Chapter III
Compliance Audit

Audit of transactions of the Government Departments, their field formations as well as audit of the autonomous bodies brought out lapses in management of resources and failures in the observance of the norms of regularity, propriety and economy, which have been presented in the succeeding paragraphs under broad objective heads.

Animal Husbandry and Higher Education Departments

3.1 Loss to the contributors of New Contributory Pension Scheme

Loss of ₹ 3.49 crore to the subscribers of New Contributory Pension Scheme due to keeping funds in savings bank account and delay in transferring the contributions to National Securities Depository Limited.

Government of Rajasthan (GoR) introduced (January 2004) new Contributory Pension Scheme (NPS) for State Government employees appointed from January 2004. The contributions were required to be deposited in the pension account maintained with Pension Fund Regulatory and Development Authority (PFRDA), which was to be appointed on a later date. Meanwhile, GoR notified (August 2005) that the amount of contribution towards the pension account shall be retained in interest bearing Personal Deposit (PD) account as an interim measure. Further, Finance Department, GoR issued (June 2005 and July 2009) directions that funds of NPS subscribers kept in PD account, shall carry an interest of eight *per cent* per annum. Subsequently, GoR did not appoint PFRDA and opted (August 2009) for NPS of Government of India (GoI). Thereafter, GoR signed (November 2010) an agreement with National Securities Depository Limited (NSDL) for maintenance of accounts and the funds were to be transferred to NSDL from July 2011. The scheme was also applicable to employees of all universities in the state.

Under NPS, the total contribution uploaded in an employee's account was to be divided among the three Pension Fund Managers[1] (PFMs) in a ratio prescribed by GoR and units to be allotted in the subscribers account accordingly. PFMs would invest the money in different financial instruments within the investment guidelines laid down by PFRDA and declare Net Asset Value (NAV) at the end of each day. Accordingly, units based on NAV were to be credited in the subscriber's account. The present value of the investment was to be arrived at by the units held multiplied by NAV.

Test check (February-June 2018) of the records of University of Kota, University of Rajasthan, Jaipur and Rajasthan University of Veterinary and

[1] SBI Pension Funds Private Limited, UTI Retirement Solutions Limited and LIC Pension Fund Limited.

Animal Sciences (RAJUVAS)[2], Bikaner revealed that ₹ 20.59 crore collected as contribution from the salary of 671 employees of the Universities as well as employer's contribution under NPS for the period 2005-2018, was deposited in the savings bank accounts by the Universities contrary to the direction of the Finance Department to deposit in PD account bearing interest of eight *per cent*.

Further, the funds accumulated upto 2010-11 were also required to be transferred to NSDL from July 2011 as directed by GoR. The Universities however, did not follow the direction concurrently and deposited only ₹ 18.22 crore with NSDL from later periods. The universities however did not deposit ₹ 2.47 crore with NSDL as of June 2018, as details given in **Table 1**.

Table 1

(₹ in crore)

Name of the University	No. of Employees	Period for which contribution received	Amount to be deposited with NSDL	Amount deposited with NSDL	Amount not deposited with NSDL	Loss of returns to the contributors based on NAV	Interest earned in the Saving Bank Account	Net loss
University of Kota	113	2005-18	3.38	2.87	0.51	1.18	0.27	0.91
University of Rajasthan, Jaipur	413	2005-18	11.39	10.62	0.77	1.42	0.25	1.17
RAJUVAS, Bikaner	145	2005-18 (Upto June 2018)	5.92	4.73	1.19	1.62	0.21	1.41
Total	**671**		**20.69**	**18.22**	**2.47**	**4.22**	**0.73**	**3.49**

Thus, failure to deposit contribution with NSDL from July 2011 resulted in a loss of ₹ 3.49 crore ***(Appendix 3.1)*** to the contributors, which is the difference between returns based on NAV[3] declared by one of the fund managers i.e. SBI Pension Fund on accumulated fund to be deposited with NSDL and interest earned on the amount retained in saving bank account during that period.

GoR, in case of University of Kota and University of Rajasthan, stated (August 2018) that balance contribution along with interest has been deposited in Permanent Retirement Account Numbers (PRANs) accounts of employees of the University of Kota in July 2018 and the balance contribution along with interest of employees of the University of Rajasthan is being reconciled and after reconciliation, the same would be deposited in respective accounts of the contributors.

In case of RAJUVAS, GoR stated (September 2018) that delay in transferring contributions to NPS was due to non-availability of PRANs. The reply was not

[2] The RAJUVAS, Bikaner was constituted and came into existence in May 2010 under RAJUVAS Act, 2010 consequent to carving out of units pertaining to Veterinary and Animal Sciences from Swami Keshwanand Rajasthan Agricultural University (SKRAU), Bikaner and Maharana Pratap University of Agriculture and Technology, Udaipur.

[3] The NAV prevailing on the last day of each year has been taken for calculation of the loss in the absence of details of monthly contribution.

convincing as the University was also responsible for allotment of PRANs to the contributors for timely transferring of their contribution to NSDL.

The fact remains that retaining the contributions in savings bank accounts instead of PD accounts and delay in depositing the contribution with NSDL resulted in a loss of return of ₹ 3.49 crore to 671 employees of three Universities.

Thus, the Universities on the one hand, kept the funds in saving bank accounts with lower interest rates and on the other hand did not transfer the same to NSDL from July 2011 resulting in loss to the employees making NPS contributions.

Public Health Engineering Department

3.2 Irregular and unauthorized expenditure on additional works

Irregular and unauthorised expenditure of ₹ 7.15 crore on execution of additional works in contravention of financial rules.

Rajasthan Public Works Financial and Accounts Rules (PWF&ARs) delegate the financial power of sanction, execution and payment of additional quantities of items existing in Schedule 'G' or Bills of Quantities (BoQ) of a particular work to the various levels of authorities in the Department. Accordingly, Chief Engineer (CE)/Additional Chief Engineer (ACE)/Superintending Engineer (SE)/Executive Engineer (EE) could sanction additional quantity up to 5 *per cent* of original quantity of each item subject to 5 *per cent* of tendered amount of works sanctioned by the authority concerned. Additional quantity up to 25 *per cent* of original quantity could be sanctioned by next higher authorities subject to 25 *per cent* of tendered amount of work concerned. Administrative Department could sanction additional quantity up to 50 *per cent* of original quantity subject to 50 *per cent* of tendered amount of work concerned.

(i) Test check (November to December 2017) of records of EE, Public Health Engineer Department (PHED) District Division-III, Jodhpur and SE, PHED, Circle Sawai Madhopur revealed that the CE (Project), Jodhpur and the SE, Sawai Madhopur approved (September 2013 and September 2015) the rates of the respective lowest bidders[4] for carrying out the works valuing ₹ 2.50 crore and ₹ 0.80 crore respectively. Therefore, they were empowered to sanction additional quantities of ₹ 0.125 crore and ₹ 0.04 crore respectively (being 5 *per cent* of the tendered amount) over the original quantities sanctioned by them.

However, after exhausting the financial limits for these works, the tender approving authorities (CE, Jodhpur and the SE, Sawai Madhopur), continued the rate contracts, without inviting fresh tenders and the contractors executed the works of ₹ 4.95 crore against the total tendered amount of ₹ 3.30 crore,

[4] M/s Shiv Construction Co., Jodhpur and M/s Ram Swaroop Gurjar, Sawai Madhopur.

which was ₹ 1.65 crore (50 *per cent)* over the tendered amount and for it, the approval from administrative level of the department was required but the same was not obtained.

