Chapter II

Performance Audits

Health, Medical and Family Welfare Department

2.1 Reproductive and Child Health under National Rural Health Mission

Executive Summary

The Reproductive and Child Health (RCH) programme initiated under NRHM emphasised public health measures essential for enhanced maternal and child survival and lower RCH morbidity. The performance audit of Reproductive and Child Health under National Rural Health Mission was conducted (during April to August 2017), covering the period from 2012-13 to 2016-17.

Annual Facility level surveys for identification and fixing of decentralised monitorable goals, indicators and gaps/deficiencies in the existing healthcare facilities and areas of interventions were not conducted. Bottom-up and community owned approach to public health planning was also not followed in preparation of State Program Implementation Plans (SPIPs).

The Department had not utilised fully the funds released in any of the years under review. Utilisation ranged between 38 and 44 per cent only during 2012-14 and between 39 and 46 per cent only during 2014-17. Shortfall in spending on maternal health ranged between 31 to 50 per cent during 2014-17. The expenditure on child health component did not exceed 26 per cent of the approved outlay in any year during the period 2014-17.

The institutional deliveries declined from 69 per cent (2013-14) to 42 per cent (2016-17) in public health facilities as compared to deliveries in private health facilities which registered an increase from 31 to 58 per cent. Telangana had a very high rate of Caesarean-section deliveries at 45 per cent out of the total deliveries reported in the State. In private health institutions it was higher at 67 per cent. Adequate attention on availability of required physical as well as human infrastructure in the health facilities was not accorded. Maternal Death Review (MDR) and the Infant Death Review (IDR) were largely not conducted. In other cases, these Reviews were ineffective. The State had achieved 100 per cent immunisation of children of 0 – 1 year age group. Maternal Mortality Ratio and Total Fertility Rate was satisfactory at State level.

2.1.1 Introduction

National Rural Health Mission (NRHM)[1] was launched in India in April 2005 with a view to provide accessible, affordable and quality health care to rural population, especially the vulnerable sections. NRHM is an umbrella programme subsuming the existing programmes

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

of health and family welfare. It comprises the components of health systems' strengthening, reproductive, maternal health, newborn, child & adolescent health and national disease control programmes.

The Reproductive and Child Health (RCH) programme initiated under NRHM emphasised[2] all public health measures were essential for enhanced maternal and child survival and lower RCH morbidity.

For the implementation of the above activities under RCH, the NRHM Framework (2005-12) underlined the need for upgradation of Community Health Centres (CHCs) as First Referral Units (FRUs) for dealing with Emergency Obstetric Care[3], 24X7 delivery services at the Primary Health Centres (PHCs) and operationalising of Sub-Centres[4] (SCs). As per NRHM Framework (2012-17), NRHM seeks to reduce the Maternal Mortality Ratio (MMR) in the country to 100 per one lakh live births, reduce Infant Mortality Rate (IMR) to 25 per 1000 live births and reduce the Total Fertility Rate (TFR) to 2.1 per woman.

2.1.1.1 Organisational Setup

At the Central level, the Mission Steering Group (MSG) headed by the Union Minister of Health and Family Welfare provides policy direction to the Mission.

At the State level, the Mission functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The State Program Management Unit (SPMU) acts as the Secretariat to the State Health Mission. The State Society was headed by an Executive Director/Mission Director. Every district has a District Health Society (DHS), which is headed by the District Collector.

Primary Health Centre (PHC) is the first contact point between village community and the medical officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotional aspects of health care. The Community Health Centres (CHCs), constituting the secondary level of health care, were designed to provide referral as well as specialist health care to the rural population. Similarly, specialist services in providing emergency obstetrics care and neonatal care are to be made available in Area Hospitals (AHs) and District Hospitals (DHs).

NRHM would seek to empower the Panchayati Raj Institutions (PRIs) at each level, i.e., Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District). This was to take leadership to control and manage the public health infrastructure at district and sub-district levels. The Sub-Centre (SC) is the most peripheral and first contact point between the primary health care system and the community. The organisational structure of NRHM in the State is shown in Organogram below.

[2] care in pregnancy, all aspects of Essential Newborn Care, Immunisation, all aspects of prevention and management of malnutrition, family planning services, identification and management of anaemia
[3] cases of emergency with respect to the management of normal and complicated pregnancy, delivery and the postpartum period
[4] Sub-Centre is the first contact point between the primary health care system and the community

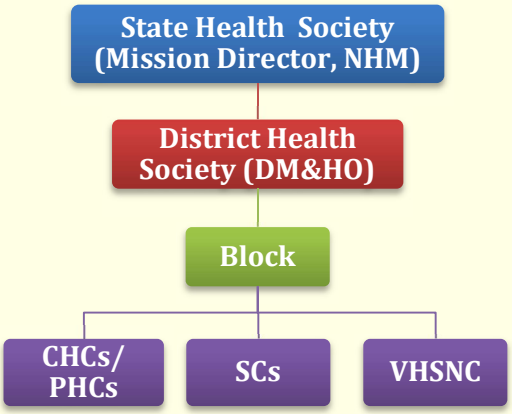
2.1.2 Audit Framework

2.1.2.1 Audit objectives

Performance audit of the RCH Programme under NRHM was carried out to assess

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

Organisational structure of NRHM in the State



CHCs: Community Health Centres; **PHCs:** Primary Health Centres; **SCs:** Sub-Centres; **VHSNC:** Village Health Sanitation and Nutrition Committee

Source: 'NRHM Operational guidelines for Financial Management', January 2012

2.1.2.2 Audit Criteria

Audit findings were benchmarked against criteria sourced from the following:

⇒ Indian Public Health Standards (IPHS) – Guidelines (Revised 2012);

⇒ NHM Framework for Implementation (2012-17);

⇒ NRHM Operational Guidelines for Financial Management, 2012;

⇒ Guidelines of Janani Suraksha Yojana (JSY), 2005; Janani Shishu Suraksha Karyakram (JSSK), 2011; Rashtriya Bal Swasthya Karyakram (RBSK), 2013 etc.;

⇒ Operational guidelines for Quality Assurance in Public Health Facilities 2013;

⇒ Health Management Information System[5] (HMIS) data;

⇒ Assessor's Guidebook for Quality Assurance in District Hospitals 2013; Community Health Centres (First Referral Unit) 2014; Primary Health Centres (24 x 7) 2014;

⇒ Orders, circulars, etc., issued by the State Government from time to time; and

⇒ Sustainable Development Goals as envisioned by the United Nations.

2.1.2.3 Audit Scope and Methodology

The performance audit was conducted (during April to August 2017), covering the period from 2012-13 to 2016-17. It involved test-check of records in the State Health Society (SHS)/Commissionerate, at the State level. At the field level, three[6] District Health Societies, three District Hospitals (DHs) (out of six), nine Community Health Centres (CHCs)/Area Hospitals (AHs) (out of 157), 27 Primary Health Centres (PHCs) (out of 836) and 81 Sub-Centres (SCs) (out of 4,745) were also test-checked.

[5] Web based monitoring system maintained by Ministry of Health and Family Welfare, GoI
[6] Medak, Nalgonda and Warangal

Audit Sample

The districts were selected by Simple Random Sampling without replacement method (SRSWOR) method. In each sampled district, one DH along with three AHs/CHCs, nine PHCs and 27 SCs were selected for test-check under SRSWOR method. Details of sampled units are given *Appendix-2.1*.

Entry conference was held (April 2017) with the Special Chief Secretary to Government and the Mission Director, NHM, wherein audit objectives and criteria were explained. An Exit Conference was held with Government representatives in January 2018 to discuss Audit findings. Replies of the DMHOs/Medical Superintendent (DHs/AHs and CHCs)/ Medical Officer (PHCs) and the Commissioner of Health and Family Welfare (Mission Director, NHM) wherever available have been considered/incorporated at appropriate places in the Report. Views expressed by the Government during the Exit Conference and their responses in written replies have also been incorporated at appropriate places in the report.

Acknowledgement

We acknowledge the cooperation and assistance rendered by the officials of the Health, Medical and Family Welfare Department during the conduct of the Performance Audit.

Audit findings

2.1.3 Planning

2.1.3.1 Annual facility level surveys

Under NRHM guidelines, every health facility centre has to identify gaps in health care facilities, areas of interventions, etc., that would be required for providing quality health care. Every SHS will have to conduct an Annual Facility survey to finalise an annual plan of activities for creation and strengthening of infrastructure in health care facilities.

Audit, however, observed that no annual facility level surveys were conducted in the State. Therefore, identification and fixing of decentralised monitorable goals, indicators and gaps/deficiencies in the existing health care facilities, areas of interventions, etc. required for providing quality health care was not possible.

In their reply (January 2018) Government stated that proposals for conducting Annual Facility survey had been submitted to GoI in Program Implementation Plan (PIP) for the year 2017-18. The sanction for the same was awaited from GoI.

2.1.3.2 State Program Implementation Plans

The NRHM envisaged a bottom-up, decentralised and community owned approach to public health planning. The process begins at the block level, which prepares the 'Block Health Action Plan (BHAP)' and sends it to district. This is based on inputs/discussions with the implementing units. These BHAPs are then aggregated to form an Integrated District Health Action Plan (IDHAP). IDHAP is further sent to the State level. State Program Implementation Plan (SPIP) is to be prepared on the basis of District Health Action Plans (DHAPs).

Audit noticed that the SPIPs were prepared without obtaining any inputs from district/ village level authorities/committees during 2012-17. The Mission was thus being

implemented in the State without following the bottom-up approach. The gaps in services, areas of interventions, probable investment in each area, requirement and the availability of resources were also not identified.

Government accepted the audit observation and stated (January 2018) that in view of reorganisation of 10 districts into 31 districts in 2016, the inputs from districts and block level committees could not be considered. It was further stated that the same would be followed while preparing SPIPs from 2017-18 onwards.

2.1.4 Financial Management

2.1.4.1 Budget and Expenditure

NRHM is being implemented as a Centrally sponsored scheme and the funding was in the ratio 75:25 by GoI and State Government up to 2014-15 and revised to 60:40 from 2015-16 onwards. NRHM Funds are pooled together under a "Mission Flexi Pool" which is further divided into

- 'RCH' component for activities such as maternal health, child health, family planning, etc.
- 'Additionalities under NRHM' component for any additional activities like ASHA[7], RKS[8], Untied funds, annual maintenance grants, etc.
- 'Immunization' component for routine immunization and pulse polio activities and
- National Disease Control Programmes.

The funds received by the State are further disbursed to the District Health Societies in accordance with the requirements stated in the respective District Health Annual Plans (DHAPs). The district authority disburses funds to the blocks which in turn disburse funds to various implementing units (CHCs/PHCs/SCs/VHSNCs) for programme implementation activities. The year-wise details of funds released by the Ministry, State share released *vis-à-vis* the expenditure incurred during the last five years were as under:

Table-2.1

(₹ in crore)

Year	Opening balance	Central Share released	State share credited	Total fund available	Expenditure	Unspent balance (%)
2012-13	583.42	529.94	506.78	1620.14	720.25	899.89 (56)
2013-14	899.89	498.35	225.75	1623.99	617.44	1006.55 (62)
2014-15 (1 June 2014)	1006.55	0.03	21.48	1028.06	48.81	979.25* (95)
2014-15 (2 June 2014 to March 2015)	354.98*	278.83	142.36	776.17	315.80	460.37 (59)
2015-16	460.37	118.68	94.08	673.13	308.16	364.97 (54)
2016-17	364.97	423.52	433.37	1221.86	473.01	748.85 (61)

Source: Records of State Health Society

** The erstwhile State of Andhra Pradesh was bifurcated into AP and Telangana w.e.f. 2 June 2014. The unspent balance for 2014-15 as allocated to Telangana State, was adopted*

[7] Accredited Social Health Activist
[8] Rogi Kalyan Samiti

The year-wise utilisation was poor and non-utilisation ranged between 56 and 62 *per cent* during 2012-14 (composite State of Andhra Pradesh) and 54 and 61 *per cent* during 2014-17. Government replied (January 2018) that as the funds were received during last quarter of the financial years and carried forward to the next financial year for the purpose for which the fund had been released. Due to this reason huge unspent balances were available with SHS.

Substantial unspent balances calls for rationalising the procedure for timely release of funds by the Government to SHS.

(i) Utilisation of funds under free essential drugs initiative

Free essential drugs initiative was introduced under NRHM for ensuring uninterrupted availability of drugs in the public health system and relief to the patients in reducing the out-of-pocket expenditure on purchase of drugs.

The State incurred a meagre expenditure of ₹10.11 crore (12 *per cent*) against the allocation of ₹83.99 crore during 2014-17 on provision of free essential drugs as shown in Table-2.2.

The unspent balances ranged from 55 to 100 *per cent* during 2014-17. Government accepted the audit observation and promised to look into the matter.

Table-2.2 **(₹ in crore)**

Year	Allocation	Expenditure	Unspent (%)
2014-15	40.00	Nil	40.00 (100)
2015-16	23.89	1.07	22.82 (96)
2016-17	20.00	9.04	10.96 (55)
Total	**83.99**	**10.11**	**73.88 (88)**

Source: Records of State Health Society

Non-utilisation of funds on procurement of generic medicines for supply to public health facilities resulted in non-availability of essential medicines to patients.

2.1.4.2 Utilisation of funds under Maternal Health and Child Health

NRHM-RCH Flexible Pool is one of the components of NRHM funding, under which Audit examined two sub-components of Maternal Health and Child Heath. Scrutiny of approved projected outlay, i.e., State Program Implementation Plan (SPIP) *vis-à-vis* the expenditure under the two components of Maternal Health and Child Health revealed that expenditure on projected outlays under maternal health and child health was very poor.

