Identification of Children

Section 9 of the RTE Act 2009 stipulates that every local authority shall maintain records of children up to age of 14 years residing in its jurisdiction through Household Survey, which will be updated annually.

It was observed that the State Government notified[62] *Zila Parishad* (ZP) as the local authority for RTE purpose (February 2014) with a delay of four years from the commencement of the Act. The ZPs did not conduct any Household Survey so far for identification of children aged upto 14 years, though required to do so. A Child Tracking Survey was conducted by the State Government in 2010 for identification of children. Despite repeated requests, details of 'out of school' children only was provided to Audit.

In the absence of specific identification of children in the age group of upto 14 years through a Household Survey and the lack of its annual updation as prescribed under the Act/Rules, the entire process of identification was diluted.

State Government stated (November 2016) that admissions are being done through identification of children on the basis of records maintained in Village Education Register/Ward Education Register (VER/WER) however, these registers would be updated. The reply was not convincing as no details of VERs/WERs were made available to Audit and as per RTE Rules, a Household Survey was required to be conducted annually, which was not done.

2.2.4.2 Enrolment of Children

Section 3 of the RTE Act 2009 stipulates that every child of the age of six to 14 years shall have a right to free and compulsory education in a neighborhood school till completion of elementary education.

The State level comparison between projected number[63] of children attaining the age of enrolment for elementary education as per Census 2011 (as the

62 The State Government appointed *Zila Parishad* and Government itself as local authority for schools falling under their respective administrative control.

63 As per Single Year Age Data (Table C-13) table downloaded from site of Ministry of Home Affairs, Office of the Registrar General & Census Commissioner of India.

Household Survey was not conducted by the concerned ZPs) and number of children admitted in both Government and Non-Government Schools during 2010-16 is exhibited in **Table 2.12**.

Table 2.12

(Number in lakh)

Year	The position of children in age group of 6 to 10 years			The position of children in age group of 11 to 13 years		
	Numbers as per Census 2011	Enrolled in Primary classes as per DISE data	Children not enrolled *(Percentage)*	Numbers as per Census 2011	Enrolled in Upper Primary classes as per DISE data	Children not enrolled *(Percentage)*
2010-11	NA	63.39	Can't be determined	NA	29.47	Can't be determined
2011-12	83.09	67.06	16.03 (19)	48.44	31.76	16.68 (34)
2012-13	80.43	69.74	10.69 (13)	52.94	36.55	16.39 (31)
2013-14	81.38	69.13	12.25 (15)	48.98	36.24	12.74 (26)
2014-15	78.99	67.10	11.89 (15)	51.45	36.49	14.96 (29)
2015-16	79.22	68.60	10.62 (13)	46.95	37.24	9.71 (21)

Source: DISE information and data as per Census 2011 (Data of Household Survey was not available).

The table above depicts that from 2011-12 to 2015-16, the number of children admitted in Primary and Upper Primary classes increased gradually, however, 13 to 19 *per cent* children in Primary and 21 to 34 *per cent* children in Upper Primary classes were not enrolled in any school in the State.

State Government stated (November 2016) that number of *'out of school'* children were less than that pointed out by Audit as many children of 6-10 years of age were also enrolled in class VI and above and at the very same time many children of 11-13 years of age were enrolled in primary classes as well as class IX.

However, comparison of figures provided by the State Government with census data is shown in the **Table 2.13**.

Table 2.13

Year	Number of children of 6-13 years of age (in lakh)		
	As per census 2011	Enrolled as per reply of State Government (in any class up to IX)	Not enrolled in any class up to IX (*Per cent*)
2012-13	133.37	108.37	25.00 (18.74)
2013-14	130.36	109.54	20.82 (15.97)
2014-15	130.44	107.72	22.72 (17.42)
2015-16	126.17	110.52	15.65 (12.40)

Thus, the fact remains that 12.40 *per cent* to 18.74 *per cent* children of 6-13 years of age were not enrolled in any class during 2012-16 and remained out of school.

Non-enrolment of children of 6-13 years of age in any class in test checked districts during 2012-16 is given in **Table 2.14**

Table 2.14

Name of district	Percentage of non-enrolment of children in any class in			
	2012-13	2013-14	2014-15	2015-16
Barmer	19.63	17.65	24.46	21.37
Jaipur	21.60	15.89	10.27	5.81
Jhunjhunu	16.32	13.86	11.91	9.22
Rajsamand	16.36	13.43	13.95	8.10
Sikar	22.67	18.96	14.62	10.31
Udaipur	24.42	22.22	25.54	19.56

Source: Data as per census 2011 and provided by RCEE

From the table above it can be seen that the percentage of non-enrolled children in any class in test checked districts ranged between 5.81 *per cent* and 25.54 *per cent.* Barmer and Udaipur districts had more non-enrolled children than the State average.

2.2.4.3 Enrolment of children in classes appropriate to their age

Section 4 of the RTE Act stipulates that where a child above six years of age has not been admitted in any school or though admitted could not complete its elementary education, shall be admitted in a class appropriate to age. Such a child has a right to receive special training to be at par with other children. Under Rule 6 of RTE Rules, School Management Committee (SMC) was required to organise special training for children admitted in a class appropriate to their age.

Scrutiny of records revealed that 83.17 lakh children {i.e. 20.64 *per cent* of the total enrolled children (402.92 lakh) in Government Schools} were enrolled in lower classes instead of class appropriate to their age. Moreover, 17.70 lakh children of more than 14 years of age were found enrolled even in class-III and above ***(Appendix 2.3)***.

Further, as per Physical Monthly Progress Report (MPR) of RCEE, special training was given to 1.30 lakh such children against the targeted 2.80 lakh children[64] during 2010-16 as detailed in **Table 2.15**.

Table 2.15

(Numbers in lakh)

Year	Numbers of children targeted for special training	Numbers of children given special training	Shortfall (in *Percentage*)
2010-11	0.18	0.09	0.09 (50)
2011-12	0.92	0.43	0.49 (53)
2012-13	0.94	0.31	0.63 (67)
2013-14	0.24	0.19	0.05 (21)
2014-15	0.27	0.14	0.13 (48)
2015-16	0.25	0.14	0.11 (44)
Total	**2.80**	**1.30**	**1.50 (53.57)**

Further, in the selected districts it was noticed that DEEO, Jhunjhunu, Rajsamand, Sikar and Udaipur did not maintain actual number of children. Barmer and Jaipur districts, provided (during 2010-16) training to 10,862 and 9,219 children respectively whereas details of total enrolled children were not maintained.

64 In the absence of any clear data of children enrolled in schools and requiring training, it has been assumed that the figures in MPR pertain to the total number of children requiring the special training.

State Government stated (November 2016) that concerned DEEOs have been instructed to maintain and update records of children admitted in classes appropriate to their age.