GoR stated (August 2018) that financial limit was enhanced upto 50 *per cent* of the tendered amount by CE (Project) for the work of District Division-III, Jodhpur as per Rule 73 of Rajasthan Transparency in Public Procurement (RTPP) Rules. Reply is not convincing as the audit contention is not about enhancement in the work but on the failure to get the requisite approvals from the competent authority as per PWF&ARs to sanction this enhancement in work.

(ii) Similarly, test check (March 2017) of records of Executive Engineer, PHED, Project Division, Sardarshahar, revealed that the Finance Committee (FC) of Rajasthan Water Supply and Sewerage Management Board approved (August 2013) the rate of M/s L&T Construction, Chennai for '*Ratangarh Sujangarh Water Supply Project Phase-II'* for ₹ 591.40 crore. The work included laying of 280 mm and 315 mm UPVC-3 pipe of lengths 839 and 3,637 meters respectively. However, the contractor was paid (March 2018) for 25,388 and 10,864 meters quantities respectively upto 47th running bill (details given in **Table 2**).

Table 2

(₹ in crore)

S. No.	Item	Details of pipes provided in Work order		Details of payment made to the contractor		Quantity excess over sanctioned quantity
		Length (in meter)	Amount	Length (in meter)	Amount[5]	
1.	280 mm UPVC-3 pipe	839	0.15	25,388	4.20	2,926 *per cent*
2.	315 mm UPVC-3 pipe	3,637	0.86	10,864	2.31	199 *per cent*
Total			**1.01**		**6.51**	

It is evident from the table that the total tendered value of the items was ₹ 1.01 crore but the EE paid the contractor for quantities valuing ₹ 6.51 crore, which was 545 *per cent* (₹ 5.50 crore) more than the original value. According to PWF&ARs, the competent authority was empowered to sanction additional items valuing ₹ 0.51 crore (50 *per cent* of the original value) however, approval of the competent authority for the additional quantities valuing ₹ 5.50 crore was not obtained by EE before making payment to the contractor.

GoR stated (August 2018) that quantity of 280 mm and 315 mm pipes were enhanced due to revision in drawings on the basis of final survey conducted by the contractor and deviation statement would be submitted for approval after completion of the work. Reply is not convincing as the increase in quantity of pipes after the final survey conducted by the contractor leading to revision in drawings, indicated improper planning for execution of the work and hence required approval of the higher authorities as per PWF&ARs.

[5] Calculated at 90 *per cent* of full rate for UPVC-3 Pipes (280 mm: ₹ 1,836 per meter and 315 mm: ₹ 2,361 per meter) for laying of pipes, pending sectional testing and commissioning.

Thus, execution of additional works in contravention of PWF&ARs led to irregular and unauthorised expenditure of ₹ 7.15 crore.

3.3 Unfruitful expenditure due to reduction in quantity and quality of pipes

Unjustified reduction in quantity and quality of pipes with an intention to limit the value of sanction within the competency of Additional Chief Engineer led to non-commissioning of Over Head Service Reservoirs for more than three years and rendered expenditure of ₹ 0.94 crore unfruitful. Besides, not achieving intended objective of providing drinking water to habitations.

Superintending Engineer (SE) (Operation & Maintenance), Project Management Cell, Public Health Engineering Department (PHED), Circle-Churu issued (August 2012) two separate Technical Sanctions (TSs) each of ₹ 0.43 crore for providing drinking water to two water deficit zones of Sardarshahar town namely Zone 5 and 6 inhabited predominantly by persons belonging to scheduled caste/scheduled tribe community. The TSs included the work of construction of two new Over Head Service Reservoirs (OHSRs) one for each zone and connecting them with the existing distribution network by providing pipes for rising and distribution mains. Subsequently, Additional Chief Engineer (ACE), Bikaner issued (November 2012) two Administrative and Financial (A&F) sanctions for ₹ 49.86 lakh and ₹ 49.71 lakh. Rates of M/s Rathore Construction Company were approved (October 2013) by ACE and the SE issued (October 2013) work orders for ₹ 1.02 crore[6]. The works were completed and the contractor was paid ₹ 0.94 crore[7]as of November 2014.

Scrutiny of the records (March 2017) of Executive Engineer (EE), Project Division- Sardarshahar and further information collected (September 2017, January 2018 and June 2018) revealed that two separate proposals were made for a work of similar nature i.e. construction of OHSRs and laying of pipelines in two adjacent zones. The proposals *inter alia* included theprovision of Unplasticised Polyvinyl Chloride (UPVC) pipes for rising mains instead of Ductile Iron (DI) pipes against the approved (May 2010) pipe policy adopted by the department.

Further, the provision of 7,872 meter pipe line approved (August 2012) in TSs was reduced to 3,535 meter[8] while issuing Notice Inviting Tender (NIT) without any justification. As a result, the works of rising main and distribution system could not be completed and OHSRs could not be commissioned for supplying water. Later, a revised single proposal for ₹ 4.83 crore was prepared (March 2017) for commissioning of OHSRs and augmentation of water supply of Zone 5 and 6. This included provision for 32,445 meters pipeline including 7,700 meters DI pipe[9] for rising mains which was not taken in the earlier

6 Zone 5: ₹ 0.51 crore and Zone 6: ₹ 0.51 crore.
7 Zone 5: ₹ 0.48 crore and Zone 6: ₹ 0.46 crore.
8 2,335 meter MS pipe, 200 meter DI pipe and 1,000 meter UPVC pipe.
9 Costing ₹ 1.22 crore.

works. This indicated that the requirement of quantity of pipeline for the work in the original assessment was grossly underestimated. As a result, OHSRs constructed at a cost of ₹ 0.94 crore could not be commissioned and the possibility of their damage due to passage of time could not be ruled out.

GoR stated (December 2018) that due to non-availability of land at the proposed locations, the department decided to construct these OHSRs at other locations which led to increase in length of rising mains. It was also stated that the work would be completed by December 2018.

The reply is not tenable as department should have conducted proper survey and ensure availability of land before submitting the proposal for technical sanction but the same was not done by the authorities concerned. As a result, the department had to change the sites of OHSRs. Further, even after knowing the requirement of 6,600 meters pipes for rising main, the department took only 2,535 meter pipes for rising mains in Notice Inviting Tenders due to which the constructed OHSRs remained unconnected as of December 2018.

This resulted in non-commissioning of OHSRs for more than three years and rendered expenditure of ₹ 0.94 crore on these works unfruitful. Besides, the objective of providing 100 Liters Per Capita Per Day (LPCD) drinking water to the habitations of Zone 5 and 6 of Sardarshahar could not be achieved as they are getting only 30 LPCD drinking water since 2014.

Medical Education Department

3.4 Construction of Maternal Child Health unit caused damages to existing structure

Construction of Maternal Child Health unit above first floor of old hospital building without ensuring structural safety, resulted in structural damages to the whole building and unfruitful expenditure of ₹ 10.47 crore.

Construction of 100 bedded Maternal Child Health (MCH) unit at Government Pannadhaya Hospital (hospital), Udaipur (constituent hospital of Medical College, Udaipur) as a separate unit, was included in the State Programme Implementation Plan for 2012-13 under National Rural Health Mission (NRHM). Accordingly, Administrative sanction was issued by Mission Director, NRHM in June 2012 for construction of MCH unit having 7,095 square meter area. Financial Sanction for ₹ 15.27 crore was issued in August 2013, which was subsequently revised to ₹ 17.64 crore in January 2015.