Chart-2.1 (a)
Utilisation of funds under Maternal Health

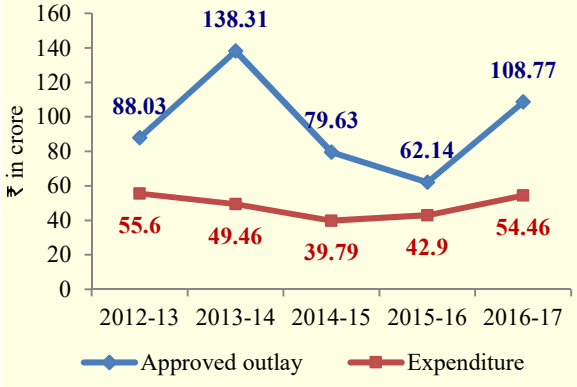
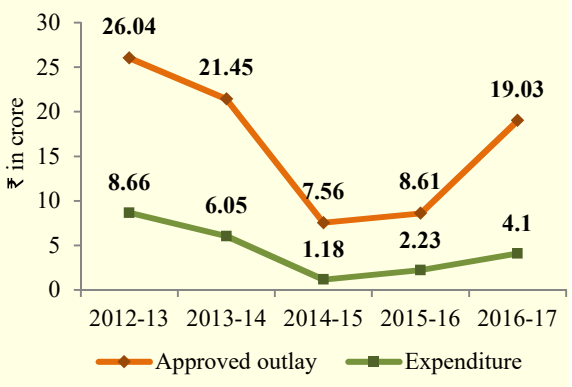


Chart- 2.1 (b)
Utilisation of funds under Child Health



Source: Records of State Health Society

The shortfall in spending on maternal health ranged between 31 to 50 *per cent* during 2014-17 whereas the expenditure on child health component had not exceeded 26 *per cent* of the approved outlay in any year during the period 2014-17. Shortfall in utilisation of funds under maternal and child health components showed ineffective implementation of RCH programmes and enhanced the risk of maternal and infant deaths.

Government replied (January2018) that the facility-wise analysis on utilisation of RCH funds would be conducted immediately.

2.1.4.3 Selection of an ineligible NGO

Area Hospital, Siddipet, of erstwhile Medak district entered (February 2015) into an agreement with an NGO[9] for providing vehicles for referral services at the rate of ₹8 per kilometre and drop back services to pregnant women and delivered mothers at agreed rate of ₹250 per case.

Audit observed that, the NGO did not have any motor fleet for executing the above services and the said services were performed by private individuals. An amount of ₹10.85 lakh towards payment for the above services[10] from JSSK funds had been released to an outside agency[11] (fuel filling station) not connected either with NGO or the owner of the vehicle.

Thus, agreement was entered into with one agency (NGO), vehicles were being operated by other agency (Hospital) and payments were released to a third agency (fuel filling station) which amounted to misutilisation of scheme funds. The matter calls for a probe by the Department.

Government replied (January 2018) that the DMHO would be asked to conduct a detailed enquiry and submit a report through the District Collector.

2.1.5 Implementation of Reproductive and Child Health services

Majority of pregnancy complications can be averted by preventive care of pregnant women, such as antenatal check-ups, early detection of risks, appropriate and timely management of obstetric complications, postnatal care, etc.

2.1.5.1 Antenatal Care (ANC)

Antenatal Care (ANC) to pregnant women (PW) required important considerations regarding diet, life-style and drug therapies to achieve a good foetal outcome with minimal maternal morbidity and mortality. Good ANC reduces the risk of childbirth complications. The World Health Organisation recommends that PW should receive four antenatal check-ups. Guidelines[12] also aimed to provide four ANCs to all PW for ensuring proper investigations like haemoglobin, blood grouping, urine examination, administration of two doses of Tetanus Toxoid (TT) and supply of 100 Iron Folic Acid (IFA) tablets. The first ANC was to be provided within 12 weeks, second within 14-26 weeks, third within 28-34 weeks and fourth check-up within 36 weeks up to term of pregnancy to monitor the progress.

[9] NGO named CARPED
[10] for Referral transport @ ₹8 per km and Dropback services @ ₹250 per case
[11] Sai Ranga filling station
[12] for Antenatal Care and Skilled Attendance at Birth, 2010 issued by MoH&FW

The data pertaining to the first three ANC check-ups to pregnant women for the period 2012-17 was not available with SHS. In their reply, Government confirmed (January 2018) that during 2014-17 the data of ANC check-ups was not captured in HMIS[13] data, although it was done at field level.

Iron Folic Acid (IFA) administration

Anaemia is considered as the leading cause of maternal mortality. Reproductive and Child Health (RCH) programme under NRHM, therefore, emphasised administration of IFA tablets for pregnant women for a period of 100 days.

During 2012-17, SHS reported that 41. 93 lakh pregnant women were registered for ANC. Further, it was seen that during the period 2012-15, up to 97 *per cent* and during 2015-17, cent *per cent* ANC registered women were given IFA tablets.

Audit, however, noticed that anaemia cases increased from 1.42 lakh in 2012-13 to 2.93 lakh in 2016-17. Similarly, severe anaemia cases also increased from 11,373 cases (2012-13) to 14,848 cases (2016-17) with maximum of 28,182 cases in 2015-16. Reasons for increase in cases of severe anaemia were not stated by Government.

In the three sampled districts, it was seen that the shortfall in administration of IFA tablets ranged from 2 to 19 *per cent*. Further, in Warangal district, the cases of severe anaemia increased drastically from 109 cases in 2012-13 to 2121 cases in 2016-17 despite the administration of IFA tablets up to 97 *per cent* of the registered ANC.

DMHO Warangal has assured that although the awareness about the consumption of IFA tablets by PW is a continuous programme at sub-centre level, all efforts would be made to improve the consumption of IFA tablets by PW.

Government replied (January 2018) that previously pregnant women were given only 100 IFA tablets during pregnancy but from 2016-17 all the pregnant women received 180 tablets (from 2nd trimester till delivery) and moderate to severe anaemia were given double the dosage (360 tablets). The reply is, however, not acceptable as the rise in anaemic cases during the period was contrary to the claim made by Government.

2.1.5.2 Deliveries

Institutional deliveries

Out of 41.93 lakh pregnant women registered for ANC during 2012-17, only 21.34 lakh (51 *per cent*) deliveries were reported by SHS. The data pertaining to the remaining 20.61 lakh women including any Medical Termination of Pregnancies (MTPs) was not furnished to Audit.

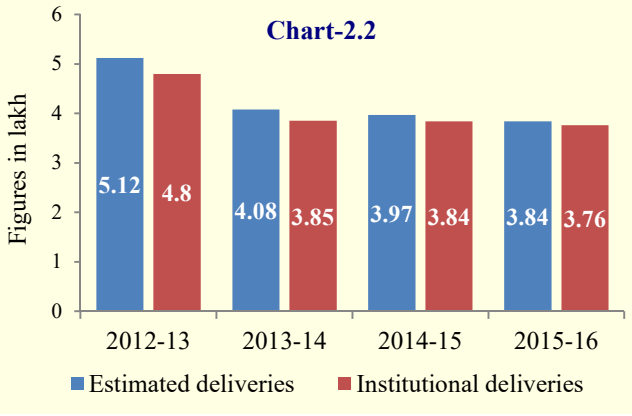
Achievement of Institutional deliveries against those targeted ranged from 94 to 98 *per cent* during the period 2012-13 to 2015-16[14].

[13] Health Management Information System
[14] data for Targeted deliveries for the period 2016-17 was not furnished by SHS

The number of deliveries in the year 2016-17 was 5.08 lakh. However, the target for Institutional deliveries for the year 2016-17 was not furnished to Audit.

As per SHS data, the institutional deliveries in public health facilities decreased from 69 *per cent* (2013-14) to 42 *per cent* (2016-17) against the total institutional deliveries in the State.

Chart-2.2



Source: Records of State Health Society

Deliveries in Private and Public Institutions are indicated in Table-2.3.

Table-2.3

Year	Total deliveries	Public (*per cent*)	Private (*per cent*)
2013-14	385435	265113 (69)	120322 (31)
2014-15	384287	240548 (63)	143739 (37)
2015-16	375957	193412 (51)	182545 (49)
2016-17	507896	211384 (42)	296512 (58)

Source: SHS data

The deliveries in public institutions declined from 69 to 42 per *cent* and whereas in private health institutions it increased from 31 to 58 *per cent.* It was observed that there was a shortage of health centres like CHCs, shortage of manpower in PHCs, non-functional PHCs which led the public to prefer private hospitals in anticipation of better infrastructure and health care which are discussed in detail in *Paras 2.1.6 and 2.1.8*.

Caesarean section deliveries

In order to manage the complications developing during delivery/child birth, deliveries are made through a surgical incision called Caesarean section (C-section) as an emergency procedure.

Telangana State, with 45 per cent, had a very high C-section rate in the country. Audit noticed from SHS data that C-section deliveries increased from 33 *per cent* (2013-14) to 45 *per cent* (2016-17). This indicated the ineffective Antenatal care provided in the State which resulted in an increase in C-section deliveries. ***It was further observed that C-section deliveries at private institutions were on higher side (67 per cent) as compared to those at public health facility centres (33 per cent).***

As per World Health Organisation (WHO), C-sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. The ideal rate for C-Sections should be between 10 and 15 per cent

Due to shortage of gynaecologists, anaesthetists, and general surgeon in Public Health Facilities, people were forced to go to private health facilities for C-section deliveries.

Government during Exit Conference (January 2018) admitted the fact of higher side of C-section deliveries in Private institutions. Government, in its written reply (January 2018) also stated that special trainings would be given to Medical Officers and Staff Nurses to conduct normal deliveries.

The State had failed to put in place a mechanism to discourage higher incidences of C-section deliveries in private institutions.

2.1.5.3 Postnatal care

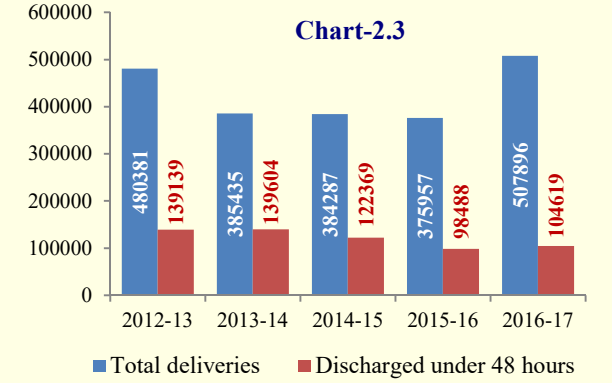
Discharging of mothers within 48 hours of delivery

As per RMNCH+A[15] guidelines, obstetric complications and maternal deaths occur during delivery and intra-partum period[16], a critical time for recognising and responding to obstetric complications and seeking emergency care to prevent maternal deaths.

Audit noticed that in 21 to 36 per cent cases of reported Institutional deliveries during 2012-17, mothers were discharged within 48 hours of delivery.

In the sampled districts, it was seen that the percentage of discharge of delivered mothers within 48 hours of delivery ranged from 1 to as high as 70 *per cent* in Medak, from 10 to 18 *per cent* in Nalgonda and up to 48 *per cent* in Warangal, during 2012-17.

This maximised the risk of maternal and infant deaths due to complications arising during *intra-partum* period.



Source: Records of State Health Society

In their reply (January 2018), Government stated that mothers who delivered without C-Section would prefer to go home within 48 hours as there was no support system for them at home to take care of their other children. It was, however, stated that the Audit observation would be addressed.

Post-partum check-up

National Rural Health Mission guidelines state that the first 48 hours of the post-partum (PP)[17] period followed by first one week are the most crucial period for the health and survival, of both the mother and her newborn. Further, most of the fatal and near-fatal maternal and neo-natal complications occur during the post-partum period. Ensuring post natal care during this period is hence, important for identification and management of emergencies.

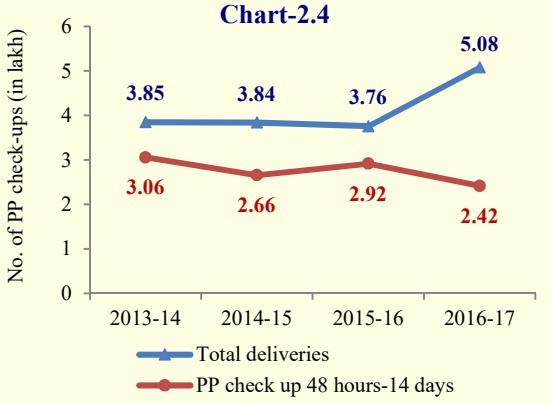
[15] Reproductive, Maternal, Newborn, Child and Adolescent Health
[16] the first 48 hours after childbirth
[17] A Postpartum(or postnatal) period begins immediately after the birth of a child and extends for about six weeks, as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state

Audit noticed that during 2013-17, 21 to 52 per cent of delivered mothers had not received the PP check-up between 7 and 14 days of the delivery.

The above shortage in the stipulated PP check-ups put the mothers at the risk of fatal complications.

Government in their reply (January 2018) stated that steps were being taken to ensure 100 *per cent* reporting for PP check-ups.

Chart-2.4



Source: Records of State Health Society

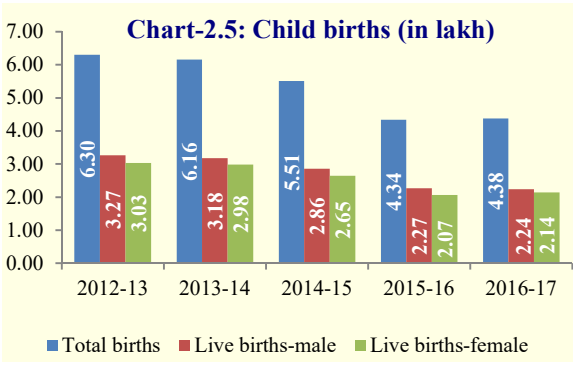
During Exit Conference, it was further stated that Telangana stood 2nd in the country in respect of newborn care and was the best as far as IMR and MMR was concerned.

Live births & weight of newborn

Gender inequalities & child sex ratio

Sex selective abortions result in declining sex ratio at birth. Preventing illegal sex determination and sex selective abortions require implementation of the provisions of Pre-Conception & Pre-Natal Diagnostic Technique Act (PC&PNDT) and Medical Termination of Pregnancy (MTP) Act so as to safeguard the rights of women to access safe and comprehensive abortion care services.

Chart-2.5: Child births (in lakh)



Source: Records of State Health Society

During 2012-17, reported total live births were 26.70 lakh. Of these, rate of male child birth continued to be at 52 *per cent* while the rate of female child birth stood at 48 *per cent*. The rate of female-male sex ratio at birth declined from 925 females (2012-13) to 915 females (2015-16) against 1,000 male live births. However, the ratio in 2016-17 increased to 959:1000.