Identification and Enrolment of Children

The identification of children in the age group upto 14 years through a Household Survey was not done. As regards enrolment of children in schools, 12.40 to 18.74 per cent children were not enrolled in schools in the year 2012-16. Thus, the objective of providing free and compulsory education to all children upto 14 years of age through proper identification and enrolment has not been achieved.

Recommendation:

1. *The State Government/local authority should conduct annual Household Survey to identify number of children who attained the age upto 14 years and to ensure 100 per cent enrolment in schools.*

2.2.5 Access and retention in schools

Audit objective 2: Whether RTE criteria regarding access to schools including availability of neighborhood school and retention in schools was ensured.

2.2.5.1 Access to school

As per Rule 7 of RTE Rules, Primary Schools and Upper Primary Schools should be established within one and two kilometers distance from the neighborhood respectively.

Further, Rule 8(2) of RTE Rules assigns responsibility to the State Government or local authorities to undertake school mapping every year for determining neighborhood schools. RCEE conducted Geographical Information System (GIS) mapping only once (2010-12) after the implementation of the Act. Further, RCEE and DEE did not provide the data of that mapping and any other information about number of schools required as per GIS mapping to Audit.

The numbers of Government and Non-Government Schools having Primary/Upper Primary classes existing during 2010-16 in the State are given in **Table 2.16**.

Table 2.16

Year	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Number of Government Schools	78,460	79,149	80,787	85,685	72,200	72,915
Number of Non-Government Schools	26,730	30,040	32,314	33,866	34,054	35,021
Total	**1,05,190**	**1,09,189**	**1,13,101**	**1,19,551**	**1,06,254**	**1,07,936**

Source: As per DISE information.

The above table indicates that rather than increasing the numbers of schools for meeting the neighborhood school criteria, the schools were merged in August 2014 and the number of Government schools was brought down from 85,685 in 2013-14 to 72,915 in 2015-16 i.e., a decrease of 14.90 *per cent*. The reasons for the merger were to improve the quality of education and increase the transition rate to higher classes as many schools were having negligible enrolment. While there was marginal improvement in the transition rate (transition of children from class-V to class-VI) from 81.44 *per cent* in 2013-14 to 92.11 *per cent* in 2014-15[65] in Government schools, the fact remained that the accessibility of children to the neighbouring schools further decreased.

Owing to merger (August 2014) of schools, 4,399 school buildings were vacant and unused as of May 2016. DSE issued directions (May 2016) for utilisation of these vacant buildings in respect of schools merged with Secondary/Senior Secondary Schools. No such directions were issued by DEE for PSs/UPSs under his control. State Government stated (November 2016) that necessary instructions have been issued in this regard.

Further, the Reports of Monitoring Study conducted by two GoI nominated external agencies[66] for the year 2014-15 shows that children of seven schools each in Alwar and Sikar districts (out of 37 sample PS/UPS) and 459 children in Udaipur district (out of 40 sample PS/UPS) had to cover more distance than prescribed in RTE Rules for neighborhood schools as a result of the merger.

In test checked districts, requirement of schools as per the RTE norms was not worked out by any of the five DEEOs except DEEO Udaipur. DEEO, Udaipur intimated that requirement of schools in Udaipur district as per the RTE Rules for 2013-14 and 2015-16 worked out to be 4,153 and 3,665 schools respectively. Keeping in view the increasing trend in population, reduction in requirement of schools in 2015-16 as compared to 2013-14 doesn't seem justified.

State Government accepted the facts and stated that GIS report was used for opening and upgradation of schools. The reply was not convincing as State Government did not conduct the GIS mapping after 2012, as required by the RTE rules.

(i) Transport Allowance

As per RTE Rules, in case of small hamlets where no school exists within the area or limit of neighborhood specified above, free transportation and residential facilities shall be provided to children for elementary education.

State Government identified and sanctioned transport allowance to 12,097 children of 10 districts in 2011-12, whereas during 2013-14, transport allowance was paid merely to 961 children of Dungarpur and Udaipur districts

65 Out of 8.46 lakh children enrolled in class-V in 2013-14, 6.89 lakh (81.44 per cent) children were promoted in class-VI in 2014-15. Similarly, out of 8.62 lakh children enrolled in class-V in 2014-15, 7.94 lakh (92.11 per cent) children were promoted in class-VI in 2015-16

66 Centre for Development Communication and Studies in Alwar and Sikar districts and Shiv Charan Mathur Social Policy Research Institute in Udaipur district.

out of 87,561 identified children of 22 districts in the State. Identification of children eligible for transport allowance was not done during the period 2014-15 and 2015-16.

State Government stated (November 2016) that transport allowance was provided as per budget sanctioned by GoI. Reply was not tenable as in accordance to State RTE Rules, it was the obligation of the State Government to either ensure availability of neighborhood school within the prescribed limit or to provide transport allowance to children.

(ii) Transportation Arrangement for Children with Disability

As per Rule 7(7) of RTE Rules, the State Government or local authority shall make appropriate and safe transportation arrangements for children with disability to attend school and complete their elementary education. The details of transport allowance provided to disabled children are given in **Table 2.17**.

Table 2.17

Year	Number of children with disability			Status of utilisation of funds on IE[67] activities	
	Identified	Enrolled	To whom transport allowance was provided (*Per cent*)	Allocation as per AWP&B	Utilisation
				(₹ in crore)	
2010-11	2,34,121	2,20,626	3,183 (1.44)	32.44	17.23 (53.11)
2011-12	1,17,180	94,525	6,359 (6.73)	23.18	16.08 (69.37)
2012-13	1,30,327	1,15,857	8,425 (7.27)	23.44	18.88 (80.55)
2013-14	1,16,358	1,07,806	Nil	11.60	11.06 (95.34)
2014-15	1,25,081	1,17,911	10,950 (9.29)	11.63	8.35 (71.80)
2015-16	1,22,138	1,16,683	11,722 (10.05)	12.56	10.84 (86.31)
Total	**8,45,205**	**7,73,408**	**40,639 (5.25)**	**114.85**	**82.44 (71.78)**

Source: Information provided by RCEE. AWP&B: Annual Work Plan and Budget of SSA.

The table above depicts that during 2010-16, the State Government provided transport allowance to merely 5.25 *per cent* children with disability. Out of ₹ 114.85 crore allotted for IE activities for disabled children, ₹ 32.41 crore was lying unutilised during 2010-16. This could have been utilised for providing transport allowance to all disabled children. In six test checked districts, transport allowance was paid at the average of only 4.66 *per cent* to disabled children during 2010-16.

State Government stated that transport allowance was provided to disabled children (having 40 *per cent* or more disability except those with learning disability) going to Government schools within the budget provided by GoI. It was further stated that if transport allowance is paid to all disabled children then it will not be possible to provide other facilities[68] within the budget ceiling prescribed by GoI.

The fact however remains that RTE rules do not categorise disability of children for providing of transport allowance and the State Government

67 Inclusive Education (IE) activities include providing transport facility and other facilities to children with disability.