Test check (February 2018 to March 2018) of records revealed that a departmental committee[10] constituted in May 2012 recommended (October

[10] Consisting of Principal, Medical College, Udaipur; Superintending Engineer, Medical & Health, Jodhpur; Senior Architect, Medical and Health, Jaipur; Executive Engineer, Medical and Health, Udaipur; Assistant Engineer, City Division, Public Works Department, Udaipur; and Assistant Engineer, Medical and Health, Udaipur.

2012) construction of MCH unit having 40,000 square feet area above the first floor of the existing hospital building[11]. However, the committee also suggested that before carrying out the construction, a Structural Safety Certificate for the building should be obtained from the Public Works Department (PWD).

It was, however, observed that without obtaining Structural Safety Certificate from PWD, the Executive Engineer (EE) Medical and Health, Udaipur awarded (August 2013) the work to M/s Chirag Infraprojects Pvt. Limited for ₹ 4.23 crore with stipulated date of completion in February 2015. Meanwhile, another technical committee[12] noted (October 2013) that as the walls of the hospital were nearly sixty years old and was constructed with stone masonry and lime mortar, the normal load bearing capacity was only 30 to 35 feet. As the height of the building was more than 35 feet, the committee recommended that construction of an additional floor was not feasible. Later, as the contractor executed only 28.58 *per cent* (₹ 1.21 crore) of the work upto November 2014, the contract was rescinded (February 2015).

Without taking into account, the recommendations of both these committees (October 2012 and October 2013), EE awarded (June 2015) the remaining work to another contractor i.e. M/s Shailendra Sharma with stipulated date of completion as February 2016 who completed the work in April 2016 and handed over to the department in February 2017. The updated expenditure on the work was ₹ 10.47 crore.

Thereafter, severe horizontal cracks in the walls, lintels and roof were noticed in March 2017. Consequently, another technical committee[13] was constituted (March 2017), which reported (March 2017) that cracks occurred due to increase in gravity loading by additional construction of second floor and was propagating in due course of time. These cracks further influenced the lintels and stone *patty* roofing of ground floor and led to an unsafe condition. The committee concluded that strengthening work of the floors was not executed before carrying out construction of MCH unit. Further, another committee headed by a professor of Malaviya National Institute of Technology, Jaipur was designated (March 2017) by the State Government. The committee endorsed the finding of the earlier technical committee and suggested (May 2017) remedial measures for strengthening of the structure.

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11 Total area of the ground and first floor occupied by the hospital was 1,04,000 square feet.

12 Consisting of Chief Architect, PWD, Jaipur; Additional Chief Engineer, PWD, Udaipur; Principal, Medical College, Udaipur; Superintendent, Maharana Bhupal Hospital, Udaipur; Superintending Engineer, PWD, Jaipur, two Associate Professors, Malviya National Institute of Technology, Jaipur and Executive Engineer, PWD, City Division, Udaipur.

13 Consisting of Additional Chief Engineer, PWD, Udaipur; Executive Engineer, PWD, City Division, Udaipur and Assistant Engineer, NRHM, Udaipur.

Horizontal cracks in the walls, lintels and roof of Government Pannadhaya Hospital, Udaipur

GoR while accepting the facts stated (July 2018) that the executing agency for construction of MCH unit was NRHM and the Structural Safety Certificate was not obtained by it before commencement of work inspite of the Assistant Engineer, Medical and Health, Udaipur being a member of the committee. Further, Principal & Controller, RNT Medical College, Udaipur at the behest (June 2018) of the District Collector, Udaipur has issued instruction to vacate the building keeping in view the safety of the public and transfer the medical services to other places.

Thus, haste in awarding of the work, initially by the EE before obtaining Structural Safety Certificate and later re-awarding the remaining work ignoring the recommendation of the committees for strengthening the existing structure before carrying the construction led to severe structural damages to the existing Government Pannadhaya Hospital building. Thus, before the entire building is utilised again, an additional expenditure would be needed for strengthening of the structure besides expenditure of ₹ 10.47 crore remaining unfruitful so far.

3.5 Unfruitful expenditure on Out Patient Department cum Emergency Block

Expenditure of ₹ 3.67 crore on construction of Out Patient Department cum Emergency Block remained unfruitful due to improper planning and leaving the incomplete structure of no use.

Construction of a new Out Patient Department (OPD) cum Emergency Block within one year, at Umaid Hospital, Jodhpur was decided (March 2012) in the budget speech 2012-13 to fulfil the urgent need of OPD patients as the existing OPD was not sufficient to meet the requirements of patients. Accordingly, Administrative and Financial (A&F) sanction[14] and Technical Sanction[15] were issued in June 2012 and November 2012 respectively for

[14] Issued by Medical Education Department, Government of Rajasthan.
[15] Issued by Additional Chief Engineer, PWD, Jodhpur.

₹ 3.50 crore[16]. The work was to be executed by the Executive Engineer (EE), Public Works Department (PWD) Medical Division, Jodhpur. PWD awarded (March 2013) the work with stipulated date of completion as March 2014.

Scrutiny (February 2018) of the records revealed that though the sanction of ₹ 3.50 crore was issued only for construction of OPD cum emergency block on ground floor, the Superintendent of the hospital proposed construction of an underground parking along with the OPD cum emergency block after award of work to the contractor during the ceremony for laying of foundation stone. Consequently, the scope of work was enhanced and the EE submitted (September 2013) revised estimate for ₹ 7.40 crore, which was not approved. Thereafter, between August 2012 and November 2015 the design was also changed three times to accommodate the provision for basement parking but the revised estimates were not sent for revision in A&F sanction.

It was also observed that the final layout and designs for the work including underground parking was provided by PWD to the contractor in November 2015 without getting revised sanction of the State Government. This resulted in the work not being completed (June 2018) and since February 2017, the work is at a standstill in spite of incurring an expenditure of ₹ 3.67 crore. Further, Chief Engineer, PWD submitted (June 2017) revised proposal for A&F of ₹ 6.86 crore to Director, Medical Education Department for underground parking, ancillary and extra items of civil works and additional electrical work. The revised A&F sanction for ₹ 6.86 crore was yet to be accorded by the State Government as of March 2019.

Thus, OPD block which was required to be constructed within one year to meet the urgent need of the patients could not be completed even after lapse of six years of A&F sanction and expenditure of ₹ 3.67 crore[17].

Incomplete structure of OPD cum Emergency Block and underground parking at Umaid Hospital, Jodhpur

Further, a committee constituted (November 2017) by the State Government for examining the causes for delay also stated that the work has been delayed due to belated decision on underground parking and related changes in the

[16] Civil work: ₹ 2.45 crore, joinery work: ₹ 0.17 crore, sanitary work: ₹ 0.10 crore, electric work: ₹ 0.34 crore, other overheads: ₹ 0.04 crore and prorata charges: ₹ 0.40 crore.

[17] Civil work, joinery work and sanitary work: ₹ 2.91 crore; electric work: ₹ 0.34 crore and prorata charges: ₹ 0.42 crore.

drawings. However, no action was taken for this lapse as well as for initiating work without obtaining revised sanction of the Government.