The SHS attributed (October 2017) the decline in birth of female child during 2012-13 to 2016-17 to (a) the male preferences in the families; (b) the religious beliefs and faiths; (c) increase in illiteracy even though huge government's efforts were on to improve the literacy rate in the State, and (d) non-awareness about the importance of gender equality, etc. It was further stated that measures were being taken to identify unregistered machines/clinics/hospitals outside the list of registered centres through regular inspections by the district health authorities. Detailed list of registered centres under PC&PNDT Act was, however, not yet published.

Government replied (January 2018) that advertisements were floated in radio and electronic media, kalajatara, role plays, etc. regarding the consequences of illegal activity relating to disclosure of sex of the foetus.

However, the comparatively lower rate of female births reported is a matter of serious concern, indicative of ineffective enforcement of MTP and PC&PNDT Acts in the State.

Low birth weight children

Low Birth Weight (LBW) is closely associated with foetal and neonatal mortality and morbidity, inhibited growth and cognitive development, and chronic diseases later in life. In order to strengthen the care of LBW newborns, Special Newborn Care Units (SNCU) were to be established[18] at District Hospitals and tertiary care hospitals.

Audit observed that 7 to 18 *per cent* of live births during the period 2012-17 were not weighed within 24 hours of birth. Audit further observed that during the period, seven *per cent* of the newborns weighed were identified as LBW, i.e., having less than 2.5 kilograms at birth. Further, in the test-checked AHs/CHCs, four out of nine hospitals lacked the facility for identification and management of such LBW infants.

Thus, non-identification of LBW children among the live births is fraught with the risk of impaired growth, higher mortality and risk of chronic adult diseases.

Government while accepting the audit observations stated (January 2018) that reorientation training would be provided to staff working at delivery points.

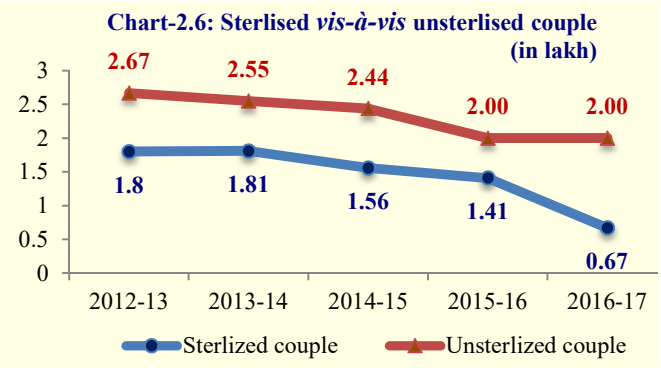
2.1.5.4 Family planning

As per RMNCH+A guidelines, family planning services would be utilised as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilising population. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for promotion of family planning and improving reproductive health.

Limiting methods

The limiting methods to be adopted by females include Laparoscopy (Tubectomy), Minilap procedures etc. while those by males include Conventional/Non-Scalpel Vasectomy.

Audit noticed that out of 11.66 lakh estimated unsterilised eligible couples, 7.25 lakh (62 *per cent*) had undergone sterilisation procedure during the period 2012-17. The total sterilisations on the whole during the period showed a decreasing trend which ranged from 67 *per cent* (2012-13) to 33 *per cent* (2016-17).



Source: Records of State Health Society

[18] As per WHO and NHM guidelines

The female sterilisations constituted the majority, i.e., 95 *per cent* of the total procedures in 2014-17, while the number of male sterilisations constituted only 5 *per cent*. State Health Society cited (December 2017) scarcity of trained Non-Scalpel Vasectomy (NSV) Surgeons as the reason for the above.

Government in their reply (January 2018) stated that IEC[19] and BCC[20] activities were being conducted on World Population Day and Vasectomy Fortnight to promote the family planning sterilisations to achieve the stipulated targets.

Spacing methods

Oral pills, condoms and Intra Uterine Device (IUD) insertions are the three prevailing spacing methods of family planning to regulate fertility and promote couple protection rate.

Audit noticed a declining trend in usage of IUD insertions. The shortfall ranged from 41 to 60 *per cent* of targeted users of family planning methods. Similarly, the shortfall in the usage of oral pills increased from 59 to 75 *per cent* against the targeted users and usage of condoms from 60 to 78 *per cent*.

Thus, the implementation of family planning programme in the State was inadequate.

Government accepted the audit observation and stated (January 2018) that intensive campaigns and IEC activities would be taken up to address the issue in low performing areas.

2.1.5.5 Immunization

Universal Immunization Programme (UIP), 1985 of GoI aims to reduce mortality and morbidity due to Vaccine Preventable Diseases (VPDs), ***particularly for children in preventable diseases****.*

Immunization of children in 0 to 1 year age group

Bacillus Calmette Guerin (BCG), measles, Diphtheria Pertusis Tetanus (DPT) and Oral Polio Vaccine (OPV) for protection against childhood diseases like tuberculosis, measles, diphtheria, pertusis, tetanus and polio respectively, are given to children up to one year of age.

The target of full immunization of children of 0 to 1 year age group has been achieved during 2012-14 exhibiting full compliance to Government stipulations.

Audit observed that phase wise coverage (in four phases) of Mission Indradhanush[21] to administer full immunization to the left out children was implemented during April 2015 to April 2017 covering 100 *per cent* of the children.

[19] Information Education and Communication
[20] Behaviour Change Communication
[21] Mission Indradhanush is a GoI initiative launched on 25 December 2014 to ensure full immunisation of all children in India

2.1.6 Health Care Infrastructure

2.1.6.1 Physical Infrastructure

NRHM envisages establishing functional health facilities through revitalisation of existing infrastructure and new construction or renovation wherever required. The Mission developed comprehensive Indian Public Health Standards (IPHS) in the year 2012 defining infrastructural standards for different levels of health facilities.

Availability of health centres against requirement

As per the Indian Public Health Standards (IPHS) norms prescribed by GoI, the requirement of SC, PHC and CHC are based on population as given in Table 2.4.

The norm prescribed *vis-à-vis* availability of health facilities is indicated in the Table-2.5.

Table-2.4

Type of health centre	Population norms	
	Plain area	Hilly/tribal/ difficult area
Sub-centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: Records of SHS and Socio-economic outlook 2017 of Telangana

Table-2.5

Type of health centre	Required	Available
Sub-centre	4320	4745
Primary Health Centre	720	836
Community Health Centre	180	126

Note: Calculated on the basis of rural population of Telangana at 2.16 crore; Source: SHS data

It is seen from the above that shortage of CHCs was 30 *per cent.*

Thus, provision of referral health care for cases from PHCs level and specialist care to those approaching the centre directly was not met for rural public to that extent.

Government during Exit Conference (January 2018) stated that the State had sufficient health care facilities. However, the CHCs which are the First Referral Units were not sufficient in number.

Non-functional newly constructed PHCs

In April 2012, Government sanctioned establishment of 55[22] new PHCs in the State. In the sampled districts, 19 PHCs (Medak: 9[23]; Nalgonda: 2[24] and Warangal: 8[25]) were constructed at a cost of ₹11.19 crore[26] during 2014-17. However, Audit observed that these PHCs were not functioning as of June 2017 due to non-deployment of manpower and equipment. The PHC-wise details are given in *Appendix-2.2*.

The Department accepted (October 2017) that the health centres were yet to be made operational even though they were completed 9 to 33 months ago due to non-filling up of posts. It was further stated that orders to fill the posts were awaited from the Government. This deprived the public of the intended benefits of health facilities.

[22] construction of 3 PHCs not commenced due to site problems (status of PHCs yet to be furnished by SHS)
[23] Medak: PHCs at Chintamadaka; Markuku; Ramakkapeta; Sirigipally; Rajgopalapet; Akkannapet; Bollaram; Turkapally and Jagdevpur
[24] Nalgonda: PHCs at Thangadpally and Boddupally
[25] Warangal: PHCs at Malyala; Thatikonda; Pidipalli; Kundaparthi; Siddapur; Ippaguda; Obula Kesavapur and Kuravi
[26] Medak: ₹5.65 crore; Nalgonda: ₹0.90 crore and Warangal: ₹4.64 crore

Location of health facilities

As per Indian Public Health Standards (IPHS) norms, SCs are to be located within the village for providing easy access to the people and visit by Auxiliary Nurse and Midwife (ANM). Further, it should be so located that a person is required to travel not more than 3 kilometres to reach there. Sub-Centres should also have proper facility of road communication/public transport/telephone. Similarly, PHCs and CHCs should be centrally located in an easily accessible area.

The position of SCs in the sampled districts is given as below.

Table-2.6

Sl. No.	Factors found deficient	SCs	
		Number	%
1.	Distance of more than three kilometres from the remotest village	53	65
2.	Not accessible by public transport	13	16
3.	Centre located more than 30 min walking distance from the remotest village	43	53

Source: Records of test-checked SCs

The above position indicated that Mission could not ensure location of health centres to ensure easy access for people.

Government in their reply stated (January 2018) that the mapping of districts and Sub-centres (SCs) was still under process due to reorganisation of districts in the State. It was further stated that after completion of the reorganisation, the actual distance and location of SCs would be ascertained.

Infrastructure in health facilities

For effective delivery of RCH services, IPHS laid down norms for infrastructure in SCs, PHCs and CHCs, apart from basic amenities such as provision for own building, electricity, water supply, vehicles for referral services, etc.

In the test-checked health facility centres, 43 *per cent* of SCs had no own buildings, 44 *per cent* had no water supply and 27 *per cent* had no power supply. Similarly, in the selected PHCs there was no functional labour room (19 *per cent*) and newborn care corners (37 *per cent*) respectively. The test-checked CHCs/AHs had no newborn care facilities (33 *per cent*), separate wards for male and female (11 *per cent*) and operation theatre (11 *per cent*) respectively. The status of availability of infrastructure in the test-checked health facilities is given in *Appendix-2.3*.

Thus, quality of health care was not given adequate attention thereby forcing the patients to go to private institutions for treatment. Government did not offer any specific reply.

2.1.7 Medicines and equipment

Financial support is provided to States under NRHM to strengthen the health system including supply of drugs.

2.1.7.1 Availability of essential medicines

The IPHS norms and the State Government orders prescribed certain types of drugs/ medicines for each type of health facility depending upon its requirement.

Audit observed shortage in availability of essential medicines at test-checked CHCs, AHs and DHs which ranged from 10 to 75 *per cent* during 2014-17 as shown in *Appendix-2.4*. Government in their reply (January 2018) accepted the audit observations and promised to suitably address the issue in the larger public interest.

Due to non-availability of drugs, the patients were either deprived of the medications or had to purchase the medicines from open market thereby not fulfilling the objective of NRHM.

2.1.7.2 Provision of equipment for RCH services

As per Indian Public Health Standards (IPHS), for PHC, the necessary equipment viz. normal delivery kit, equipment for assisted deliveries, standard surgical set, etc., to deliver the assured services, were envisaged. The CHC should be provided with standard surgical set of various types, normal delivery kit, imaging equipment, etc. The equipment norms were different for each grade of DH. In all DHs, certain essential equipment viz. imaging equipment, SNCU equipment, blood storage unit, etc. were to be made available.

Scrutiny of relevant records of test-checked health facilities revealed severe shortages of essential equipment as stipulated in IPHS norms (*Appendix-2.5*).

As a result, patients were denied the provision of required services like diagnostics, X-ray services, ECG tests, etc., free of cost. Further, the patients were forced to get the above services from private agencies out of their pocket.

Government replied (January 2018) that as part of ongoing standardisation of labour rooms, all necessary equipment for labour rooms and hospitals would be supplied.

2.1.8 Human Resource in health facilities

The Mission aimed at ensuring uninterrupted and quality health care by increasing the availability of doctors, specialists, paramedical staff, ANMs[27] and ASHAs. State Government was to fill up the existing vacancies by new contractual appointments for which GoI provides funds. Audit analysis of the staffing requirements as per IPHS/ sanctioned strength *vis-à-vis* those positions across various facilities is presented below:

2.1.8.1 Manpower in SCs and PHCs

As per Indian Public Health Standards (IPHS) norms, each Sub Centre is required to be manned by at least one auxiliary nurse midwife (ANM)/female health worker and one male health worker.

[27] Auxiliary Nurse Midwife

Audit noticed 100 *per cent* shortfall in availability of Male Health Workers, i.e., 4,745 in SCs in the State. The post of Male Health Assistant was neither sanctioned nor posted in any SC in the State.

As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 12 paramedical and other staff. There was, however, shortfall in availability of manpower in PHCs at 4,775, i.e., at 43 *per cent*[28]. Further, posts of Data entry operator were not filled in any PHC in the State.

Further, out of 27 test-checked PHCs, seven PHCs[29] were functioning without a lab technician, eight PHCs[30] without Pharmacist and one PHC[31] without Staff Nurse (June 2017).

Due to the severe shortages in manpower especially in critical areas as discussed above, proper functioning of above PHCs was doubtful which affected delivery of health care services.

Government during Exit Conference (January 2018) stated that the recruitment of doctors and paramedical staff was under process.

2.1.8.2 Specialists in CHCs/AHs/DHs

As per IPHS norms, five specialists in specialities of Surgery, Medicine, Obstetrics & Gynaecology (O&G), Paediatrics and Anaesthetist for RCH programmes are to be positioned in CHCs. Specialist services in above fields were to be made available.

Shortage of Specialists[32] for RCH programme in the test-checked hospitals ranged from 23 to as high as 73 *per cent* in CHCs/AHs/DHs.

Further, 71 (48 *per cent*) Anaesthetists were only available in the State as against requirement of 169 Anaesthetists as per IPHS norms. Similarly, other specialist services were also not available in the State as required. The shortage of specialist services in General Medicine was at 117 (69 *per cent*); General Surgeon at 123 (73 *per cent*); O&G at 41 (23 *per cent*) and Paediatrics at 88 (50 *per cent*). The details of shortages are given in *Appendix*-2.6.

Shortfall in availability of specialists in Government hospitals resulted in denial of speciality services as envisaged under RCH programme.