68 Large print books, braille books, hearing aids, speech therapy, tri-cycle, wheel chairs, calipers, correction surgery, educational support and physiotherapy etc.

should make appropriate transportation arrangement from its own funds. Moreover, even in case of Total Blind, Physically Impaired and Mentally Retarded enrolled children, the transport allowance was paid to only 4.72 *per cent* to 25.05 *per cent* of such disabled children. Thus, the objective of providing transport allowance for children with disability was not fulfilled.

2.2.5.2 Retention of Children in Schools

One of the main objectives of the RTE Act was to provide compulsory elementary education to all children in the age group of 6-14 year and this entailed retention of all children in schools till standard eight. The retention of children till elementary level consistently decreased during the period 2011-16, except 2015-16. The details of drop out children[69] are given in **Table 2.18**.

Table 2.18

(Number in lakh)

Numbers of children enrolled in classes-I to VII				Numbers of children enrolled in classes-II to VIII in the succeeding year				Numbers of drop out children		
Year	Gover-nment Schools	Non-Gover-nment Schools	Total	Year	Gover-nment Schools	Non-Gover-nment Schools	Total	Gover-nment Schools	Non-Gover-nment Schools	Total
1.	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9 (2-6)**	**10 (3-7)**	**11 (4-8)**
2010-11	64.93	43.42	108.35	2011-12	60.88	43.12	104.00	4.05	0.30	4.35
2011-12	65.47	46.65	112.12	2012-13	60.13	47.28	107.41	5.34	-0.63	4.71
2012-13	62.34	50.55	112.89	2013-14	56.50	48.36	104.86	5.84	2.19	8.03
2013-14	58.71	51.61	110.32	2014-15	52.03	49.80	101.83	6.68	1.81	8.49
2014-15	54.60	53.41	108.01	2015-16	53.26	49.79	103.05	1.34	3.62	4.96
Total	**306.05**	**245.64**	**551.69**	**Total**	**282.80**	**238.35**	**521.15**	**23.25**	**7.29**	**30.54**

Source: DISE information.

From table above it can be inferred that:

- Total number of drop out children from Primary and Upper Primary classes during 2010-11 to 2014-15 worked out to 30.54 lakh i.e. 23.25 lakh in Government Schools and 7.29 lakh in Non- Government Schools.

- It was noticed that as per RCEE claim of 9.08 lakh drop out children in Government schools, the number of drop out children calculated as per DISE data works out to 23.25 lakh.

As per information provided by the DEEOs of selected districts, the percentage of children dropping out from Government Schools during 2010-15 ranged from 0.03 to 13.50 *per cent*. Further, as per DISE data, the percentage of drop out children from Government Schools in the selected districts during 2010-15 also was similar and ranged from 0.34 to 13.94 *per cent* ***(Appendix 2.4)***.

State Government stated (November 2016) that the number of drop out children is based on district level information and is not based on DISE data.

69 In order to calculate the number of children dropping out class wise, a method was adopted by Audit wherein the number of children enrolled in class I to VII of a year was compared with number of children enrolled in class II to VIII of the succeeding year. The difference between the two would give the net figure of children dropping out in each class.

The reply is not convincing as the ultimate source of information of DISE is the data supplied by the schools. Thus, there is a need to reconcile the RCEE data with the DISE data. State Government also stated (November 2016) that suitable action would be taken to minimise drop out and increase retention.

Access and Retention in Schools

Due to non-execution of GIS mapping, the exact requirement of neighborhood schools could not be assessed. Reduction in number of schools by 14.90 per cent and non-distribution of transport allowance to children further lead to no significant improvement in increasing accessibility as required under the RTE Act/Rules. Further, the objective of retention of all enrolled children was not achieved.

Recommendations:

2. *The State Government should ensure either availability of neighborhood schools within prescribed distance or provide transport facility.*

3. *The State Government may take adequate steps to retain children, particularly in Government Schools till the completion of elementary education as mandated in the RTE Act.*

2.2.6 Implementation of RTE Act in Non-Government Schools

Audit objective 3: Whether RTE criteria regarding admission of children in Non-Government Schools under 25 per cent RTE quota was adhered to

2.2.6.1 Admission of weaker sectio n and disadvantaged group in Non-Government Schools

Sub Section (1)(c) of Section 12 of the RTE Act stipulates that Non-Government Schools shall admit children belonging to weaker section[70] and disadvantaged groups[71] in pre-primary and first standard to the extent of at least 25 *per cent* of the strength of that class in the neighborhood and provide free and compulsory elementary education to such children till its completion.

As per Sub Section (2) of the RTE Act *ibid*, these schools shall be reimbursed expenditure so incurred by them to the extent of per child expenditure incurred by the State or actual amount charged from the child, whichever is less. The

70 The State Government notified (March 2011) the child belonging to the following categories as 'child belonging to weaker section' (a) A child whose parents are included in the list of Below Poverty Line families (both Central and State lists) prepared by the Rural Development Department/Urban Development Department of the State Government, and (b) A child whose parents' annual income does not exceed ₹ 2.50 lakh.

71 The State Government notified (March 2011) the child belonging to the following categories as "child belonging to disadvantaged group" (a) the Scheduled Castes, (b) the Scheduled Tribes, (c) Other Backward Classes and Special Backward Classes whose parents' annual income does not exceed ₹ 2.50 lakh, and (d) a child covered under the definition of "person with disability" under clause (t) of Section 2 of the Person with Disability (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.

implementation of these provisions were to be monitored by DEEOs/DEOs. In this regard, the observations of Audit are as under:

Delay in implementing 25 per cent RTE quota

(i) The State Government made the provisions of admission under 25 *per cent* RTE quota applicable in the State since academic year 2012-13 i.e. with the delay of two years from the commencement of the Act. Hence, children belonging to weaker section and disadvantaged groups were deprived of free education in Non-Government Schools to that extent. Education Department attributed (June 2016) this delay to departmental procedures.

(ii) The process of admission of children in Non-Government Schools under 25 *per cent* RTE quota was started from academic year 2012-13 and admissions were given by these schools at their own level. The RTE web portal became fully operational in 2014-15. Thereafter, system of receiving online applications and preparing priority lists based on lottery through RTE web portal for admission in Non-Government Schools under 25 *per cent* RTE quota came into being.

State Government accepted (November 2016) the facts.

2.2.6.2 Non-implementation of 25 per cent RTE quota in Non-Government Schools

The details of Non-Government Schools in the State and children admitted therein under 25 *per cent* RTE quota during 2014-16 are given in **Table 2.19**.