GoR accepted the facts and stated (August 2018) that cost of the work increased due to inclusion of underground parking, ramp and other items in the original estimate. Further, the proposal for getting revised sanction is under process for approval since July 2018. Reply is not convincing as the requirement of the underground parking was not evaluated before commencement of the work and this has already led to the work lying incomplete even after six years from its sanction.

Thus, failure of the department to properly assess the requirement of underground parking before obtaining the A&F sanction, delay in finalisation of revised design/obtaining additional funds resulted in unfruitful expenditure of ₹ 3.67 crore on construction of OPD cum Emergency Block which is lying incomplete even after lapse of six years from its sanction. Besides, the objective of providing facility of new OPD cum Emergency Block within one year to the patients was not achieved.

Women and Child Development Department

3.6 Functioning of *Anganwadi* Centres

3.6.1 Introduction

Anganwadi Centres (AWCs) are the ground level out posts tasked with implementation of the Integrated Child Development Services (ICDS) programme. ICDS has been implemented as a centrally sponsored scheme since 1975. ICDS offers six services[18] to children under six years of age, pregnant women and lactating mothers through AWCs. After the notification of the National Food Security Act (NFSA) 2013, the standards and quantities prescribed for supplementary nutrition under ICDS have been dovetailed with those under NFSA.

Director, ICDS, functioning under Department of Women and Child Development, Government of Rajasthan (GoR), Jaipur, has overall responsibility for implementation and monitoring of the scheme at State level. At district level, Deputy Director and at block level, Child Development Project Officer (CDPO) are responsible for effective implementation of programmes. Delivery of various services under the scheme takes place at the village/ward level through AWCs by *Anganwadi* Worker (AWW), Helper and Accredited Social Health Activist (ASHA) *Sahayogini*. AWW is mainly responsible for effective delivery of ICDS Services to children and women in the community. *Anganwadi* Helper is appointed to assist an AWW. At the

[18] Supplementary Nutrition, Pre-school Education, Nutrition & Health Education, Immunization, Health Check-up and Referral Services. Three out of the six services namely Supplementary Nutrition, Pre-school Education and Nutrition & Health Education are delivered through Anganwadi Centres and the remaining services are delivered through public health system.

community level, ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children.

During the period 2015-18, ICDS has delivered services to 110.87 lakh beneficiaries through a network of 61,121 AWCs (March 2018) in the State at a cost of ₹ 2,188.31 crore[19], of which a major portion of expenditure was on supplementary nutrition (80.92 *per cent*).

With a view to assess regular and effective delivery of services by AWCs, a thematic audit on Functioning of *Anganwadi* Centres (AWCs) was conducted (June-September 2018) for the period 2015-18. Out of total of 304 CDPOs, 15 CDPOs (including five tribal blocks representing the *Saharia* and *Kathodi* tribes) and 60 AWCs (four AWCs within each selected CDPO) were selected on random sampling basis as detailed in ***Appendix 3.2***. Two AWCs (Pachanwaa mini in Ahore and Ward 13-iii in Gangapur City) were found to be non-functional during field study.

Audit Findings

Important findings related to the functioning of *Anganwadi* Centres regarding planning, availability/utilisation of resources, implementation of schemes and internal controls are discussed in the subsequent paragraphs.

3.6.2 Planning

Formulation of State/District Child Development Action Plan is the key strategy for integrated action under the ICDS Mission. The process of the development of these Plans would be based on initiation, demarcating population, understanding the local context of AWCs and district ICDS development plans. Audit scrutiny of the planning process revealed the following:

3.6.2.1 Lack of inputs in Annual Plans from Districts

ICDS Mission Guidelines focus on decentralized planning and management by identification of specific needs at State, District, Project and local level through Annual Programme Implementation Plans (APIP), prepared at State level, after carrying out needs assessment and local mapping. APIP includes provisions related to development and maintenance of *Anganwadi* Centres so that they are able to deliver services effectively. APIP for ICDS mission are being made annually since 2015-16. In order to develop specific locally relevant strategies, they were to be made with inputs from the district level.

Audit scrutiny revealed that none of the test checked districts prepared any district plan for inclusion in APIP. It was also observed that none of the test checked 58 AWCs forwarded proposals of local requirements to CDPO which would have been used as an input to prepare the district plan.

[19] Supplementary Nutrition Programme- ₹ 1,770.74 crore (80.92 *per cent*), ICDS-General- ₹ 401.44 crore (18.34 *per cent*) and ICDS Systems Strengthening and Nutrition Improvement Project- ₹ 16.13 crore (0.74 *per cent*).

GoR stated (December 2018) that the APIPs were prepared on the basis of information available in Monthly Progress Report received from district/ CDPOs office.

Thus, in absence of local inputs and lack of preparation of district plans, the APIPs were prepared by the Directorate at State Level without incorporating the actual needs of the villages and blocks. Deficiencies in respect of state APIPs noticed are discussed as under:

3.6.2.2 AWCs/mini AWCs & crèches sanctioned without assessment of requirement

As per ICDS Mission Guidelines, CDPO will assess the requirement of AWCs on the basis of survey reports and identify the places where AWCs/Mini AWCs[20] are required in the block.

Scrutiny of records of 15 test checked CDPOs revealed that:

- AWCs/Mini AWCs at four localities in CDPO Bakani, despite being sanctioned, were found non-functional. When enquired, CDPO stated (September 2018) that two localities (Kotda and Koli Mini) already had functional AWCs while the other two were sanctioned in the villages (Borkhedi and Bodikhedi Mini) which were not in existence in the block. This clearly indicates deficiencies in sanctioning due to lack of inputs from village/block/district levels regarding preparation of plans.

- As per guidelines, the provision of day care crèches is essential for care and development of children in six months to six years age group, whose mothers go for work and there are no adult at home to take care. GoR sanctioned (November 2012) 200 creches in CDPO Kishanganj and Shahbad. An additional *Anganwadi* Helper was posted in each AWC cum crèches, whereas only 141 creches remained functional during 2015-18. It was also noticed that none of the children stayed in these creches during 2015-18. On being pointed by audit, CDPO accepted these facts and stated that he had recommended for closure of these creches to Dy. Director ICDS.

  Moreover, an expenditure of ₹ 84.78 lakh incurred on honorarium for additional *Anganwadi* workers posted at these crèches proved to be unfruitful.

GoR stated (December 2018) that the AWCs/Mini AWCs and cr**è**ches were opened as per population norms and identification/examination of locality area. The reply is not tenable as AWCs/Mini AWCs were opened without adhering to population norms and identification of local area. Further, cr**è**ches were opened without assessing the requirement of beneficiaries.

[20] AWC was to be established for minimum population of 400 persons in rural/urban area and 300 persons in tribal area, whereas mini AWC was to be established for minimum population of 150 persons in all areas.

Thus, AWCs/mini AWCs and crèches were sanctioned/opened without obtaining proposals from the village/ block functionaries.

3.6.2.3 Targets not set for Indicators of Nutritional Status

The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anemia, utilization and quality of health and family planning services.

One of the indicators of nutritional status of a child that is provided by NFHS is 'wasting'. It is a weight to height ratio and measures body mass in relation to body length/height thereby indicating the current nutritional status.

During comparison of NFHS-3 (2005-06) and NFHS-4 (2015-16) it was observed that the performance of the State on indicators, such as percentages of underweight children under five years age had reduced from 39.9 to 36.7. However, percentage of children (under 5 years) who were categorized as 'wasted[21]', increased from 20.4 to 23.0 and 'severely wasted' increased from 7.3 to 8.6. Also, the percentage of 'wasted' and 'severely wasted' children in the State was higher than the national average of 21.00 *per cent* and 7.40 *per cent* respectively. However, no targets were set for 'wasted' and 'severely wasted' categories even though the state performed poorly on these indicators.