Government replied (January 2018) that the recruitment of specialist doctors was under process.

2.1.8.3 Paramedical Staff in CHCs/AHs/DHs

Shortage of paramedical staff in CHCs, AHs and DHs ranged from 17 to as high as 100 *per cent* against the IPHS norms. Further, shortage of Staff Nurses at 17 *per cent*, Pharmacists at 18 *per cent*, Laboratory Technicians at 79 *per cent* and Radiographers at

[28] Accountant:836; Staff Nurse: 33; Pharmacist: 251; Lab Technician: 311; ANM: 836; Group D workers:1672; Watchman: 836
[29] Medak: 1; Nalgonda: 5; Warangal: 1
[30] Medak: 2; Nalgonda: 4; Warangal: 2
[31] Warangal: 1
[32] in disciplines of General Medicine, General Surgeon, Obstetrician & Gynaecologist and Anaesthetist

60 *per cent* against the IPHS norms was also noticed in the above hospitals (*Appendix-2.6 refers*). In the sampled districts, the shortages of paramedical staff *vis-à-vis* the sanctioned strength in CHCs, AHs and DHs were - Staff Nurses: 6 *per cent*; Pharmacists: 32 *per cent;* Laboratory Technicians: 30 *per cent* and Radiographers: 25 *per cent*. Government replied (January 2018) that the recruitment of the paramedical staff was under process.

Thus, patients were deprived of support for emergency services in Public Health Institutions.

2.1.9 Quality of health care

2.1.9.1 Allocation of funds for Quality Assurance and its utilisation

States are responsible for including the requirement of funds for Quality Assurance (QA) Programme in the annual State Programme Implementation Plan (SPIP).

Audit noticed that the amount of ₹3.14 crore, released during 2014-17, was almost not utilised by the State (spent only ₹0.02 crore, i.e., less than one *per cent*) on the quality assurance and the amount of ₹3.12 crore was lying with SHS.

The low utilisation of funds was attributed (May 2017) by SHS to non-recruitment of required manpower. This coupled with non-conduct of envisaged training for health personnel also contributed to low spending.

Government stated (January 2018) that recruitment of necessary human resource in the State was under process.

Quality Assurance Committee/State Quality Assurance Unit/District Quality Assurance Committee and District Quality Team/Internal Quality Assurance Teams

As per Operational Guidelines for Quality Assurance in Public Health Facility 2013, State Level Quality Assurance Committee was to be constituted to oversee the quality assurance activities across the State for providing overall guidance, mentoring and monitoring of quality assurance efforts in the State.

Although State Quality Assurance Committee (SQAC) was constituted in March 2015, no meetings were conducted as of July 2017. Thus, reviewing and discussion of Key Performance Indicators (KPIs) of RCH was totally absent in the State during 2014-17.

Similarly, State Quality Assurance Unit (SQAU) was to be constituted to provide support to SQAC for implementation of quality assurance activities in the State. However, it was observed that SQAU was not constituted in the State as of July 2017.

Test-check also revealed that District Quality Assurance Committees were not constituted till November 2017 in Medak and Nalgonda districts. It was also seen that IQATs were not constituted in 19 out of 27 test-checked PHCs (70 *per cent*) and 7 (out of 9) test-checked CHCs/AHs.

Thus, quality of services delivered at the health facilities in the State during the period 2014-17 remained unassessed.

Government stated (January 2018) that SQAC meetings would be held in February 2018 to review of KPIs, RMNCH+A services, gaps observed in quality interventions, etc.

2.1.10 Management, Monitoring and Evaluation

2.1.10.1 Review of maternal and infant death cases

Maternal Death Review

Maternal Death Review (MDR) is an important strategy to improve the quality of obstetric care and reduce maternal mortality[33]. Every health facility is required to conduct death audit for all deaths happening in the facility. The facility should also report the data relating to maternal and infant deaths to DQAU on monthly basis. DQAU in turn are to report the maternal deaths in the district to SQAC.

Against 1,375 maternal deaths that occurred in the State (during 2013-17), 1,129 deaths were stated to have been reviewed. However, the review of 246 deaths was not carried out by the health facilities.

In the three sampled districts, 310[34] maternal deaths were reported during 2013-17 and in 151 of the cases the envisaged review was not carried out by the facilities. Further, the districts did not report any death case to SQAU. Specific reasons for non-conduct of MDR in the State was not furnished.

Due to non-conduct of MDR, the delays and gaps that contribute to maternal deaths at various levels and the information used to adopt measures to fill the gaps in service could not be identified. ***Thus, quality of obstetric care was not ensured.***

Government in their reply stated (January 2018) that since SQAC has now been formed in Telangana, MDR would henceforth be regularly conducted.

Infant Death Review

Reducing infant mortality is one of the key goals under NRHM. Infant Death Review is an important strategy to understand the geographical variation in causes leading to newborn and child deaths, and thereby initiating State-specific child health interventions. Analysis of child deaths provides information about the medical causes of death, helps to identify the gaps in health service delivery and social factors that contribute to child deaths.

Information on infant deaths in the State and the status of review was not made available by SHS. In the sampled districts, 7,538[35] infant death cases were reported during the period 2013-17. However, none of the deaths was reviewed. Thus, initiating remedial measures for their elimination by NRHM was not possible.

Government replied (January 2018) that training for Trainer of Trainers (ToTs) for conducting Infant Death Reviews in most of the districts had been completed. It was further stated that training of to various cadres was in progress.

[33] as per Maternal Death Review (MDR) guide book
[34] Medak:128; Nalgonda: 94 and Warangal: 88
[35] Medak; 3,051; Nalgonda: 2,838; Warangal: 1,649

Monitoring of Key Performance Indicators (KPIs)

Hospital Managers are required to collate critical data from the departments and calculate KPIs to monitor them on monthly basis and report these indicators to DQAC and SQAC.

In selected districts, the DMHOs replied (July 2017) that the KPIs were not being monitored.

Since KPIs were not captured at the facility level, the monitoring of indicators pertaining to RCH *viz*., mothers receiving antenatal care, institutional deliveries, safe delivery and mothers receiving postnatal care and immunisation coverage could not be monitored by DQAC and SQAC for evaluation and remedial measures.

Government replied (January 2018) that the process of collecting KPIs in 7 CHCs (out of 126) and in 86 PHCs (out of 836) was started from August 2017.

2.1.11 Impact of NRHM on MMR, IMR and TFR

2.1.11.1 Millennium Development Goals

Ministry of Health and Family Welfare (MoHFW), GoI in the 'Framework for Implementation (2005-2012)' and subsequent revised 'Framework for Implementation (2012-17)' had laid down certain expected outcomes (National Targets) to be achieved in line with the Millennium Development Goals outlined by the United Nations in the year 2000.

Table-2.7

Sl. No.	Framework of Implementation (2005-2012)	Framework of Implementation (2012-17)	Millennium Development Goals (2015)
1	Infant Mortality Rate (IMR) reduced to 30/1,000 per 1,000 live births by 2012.	Reduce IMR to 25/1,000 live births	Reduce IMR to 27 per 1,000 live births
2	Maternal Mortality Ratio (MMR) reduced to 100 per 1,00,000 live births by 2012.	Reduce MMR to 100/1,00,000 live births	Reduce MMR to 109 per 1,00,000 live births
3	Total Fertility Rate (TFR) to 2.1 by 2012.	Reduce TFR to 2.1	--

Source: GoI Guidelines

IMR, MMR and TFR

The year-wise targets and achievements during 2012-17 were as given in Table-2.8 below.

Table-2.8

Year	IMR		MMR		TFR	
	Target	Achievement	Target	Achievement	Target	Achievement
2015-16	25	28	100	92	2.1	1.8
2016-17	25	28	100	80	1.8	1.8

Note: Data for the years 2012-13 to 2014-15 was not made available to Audit
Source: Records of State Health Society

The rate of achievement on MMR and TFR was satisfactory at State level. However, MMR in tribal districts like Adilabad, Khammam and Mahabubnagar was very high at 152, 99 and 98 respectively as against 92 in the State. Increased trend of MMR in the above districts was an area of concern. The increase of MMR in tribal districts was mainly due to

non-availability of outreach RCH services on account of meagre spending (22 to 71 *per cent* of the fund allocations during 2014-17) on the services.

Audit further observed that IMR was above the rate of ceiling of 25 during 2015-17. As per SRS[36] 2016, IMR was 35 in rural areas of Telangana State. However, SHS did not furnish the details of infant deaths that occurred in the State during 2012-17. Hence, IMR figures claimed as being achieved could not be verified in Audit.

Government during Exit Conference (January 2018) stated that the levels of IMR in the State were reduced from 35 (in 2014) to 28 (in 2017). However, the NRHM target (for IMR) of 25/1,000 live births by the year 2017 had not been achieved.

2.1.12 Data collection, Management and Reporting

The interventions to ensure fundamental corrections in the existing health care delivery system have increased the demand for data on population and health for use in both micro-level planning and programme implementation. A continuous flow of good quality information on inputs, outputs and outcome indicators facilitate monitoring of the objectives of NRHM.

In the test-checked districts, it was noticed that computers were either not available or not functional in 12 out of 27 PHCs. Further, DEOs were not available in PHCs. This was one of the contributing factors for incomplete reporting by the health facility centres to HMIS portal meant for quality information on inputs, outputs and outcome indicators. Thus, deficient IT infrastructure and networking compounded the problem preventing timely updation and smooth flow of data.

In their reply (January 2018) Government stated that DEOs would be positioned in health facilities shortly. It was further stated that all health facilities would be provided with computers along with internet connection.

2.1.13 Conclusion

The State has achieved the goals of Maternal Mortality Ratio (MMR) and Total Fertility Rate (TFR). The State has also achieved the target of immunisation of children of 0 to 1 year age group. However, the implementation of Reproductive and Child Health (RCH) overall under NRHM in the State was far from satisfactory. The MMR in certain tribal districts like Adilabad and Khammam was much below the targets. IPHS norms under all components of RCH were not met. This was mainly due to the State Government not being able to utilise the Central grant fully as approved under RCH programme.

Annual facility level surveys intended for identification of gaps/deficiencies in the existing health care facilities, areas of interventions, etc. for ensuring quality health care, were not conducted. State Program Implementation Plans (SPIPs) were prepared without the inputs from Block and District Health authorities as a result of which funds available could not be fully utilised. Adequate attention on availability of required physical as well as human infrastructure in the health facilities was not accorded.

[36] Sample Registration System

Female-male sex ratio at birth declined during 2012-16 due to ineffective implementation of PC&PNDT and Medical Termination of Pregnancy Acts. There was increasing trend in ANC registrations. However, the institutional deliveries in public health facilities declined. Ineffective implementation of Maternal and Child Health components contributed to heightened risk of maternal and infant deaths. State Health Society did not maintain the accurate data on health indicators. Key Performance indicators were not captured at facility level and were not monitored for evaluation and remedial measures. This was mainly due to non-constitution of State Quality Assurance Committee which was formed only in March 2015. However, no requisite meetings were conducted as of January 2018. The computers and networking was deficient and adversely affected timely updation of data.

2.1.14 Recommendations

(i) The Department should conduct annual facility surveys for identifying and bridging the gaps/deficiencies in provision of health care facilities;

(ii) Government should put in place an effective mechanism to facilitate effective monitoring of the GoI allocations/releases as well as the spendings to ensure full utilisation of grant as approved by GoI for implementation of RCH programmes;

(iii) Government should give priority to augmenting the physical as well as human infrastructure across all levels of the healthcare system for effective implementation of RCH programme. This would ensure quality health care at public health institutions;

(iv) Government need to create awareness through Electronic and Print Media on advantages of natural deliveries and disadvantages of C-Sections;

(v) Vacant posts of Obstetricians and Gynaecologists (O&G) in CHCs/AHs/DHs should be filled up so as to reduce C-Section deliveries in Private Hospitals; and

(vi) State Quality Assurance Committee/District Quality Assurance Committees/Internal Quality Assurance Teams should strengthen their activity on reviewing and discussion of key performance indicators of RCH programme.

During Exit Conference, Government assured of remedial action on the points raised by Audit. The recommendations made by Audit were also discussed and accepted by Government.

School Education Department

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

Executive Summary

The Right of Children to Free and Compulsory Education Act, 2009 (RTE Act) became operational with effect from 01 April 2010 to make elementary education (Class I to VIII) a fundamental right of all children. The Act provides that all children in the age group of six to fourteen years have a right to free and compulsory education in a neighbourhood school within three years of the enactment of the Act. The Performance Audit of implementation of the RTE Act was conducted (April - July 2017) covering the period from 2012-13 to 2016-17.

There was significant shortfall (50 per cent) in release of funds by GoI and the State Government as compared to the budget approved by Project Approval Board (PAB) during 2014-17. There were considerable delays in release of funds by GoI as well as the State Government to the Telangana Sarva Shiksha Abhiyan Society (TSSA).

In Government Primary Schools, the enrolment declined by 1.12 lakh during 2014-17. On the other hand, in case of Private Primary Schools, enrolment increased by 0.61 lakh during the same period. The enrolment in Government Upper Primary Schools decreased by 0.20 lakh, whereas enrolment increased by 0.03 lakh in Private Upper Primary Schools. There was high dropout rate of students during transition from class I to VIII in respect of SC/ST boys and girls. Fourteen to 26 per cent children at Primary level and 21 to 47 per cent in Upper Primary level scored less than 40 per cent during the years 2014-17.

Child tracking system was not in existence in the State and thereby continuity of education of children in one school or other could not be ensured. Under Inclusive Education to Children with Special Needs (CWSN) ₹15.42 crore (35 per cent) of funds approved by PAB were only spent during 2014-17. The State had not implemented provisions of RTE Act and the State Rules with regard to 25 per cent reservation for disadvantaged group children in private unaided schools.

The benefit of transport allowance for attending neighbourhood schools was denied to 44,412 eligible/identified children in the State during 2014-15 and 2016-17. The schools were largely deficient in basic infrastructural facilities/amenities. Seventy five per cent of the schools in the State had no basic infrastructural amenities.