Table 2.19

Year	Number of Non-Government Schools					Total Number of applications received on portal for enrolment under 25 *per cent* RTE quota	Total Number of children enrolled out of the applications received	Children not enrolled (*Percentage)*
	As per DISE	Registered with RTE portal	Which received applications under 25 *per cent* RTE quota	Which gave admiss-ions under 25 *per cent* RTE quota	Which did not give admission to children under RTE quota			
1	**2**	**3**	**4**	**5**	**6 (4-5)**	**7**	**8**	**9 (7-8)**
2014-15	34,054	31,951	28,669	25,776	2,893	3,26,642	1,76,719	1,49,923 (46)
2015-16	35,021	33,619	27,360	22,458	4,902	3,46,748	1,69,090	1,77,658 (51)
Total	**69,075**	**65,570**	**56,029**	**48,234**	**7,795**	**6,73,390**	**3,45,809**	**3,27,581 (49)**

Source: Information provided by RCEE.

It is evident from the table above that:

(i) During the years 2014-16, 3,505 Non-Government Schools representing 5.07 *per cent* of the total schools (as per DISE data) were not registered on RTE web portal. 7,795 schools received applications for admission under 25 *per cent* RTE quota but did not admit children. Thus a total of 11,300 Non-Government Schools representing 16.36 *per cent* of the total schools (as per DISE data) flouted the RTE Act.

State Government stated (November 2016) that there may be difference between number of registered schools and number of schools which did not give admission under 25 *per cent* RTE quota because many schools (minority schools, schools starting from second standard etc.,) though registered with

RTE web portal were exempted from admission under 25 *per cent* RTE quota. State Government however, did not provide category wise number of such registered schools.

(ii) During 2014-16, 49 *per cent* children who applied for admission under RTE quota were not enrolled in Non-Government Schools.

State Government stated (November 2016) that many seats under 25 *per cent* RTE quota remained vacant as many children applied in more than one school but took admission only in one school.

The fact remained that it was not possible to distinguish between the cases where the school denied admission and where the parents opted not to enroll their child in that school. In absence of any system of assessment, it is not clear how the RCEE was convinced of the schools' claims that the children were not interested in claiming admission in that school under the 25 *per cent* quota.

(iii) During test check of 11 Non Government Schools, it was seen that one school[72] admitted children under RTE quota in pre-primary class only during 2012-16 and did not admit them in Class-I. Thus 51 children were denied admission under RTE quota in Class-I during 2012-16. No information regarding any action taken against the school was made available.

State Government stated (November 2016) that DEEO, Jaipur-I has been instructed to take action against the school.

(iv) During test check of Non-Government Schools, it was noticed that in four schools, 63 under-age children were admitted in class-I under 25 *per cent* RTE quota. As per verification report of the year 2015-16, District Authorities had verified all such children and recommended for reimbursement of fees.

State Government stated (November 2016) that necessary directions have already been issued in this regard. The State Government however, did not intimate what action has been initiated against the defaulters.

2.2.6.3 Reimbursement to Non-Government Schools

As per RTE Rules, the reimbursement to Non-Government Schools for admitted children under 25 *per cent* RTE quota was to be made in two installments, first in October and second in June of the succeeding year. The position of reimbursement (as on 10th May 2016) made to Non-Government Schools during the years 2012-13 to 2015-16 is given in ***Appendix 2.5***.

Scrutiny of reimbursement data revealed that second installment was not paid to Non-Government schools for three to nine *per cent* of enrolled and verified children. Further, six to 29 *per cent* children for whom second installments was paid dropped out before moving to the next class. The reasons for dropout

72 Maharaja Sawai Mansingh Vidhyalaya, Jaipur.

were not analysed by the respective DEOs and BEEOs. Further, in the test checked Non-Government Schools, 11.22 *per cent* to 17.95 *per cent* children, admitted under 25 *per cent* RTE quota during 2012-13 to 2014-15, dropped out, the reasons for which were not intimated to Audit.

State Government stated (November 2016) that one of the reasons for providing second installment for lesser number of children to schools might be non-submission of necessary certificates by the schools regarding supply of free text books and ancillary material to children. This indicates that the State Government was not even aware of the actual reasons for dropping out by children.

2.2.6.4 Non-recognition of Non-Government Schools

Section 18 and 19 of the RTE Act stipulate that no school other than those owned or controlled by the appropriate Government or the local authority shall be established or function without obtaining a certificate of recognition from authority, in such form, within such period and such manner as may be prescribed. Such recognition shall be granted on fulfilling the norms[73] and standards specified in the Schedule annexed to the RTE Act.

Schools that do not conform to the norms, standards and conditions mentioned in the RTE Act and Rajasthan Recognition Rules[74], 2011, within three years from the commencement of the RTE Act, shall cease to function.

Scrutiny of information collected from five test checked districts (except Jaipur[75]) and information provided (June 2016) by DEE in respect of additional nine districts **(*Appendix 2.6*)** revealed that 7,040 Non-Government Schools did not apply for grant of recognition till March 2013 i.e. three years from the commencement of the RTE Act. Even as of December 2015, 1,434 Non-Government Schools did not apply for grant of recognition and are running in violation of the provisions of the RTE Act. Further, test check of 66 Non-Government Schools confirmed that even in Jaipur and Jhunjhunu districts, three[76] schools were running without recognition and recognition of five schools[77] had expired on March 2015 in Jaipur district.

State Government accepted the facts and stated (November 2016) that the instructions have been issued to DEEOs in this regard.

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73 Norms include maintenance of prescribed Pupil Teacher Ratio, building and other infrastructure etc.

74 Rajasthan Non-Government Educational Institution (Recognition, Grants and Service conditions etc.) (Amendment) Rules, 2011.

75 Data regarding recognition of Schools was not available with DEEO for Jaipur district.

76 Saint Francis Senior Secondary School, Jaipur, New Adarsh Vidya Mandir UPS, Mahlan, (Dudu block) Jaipur and Yuvraj Public School, Makoro, Jhunjhunu.

77 Tanuj Bal Niketan UPS Dev ka Harwada, Saraswati Bal Vidhya Mandir Gidhani, Shri Krishna Academy UPS Hachukuda, Jakhar Vidhya Peeth Secondary School, Seva and Shri Dev BaL Secondary School Heerapura.

Implementation of RTE Act in Non-Government Schools

The provisions for admission under 25 per cent RTE quota were made applicable after a delay of two years by the State Government. This deprived children belonging to weaker sections and disadvantaged groups of free education in Non-Government Schools. Also 11,300 Non-Government Schools representing 16.36 per cent did not adhere to the provision of 25 per cent RTE quota. Further 1434 Non-Government Schools did not apply for grant of recognition and are running in violation of the provisions of the RTE Act.

Recommendations:

4. *The State Government should ensure that the provisions of the RTE Act regarding admission under 25 per cent quota into all Non-Government Schools should be strictly adhered to.*

5. *The State Government should ensure that all Non-Government Schools are recognized and are not running in violation of the provisions of the RTE Act.*

2.2.7 Pupil Teacher Ratio

Audit objective 4: Whether RTE criteria regarding Pupil Teacher Ratio was adhered to within prescribed period.