GoR stated (December 2018) that the supplementary nutrition was provided to beneficiaries to eliminate malnutrition as per GoI norms. The reply is not convincing as the under nourished children increased in a decade from NFHS-3 to NFHS-4.

Thus, the increase in percentage of 'wasted' children indicates that an important parameter of malnutrition was not identified, recognized and addressed in the supplementary nutrition programme effectively.

3.6.2.4 Non utilisation of funds of SC plan components for bonafide purpose

GoR, in order to achieve the basic objectives of SC/ST Sub-Plan, issued circular and instructed that funds for schemes of personal/group beneficiaries will be marked in proportion to beneficiaries of scheduled castes and also instructed that while making provisions for SC Sub-Plan in budget, the area with dominantly SC population may be given priority.

During scrutiny of records of Commissioner ICDS, it was revealed that the GoI sanctioned ₹ 348.92 crore under SC component for Supplementary Nutrition and ICDS (general). However, the expenditure against this sanction was incurred on all the AWCs without prioritising SC majority areas due to non-identification of such areas.

[21] Wasting is low weight for height, which is strong predictor for mortality among children under five year's age.

GoR accepted the facts and stated (December 2018) that none of the AWCs were identified according to SC population of the locality and the expenditure of Sub-Plan was being booked under general budget. Moreover, the process for identification of AWCs as per Sub-Plan is being carried out and in future funds will be utilised accordingly.

This clearly indicates that the objectives with which the SC/ST Sub-Plan was made, were not achieved with respect to services provided by AWCs.

3.6.2.5 Non Linking with Aadhar under ICDS

As per GoI notification issued in February 2017, with effect from 01.04.2017 (further extended up to 31.3.2018), individuals availing benefits of supplementary nutrition were required to furnish proof of possession of *Aadhar* number or undergo *Aadhar* authentication. Accordingly, GoI accorded (December 2017) sanction for ₹ 13.68 crore for *Aadhar* enrolment kits (i.e. one desktop computer, one laptop, one tablet along with scanner, printer, slap fingerprint scanner, Iris scanner and GPS device).

Scrutiny of records however, revealed that no such kits were procured by the department even after lapse of the target date of completion of *Aadhar* authentication.

As a result, against a target of 100 *per cent Aadhar* seeding of beneficiaries by 31 March 2018, *Aadhar* seeding of 9.14 *per cent* children of age group 0-3 year, 14.82 *per cent of* children of 3-6 year and 62.22 *per cent* pregnant women and lactating mothers only could be achieved.

GoR stated (December 2018) that the instructions to link 100 *per cent* beneficiaries with *Aadhar* upto 31 March 2018 were already issued to Dy. Director/CDPOs. Further, procurement of *Aadhar* Kits is under process. The fact remains that *Aadhar* seeding of beneficiaries was delayed due to lack of procurement of *Aadhar* enrolment kits.

3.6.3 Availability and utilisation of infrastructure, equipment and manpower

Keeping in view the importance and enhanced role being played by AWCs in the delivery of services to the targeted population, GoI prescribed (March 2011) an indicative and suggestive model/layout of AWC buildings. Accordingly, an AWC must have multipurpose room, examination room, consultation room, separate kitchen, store for storing food items, child friendly toilets and space for playing (Indoor and outdoor activities) with safe drinking water facilities. It was also prescribed that it would meet the minimum requirements, if an AWC is constructed in a covered area of not less than 600 square feet as per the standard specifications. The observations of Audit in this regard are discussed below.

3.6.3.1 Infrastructure

(i) Absence of basic infrastructure

There were 61,121 functional AWCs in the State as on March 2018. Of these, toilet facility was available only in 29,410 AWCs (48.12 *per cent*) and drinking water in 47,358 AWCs (77.48 *per cent*). Thus, a substantial number of AWCs were without these basic facilities. Audit test checked 58 AWCs. The test check revealed that:

- Of 30 AWCs which were running in own buildings, 18 AWCs (60 *per cent*) did not have the prescribed land area of 1,500-2,000 square feet and 11 AWCs (36.67 *per cent*) did not have prescribed constructed area of 600 square feet.

- Four AWCs did not have multipurpose room, 27 AWCs (90 *per cent*) were without examination room and 27AWCs (90 *per cent*) did not have consultation room.

- Toilet facility was available only in 18 AWCs (31.03 *per cent*) however, out of these, toilets were not usable in six AWCs due to non-availability of water facility.

- Electricity was available in only three AWCs (5.17 *per cent*).

- Drinking water facility was not available in 12 AWCs (20.69 *per cent*). Further, GoI approved ₹ 2.57 crore (December 2017) for procurement of water containers (10 litres capacity) for 36,697 AWCs. However, no water containers were procured so far despite availability of funds.

GoR stated (December 2018) that there was no provision/budget for providing electricity. Thus, a significantly large number of AWCs were lacking drinking water, toilet and electricity facilities.

(ii) Toilets not constructed despite availability of funds

Audit scrutiny revealed that GoI accorded sanction of ₹ 4.71 crore for construction of toilets in 3,928 AWCs (₹12,000 each for AWCs running in the government buildings) during 2017-18, but construction work was not started.

On being pointed out (October 2018) GoR stated (December 2018) that proposals for construction of toilet and drinking water facilities were not received from the districts. Therefore, funds could not be allotted to them. Further, the funds sanction will be revalidated by GoI and thereafter funds would be disbursed into the PD accounts of respective *Zila Parishads*. The fact still remains that despite availability of sufficient funds, essential facility of toilets were not provided to the beneficiaries at AWCs.

(iii) Construction and funding delays regarding AWC buildings

Guidelines for construction of *Anganwadi* centres under Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) were issued (August 2015 and February 2016) by Ministry of Rural Development to develop the *Anganwadi* centre as a vibrant Early Childhood Development (ECD) centre and to become the first village outpost for health, nutrition and early learning. Accordingly, States/ UTs were required to identify the blocks where there was acute shortage of AWC buildings. The identification of exact location was to be done by the *Gram Panchayats*. Out of 61,039 functional AWCs[22] in the State, only 25,406 AWCs (41.62 *per cent*) were functioning from their own buildings, while other AWCs were running either in rented buildings or other community buildings. Audit scrutiny revealed that:

- Construction work of 1,385 AWCs was included in Annual Plan 2015-16, which were to be completed within six months of issue (March 2016) of financial sanction including first instalment of grant-in-aid amounting to ₹ 8.31 crore. Second instalment was to be released after completion of work, but, construction of these AWCs was not completed within scheduled time. As a result, GoI did not release second instalment of ₹ 8.31 crore for want of completion certificate of works. On being pointed out by Audit, GoR stated (December 2018) that construction work regarding 207 AWC (14.95 *per cent*) buildings was completed, 922 (66.57 *per cent*) was under progress and 256 (18.48 *per cent*) was yet to be started.

- Construction work of 2,000 AWCs was included in Annual Plan 2016-17 and GoI released first and second instalments each of ₹ 12 crore in May 2016 and August 2016 respectively, but exact location of AWCs was not identified before sending proposal to GoI. This resulted in slow progress of construction work. On being pointed out by Audit, GoR stated (December 2018) that construction work regarding 283 AWC (14.15 *per cent*) buildings was completed, 970 (48.50 *per cent*) was under progress and 747 (37.35 *per cent*) was yet to start.