2.2.1 Introduction

The Right of Children to Free and Compulsory Education Act, 2009, popularly known as Right to Education (RTE)[37] Act, became operational with effect from 1 April 2010 to make elementary education (Class I to VIII) a fundamental right of all children. The RTE Act is

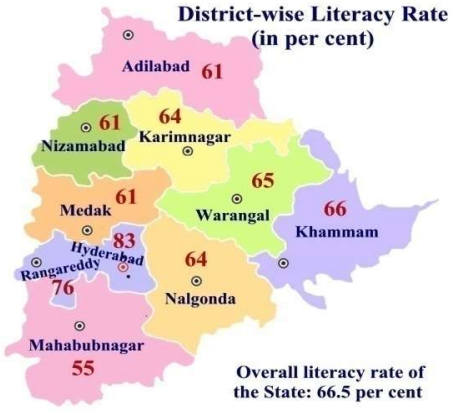
[37] along with the enabling Article 21A of the Constitution of India

implemented by the Ministry of Human Resource Development (MoHRD), Government of India (GoI) as a Centrally Sponsored Scheme.

The RTE Act provides that all children in the age group of six to fourteen years have a right to free[38] and compulsory education[39] in a neighbourhood school[40] within three years of the enactment of the Act. The Sarva Shiksha Abhiyan (SSA) run by GoI, is the main vehicle for implementing the provisions of the RTE Act.

The State of Telangana came into existence as a separate State with effect from 2 June 2014 as per the Andhra Pradesh Reorganisation Act, 2014. The erstwhile Government of Andhra Pradesh issued the Andhra Pradesh Right of Children to Free and Compulsory Education (AP RTE) Rules, 2010, which came into effect from 1 April 2010. The AP RTE Rules were deemed to have been adapted[41] to the State of Telangana with effect from 2 June 2014.

The total population of the children in the age group of 6 to 14 years in the State was 45,76,393 (Boys: 23,50,757 and Girls: 22,25,636) for year 2016-17. As per census 2011, the overall literacy rate of the State of Telangana was 66.5 *per cent* (Rural: 57 and Urban: 81 *per cent*). In pursuance of RTE Act, 2009, the Government was to take various initiatives, for universalisation of elementary education. These included strengthening of existing schools, opening of new primary schools and provision of transport facility in remote and un-served habitations in the State.



Source: Educational statistics 2015-16, SSA

During 2014-17, the Gross Enrolment Ratio (GER) ranged from 115 to 126 *per cent* at Primary level. At Upper Primary level, the GER ranged from 85 to 100 *per cent.*

2.2.1.1 Organisational Setup

The Organisational setup from Government level to School level is as depicted below.

State Government	• **Special Chief Secretary to Government School Education Department**
Head of the Department	• **Commissioner & Director of School Education and Ex- Officio State Project Director, Telangana Sarva Shiksha Abhiyan Society**
District	• **District Educational Officer and Ex- Officio District Project Officer, Telangana Sarva Shiksha Abhiyan Society**
Mandal	• **Mandal Educational Officer**
School	• **School Management Committee** • **Head Master**

[38] as per the SSA Framework for Implementation 'free education' is defined as 'removal of any financial barrier by the State that prevents a child from completing eight years of schooling'

[39] as per the SSA Framework for Implementation 'compulsory education' is defined as 'obligation of appropriate government to provide free elementary education and ensure compulsory admission, attendance and completion of elementary education to every child in the six to fourteen years age group'

[40] school within a walking distance of 1 km and 3 km of neighbourhood for Classes I to V and VI to VIII respectively

[41] as per Section 101 of the AP Reorganisation Act read with GO Ms No.45 dated 1 June 2016 issued by Law Department, Government of Telangana

2.2.2 Audit Framework

2.2.2.1 Audit objectives

Performance audit of the RTE Act was carried out to verify whether

- the RTE Act achieved its objective of making elementary education as a fundamental right for all children between age group of 6-14 years by 31 March 2013 (in districts of Telangana region of erstwhile combined State);
- the funds allocated were utilised in an economic and efficient manner;
- the RTE Act was implemented and monitored in a planned manner; and
- the associated Sustainable Development Goal (SDG) Indicators were tracked.

2.2.2.2 Audit Criteria

Audit findings were benchmarked against criteria sourced from the following:

- Right of Children to Free and Compulsory Education Act, 2009
- Telangana State Right of Children to Free and Compulsory Education Rules, 2010 (State RTE Rules)
- Orders, Notifications, Circulars, Instructions and Guidelines issued by MoHRD (GoI)/ State Government with respect to RTE Act/RTE Rules
- Annual Work Plans and Budgets prepared by the Telangana Sarva Shiksha Abhiyan Society (TSSA)
- Unified District Information System for Education (UDISE) data
- Financial Code, Budget Manual
- Goal 4 of Sustainable Development Goals as envisioned by the United Nations

2.2.2.3 Audit Scope and Methodology

The Performance Audit was conducted during April-July 2017 covering the period 2014-15 to 2016-17 (in the sampled districts, however, for the period 2012-13 to 2016-17). Audit methodology involved scrutiny of records of:

- Commissioner and Director of School Education and Ex-officio State Project Director (SPD), TSSA (hereinafter referred to C&DSE)
- District Educational Offices (DEOs) and Ex-Officio District Project Offices (DPOs) of three selected erstwhile districts of Khammam, Rangareddy and Warangal
- Four Mandal Educational Offices (MEOs) (three rural & one urban) and 30 schools (20 Government/Specified Category[42] schools and 10 Aided schools) in each sampled district *(Appendix-2.7)*.

Physical verification of the 90 test-checked schools[43] was also conducted. Audit also collected information from offices of the Secretariat department at Government level and the State Council of Education Research and Training (SCERT).

[42] in relation to a school means the residential schools including KGBVs, TREIS, Telangana State Model Schools, etc.
[43] two sampled Aided schools were non-functional during 2014-17 in Khammam district

An Entry Conference was held with C&DSE in December 2016 wherein audit objectives, methodology, scope, criteria and audit sample were explained. An Exit Conference was held with Government representatives in December 2017 to discuss the audit findings. The responses of C&DSE and the Government have been incorporated at appropriate places in the report.

Audit Sample

The districts were selected by Probability Proportional to Size without Replacement (PPSWOR) method. In each sampled district, three rural and one urban mandals along with 30 schools [44] were selected for test-check using Simple Random Sampling without Replacement (SRSWOR) method.

Acknowledgement

We acknowledge the cooperation and assistance rendered by the officials of the School Education Department during the conduct of the Performance Audit.

Audit findings

2.2.3 Planning

The budget proposals under SSA are prepared in the form of Annual Work Plan & Budget (AWP&B), covering all the interventions specified in the SSA norms. Annual Work Plans, to achieve the goal of universalisation of elementary education, were to be prepared from the district level. The District and State Annual Work Plans were to be prepared based on the guidelines of the MoHRD, GoI with reference to the Act. Preparation of Annual Work Plan should be based on identification of problems through a household survey conducted by the School Management Committee (SMC). The AWP&B of each State/UT is then reviewed and approved by the Project Approval Board (PAB) constituted by the MoHRD.

Audit observed in the three test-checked districts that all the districts prepared the annual plans based on household surveys every year and submitted them to the C&DSE. It was further observed that the State Government had prepared AWP&B and submitted them to PAB in time annually.

2.2.4 Financial Outlay

2.2.4.1 Budget and Expenditure

The fund sharing ratio between the Government of India and State Government was 65:35 up to the year 2014-15 which was revised to 60:40 from 2015-16. Budget is allocated under SSA. The approved amount of fund was released directly by the Central/State Government to State Implementing Societies[45] (SISs) up to the year 2013-14. From the year 2014-15 onwards, the Central share is released to the State. The State Government releases it along with their matching share to TSSA Society. The Society in turn releases to District Offices and therefrom to Unit Offices[46] through RTGS/NEFT[47]. The fund flow chart is given below.

[44] 70 *per cent* of Primary/Upper Primary schools and 30 *per cent* of High Schools
[45] it is a TSSA society created under Sarva Shiksha Abhiyan (SSA) Programme and functions under the administrative and financial supervision of State Government
[46] i.e. Mandal Resources Centres (MRCs), Cluster Resource Centres (CRCs) and Schools/SMCs
[47] Real Time Gross Settlement/National Electronic Fund Transfer

As per RTE Act, after approval of AWP&B of States by PAB, the Ministry (MoHRD) releases first instalment of Central assistance in April/May. The second instalment is released in September/October based on progress of expenditure incurred out of the first instalment.

During the period 2012-14, PAB approved a budget of ₹7,834.34 crore. Against this, ₹5,054.48 crore was released by the erstwhile Government of Andhra Pradesh to SSA Society. Out of this, the Society utilised an amount of ₹6,055.16 crore. Post-bifurcation (2014-17), against ₹2,693.55 crore released (PAB approved Budget: ₹5,360.41 crore) by the Telangana Government to TSSA, an amount of ₹2,851.01 crore had been utilised. The excess expenditure was met from out of the unspent funds in the previous years carried over to subsequent years. These included interest earned and retrieval of funds from subordinate offices/schools.

The year-wise details of funds made available as well as the expenditure under SSA during the period 2012-14 and 2014-17 are given in table below.

Table-2.9

(₹ in crore)

Year	Budget approved by PAB			Releases			Expenditure by SSA/TSSA Society
	GoI share	State share	Total	GoI	State	Total	
Combined State of AP							
2012-13	3084.81	1661.05	4745.86	1360.49	745.23	2105.72	3144.30
2013-14	2007.51	1080.97	3088.48	1797.15	1151.61	2948.76	2910.86
Total	**5092.32**	**2742.02**	**7834.34**	**3157.64**	**1896.84**	**5054.48**	**6055.16**
Telangana							
2014-15 (w.e.f. 2 June 2014)	1231.80*	607.55	1839.35	506.40#	324.69	831.09	846.03
2015-16	1000.40	666.94	1667.34	428.84	252.27	681.11	759.15
2016-17	1112.23	741.49	1853.72	417.76	763.59	1181.35	1245.83
Total	**3344.43**	**2015.98**	**5360.41**	**1353.00**	**1340.55**	**2693.55**	**2851.01**

** includes ₹103.50 crore under General Head from 13th Finance Commission (FC) award proposed;*
 # includes ₹86.28 crore from 13th FC award

Source: Figures furnished by the C&DSE

There was significant shortfall (50 *per cent*) in release of funds by GoI and the State Government as compared to the budget approved by PAB during 2014-17. Further, Audit observed that there were considerable delays in release of funds by GoI as well as the State Government to the TSSA Society. This resulted in the important interventions intended for benefit of eligible students in the State not being implemented as envisaged in the RTE Act, as discussed in *Paras 2.2.4.2 and 2.2.4.3* of this Report. The Department attributed (July 2017) the short release of funds to policy decisions of GoI and the State Government.

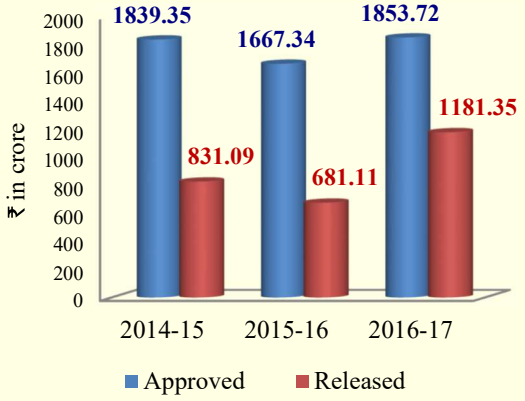
During Exit Conference (December 2017), Government accepted the Audit observation and attributed the short releases to the ways and means position of the Government.

2.2.4.2 Short release and delay in release of funds by GoI and State

It can be seen from Table-2.9 and the graph alongside that during the period 2014-17, ₹2,693.55 crore was released by GoI and the State Government, against ₹5,360.41 crore approved by the PAB. This resulted in short release of ₹2,666.86 crore (50 *per cent*) by GoI (₹1,991.43 crore) and State Government (₹675.43 crore).

The C&DSE replied (July 2017) that the short releases were due to policy decisions of GoI and the State Government.

Chart-2.7:
PAB approvals and Releases



GoI releases funds to Finance department of State Government which in turn releases funds along with State share to TSSA Society. Further, as per the norm, State Government is to release its corresponding share within one month of the receipt of the Central share.

During the period 2014-17, there were delays of up to seven months in release of funds[48] from the date of receipt of funds in Finance department of State Government to the date of receipt of funds by TSSA. There were also delays up to six months in release of State share of the funds. Government accepted (December 2017) the delays in release of funds but have not cited specific reasons for the same.

Audit observed that due to short/belated release of funds, the important quality interventions could not be implemented fully. These included Computer Aided Education, Trainings, Academic support, Interventions for Children with Special Needs (CWSN), Community Mobilisation, Special Training for Mainstreaming of Out of School Children (OoSC), Learning Enhancement Programme (LEP) and Research Evaluation Monitoring and Supervision (REMS) as discussed in subsequent paragraphs.

2.2.4.3 Major expenditure on Salaries, KGBVs and Civil works

All expenditure on quality education is bound to have a multiplier effect on learning outcomes. Out of total expenditure of ₹2,851.01 crore incurred during 2014-17, the major share of ₹2,108.76 crore (74 *per cent*) was on salaries, KGBVs and civil works *(Appendix-2.8)*. Only ₹742.25 crore (26 *per cent*) was utilised on other quality interventions referred to in *Para 2.2.4.2* above. The Department attributed this (July 2017) to short release of Central share and State share for the programme implementation.

Meagre expenditure on quality interventions has had the adverse impact on quality education. This resulted in low proficiency levels of children (Para 2.2.6.5 infra refers).

[48] both GoI and State shares in lumpsum

During Exit Conference Government cited short releases as being the reason for the low spending on quality interventions. It was, however, stated that funds were targeted towards priority interventions despite short releases from GoI.

2.2.5 Implementation of the Act

The activities/interventions to be implemented under SSA are to be aligned with the provisions of RTE Act as mandated in SSA framework, *viz*.

Category-I: Reimbursement against admissions under Section 12(1)(c) of RTE Act, free textbooks, provision of two sets of free uniforms, Inclusive Education, School Grant, Project Management, KGBVs[49] etc.;

Category-2: Transport allowance to children attending neighbourhood schools, Transport/Escort facility to CWSN, Special Training to OoSC, In-service Teacher Training, LEP, REMS, Community Mobilisation etc.; and

Category-3: Teachers' salary and Civil Works, etc.