(i) Section 25(1) of the RTE Act stipulates that within three years from the date of commencement of this Act, the appropriate government or local authority shall ensure the Pupil Teacher Ratio (PTR) in each school as specified in the Schedule[78] annexed to the RTE Act.

The position of single teacher schools and PTR in Government PS and UPS during 2010-16 at the State level is given in **Table 2.20**.

Table 2.20

Year	Number of school	Number of single teacher schools		Number of schools (not single teacher) having PTR more than prescribed limit	Total number of schools not maintaining prescribed PTR (in *per cent)*
		having enrolment up to 30 children	having enrolment more than 30 children		
2010-11	68,659	4,062	10,395	23,265	37,722 (72.72)
2011-12	68,954	NA	NA	NA	NA
2012-13	69,966	5,097	9,100	21,929	36,126 (51.63)
2013-14	73,069	6,265	6,517	18,853	31,635 (43.29)
2014-15	58,743	6,067	7,216	14,669	27,952 (47.58)
2015-16	59,293	5,453	5,983	19,113	30,549 (51.52)

Source: DISE information.

78 **For Primary classes**: At least two teachers should be there for up to 60 children, three teachers for 61-90 children, four teachers for 91-120 children, five teachers for 121-150 children and five teachers plus one head teacher for more than 150 children. **For Upper Primary classes:** (1) At least one teacher per class should be there so that there shall be at least one teacher each for (i) Science and Mathematics, (ii) Social Studies, (iii) languages; (2) one teacher for every 35 children, (3) where children are more than 100 (i) one full time head teacher; (ii) part time instructors for-Art Education, Health and Physical Education and Work Education.

(a) As per the norms of RTE Act, prescribed PTR should be achieved within three years from the commencement of the Act. However, from the table above it can be observed that during 2013-14 i.e. three years after the commencement of the Act, PTR was above the required ratio in 31,635 schools (43.29 *per cent*). Further, even after five years i.e. in 2015-16, the PTR has not been achieved in 30,549 schools (51.52 *per cent*).

(b) As per the norms of RTE Act, the minimum requirement of teachers in PS and UPS is two and three respectively. However, in violation of the PTR norms 12,782 and 11,436 PS/UPS were running with a single teacher in 2013-14 and 2015-16 respectively.

Further, of the 126 test checked Government schools in six districts, the PTR in 2015-16 was higher than the prescribed limit in 99 schools (78.57 *per cent*). Of these 25 PSs were single teacher schools.

State Government stated (November 2016) that action is being taken to maintain prescribed PTR through rationalisation of posting of teachers.

(ii) Rule 21 of RTE Rules prescribes that the appropriate government or the local authority shall notify sanctioned strength of teachers in each school every year. The requirement of teachers is to be assessed every year on the basis of the number of children appearing in the last summative evaluation in the preceding academic session and DEE is responsible to consolidate sanctioned and working strength of teachers.

It was observed that such exercise was not done by DEE for the years 2010-11, 2011-12, 2012-13, 2013-14 and 2014-15. Only in June 2015, DEE determined requirement of 1,97,192 teachers as per RTE norms for 52,281 Government schools and sent it to the State Government for approval which remained pending before the State Government as of May 2016. State Government stated (November 2016) that now as per RTE Act/Rules school wise teachers have been sanctioned. The State Government however did not intimate total number of teachers required as per RTE norms in the State.

In the 126 test checked Government Schools, the position of shortage and excess of teachers as per requirement of the RTE Act is given in **Table 2.21** below:

Table 2.21

Standard	Number of teachers short, as per RTE Act						Number of teachers excess, as per RTE Act					
	In Urban area		In Rural area		Total		In Urban area		In Rural area		Total	
	S	T	S	T	S	T	S	T	S	T	S	T
Primary	11	16	47	69	58	85	6	10	13	18	19	28
Upper primary	13	25	30	56	43	81	2	2	28	43	30	45

S-Number of schools T-Number of teachers

Thus, there is a need to rationalise the posting of excess teachers in line with the requirements.

Pupil Teacher Ratio

The prescribed Pupil Teacher Ratio was not maintained in 30,549 schools which constitute 51.52 per cent even after five years of the commencement of the Act. Further the requirement of teachers, which was assessed only in 2015-16, has not been provided so far.

Recommendation:

6. *The State Government should ensure that the prescribed Pupil Teacher Ratio should be maintained at the earliest by working out the requirement of teachers and take necessary steps to appoint them speedily.*

2.2.8 Infrastructure Facilities and Qualification of Teachers

Audit objective 5: Whether RTE criteria regarding basic infrastructure facilities and qualification of the teachers were adhered to.

2.2.8.1 Infrastructure Facilities

As per Section 19 of the RTE Act, every school should have all weather building consisting of at least one class room for every teacher, barrier free access, separate toilets for boys and girls, safe and adequate drinking water facility for all the children, a kitchen where mid-day meal is cooked in the school, play ground, library and arrangements for securing the schools building by boundary wall or fencing, within the period of three years from the commencement of the Act.

(i) Out of the total 72,915 Government schools in the State, 69,152 PSs and UPSs were maintained[79] by the State Government. Out of the 69,152 schools, 67,484 schools were having their own building, 166 schools were running in rented buildings, 925 were running in rent free buildings and 577 schools were running without buildings. The details of lack of infrastructure facilities in 67,484 Government Schools as per DISE data 2015-16 is given in **Table 2.22**.

Table 2.22

Sl. No.	Facility	Lacking in number of schools (*Per cent*)	Sl. No.	Facility	Lacking in number of schools (*Per cent*)
1.	All weather Building	577 (0.85)	7.	Play ground	38,549 (57)
2.	Additional class room	17,633 (26)	8.	Library	16,746 (25)
3.	Ramp	27,331 (41)	9.	Boundary wall	12,152 (18)
4.	No toilet/separate toilet for boys & girls	3 (0.004)	10.	Electricity	39,860 (59)
5.	Drinking Water	2,175 (3)	11.	School building requiring major repair	14,598 (22)
6.	Kitchen shed	9,880 (15)	12.	Class rooms requiring major repair	28,672 (42)

Source: DISE information.

79 Government schools include schools running under Department of Education, Local Body, Sanskrit Education and Shiksha Karmi Management only. They do not include schools running under Central Government, Tribal Welfare Department, Madarsas, Kasturba Gandhi Balika Vidhyalayas and Child Labour schools.

The table above depicts the weaknesses in the infrastructure in the schools requiring attention.

- Lack of electrical connections in 39,860 (59 *per cent*) schools is the major infrastructural bottleneck in Government schools in the State.

State Government stated (November 2016) that under SSA there was provision for carrying out work related to internal electrical fittings in school building up to 2012-13 only. There was never any provision for providing of electricity connection since beginning itself. GoI is also not providing funds for carrying out work related to internal electrical fittings in school building since 2012-13.