- Construction work of 1,000 AWC buildings in urban localities was included in Annual Plan 2016-17. GoI released first instalment of ₹ 13.50 crore (May 2016), but construction was not started due to non-identification of exact site and sanction of lower construction cost (₹ 4.50 lakh per unit) in urban localities as compared to rural localities (₹ 7.00 lakh per unit). GoR stated (December 2018) that GoI discontinued (December 2017) funding from ICDS for construction work of AWC buildings in urban areas. The fact remains that the funds obtained from GoI were not utilised.

[22] As per information available with construction wing.

- Further, test check of 15 CDPOs revealed that as many as 35 AWCs[23] were running in *kutcha* buildings and six AWCs[24] in open space in one project (CDPO Kishanganj-Baran). GoR stated (December 2018) that the construction work of building would be carried out after availability of funds and land.

Thus, pace of construction of AWC buildings was very slow despite the fact that there was acute shortage of own buildings of prescribed facilities in the state for the AWCs.

(iv) Repair and maintenance of AWCs was not done despite availability of funds

GoR released an amount of ₹ 40 crore in 2016-17 and ₹ 6.29 crore in 2017-18 to Local Bodies for repair, maintenance and construction of wall embedded *almirah* in 5,432 AWCs and 871 AWCs in respective years.

Audit scrutiny of records of Dy. Director, ICDS of 13 test checked districts[25], revealed that out of 2,161 AWCs, construction works of *almirah* were completed only in 130 AWCs while repair and maintenance works were completed in 284 AWCs. Further, there was necessity of repair and maintenance in 14 out of 58 test checked AWCs but no repair and maintenance work was undertaken in these AWCs.

GoR stated (December 2018) that out of 5,432 AWCs, repair and maintenance of 1,663 AWC buildings was completed, work was under progress in 1,603 AWCs and work was yet to start in 2,166 AWCs. GoR, however, did not offer comments on non-completion of *almirah* and repair and maintenance work in 2,161 AWCs of test check districts.

Thus, slow progress in repair and maintenance of AWCs affected delivery of services.

3.6.3.2 Equipment: Non-availability of basic equipments

Equipments[26] like Infantometer, Stadiometer, MUAC (Mid-Upper Arm Circumference) monitor, Weighing Scales (Infant and Adult) are essential to monitor the growth of children while Blood Pressure (BP) instrument, Hemoglobin (Hb) meter, examination table and curtain etc., are needed for health checkup of beneficiaries. Similarly, indoor/outdoor play equipment

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[23] Acharpura Mini, Ahaliyabasti Mini, Asnavar 2, Balon Mini, Bandrpura Mini, Bhairupura Mini, Bhutpura Mini, Bislai, Borda, Chhatarpura Dand 2, Dob Mini, Himmatgad Mini, Jagdevpura, Jalwada 1, Jalwada 4, Kamtha, Karvarikalan 2, Keshwpura Mini, Kundi 3, Laxmipura Mini 2, Mahrawata 3, Missaika Danda Mini, Nahargarh 5, Nahargarh 6, Nahargarh 7, Nahargarh 9, Nathan Mahodri Mini, Pitampura 2, Prempura Mini, Rajkheda Mini, Shariya Basti Ranibadoud Mini, Simlod 2, Suwas Mini, Tagariyadani and Vijaypura Mini.

[24] Madanpura Mini, Mohanbamori Mini, Piliya Dhani, Ramnagar Mini, Shariyabasti Chhinod Mini and Vedhji Tapri Mini.

[25] Baran, Banswara, Barmer, Dausa, Jaipur, Jalore, Jhalawar, Jhunjhunu, Pali, Pratapgarh, Sawaimadhopur, Tonk and Udaipur.

[26] For measurement of length, height and weight of children.

such as swing (*jhula)*, slide and *mat/dari* are essential for the purpose of playing/sitting at AWCs. Audit scrutiny in 58 test checked AWCs revealed that:

- Infantometers/Stadiometers were not available in 18 AWCs (31.03 *per cent*), MUAC monitors were not available in 19 AWCs (32.76 *per cent*).

- Weighing Scales (Infant) and Weighing Scales (Adult) were not available in 11 AWCs (18.97 *per cent*) and 13 AWCs (22.41 *per cent*) respectively. In 19 AWCs Weighing Scales (Infant) and in six AWCs Weighing Scales (Adult) though available but were found non-functional.

- Similarly, BP instruments were not available in 38 AWCs (65.52 *per cent*). Hemoglobin meters were not available in 52 AWCs (89.66 *per cent*) while examination tables were not available in 31 AWCs (53.45 *per cent*). Further, curtains were also not available in 51 AWCs (87.93 *per cent*).

- Indoor/outdoor play equipment like puppet/dolls for role plays, building blocks, props for dramatic play, balls, carom, chess, football etc., were not available in 42 AWCs (72.41 *per cent*).

- Swing (*Jhula*) and slides were not available in 57 AWCs (98.28 *per cent*). Further, mats/*dari* were not available in 9 AWCs (15.52 *per cent*) and damaged mats/*dari* were found in other two AWCs.

Thus, due to unavailability/shortage of prescribed equipment, the monitoring of important development parameters could not be fully done.

3.6.3.3 Manpower management

Efficiency and quality of AWC services are largely dependent on the availability of adequate number of trained supervisory personnel as well as grass root level functionaries. Audit scrutiny revealed the following deficiencies:

(i) Shortage of manpower

The services of ICDS at village/ward level are delivered by *Anganwadi* Workers and Helpers at AWCs. Child Development Project Officers (CDPO) posted at block level, are responsible for effective implementation/monitoring of programmes. Selection of *Anganwadi* Worker, Helper and *Sathin* and operation of *Anganwadi* Centres, distribution of nutrition etc., are being done in coordination with the *Panchayat Samitis* and *Zila Parishads*. Position of vacancies against the sanctioned posts in various supervisory cadres and vacancies in 62,020 sanctioned AWCs/Mini AWCs as on March 2018 are given in the **Table 3.**

Table 3

Name of post	Sanctioned post	Working post	Vacant post	Shortage in *per cent*
CDPO/ACDPO	425	202	223	52.47
Supervisor	2,197	1,501	696	31.68
AWW (Including Mini AWC)	62,020	58,372	3,648	5.88
AWH	55,816	52,295	3,521	6.31
Total	**1,20,458**	**1,12,370**	**8,088**	

It can be seen from the table that there was shortage of 52.47 *per cent* CDPOs, 31.68 *per cent* of supervisors, 5.88 *per cent* of *Anganwadi* Workers (AWWs) and 6.31 *per cent* of *Anganwadi* Helper (AWH) as on 31 March 2018. Shortages of CDPOs and supervisors hampered the effective supervision of AWCs as discussed in **paragraph 3.6.5 (i)**.

GoR stated (December 2018) that recruitment of CDPO/Supervisor is under process.

(ii) Shortfall in achievement of targets related to trainings

At the time of joining of service the Supervisors, *Anganwadi* Workers and *Anganwadi* helpers were required to be imparted job orientation training which would include exposure to duties to be discharged by incumbents effectively while delivering the ICDS services. A refresher course was also required to be provided after two years of job orientation training.