2.2.5.1 Coverage of Schools

As per Section 3(1) of the RTE Act and sub-rule (1) and (4) below Rule 5 of State RTE Rules, the State Government shall establish a school within a walking distance of one and three kilometres of the neighbourhood for children in Classes I to V and Classes VI to VIII respectively.

Out of total 25,660 habitations in the State, 556 (2 *per cent*) habitations with 4,909 identified children did not have Primary Schools (PS) within the prescribed distance of one kilometre of their neighbourhood as of March 2017. Similarly, 1709 (7 *per cent*) habitations with 19,380 identified children had no Upper Primary Schools (UPS) within the prescribed distance of three kilometres.

Government in its reply stated (December 2017) that since the above habitations in the State were having less than 20 children in the prescribed age groups, they could not be considered for setting up of schools as per existing stipulations. Government further stated that these children were attending other nearby schools and residential schools.

Audit, however, observed that during 2016-17, neither any effort was made to club habitations and provide transport nor was any transport allowance provided to children to attend neighbourhood school (*Para 2.2.5.8 refers*). Thus, the objective of establishment of neighbourhood schools was not fully achieved even after seven years of the commencement of the RTE Act.

2.2.5.2 Schools under Government and Private sectors

As of March 2017, 48.18 lakh[50] children in the age group of 6-14 years were enrolled in Government (including Local Bodies and Aided Schools) and Private Primary/Upper Primary Schools in the State. The year-wise details are given in table below.

[49] Kasturba Gandhi Balika Vidyalaya

[50] includes 38,777 children enrolled in other schools like National Child Labour Project Schools, Urban Residential Schools, Madarsas, etc.

Table-2.10

Year	Schools with Primary Sections (Primary Schools) and enrolment				Schools with Upper Primary Sections (Upper Primary Schools) and enrolment			
	No. of Govt. PS	Enrolment in Govt. PS (in lakh)	No. of Private PS	Enrolment in Private PS (in lakh)	No. of Govt. Upper Primary Schools	Enrolment in Govt. Upper Primary Schools (in lakh)	No. of Private Upper Primary Schools	Enrolment in Private Upper Primary Schools (in lakh)
2014-15	24047	14.64	9014	16.64	9381	9.37	8957	7.82
2015-16	23910	14.17	9532	17.62	9402	9.33	9230	8.14
2016-17	24149	13.52	10163	17.25	9652	9.17	9861	7.85
Percentage change (+/-)	**+0.42**	**-7.65**	**+12.75**	**+3.67**	**+2.89**	**-2.13**	**+10.09**	**+0.38**

Note: (+)ve marked figures denote increase in percentage while (-)ve figures denote its decrease in the year 2016-17 with respect to the year 2014-15

Source: Records of C&DSE

It can be seen from the above table that:

- During the period of 2014-17, the number of Government (including Local Bodies and Aided) Primary Schools increased by only 0.42 *per cent* whereas Private Primary Schools increased by 12.75 *per cent*. However, in Government Primary Schools, the enrolment decreased by 1.12 lakh (7.65 *per cent*) during the period. On the other hand, in case of Private Primary Schools, enrolment increased by 0.61 lakh (3.67 *per cent*) during same period;
- Similarly, in case of Upper Primary Schools the number of Government schools increased by only 2.89 *per cent* whereas Private Upper Primary Schools registered a growth of 10.09 *per cent* over the same period. However, the enrolment in Government Upper Primary Schools decreased by 0.20 lakh (2.13 *per cent*), whereas enrolment increased by 0.03 lakh (0.38 *per cent*) in Private Upper Primary Schools.

Thus, the enrolment in Government schools was low when compared to Private Schools.

Government in their reply stated that Government Primary Schools had better coverage than their Private counterparts. The reply is not correct since the enrolment in Private Primary Schools was quite high as compared to Government Primary Schools as evident from the Table-2.10.

2.2.5.3 Retention, Dropout and Transition rates

Retention of children in school in general refers to the proportion of children continuing their school education through various stages. Dropout rate is the proportion of children who cease to continue their schooling due to various reasons personal or otherwise. Rate of Transition indicates the rate of up-gradation of children to the next grade after successful completion of the present grade.

As per the AWP&B for the year 2017-18, the retention, dropout and transition rates for the year 2016-17 (as per UDISE 2016-17) were as follows:

- The retention rate at Primary level was 92 *per cent* and Upper Primary level was 94 *per cent* in general. The retention rate of SC community was 95 *per cent* at Primary level and 97 *per cent* at Upper Primary level. In respect of children of ST community the retention was only 88 *per cent* at Primary level and 93 *per cent* at Upper Primary level;

- As regards the dropout rate, it was 8 *per cent* at Primary level and 6 *per cent* at the Upper Primary level. The dropout rate of SC community was 5 *per cent* at Primary level and 3 *per cent* at Upper Primary level. In respect of children of ST community, the dropout rate was high at 12 *per cent* at Primary level and 7 *per cent* at Upper Primary level;
- With regard to transition of children from Primary to Upper Primary level, it was 92 *per cent* in the State. It was 90 *per cent* in Rural areas and 96 *per cent* in Urban areas. In case of SCs the transition rate from Primary to Upper Primary level was 95 *per cent* while in case of STs it was 108 *per cent*[51]. Similarly, the transition rate for SC community in Rural areas was 89 *per cent* while the same for ST community was only 83 *per cent.*

High dropout rate of SC/ST children during transition from Class I to VIII

A high dropout rate was registered among SC/ST Girls and Boys during the transition from Class I to Class VIII as discussed below:

- The children who enrolled during 2010-11 and 2011-12 in Class I were to continue up to Class V (Primary level) during 2014-15 and 2015-16 respectively. Audit observed that the dropout rate at this level ranged from 16.10 *per cent* (girls) to 19.52 *per cent* (boys) in general. For ST boys and girls, it was as high as 38.19 *per cent* and 42.57 *per cent*. For SC boys and girls, it was as high as 22.40 *per cent* and 21.30 *per cent* respectively during the period 2014-15 to 2015-16 *(Appendix-2.9(i));* and
- Similarly, the children who enrolled during 2007-08 and 2008-09 in Class I should have continued up to Class VIII (Upper Primary level) during 2014-15 and 2015-16 respectively. It was observed that the dropout rate at this level ranged from 28.93 *per cent* (girls) to 31.93 *per cent* (boys) in general. For ST boys and girls, it was as high as 52.89 *per cent* and 54.81 *per cent*. For SC boys and girls, it was as high as 32.58 *per cent* and 31.38 *per cent* respectively during the same period (*Appendix-2.9(ii)*).

Thus, the high dropout rate of students, particularly in respect of SC/ST boys and girls, defeated the main objective of RTE Act, i.e., enrolment, retention and providing quality education to maximum children in the targeted age group of 6-14 years.

During Exit Conference Government attributed the high dropout rate to socio-economic factors[52]. It was stated that seasonal hostels have been opened in places where parents migrate for their livelihood, to provide children uninterrupted education and suitable residential facility. Further, Government assured that a detailed study would be taken up in coordination with Tribal Welfare Department to reduce the dropouts.

[51] more than 100 *per cent* was due to enrolment of children irrespective of their age group

[52] engagement of children in seasonal works by their parents, problem of language faced by children of primitive tribal groups, non-participation of the community, lack of awareness among the parents on the importance of education, migration of families, non-availability of toilet facility in schools, non-availability of teachers in schools etc. It was further stated that the Headmasters and MEOs of all mandals were instructed to enrol the students in hostels to overcome the problem of children going out for earning

2.2.5.4 Child tracking system

According to State RTE Rules[53]*, Government may in consultation with the C&DSE evolve a child tracking system. This would monitor not only the academic progress of children in the schools, but also their retention, transition and migration.*

The child tracking system was, however, not in existence in the State as of May 2017. Thus, there was no mechanism in place to monitor academic progress of children, their retention, transition and migration. As a result, continuity of education of the child in the same school or other could not be ensured. Further, his/her transition to higher grades could also not be tracked.

Best Practice

During 2016-17, Government initiated collecting child-wise information of all students using the AADHAAR. Information regarding 45 lakh children enrolled in Classes I to VIII has been collected and 42 lakh children (93 per cent) have been linked with their respective Aadhaar numbers. This facilitated in massive data cleaning, i.e., identifying and removing overlapping enrolment figures of 1.87 lakh children (4 per cent) out of 45 lakh children. The data cleaning exercise is also expected to arrest overlapping of expenditure on uniforms, textbooks, Mid-day Meal, etc.

However, child tracking system using AADHAAR as unique ID of a child was not in existence.

2.2.5.5 Mainstreaming and Training of Out-of-School Children

As per Section 4 of Act, where a child above six years of age has not been admitted in any school or though admitted, could not complete his or her elementary education (commonly referred to as Out-of-School Children (OoSC)), then he or she shall be admitted in a class appropriate to his or her age. The Act further provides for Special Training in such manner and within such timelines as prescribed. Rule 4(1) of State RTE Rules mandates that the School Management Committee/Local authority[54] *shall identify children requiring special training and organise such trainings.*

During 2014-17, out of 0.54 lakh OoSC mainstreamed, 0.28 lakh were not provided training. Thus, as at the end of 2016-17, only 0.17 lakh (27 *per cent*) of identified OoSCs were mainstreamed by the Department in a class appropriate to his/her age as shown in Table-2.11.

Table-2.11

Year	Number of OoSC identified	Number of OoSC		
		mainstreamed by providing training	mainstreamed without training	not mainstreamed (*per cent*)
2014-15	78507	12483	4975	61049 (78)
2015-16	87600	9787	9782	68031 (78)
2016-17	64941	3575	13889	47477 (73)

Source: Records of C&DSE

Thus, failure to mainstream all the OoSC and provide them training, resulted in deprival of education to 0.47 lakh children by the end of March 2017.

[53] sub-rule (6), (7), (8), (9) below Rule 7
[54] means Mandal Praja Parishads and Gram Panchayats as the case may be in their respective jurisdictions

During Exit Conference, Government stated that most of the OoSC belonged to madarsas. It was further stated that very few children from madarsas were mainstreamed as religious education was being imparted as per the choice of their parents.

2.2.5.6 Inclusive Education to Children with Special Needs

For Children with disabilities, the Government/Local Authority shall[55] *endeavour to make appropriate and safe transportation arrangements for them to attend school and complete elementary education*. Under Inclusive Education programme for Children with Special Needs (CWSN) the PAB approves important interventions[56] for strengthening of academic support to CWSN.

Against ₹43.51 crore approved by PAB, a meagre amount of ₹15.42 crore (35 *per cent*) only was released and the same was spent by the department during 2014-17. With regard to coverage of CWSN in the State, number of CWSN/teachers approved by PAB *vis-à-vis* the achievement under different sub-components is tabulated below.

Table-2.12

Intervention	Year	Number of CWSN approved by PAB	Number of CWSN covered	Number of CWSN not covered (*per cent*)
Transport allowance (@₹250 per month for 10 months in each academic year)	2014-15	8459	3077	5382 (64)
	2015-16	9537	6975	2562 (27)
	2016-17	11788	7260	4528 (38)
	Total	**29784**	**17312**	**12472 (42)**
Escort allowance (@₹250 per month for 10 months in each academic year)	2014-15	16767	3870	12897 (77)
	2015-16	10000	5364	4636 (46)
	2016-17	7000	5622	1378 (20)
	Total	**33767**	**14856**	**18911 (56)**
Aids & appliances	2014-15	17323	0	17323 (100)
	2015-16	11368	6355	5013 (44)
	2016-17	6953	0	6953 (100)
	Total	**35644**	**6355**	**29289 (82)**
Intervention	**Year**	**Number of teachers approved by PAB**	**Number of teachers covered**	**Number of teachers not covered (*per cent*)**
Training to teachers for CWSN	2014-15	22155	5586	16569 (75)
	2015-16	8671	4472	4199 (48)
	2016-17	7290	0	7290 (100)
	Total	**38116**	**10058**	**28058 (74)**

Source: Records of TSSA/Minutes of PAB meeting

It can be seen from above table, during 2014-17, transport allowance was not provided to 42 *per cent* and escort allowance to 56 *per cent* of CWSN. Further, aids & appliances were not provided at all to CWSN during the years 2014-15 and 2016-17. Training was not provided to 74 *per cent* of the teachers for CWSN.

[55] Section 3 of RTE Act read with Rule 5 (7) of State RTE Rules

[56] supply of Aids & Appliances including ICT (Information and Communication Technology) material, Transport allowance and/or Escort allowance payable @₹250/month for ten months in an academic year, Training to teachers, etc.

During Exit Conference (December 2017) Government stated that expenditure for CWSN was incurred to the extent of availability of budget. It was further stated that non-issue of pro-forma invoice by ALIMCO[57] for supply of aids & appliances in 2016-17 affected the implementation of the programme.

Thus, non-implementation of important interventions (under Inclusive Education scheme) to the identified CWSN deprived them of their right to pursue free and compulsory elementary education as envisaged in the Act.

2.2.5.7 Implementation of RTE Act (25 *per cent reservation*) in private unaided schools

The Act[58] and Rules framed there under stipulate that private un-aided schools shall admit in Class-I, to the extent of at least twenty-five per cent of the strength of that class, children belonging to the weaker sections[59] and disadvantaged groups[60] in the neighbourhood and provide free and compulsory elementary education till its completion.

In compliance of the Act provisions and the State RTE Rules, Government issued (July 2010)[61] orders prescribing twenty-five *per cent* reservation of seats to the above category of children[62]. Government further specified quantum of fee[63] of ₹9,000 per annum for Urban and ₹7,800 per annum for Rural per child. Government would reimburse this fee to Schools in respect of the reserved seats.

During the period 2014-17, it was noticed that no expenditure was incurred by the Government towards reimbursement of fee in respect of disadvantaged group children studying in such schools. In fact, C&DSE had not even included the proposals in AWP&B.