- In respect of other infrastructural deficiencies in the schools, the State Government while accepting facts, stated (November 2016) that new school buildings could not be constructed due to non availability of funds from GoI and non availability of land. Further, GoI did not approve funds for library and play grounds under SSA.

- The position of funds allotted by GoI and State Government under Capital Head for creation of infrastructure and its utilisation thereof is shown in **Table 2.23**.

Table 2.23

(₹ in crore)

Year	Opening balance	Funds allotted	Total available funds	Funds utilised	Funds lying unutilised	Percentage unutilised
2012-13[80]	-	357.41	357.41	266.75	90.66	25.37
2013-14	90.66	156.83	247.49	125.99	121.50	49.09
2014-15	121.50	163.81	285.31	228.72	56.59	19.83
2015-16	56.59	200.82	257.41	126.05	131.35	51.03
Total		**878.87**		**747.51**		**14.95**

Source: Annual Accounts of RCEE.

From the table above it can be observed that in spite of a dire need to upgrade infrastructure as given in **Table 2.22**, percentage of unutilised funds ranged from 19.83 *per cent* (2014-15) to 51.03 *per cent* (2015-16). Further, even as of March 2016, an amount of ₹ 131.35 crore remained unutilised.

(ii) In the test checked 126 Government Schools, it was observed that one school was running without school building and 33 schools did not have one classroom for every teacher. There were lack of separate toilets in seven schools, library in 18 schools, boundary wall in 34 schools, kitchen shed in nine schools, electricity connection in 23 schools, play ground in 47 schools, ramp in three schools and drinking water in 10 schools.

80 No funds were separately allotted under Capital head prior to 2012-13.

Condition of Toilets

Toilet structure in Shri Raj Public School, Vardadha in Rajsamand district.

Unhygienic toilet in Government PS, Shobhagpura, Udaipur district.

View of dysfunctional toilet in Government Girls UPS, *Losing*, Udaipur district.

Government PS, Vavda in Rajsamand district situated on the road but has no boundary wall.

2.2.8.2 Qualification of Teachers

As per Rule 16 of RTE Rules the minimum qualification laid down by the academic authority notified by the GoI under section 23 (1) of the RTE Act shall be applicable to all schools referred to in clause (n) of Section 2 of the RTE Act. No appointment of teacher for any school can be made of any person not possessing the minimum qualification laid down by central academic authority. Rule 18 *ibid* prescribes that teachers, in schools owned and controlled by the State Government or the local authority at the time of commencement of the RTE Act, who do not possess the minimum qualification laid down by the central academic authority, shall acquire such minimum qualification within a period of five years from the commencement of the RTE Act. The National Council of Teacher Education (NCTE), being

the Central Academic Authority, prescribed (August 2010 and July 2011) minimum qualification[81] for appointment of teachers for class-I to V and class-VI to VIII.

(i) There were 5.01 lakh school teachers (Government schools: 2.55 lakh and Non-Government schools: 2.46 lakh) in the State as of September 2015. The various categories of teachers include permanent teachers and contractual teachers which include para-teachers and *Shiksha Karmis*. Information regarding qualification of all teachers in Government and Non-Government schools though called for was not made available. In the absence of this information it was not possible to ascertain the compliance to Rule 16 of RTE.

Scrutiny of records of DEE however, revealed that 4,163 *Shiksha Karmis* were functioning as teachers in 2,752 *Shiksha Karmi* Schools[82] during 2015-16. As per Administrative Report 2014-15 of DEE, 3,447 untrained *Shiksha Karmis* lacked the prescribed qualification even as of 31st March 2015, i.e. cutoff date prescribed by the Act for acquiring minimum qualification. Information regarding educational status of the balance 716 *Shiksha Karmis* was not available. Similarly, 3,137 para-teachers were posted in Government Schools during 2015-16 on monthly fixed honorarium basis. However, no information was made available about their educational status also.

State Government accepted the facts (November 2016) that both trained and untrained para-teachers are working in the Government schools.

Details of the 192 test checked schools with regard to qualification of the teachers are given in the **Table 2.24**.

Table 2.24

Type of school	Total Number of schools and teachers		Number of qualified teachers		Number of un qualified teachers	
	Schools	Teachers	Schools	Teachers	Schools	Teachers
			(*Percentage*)			
Government	126	644	115 (91)	631 (98)	11 (9)	13(2)
Non-Government	66	696	27 (41)	549 (79)	39 (59)	147 (21)
Total	**192**	**1,340**	**142 (74)**	**1180 (88)**	**50 (26)**	**160 (12)**

Source: As per information provided by test checked schools.

81 Minimum qualification for classes I to V- (a) Senior Secondary with at least 50 *per cent* marks and two years Diploma in Elementary Education or Senior Secondary with at least 50 *per cent* marks and four years Bachelor Degree of Elementary Education or Senior Secondary with at least 50 *per cent* marks and two years Diploma in Education (Special Education) or Graduation and two years Diploma in Elementary Education and (b) Teacher Eligibility Test (TET) passed.
For classes VI to VIII- (a) Graduation and two years Diploma in Elementary Education or Graduation with at least 50 *per cent* marks and one year Bachelor Degree in Education or Graduation with 45 *per cent* marks and one year Bachelor Degree in Education or Senior Secondary with at least 50 *per cent* marks and four years Bachelor Degree in Elementary Education or Senior Secondary with at least 50 *per cent* marks and four years BA/B. Sc. B. Ed. or B.A. B. Ed/B. Sc. B. Ed. or Graduation with at least 50 *per cent* marks and one year B.Ed. (Special Education) and (b) TET passed.

82 *Shiksha Karmi* Schools, functioning in the State in remote villages and hamlets, was being imparted by locally available manpower on fixed monthly honorarium basis.

From the table it can be seen that the percentage of non qualified teachers was two *per cent* in Government schools. As the recruitment in Government schools is controlled by the Government, the non-compliance to the minimum qualification is restricted to the para teachers and the *Shiksha Karmis* who are engaged on a contractual basis. The fact however remains that as per the RTE Act, these teachers were supposed to acquire the basic qualification within five years of the commencement of the Act i.e. March 2015.

In the case of Non-Government schools it can be seen that the percentage of unqualified teachers (21 *per cent*) was very high in the test checked schools. In the absence of any information available on this requirement with the DEE, this important aspect could not be verified for all the 2.46 lakh Non-Government teachers in the state.

State Government stated (November 2016) that database of all Non-Government Schools is being prepared on school web-portal which includes qualification of teachers also. Necessary action would be taken regarding qualification of teachers after completion of the database.

Infrastructure facilities and qualification of teachers

The State Government could not provide basic facilities as required as per the RTE Act within the prescribed period of three years i.e. by March 2013 inspite of availability of the funds. Further even after six years i.e. March 2016, there were huge gaps in infrastructure facilities in the schools. Further RCEE had not made an overall assessment of the total funds required to provide all the necessary infrastructure as mandated under the RTE Act.