The year wise targets of job orientation trainings/refresher courses for Supervisor, *Anganwadi* Worker (AWW) and *Anganwadi* helper (AWH) and achievements there against are given in **Table 4** below:

Table 4

Details of participants	2015-16		2016-17		2017-18		Total		
	Target	Achieve-ment	Target	Achiev-ement	Target	Achiev-ement	Target	Achiev-ement	Shortfall (*per cent*)
Job Orientation training									
Supervisors	-	-	75	44	200	146	275	190	85 (30.91)
AWW	1,330	1,179	2,275	1,971	2,205	2,014	5,810	5164	646 (11.12)
AWH	2,400	1,765	4,250	2,960	3,200	2,240	9,850	6,965	2,885 (29.29)
Refresher course									
Supervisors	875	455	700	409	275	189	1,850	1,053	797 (43.08)
AWW	13,440	11,244	11,800	9,413	10,640	8,958	35,880	29,615	6,265 (17.46)
AWH	14,900	10,091	9,500	6,974	13,800	10,177	38,200	27,242	10,958 (28.69)

It can be seen from the above table that there was overall shortfall of 30.91 *per cent*, 11.12 *per cent* and 29.29 *per cent* in job orientation training for Supervisors, AWWs and AWHs respectively and 43.08 *per cent*, 17.46 *per cent and* 28.69 *per cent* in refresher courses for Supervisors, AWWs and AWHs during 2015-18.

3.6.4 Implementation and Delivery of services

The primary goal of ICDS is to break the inter-generational cycle of malnutrition, reduce morbidity[27] and mortality caused by nutritional deficiencies. Under the scheme six services namely Supplementary Nutrition, Nutrition & Health Education (NHE), Pre-school Education (PSE), Immunization, Referral Services and Health Check-up are provided at the *Anganwadi* Centres (AWCs). While the provision of first three services is the primary task of the *Anganwadi* Centre, the remaining three are designed to be delivered through the public health system. The responsibility of coordination with the health functionaries for provision of these services rests with the *Anganwadi* worker (AWW).

Scrutiny of records at various offices and test check of selected AWCs revealed the following:

3.6.4.1 Supplementary Nutrition Programme

Supplementary Nutrition is one of the six services provided under the Integrated Child Development Services (ICDS) Scheme which is primarily designed to reduce intergenerational malnutrition. Supplementary Nutrition is to be prepared and supplied to AWCs by Self Help Group (SHG) functioning at local level and given to the children (6 months to 6 years), pregnant women and lactating mothers under the ICDS. Supplementary nutrition includes morning snacks, hot-cooked meal and take home ration to be given to beneficiaries as per feeding and nutrition norms of Ministry of Women and Child Development which is given in **Table 5**.

Table 5

S. No.	Categories (Age group)	Type of meal/food	Quantity (Per day)	Calorie/Protein (Per day)
1	Children (Between 6 to 36 months)	Take home ration	125 gram baby mix	500 calories and 12-15 gram protein
2	Severely Malnourished children (between 6 to 36 months)	Take home ration	200 gram baby mix	800 calories and 20-25 gram protein
3	Children (between 3 to 6 years)	Morning snacks and hot cooked meal	55 gram (roasted *chana*with *gur/rice* with *jaggery*) or 50 *gramhalwa* and 80 gram (*khichdi/ dalia*)	500 calories and 12-15 gram protein
4	Severely Malnourished children (Between 3 to 6 years)	Morning snacks and hot cooked meal	55 gram (roasted *chana* with *gur/rice* with *jaggery*) or 50 gram*halwa* and 80 gram (*khichdi/ dalia*). Additional 75 gram baby mix	800 calories and 20-25 gram protein
5	Pregnant women and lactating or nursing mothers	Take home ration	155 gram baby mix	600 calories and 18-20 gram protein

[27] As per National Cancer Institute (NCI), Morbidity Refers to having a disease or a symptom of disease, or to the amount of disease within a population.

Audit scrutiny revealed the following:

(i) Shortfall in coverage of targeted beneficiaries

ICDS Mission guidelines have fixed the targets for providing Supplementary Nutrition to all the registered beneficiaries (100 *per cent*).

Scrutiny of records related to targets, achievements and shortfall in distribution of supplementary nutrition in the state has been tabulated in the **Table 6**.

Table 6

Year	Targeted beneficiaries	Actual beneficiaries	Shortfall	Percentage of shortfall
2015-16	57,76,537	37,38,622	20,37,915	35.28
2016-17	55,60,866	37,08,367	18,52,499	33.31
2017-18	57,80,866	36,39,539	21,41,327	37.04
Total	**1,71,18,269**	**1,10,86,528 (64.76 *per cent*)**	**60,31,741 (35.24 *per cent*)**	

It can be seen from the above table that supplementary nutrition was provided annually to an average of only 64.76 *per cent* of the targeted eligible beneficiaries during 2015-18, depriving annually an average of 35.24 *per cent* from the benefits of Supplementary Nutrition programme. Further, number of deprived beneficiaries also increased to 37.04 *per cent* in 2017-18 as compared to 35.28 *per cent* in 2015-16.

GoR stated (December 2018) that a beneficiary is registered for all six services provided at AWCs, however, supplementary nutrition is given to only the willing beneficiaries. Therefore, difference between registered and actual beneficiaries of supplementary nutrition is obvious. The reply is not convincing as all the registered beneficiaries were required to be provided Supplementary Nutrition according to the ICDS Mission guidelines.

(ii) Shortfall in provision of Supplementary Nutrition as per prescribed days

According to ICDS guidelines, supplementary nutrition was to be provided for 300 days in a year, that is, 25 days in a month. The similar provisions for supplementary nutrition were also given in the Supplementary Nutrition Rules, 2015 made under the National Food Security Act 2013. GoI issued (May 2012) instructions to follow the directions of Supreme Court that the supplementary nutrition was to be procured from Self Help Groups (SHG) and local *Mahila Mandals*.

Scrutiny of records revealed that no supplementary nutrition was provided, even for a single day, by 65 AWCs out of 60,267 AWCs (0.11 *per cent*) in 2015-16 and 577 AWCs out of 60,733 AWCs (0.95 *per cent*) in 2016-17 to the targeted beneficiaries. On being enquired (April 2018), the Commissioner, ICDS attributed this irregularity to non-availability of Self Help Groups (SHGs) within the AWCs/Mini AWCs locality as well as provision of lower rates for Supplementary Nutrition. Further, instructions have been issued from time to time to CDPO/DD offices to comply with the provisions of NFSA .

It was further observed during test check that in one project (Mahuwa-Dausa district) all 211 AWCs did not provide supplementary nutrition to the beneficiaries during the period April 2017 to March 2018. Similarly, in Kishangarhbas project, all 261 AWCs did not provide morning snacks to 2,941 beneficiaries during 2013-18. When enquired, Deputy Director, Dausa stated that on the basis of complaints regarding alleged fraud, payment to SHG was denied due to which it had discontinued further supply. CDPO Kishangarhbas replied that nutrition was not provided as no SHG accepted the prescribed lower rates for supply of morning snacks.

Further, the data regarding providing supplementary nutrition at AWCs for minimum 25 days in a month was not maintained. Instead, it was being maintained for 21 days. It was found during scrutiny of records that 2,235 AWCs out of 60,267 AWCs in 2015-16 (3.71 *per cent*) and 2,605 AWCs out of 60,733 AWCs in 2016-17 (4.29 *per cent*) did not provide the supplementary nutrition to the targeted beneficiaries for minimum prescribed days.