Government in their reply (December 2017) expressed its inability to enforce the above stipulation as it would have an adverse impact on the enrolment, infrastructure and services of teachers in Government schools. It was stated that this involved a recurring financial burden of at least ₹218 crore per annum on State exchequer. Further, the request of State Government to review the provisions of the Act on the above cited grounds was stated to be pending with GoI.

The fact, however, remained that the provisions of the RTE Act as well as the Government orders with respect to 25 *per cent* reservation remained unimplemented in the State. In this context, Audit reviewed the position in other States. It was seen that these provisions of the Act were successfully being implemented in several other States like Bihar, Chhattisgarh, NCT of Delhi, Karnataka, Madhya Pradesh, Rajasthan, Tamil Nadu and Uttarakhand.

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[57] Artificial Limbs Manufacturing Corporation of India
[58] Section 12(1)(c) read with Section 2(n)(iii) & (iv) of the Act
[59] refers to a child belonging to BC, Minorities and includes OCs whose parents' income does not exceed ₹60,000 per annum
[60] refers to a child belonging to the Scheduled Caste, Scheduled Tribe, orphans, migrant and street children, Children With Special Needs and HIV affected/infected children
[61] GOs. Ms No.42 and 44 SE (PE Prog I) Department dated 30 July 2010
[62] *viz.* Scheduled Castes (10 *per cent*); Scheduled Tribes (4 *per cent*) and to Orphans, HIV affected and disabled (5 *per cent*) and at the rate of 6 *per cent* to Weaker Sections *viz*. Backward Castes, Minorities and Other Castes whose annual income does not exceed ₹60,000 per annum
[63] fee being the same for both Primary and Upper Primary levels

2.2.5.8 Provision of transport facility to children attending neighbourhood schools

For children from small hamlets or any other place as identified by the State Government/Local Authority, where no school exists within the area or limits of neighbourhood specified in State RTE Rules[64], the Government/Local Authority shall make adequate arrangements. These inter alia included free transportation in relaxation of the limits specified in the Rules.

Transport allowance for attending neighbourhood schools has been fixed at ₹300 per month payable for 10 months in a year. The State Project Director (SPD) releases funds to the district authorities who in turn release them to SMCs. The transport charges are disbursed in cash to the parents of children from Classes I to VIII. The SPD requested (December 2015) the district authorities to take the opinion of parents with regard to supply of bicycles to the children of Classes VI to VIII in lieu of cash.

Best Practice

Audit observed in Warangal district (test-checked) that during 2015-16, the District Collector implemented the orders of SPD (April 2016) ***to provide bicycles free of cost*** *to students of Classes VI to VIII. This will be as a one-time measure in lieu of providing transport allowance in cash as an innovative exercise to encourage them to attend school.*

Out of 2,520 students identified for this purpose, 2,094 students were provided bicycles while 426 students (Class I to V) were paid in cash.

Audit observed the following:

- During the year 2014-15, the State identified 26,281 children for provision of transportation and submitted proposals to PAB for approval. However, due to non-issue of the notification by the State Government, no transport allowance was approved by the PAB;
- During 2015-16, transport facility for 15,406 children only was provided (funds released and utilised: ₹1.48 crore (32 *per cent*)) against the approved budget of ₹4.62 crore. The department attributed the non-utilisation of full budgeted funds to short release of funds from GoI/State Government.
- During 2016-17, 18,131 children were identified towards provision of transportation charges. The necessary notification[65] declaring 1,517 habitations as not having neighbourhood schools, was issued by the State Government in September 2016. However, GoI did not release funds for the purpose.

Government, during Exit Conference, admitted that transport facility could not be provided to the children for the years 2014-15 and 2016-17 due to non/belated issue of Gazette notifications by State Government and hence non-release of funds by GoI.

Thus, lack of concern on the part of the Governments in providing the envisaged transport facility to all 44,412[66] eligible/identified children led to denial of the benefit of transport facility to them.

[64] sub-rule (1) below Rule 5
[65] GO Rt No.129 SE (Prog I) Department dated 12 September 2016
[66] 2014-15: 26,281 students and 2016-17: 18,131 students

2.2.5.9 Pupil-Teacher Ratio

As per Section 25 of RTE Act, Government should, within three years from the date of commencement of the Act, ensure maintaining the prescribed Pupil-Teacher Ratio (PTR). PTR should be at one teacher for every 30 children for classes I to V and one teacher for every 35 children for classes VI to VIII in each school.

The overall PTR in the State was satisfactory, i.e., 1:22 for Primary Schools[67] and 1:20 for Upper Primary Schools[68], during 2016-17. However, an adverse PTR was reported to GoI through AWP&B for 2017-18, in 1,991 Primary Schools[69] and in 1,181 Upper Primary Schools[70]. Further, in 5,806 PS there were 3,313 surplus teachers and in 4,433 Upper Primary Schools, there was shortage of 1,041 teachers.

Government in its reply stated that teachers from zero enrolment schools were redeployed to schools with high enrolment and 9,397 Vidya Volunteers were appointed during 2016-17 to mitigate the situation.

2.2.5.10 Creation of physical and educational infrastructure facility

Section 19(2) of the Act[71] stipulated provision of separate toilets for boys and girls, at least one classroom for every teacher, a room for headmaster, barrier-free access, drinking water facilities, boundary wall and playground. Government shall take steps to fulfil such norms and standards at its own expenses, within a period of three years (i.e., by March 2013) from the date of implementation of the Act.

Physical infrastructure - Civil Works

Scrutiny of records of the C&DSE revealed that the time frame of three years for completion of various infrastructural facilities[72] had not been adhered to. Out of 91,199 sanctioned civil works during 2001-02 to 2016-17, an aggregate of 21,564 works[73] (24 *per cent*) remained incomplete, of which 7,014 works relating to toilets and drinking water were in progress (March 2017).

As regards the status of spill over works (as of March 2017), C&DSE stated (July 2017) that the details (both physical and financial) would be obtained from district authorities and necessary action taken thereon.

Government in its reply quoted shortage of funds as the reason for non-completion of works in time.

Thus, the schools where the above works were incomplete still suffer from lack of basic physical infrastructure even after a period of seven years of the RTE Act coming into force.

[67] Class I to V - Number of children: 11.90 lakh and Number of teachers: 0.53 lakh
[68] Class VI to VIII - Number of children: 6.72 lakh and Number of teachers: 0.34 lakh
[69] out of 23,622 Primary Schools, i.e., 8 *per cent*
[70] out of 8,796 Upper Primary Schools, i.e., 13 *per cent*
[71] where a school established before the commencement of the Act does not fulfill the said norms
[72] school buildings, toilets, drinking water facilities, special lavatories for CWSN and Headmaster's room
[73] a total number of works-in-progress: 8,828 and number of works not yet commenced: 12,736

Availability of basic amenities

As per Schedule to Section 19 of RTE Act, no school shall be established or recognised by Government unless it fulfils the norms and standards specified therein.

The number of schools (out of 28,606 Government including Local Body schools) lacking basic amenities as of March 2017 is shown in the Table-2.13 below.

Table-2.13

Name of the amenity	No. of schools where facility did not exist (%)
(as against a total of 28,606 schools)	
At least one class room for every teacher and an Office-cum-Store	6643 (23)
Barrier-free access (ramps & hand-rails)	21547 (75)
Toilets	1261 (4)
Safe and adequate drinking water facility	0 (0)
Kitchen where Mid-Day-Meal is cooked in school	9192 (32)
Playground	12768 (45)
Boundary wall or fencing	11028 (39)
Library	888 (3)

Source: Records of C&DSE

Library in MPPS, Dandumailaram, Ibrahimpatnam mandal (9 June 2017)

It is seen from the above details that 75 *per cent* of the schools in the State did not have basic infrastructural amenities like *ramps and hand-rails*. Further, 45 *per cent* of the schools did not have playground and 39 *per cent* lacked boundary wall or fencing. The schools were, however, allowed to continue to function in violation of the provisions of the Act. Government claimed existence of library facility in 97 *per cent* of schools. It was, however, seen that the infrastructure provided in the libraries was poor without adequate study tables, closed cupboards and proper lighting.

Further, Audit found the following deficiencies in provision of basic infrastructural amenities in 88 test-checked schools in the sampled districts *vis-à-vis* UDISE data as given in Table-2.14 below.

Table-2.14

Audit findings	As per UDISE data		
Schools with at least one class room for every teacher and an Office-cum-Head Teacher's room not made available: **35** (40 *per cent*)	Not available		
Schools without barrier-free access (ramps & hand-rails): **66** (75 *per cent*)	66 (75 *per cent*)		
Schools without separate toilets for boys and girls:**22** (25 *per cent*)	***Facility***	***Boys***	***Girls***
	Toilets	5	2
	Urinals	28	23
	Running water in toilets	43	38
Schools without safe drinking water:**38** (43 *per cent*) However, C&DSE claimed that safe drinking water facility was provided to all the Government and Local Body schools (28,606) in the State	15 (17 *per cent*)		

Audit findings	As per UDISE data
Schools without play ground: **32** (36 *per cent*)	30 (34 *per cent*)
Schools without pucca boundary wall: **20** (23 *per cent*)	34 (39 *per cent*)
Schools without library facility: **14** (16 *per cent)*	3 (3 *per cent*)
Schools without electricity:**22** (25 *per cent*)	18 (20 *per cent*)

Source: Audit findings in test-checked schools and UDISE data

Thus, despite the lapse of seven years since implementation of the RTE Act, a large number of schools were deficient with regard to provision of basic infrastructural facilities/amenities.

Construction of kitchen-cum-store rooms

In 1,435 schools out of 25,991 schools in the State, Mid-Day Meal (MDM) was being served through centralised kitchens. In 24,556 schools MDM was being cooked in the school premises. Of the 24,556 schools, kitchen-cum-store rooms were available only in 14,138 (58 *per cent*) schools. Thus, 10,418 (42 *per cent*) schools did not have kitchen-cum-store rooms as of March 2017.

The Government decided to take up the construction of kitchen-cum-store rooms in rural areas under MGNREGS[74]. Accordingly, the Finance department released (December 2016) ₹80.38 crore by adjustment to PD account of Panchayat Raj and Rural Development (PR&RD) Department. Similarly, ₹11.87 crore was released to savings account of SPD, SSA for construction of kitchen-cum-store rooms in urban areas. However, online status of MGNREGS reported a meagre expenditure of ₹93.61 lakh (for 700 works-in-progress) was incurred as of June 2017.

Government in its reply (December 2017) stated that works could not be taken up in 2014-15 and 2015-16 owing to the bifurcation of State. In 2016-17, the Government tied up with MGNREGS for construction works. It was observed that out of 7,674 kitchen-cum-store-rooms sanctioned in the year 2016-17, construction of as many as 7,398 rooms[75] (96 *per cent*) was pending. Government attributed this to delay in release of MGNREGS funds by Panchayat Raj Department.

In the sampled districts, 41 out of 88 test-checked schools (47 *per cent*) did not have a kitchen for cooking. The MDM was being cooked in the open under unhygienic conditions.

Thus, due to non-construction of kitchen-cum-store rooms, the objective of cooking food in a hygienic environment was unfulfilled.

In ZPHS (Boys), Edulabad, Rangareddy district MDM being cooked in open unhygienically (21 June 2017)

[74] Mahatma Gandhi National Rural Employment Guarantee Scheme
[75] In progress: 1,927 works and construction not commenced: 5,471

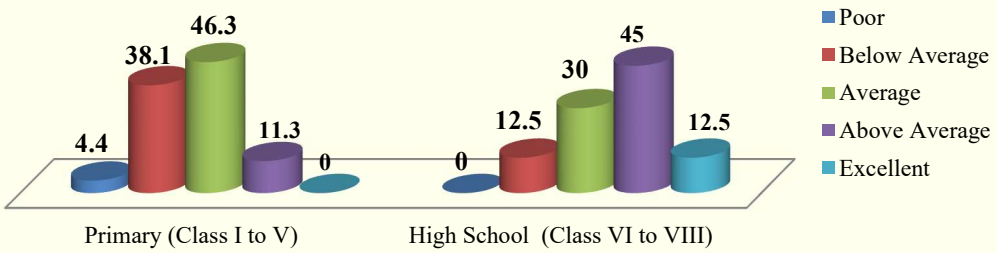
2.2.5.11 Shortfall in Teachers' Training

As per Section 9 of RTE Act, it is the responsibility of the local authority to provide training facility for teachers. As per Rule 25(2)(b) of State RTE Rules, the academic authority (SCERT) is to develop an In-service Teacher Training Design. As per Rule 22(3)(a), it is the duty of the teacher to participate in training programmes to improve his/her teaching skills for providing quality education to children.

Further, as per RTE roadmap[76], training of teachers should be completed within five years from the commencement of RTE Act.

Audit, however, observed shortfalls in teacher trainings which ranged from 20 to 40 *per cent* (*Appendix-2.10*).

Chart -2.8: Proficiency of Teachers in English (in *per cent*)



Source: Study on the Proficiency levels of Teachers and Children in English Language

There was a Study on the Proficiency levels of Teachers and Children in English Language at Elementary Level (submitted[77] to TSSA Society for the year 2014-15). The overall proficiency level of the Teachers as per the report is depicted above.

It is evident from the above chart that 89 *per cent* of the Primary School teachers and 43 *per cent* of High School teachers had *Average*/*Below Average*/*Poor* proficiency levels.

Government during Exit Conference (December 2017) attributed the non-achievement of In-service Teacher Trainings to short release of funds by GoI and the State Government. Further, Government in its written reply, accepted the audit observation and stated (December 2017) that as most of the teachers recruited were from Telugu background, they lacked proficiency levels in English language. However, as a positive step in this regard, 14,914 teachers were trained in English language by SCERT[78] in the year 2016-17.

2.2.5.12 Zero enrolment and single teacher schools

As per the prime objective of RTE Act, Government should take effective steps for increasing enrolment for universalisation of primary education.

However, the number of schools with zero enrolment and those with enrolment of less than 15 and 30 students increased during 2014-17 as shown in Table-2.15 below.