Large number of contractual teachers in Government schools are yet to acquire the minimum qualifications as prescribed under the Act. There is no centralised system to monitor the qualification of teachers in Non-Government schools and as per test check the percentage of non qualified teachers in Non-Government schools was much higher than in Government schools.

Recommendation:

7. The State Government should make an overall assessment of the total funds required to provide all the necessary infrastructure as mandated under the RTE Act and ensure availability of necessary infrastructure at the earliest.

2.2.9 Financial Management and Monitoring

Audit objective 6: Whether Financial Management and monitoring of activities were effective.

2.2.9.1 Financial Management

(i) Releases and utilisation of funds

During 2010-11 to 2014-15, the GoI and the State Government were required to share funds for implementation of the RTE Act in ratio of 65:35, which

was revised to 60:40 from 2015-16. The position of funds received and their utilization by RCEE during 2010-11 to 2015-16 is given in **Table 2.25**.

Table 2.25

(₹ in crore)

Year	Approved outlay	XIII FC Grants-in-Aid	Opening balance	Funds released by		Other receipts*	Total available funds	Actual expenditure	Closing balance (*Per cent*)
				GoI	State Govern-ment				
2010-11	3,099.79	-	246.59**	1,461.82	1,180.73	16.48	2,905.62	2,644.25	261.37 (9.00)
2011-12	3,675.46	320.00	261.37	1,485.81	1,222.10	21.15	3,310.43	3,047.69	262.74 (7.94)
2012-13	3,999.08	356.00	262.74	1,535.20	1,417.57	19.68	3,591.19	3,405.55	185.65 (5.17)
2013-14	4,215.48	394.00	185.65	2,424.89	1,129.82	55.79	4,190.15	3,641.00	549.15 (13.11)
2014-15	4,836.36	409.00	549.15	2,480.41	1,230.24	28.09	4,696.89	4,256.39	440.50 (9.38)
2015-16	5,026.14	0.00	440.50	1,934.62	2,132.09	67.29	4,574.50	4,256.35	318.15 (6.95)
Totals	**24,852.31**	**1,479.00**		**11,322.75**	**8,312.55**	**208.48**	**23,268.78**	**21,251.23**	

* Other receipts include bank interest earned on grants etc.
**This opening balance relates to unutilised funds of SSA.
Source: Audited Annual Accounts of RCEE.

During 2010-16, against the approved outlay of ₹ 24,852.31 crore, GoI/State Government released only ₹ 19,635.30 crore leaving a gap of ₹ 5,217.01 crore (20.99 *per cent*). Further, even the amount released could not be fully put to use and an amount ₹ 318.15 crore remained unutilised. This adversely impacted on provision of infrastructural facilities in schools (paragraph 2.2.8.1), IE activities {paragraph 2.2.5.1(ii)} and implementation of other activities[83] of the RTE Act.

State Government, while accepting the facts (November 2016), did not intimate action plan for utilisation of ₹ 318.15 crore.

(ii) Budget allotment by the State Government for reimbursement of fees for admission by Non-Government Schools under 25 per cent RTE quota

DEE allotted online budget through Integrated Financial Management System (IFMS) to BEEOs and DEOs for reimbursement to Non-Government schools for children admitted under 25 *per cent* RTE quota. The position of Budget Estimates (BEs), funds allocated and expenditure incurred there under during 2012-16, is given in **Table 2.26**.

Table 2.26

(₹ in crore)

Year	Budget Estimates (BEs)	Revised Estimates (REs)	Budget allocation	Expendi-ture incurred	Saving with respect to BEs (*Percentage*)	Saving with respect to REs (*Percentage*)
2012-13	92.20	42.20	42.20	16.55	75.65 (82)	25.65 (61)
2013-14	280.00	65.50	65.50	52.88	227.12 (81)	12.62 (19)
2014-15	162.50	162.50	162.50	127.54	34.96 (21)	34.96 (21)
2015-16	400.00	188.47	188.47	146.40	253.60 (63)	42.07 (22)
Total	**934.70**	**458.67**	**458.67**	**343.37**	**591.33 (63)**	**115.30 (25)**

Source: Information provided by DEE.

83 Activities like training to age appropriate children, learning enhancement programme (LEP), research evaluation monitoring and supervision (REMS), teachers training etc.

Audit observed that:

- During 2012-16, in spite of reduction of BEs of ₹ 934.70 crore to ₹ 458.67 crore (51 *per cent*) in REs, the total expenditure incurred was ₹ 343.37 crore only resulting in 25 *per cent* saving with respect to REs. Thus, substantial savings with reference to REs indicates that estimates were not calculated rationally.

State Government stated (November 2016) that (i) in 2012-13 provision in REs was made in anticipation of expenditure but due to delayed allotment (March 2013) of funds to BEEOs, there were savings, (ii) saving in 2013-14 was due to reduction in number of eligible children and fees of most of the schools was less than unit cost fixed for reimbursement and (iii) in 2015-16 target was fixed for reimbursement of 4.97 lakh children but due to reduction in number of eligible children and other reasons, there were savings.

The fact however, remained that consistent savings during 2012-16 in the range of 19 to 61 *per cent* (averaging 25 *per cent*) was high as compared to REs and pointed to the need for improved budgetary management.

- During the year 2015-16, out of allotted fund of ₹ 188.47 crore to DEE for reimbursement, ₹ 42.07 crore was lying unspent with DEE as on 31st March 2016. Further, it was noticed that 125 BEEOs generated (January-February 2016) online budget demand of ₹ 23.10 crore for reimbursement of first installment which remained pending till the end of the year despite availability of ₹ 42.07 crore with DEE.

State Government stated (November 2016) that due to non surrender of unspent funds as on 31 March 2016 by subordinate offices to DEE, funds could not be allotted to 125 BEEOs is indicative of poor management of funds.

- As per Section 7(1) of the RTE Act, the Central Government and the State Government shall have concurrent responsibility for providing funds for carrying out the provisions of the RTE Act. It was noticed that during 2012-15, the State Government reimbursed ₹ 196.97 crore from own budget head to Non-Government Schools under 25 *per cent* RTE quota. For the year 2015-16, the State Government demanded ₹ 41.71 crore from the GoI only for 1.89 lakh children out of total 3.83 lakh children admitted under 25 *per cent* RTE quota. On being pointed out, Additional Commissioner, RCEE accepted the facts and stated (June 2016) that claim for 2015-16 in AWP&B was raised for children studying in class-I and above in 2014-15. The reply was not convincing as first installment to Non-Government Schools during 2014-15, was reimbursed for 3.83 lakh children but thereafter RCEE demanded funds for lesser number of children (i.e.1.89 lakh) from the GoI.

Thus, not raising demand of funds for the years 2012-15 and demanding funds for lesser number of children in 2015-16 by the State Government from the

GoI resulted in extra financial burden of ₹ 190.84 crore[84] on the State Government.