[76] Para 1.5 of SSA Framework
[77] by Dr. R.V. Anuradha (Sr. Asst. Professor), Department of Education, The English and Foreign Languages University, Hyderabad
[78] State Council of Educational Research and Training

Table-2.15

Year	No. of schools with zero enrolment		No. of schools with enrolment of less than 15 students		No. of Schools with enrolment of less than 30 students		No. of schools with single teacher	
	PS	UPS	PS	UPS	PS	UPS	PS	UPS
2015-16	492	153	3043	864	8777	2179	1960	532
2016-17	559	234	3720	1140	9565	2511	2235	535
Increase in %	14	53	22	32	9	15	14	0.56

PS: *Primary Schools;* ***UPS:*** *Upper Primary Schools. Source: Minutes of 248th PAB meeting dated 12 May 2017*

In its reply (August/December 2017) the Department indicated the steps taken to increase the enrolment rate in schools. These are (i) a special enrolment drive was conducted in June 2017 and English medium sections were started on the demand of parents; (ii) teachers were being redeployed to schools with adverse PTR; (iii) Vidya Volunteers were engaged in single teacher schools and schools with adverse PTR[79] during the academic year 2017-18 and (iv) a proposal to merge schools based on enrolment to maintain PTR was moved but there was resistance to the concept at field level.

The steps taken by Government to increase the rate of enrolment in schools were yet to yield the desired results (December 2017).

2.2.5.13 Early childhood care and education not provided

RTE Act[80] mandates that Government have to make arrangements for providing free pre-school education for children above the age of three years. This is to prepare them for elementary education and to provide them early childhood care and education until they complete the age of six years.

The children in the age group of 3-6 years were taken care of by Anganwadi centres under the control of Women Development and Child Welfare Department (WD&CWD). Accordingly, pre-primary schools were not established by the Government. Government, through WD&CWD issued instructions (May 2017) for relocation of Anganwadi centres to Primary School premises to improve learning conditions of the children.

As of July 2017, 11,831 such Anganwadi centres (out of total 31,414 centres) were relocated to Primary School premises based on the Government orders. This is an innovation that ensures a school environment will be created for the children of Anganwadi centres.

2.2.6 Management, Monitoring and Evaluation

The RTE Act entrusts responsibility to the Department for providing schools, infrastructure, trained teachers, curriculum and teaching/learning materials. *SAC[81] at the State level and School Management Committee (SMC) at school level are to monitor the implementation of provisions of the Act.*

[79] i.e., schools with high enrolment
[80] Section 11
[81] State Advisory Council

2.2.6.1 State Advisory Council not constituted

The State Government shall constitute[82] SAC (to be chaired by Minister-in-charge of School Education) consisting of members[83] from amongst persons having knowledge and practical experience in the field of elementary education and child development. SAC shall advise the State Government on implementation of the provisions of the Act in an effective manner. Business of the council mandates a meeting once in three months.

Audit, however, observed that SAC was not constituted by the Government as of December 2017.

As a result, the implementation of the provisions of RTE Act could not be reviewed at the apex level and corrective actions, if any, could not be suggested to the State Government for effective implementation of RTE Act in the State.

Best Practice

*In pursuance of Rule 27(2) (vi) of State RTE Rules, 2010, the erstwhile Government of Andhra Pradesh initiated and established (October 2011) a **Child Rights Cell (CRC) with Toll free No** 1800-425-3525 in the Office of the SPD, TSSA, Hyderabad (whose activities are maintained by an NGO) to receive representations/grievances from public relating to problems being faced by the children and solve them.*

During the period 2014-17, 385 complaint calls were received over the toll free number from aggrieved parties. Audit, however, observed that 376 complaints were shown as settled although some of them were not fully resolved.

2.2.6.2 School Management Committees

A school shall constitute[84] SMC consisting of elected, ex-officio and co-opted representatives[85]. As per State RTE Rules[86], SMC meetings are to be conducted once in two months and minutes and decisions of the meetings are to be properly recorded.

Out of 88 test-checked schools, in 62 schools, 509 SMC meetings (55 *per cent*) were not conducted against 930 meetings to be conducted as per norms during 2014-17. Thus, the mandate of SMC was not fulfilled to a great extent. Further, in the test-checked schools, only the MEOs and CRPs visited the schools and no other authority[87] inspected the schools.

Non-conducting of SMC meetings/non-inspection by DEO/Dy. EO limited the department's capability to assess the effectiveness of the implementation of RTE Act.

Government accepted the audit observation and attributed non-conduct of meetings as stipulated and non-conduct of inspections to insufficient monitoring staff.

2.2.6.3 Collection of exorbitant fee by Private schools

Government issued orders (April 2016) for conducting inspection of private schools on the issue of collection of fee from students. The C&DSE, based on the High Court order

[82] as per Section 34 of the RTE Act and Rule 28 of State RTE Rules
[83] not exceeding 15
[84] as per Section 21 of RTE Act
[85] **Elected**: three parents/guardians elected by parents/guardians of children in each class; **Ex-officio**: Head Teacher or in-charge-Head Teacher; **Co-opted**: two school supporters (educationists/philanthropists)
[86] sub-rule (5) (a) below Rule 19
[87] DEO, Dy. EO, Academic Monitoring Officer (AMO)

identified (April 2016) 174 private schools in Hyderabad, Rangareddy and Medak districts who collected exorbitant fee and submitted a report (March 2017) to the Government. The report stated the following:

- The schools were collecting fee[88] on various pretexts[89] apart from regular tuition fee and they were not incurring expenditure as per extant Government rules[90].
- None of the schools submitted its Annual Administrative Reports and Audited Accounts.

Show cause notices were issued (February 2016 to March 2017) to 91 schools. The final outcome was still awaited (December 2017).

Audit also found cases of conducting screening tests, collection of one time capitation fee and huge tuition fee, etc. constituting breach of provisions of the RTE Act. This also reflected lack of control of Government over the private unaided schools.

The above violations reflected the lack of regular inspections of the private schools and poor monitoring at C&DSE as well as Government level. This showed a deficient internal control mechanism in the department.

2.2.6.4 Submission of Annual Administrative Reports by private unaided schools

The Educational agency, i.e., Private unaided school shall submit[91] Annual Administrative Report (AAR) to the competent authority every financial year by 30th September.

Audit, however, observed that the AARs were not submitted by any of the 3,791 private unaided schools in Khammam (474), Rangareddy (2,542) and Warangal (775).

Government accepted the audit observation. Government stated (December 2017) that instructions had been issued to DEOs to initiate action against the managements of private unaided schools who failed to submit AARs. Non-submission of AARs by private unaided schools and non-inspection of schools by inspecting authorities at regular intervals showed deficient internal controls.

2.2.6.5 Tracking of Sustainable Development Goal Indicators

The vision of the United Nations Sustainable Development Goal (SDG 4) is to ensure inclusive and quality education to all. To achieve the Sustainable Development Goal, the Department of School Education prescribed minimum proficiency levels for reading, writing and simple arithmetic (referred to as 3Rs) for the children of Classes II and III. Subject-wise minimum proficiency levels at the end of the Primary level and up to Class X were also prescribed.

[88] tuition fee collected per annum was ranged from ₹16,500 to ₹5.42 lakh and one-time Admission fee ranged from ₹30,000 to ₹1.00 lakh

[89] caution fee, admission fee, activity fee, lab and annual fee, etc. in contravention of the fee prescribed vide GO Ms No. 91 dated 6 August 2009

[90] prescribed vide GO Ms No. 1 Education dated 1 January 1994

[91] as per Rule 20 of the Andhra Pradesh Educational Institutions (Establishment, Recognition, Administration and Control of Schools under Private Management) Rules, 1993 (GO Ms No.1 Education (PS-2) Department, dated 1 January 1994)

Proficiency levels in Reading, Writing and Simple arithmetic

School Education Department, after reopening of schools every year in the month of June, conducts a pre-test for all children. Remedial teaching would be organised thereon for the children who did not achieve the prescribed 3R's level of proficiency.

Audit observed that lack of proficiency levels in respect of 3R's was as high as 38 *per cent* and 39 *per cent* for Classes II and III respectively. The overall lack of proficiency levels of Classes II to VIII for the year 2016-17 was 31 *per cent*.

Government replied (December 2017) that remedial teaching was being conducted in all schools to the children who had not achieved proficiency levels under Learning Enhancement Programme.

A non-government organisation[92] conducted voluntarily a household analysis in nine rural areas of nine districts (i.e., except Hyderabad) in the academic year 2016. The Annual Status of Education Report (ASER) brought out by it contained an analysis on the academic skills acquired by pupil in the rural government and private schools in the State. Their findings on the reading and arithmetic skills of students were as follows:

- With respect to Reading skills in Telugu, only 47 *per cent* children of Class V could read Class II level Telugu text. Only 76 *per cent* of children of Class VIII could read the same text. In respect of Reading skills in English, only 23 *per cent* children of Class V could read simple words and only 11 *per cent* of Class VIII children could read simple words.
- Children by grade and arithmetic level: Only 3 to 43 *per cent* of students of Classes I to VIII could do subtraction and 1 to 55 *per cent* could do division. Only 27 *per cent* of students of Class VIII could do subtraction and 55 *per cent* of them could do division.

  Thus, learning level of children was not at par with the required levels putting the academic future of children in jeopardy.

Thus, much needed to be done by the Department to improve the proficiency levels of children in order to conform to the standards set up under SDG.

Government replied that a special 60 day programme known as Learning Enhancement Programme (LEP)-3R was designed for low performance children and implemented in the beginning of the academic year. Under this, remedial classes for children lacking 3Rs would be taken by teachers. During Exit Conference, Government stated that the performance of teachers was being evaluated every year and awards given to deserving teachers on Teachers' Day.

Performance of Children

Under Padhe Bharat Badhe Bharat scheme for Classes I to VIII all children are to score[93] 40 per cent or above in all the subjects. Minimum grade-wise proficiency levels required for children in reading and mathematics have been prescribed in the scheme.

[92] PRATHAM – website: img.asercentre.org
[93] as per State Achievement Survey and National Achievement Survey

Scrutiny of the data related to '*Performance of Children*' (*Appendix-2.11)* showed that 14 to 26 *per cent* of children at Primary level and 21 to 47 *per cent* of children in Upper Primary level scored less than 40 *per cent* during the years 2014-17. Further, children who scored between 91 to 100 *per cent* ranged from 5 to 10 *per cent* for Primary level. It was 2 to 6 *per cent* for Upper Primary level. This reflected poor competitive levels of children in academics in Government (including Local body and Aided) schools. The Department accepted that there was lack of minimum proficiency levels of children in various subjects.

Thus, the objective of conforming to the standards set by the State Government, remained largely unachieved.

Shaala Siddhi (Evaluation for improvement)

Shaala Siddhi[94] is an instrument for school evaluation developed by NUEPA[95], MoHRD. The programme visualises 'School Evaluation' as the means and 'School Improvement' as the goal. It provided a clear road-map for each school to embark on a journey of Self Evaluation and External Evaluation, leading towards incremental school improvement with accountability. While the school as a whole should engage in the self-evaluation process, external evaluation is entrusted by the department to academic persons/institutes of their choice. It is to be implemented in all the Government and Aided schools in 2016-17. For the year 2016-17, PAB approved a budget of ₹2.33 crore. Against this, a meagre amount of ₹0.65 lakh only was spent.

Audit observed that as of December 2017, out of 29,549 Government and Aided schools (Primary, Upper Primary and High Schools) targeted in the State, 'Self Evaluation' (by schools themselves) was completed and the data uploaded in respect of only 8,585 schools. The remaining 20,964 schools had not Self Evaluated. Further, although inspections of schools were being conducted (with significant shortfalls) no 'External Evaluation' was conducted by the Department in any of the schools. Government in their reply stated that NUEPA would enable External Evaluation only after January 2018.

Thus, the implementation of Shaala Siddhi programme was very unsatisfactory despite availability of funds as the Department failed in its visualised goal of School Improvement.

2.2.7 Conclusion

The efforts made by the State Government in ensuring unique identity of children through AADHAAR authentication, establishment of a Child Rights Cell to address their grievances are innovative and commendable. Nevertheless, the implementation of RTE Act overall suffered in the State even after the lapse of seven years of its coming into effect. Majority of the provisions of the Act were not fully followed by the State Government. Only 50 per cent of the PAB approved funds (2014-17) were released under Sarva Shiksha Abhiyan – the main vehicle for implementation of the Act. Majority (74 per cent) of the total expenditure was incurred on Salaries, KGBVs and Civil Works; only 26 per cent was utilised on quality and other interventions under the programme.

[94] National Programme on School Standards and Evaluation (NPSSE) launched by GoI in November 2015
[95] National University of Educational Planning and Administration

Reservation of 25 per cent for disadvantaged groups and weaker sections envisaged in private un-aided schools was not implemented/enforced by the State Government. The Department could not mainstream all the Out-of-School Children and failed to provide special training to them as targeted which denied education to large number of children. Little progress was made by Government in setting up new schools which resulted in dependency on and flourishing of private schools. In this context, shifting the Anganwadi to school premises is an innovation that could raise the enrolment in Primary Schools.

The time frame of three years for completion of various infrastructural facilities such as school buildings, toilets, drinking water facilities, etc. had not been adhered to.

Enrolment in Government schools during the period 2014-17 showed a declining trend. The dropout rate in respect of SC/ST children was a matter of concern. State Advisory Council intended to advise the Government on implementation of the Act was not constituted in the State. School Management Committee meetings were not conducted regularly. Child tracking system was not in existence in any of the schools in the State. There was thus no mechanism in place to monitor academic progress of children, their retention, transition and migration. The prescribed minimum proficiency levels for 3Rs, i.e., reading, writing and simple arithmetic were not achieved.

2.2.8 Recommendations

(i) The department should review all infrastructure plans to ensure completion of the pending works within reasonable time;

(ii) The department should ensure a functional child tracking system to monitor academic progress, retention, transition and migration of children;

(iii) State Government should pursue with GoI for timely/adequate release of funds and release its own matching funds. Priority should be given to incur expenditure on quality interventions;

(iv) The department should ensure effective implementation of the Learning Enhancement Programme (3R's) for enhancing the minimum proficiency levels of children; and

(v) The department should ensure regular monitoring/inspection of schools and conduct meetings of School Management Committees as prescribed.

During Exit Conference, Government assured of remedial action on the points raised by Audit. The recommendations made by Audit were also discussed and accepted by Government.