(iii) Adjustment of Advances

As per para 74.1 of Manual of Financial Management (MoFM) of SSA, all funds released to the districts and block level units are initially classified as advances and indicated accordingly in the books of accounts. These advances shall be adjusted based on the expenditure Statements/utilisation certificates received in State Implementation Society of having spent the funds. Advances, if not actually spent and for which accounts have not been settled, should be shown as advances and not as expenditure.

Scrutiny of Annual Accounts of the RCEE revealed that ₹ 156.06 crore were outstanding against 15 districts level units as on 31 March 2015. However, contrary to this provision of MoFM, the outstanding amount was depicted as 'nil' in the annual accounts for the year 2014-15. The reasons for this was called for from RCEE but reply was still awaited (August 2016).

2.2.9.2 Monitoring mechanism

(i) State Advisory Council

In pursuance of Section 34 of the RTE Act and Rule 28 of the RTE Rules, the State Government constituted (June 2012) a State Advisory Council[85] (SAC) for advising on implementation of provisions of the RTE Act in an effective manner. The State Government reconstituted it in August 2014. As per Rule 28 (7) (a) *ibid* gap between last and the next meeting of the SAC shall not be more than three months.

In this regard, it was observed that against 15 quarterly meetings of SAC required to be held since its constitution, only three meetings (November 2012, May 2013 and June 2015) were held till March 2016. Further the State Government did not take concrete follow up action on the issues advised by SAC. Out of 15 issues[86] advised by SAC in its third meeting (June 2015), follow up action on only four issues[87] were taken up. Thus, neither the meetings of the SAC were held as per provisions nor comprehensive action was taken on its recommendations. Many of the issues discussed but not followed up continued to be deficiencies in the implementation of the RTE Act in the state.

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84 For 2012-13 to 2014-15: ₹ 128.03 crore (65 *per cent* of ₹ 196.97 crore) plus for 2015-16: ₹ 62.81 crore i.e. 60 *per cent* of ₹ 104.69 crore (₹ 146.40 crore- ₹ 41.71 crore already received from GoI).

85 SAC constituted under Chairmanship of Education Minister, Government of Rajasthan and consisting six ex-officio and six nominated members.

86 Pupil Teacher ratio, data updation, reconciliation of DISE data with DEE data, special training, access to schools, infrastructural facilities, minimum qualification of teachers, syllabus & curriculum, admission under 25 *per cent* RTE quota, recognition of Non-Government Schools, training to SMC members, redressal of grievances of teachers, continuous and comprehensive evaluation, withholding of children and conduct of meetings of SAC.

87 Syllabus and curriculum, redressal of grievances of teachers, continuous and comprehensive evaluation and withholding of children.

State Government stated (November 2016) that meetings of SAC will be regulated and advice on issues discussed by SAC are being implemented.

(ii) School Management Committee

Section 21(1) of the RTE Act stipulates that a Government School shall constitute a School Management Committee (SMC) consisting of the elected representatives of the local authority, parents or guardians of children admitted in such school and teachers of that school. The SMC shall perform functions like monitoring the working of the school and utilisation of grants received from the appropriate government or local authority, preparing and recommending school development plan etc.

Though SMC/executive committee were constituted in most of the test checked schools, however, the School Development Plan which was to include estimates of class-wise enrolment, requirement of additional teachers, additional infrastructure and financial requirement had not been prepared. This resulted in the issue of grants to the schools not based on development plans made by them. This defeated the very purpose of having a *'bottom up approach'* for planning.

State Government did not reply about reasons for not preparing of School Development Plan by SMCs.

(iii) State Commission for Protection of Child Right

As per Section 31 of the RTE Act, the National Commission for Protection of Child Rights (NCPCR) and the State Commission for Protection of Child Rights (SCPCR) constituted under relevant section of Commissions for Protection of Child Rights Act, 2005 shall, in addition to other functions, monitor the issue of Right of Children to Education.

The State Government through the notification of Department of Women and Child Development constituted (April 2010) Rajasthan State Commission for Protection of Child Rights (RSCPCR) under Protection of Child Rights Act, 2005. It was observed that only one person is looking after the functions of the RTE Act.

As per information provided (May 2016) by RSCPCR, the Commission received 1,041 complaints regarding lack of basic infrastructure in schools, misbehavior of teachers, shortage of teachers etc., during 2010-16. Of these only 378 complaints were disposed of by concerned offices of education department whereas 663 complaints including 361 complaints pertaining to the period prior to 2013-14 were still pending as of July 2016.

State Government did not furnish any reply in this regard.

Financial Management and Monitoring

An amount of ₹ 318.15 crore released for implementation of the RTE Act could not be utilised which impacted on activities like training to children of appropriate age , learning enhancement programme, research evaluation monitoring and supervision and teachers training. Further the State Government did not demand an amount of ₹ 190.84 crore from the GoI towards central share for implementation of the 25 per cent RTE quota in Non Government Schools. The monitoring mechanism was weak as the State Advisory Council met only three times against 15 in the last four years. Further School Development Plans were not made by School Management Committees and this defeated the very purpose of having a 'bottom up approach' for planning.

Recommendations:

8. The State Government should ensure better utilisation of funds so that the activities as mandated under the RTE Act do not suffer.

9. The State Government should ensure that for monitoring the implementation of the RTE Act, quarterly meetings of the SAC are mandatorily held and the recommendations properly followed up.

2.2.10 Conclusion

The objective of providing free and compulsory education to all children upto 14 years of age through proper identification, enrolment and retention has not been achieved as 12.40 *per cent* to 18.7*4 per cent* children of 6-13 years of age were not enrolled in any class during 2012-16. Reduction in number of schools by 14.90 *per cent* and non-distribution of transport allowance to children further led to no significant improvement in increasing accessibility as required under the RTE Act/Rules.

The provisions for admission under 25 *per cent* RTE quota were delayed by two years by the State Government and 11,300 Non-Government Schools representing 16.36 *per cent* did not adhere to the provisions. The prescribed Pupil Teacher Ratio was not achieved even after five years in 30,549 schools which constitute 51.52 *per cent*.

State Government could not provide basic facilities required as per the RTE Act even after six years and there were huge gaps in infrastructure facilities in the schools. Large numbers of contractual teachers in Government schools are yet to acquire the minimum qualifications as prescribed under the Act. The amount released for implementation of the RTE Act could not be fully utilised and this impacted the implementation of the Act. The State Government did not demand an amount of ₹ 190.84 crore from the GoI towards central share for implementation of the 25 *per cent* RTE quota in Non Government Schools. The monitoring mechanism was weak as the State Advisory Council met only three times against 15 in the last four years.

Thus, the key objective of RTE Act 2009 of universalisation of elementary education encompassing three major aspects of access, enrolment and retention of children in the age group of 6-14 years, was not fully achieved.