The failure of the department to provide supplementary nutrition for the minimum prescribed days in these cases needs to be viewed in the light of the fact that providing supplementary nutrition was the primary objective of the ICDS programme.

(iii) Denial of additional supplementary nutrition to malnourished children

World Health Organisation prescribed growth standards for children and has classified children in three categories of normal, malnourished and severely malnourished children in the age group 6–60 month old on the basis of score for standard deviation from median standards of weight for age for normal child.

ICDS guidelines for supplementary nutrition to 'severely malnourished children' prescribed 800 calories and 20-25 gram protein per day for such child. Subsequently, NFSA-2013 prescribed 800 calories and 20-25 gram of protein per day for 'malnourished child'.

Scrutiny of records of the Commissioner ICDS revealed that supplementary nutrition was provided only to 'severely malnourished children' and therefore the 'malnourished children' were not getting additional supplementary nutrition as per NFSA-2013.

Thus, 23.30 lakh (20.78 *per cent*) malnourished children (6–60 month old) were deprived of additional supplementary nutrition though mandated under NFSA-2013as given in the **Table 7**.

Table 7

Year	Total children	Classification of nutritional status for 0-5 years children		
		Normal Children	Underweight children (malnourished)	Severely underweight children (severely malnourished)
2015-16	37,92,042	28,84,443	8,99,976	7,623
2016-17	36,97,489	29,15,733	7,76,563	5,193
2017-18	37,24,072	30,65,758	6,53,572	4,742
Total	**1,12,13,603**	**88,65,934**	**23,30,111**	**17,558**

Source: Monthly Progress Report of the department.

GoR stated (December 2018) that, as per orders issued by GoI, the department is providing supplementary nutrition to children (6-72 months), severely malnourished children and pregnant women and lactating mother. Further, ICDS financial norms and nutrition standards have not been changed by GoI, to comply with NFSA and rules and hence malnourished children were not provided additional supplementary nutrition. The reply is not tenable because the department did not make any efforts to provide additional supplementary nutrition to malnourished children and get the norms changed by GoI.

(iv) Inadequacies in Growth Monitoring

A joint policy directive dated 6 August 2008 was issued by Ministry of Women and Child Development (MWCD) and Ministry of Health and Family Welfare (MoHFW), Government of India to the Secretaries of Women and Child Development and Health and Family Welfare of all the States stated that the new World Health Organisation (WHO) child growth standards would be adopted also in India with effect from 15 August 2008 and applicable to both ICDS and National Rural Health Mission. Accordingly, children below the age of three years are weighed once in a month and children in the age group of 3-6 years are weighed quarterly and results marked in a WHO Growth Monitoring Chart for each child. Identification of growth faltering would be done on this basis and appropriate counselling of care-givers especially on optimal infant and young child feeding and health care would be reinforced.

It was observed during test check that out of 58 selected AWCs, 30 AWCs (51.72 *per cent*), were not maintaining WHO card during 2017-18 for growth monitoring, therefore, the objective of early identification of faltering of growth was defeated and opportunity to take timely corrective action was lost. These shortcomings should also be viewed in light of the fact that there were shortages in health monitoring equipment such as infantometers, stadiometers etc., at the AWC levelas discussed in ***paragraph 3.6.3.2***.

GoR did not offer specific comments on the issue discussed in the para (December 2018).

(v) Supplementary Nutrition provided without Micronutrient Fortification

As per ICDS guidelines Supplementary Nutrition was to be provided through micronutrient fortification (salt with iodine and iron, wheat flour with iron, folic acid and Vitamin B-12 and edible oil with Vitamin A and D) to curb malnutrition. Further, fortified Supplementary Nutrition was to be procured through SHGs/local *Mahila Mandals* as per directions (2009) of the Supreme Court.

It was, however observed that no AWC in the state provided Supplementary Nutrition with micronutrient fortification.

GoR stated (December 2018) that Supplementary Nutritioncould not be fortified as SHGs did not have sufficient funds and technical capacity for micronutrient fortification. Further, a letter was issued to Food Department asking them to provide fortified wheat flour and oil at local level. Once it

would be available, instructions would be issued to use fortified raw material in preparing supplementary nutrition.

The fact, however, remains that beneficiaries are being deprived of fortified Supplementary Nutrition. Thus, the objective of addressing micronutrient related deficiencies by providing fortified Supplementary Nutrition was defeated**.**

(vi) Non adherence to prescribed procedure for quality tests of Supplementary Nutrition

In order to ensure quality of Take Home Ration (THR) being supplied by Self Help Groups (SHGs), instructions were issued by GoR in September 2016. Accordingly, samples were required to be tested for prescribed norms of protein and calories for recipe of 100 gram supplementary nutrition through NABL accredited labs, at the prescribed rates. Samples were to be selected randomly from the AWCs. In case of failure of samples, the concerned SHG would be warned to maintain the quality of Supplementary Nutrition in future and a prorata recovery was also to be effected.

Scrutiny of records of Deputy Director, Jalore revealed that 346 samples of Supplementary Nutrition (supplied by 21 SHGs) collected from 23 AWCs were sent to *'Fare Lab'* Gurgaon during October 2017 to March 2018. Of these, contamination due to yeast and mould[28] was found in 23 samples (6.65 *per cent*). Despite the fact that samples were not of the prescribed quality, Supplementary Nutrition of same batch was distributed to beneficiaries as quality test was not made mandatory prior to distribution of the Supplementary Nutrition.

Further, the requisite follow up action regarding warning to terminate the MoU with SHG was initiated by the Deputy Director in August 2018 only after four months and at the instance of Audit. This placed the beneficiaries at risk of getting sick due to consumption of contaminated supplementary nutrition.

GoR accepted the fact and stated (December 2018) that in a decentralised system, the supplementary nutrition is prepared by hand at large scale at local level by SHG because of which possibility of contamination may not be ruled out in some cases.

The fact remained that there was lack of effective efforts by the department to ensure the quality of supplementary nutrition being delivered as the follow up action to terminate the MoU with SHG who failed to adhere the prescribed quality norms was initiated by the Deputy Director in August 2018 only after four months and at the instance of Audit.

[28] Presence of yeast and mould is known to cause allergic reactions and many respiratory problems.

(vii) Supplementary Nutrition not provided to adolescent girls

AWCs were to provide both nutritional and non-nutritional components to adolescent girls in the age group of 11 to 18 years in 10 districts[29] under Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-Sabla, introduced by GoI in January 2011. The scheme envisaged providing 600 calories for 300 days in a year at ₹ five per beneficiary per day. Later, GoI extended the coverage of the scheme to other districts of the State (during November 2017 to April 2018) and renamed the scheme as "Scheme Adolescent Girl[30]" (SAG).

Scrutiny of records revealed that 6,25,423 adolescent girls were provided supplementary nutrition during 2014-15 but none were provided during 2015-18, despite availability of fund amounting to ₹ 29.81 crore since April 2015.

On being pointed out (May 2018), the Department stated (December 2018) that there was disparity in the rates of nutrition under ICDS and SABLA and SHGs could not be paid at two different rates for same Supplementary Nutrition. Hence, GoI was requested to modify the rates accordingly. Further, GoR also denied consent for additional funds to match the gap between the two schemes and therefore, the scheme could not be implemented. Reply is not tenable as GoI revised (October 2017) the rate to ₹ 9.50 and released (December 2017) additional funds ₹ 39.38 lakh but none of the adolescent girls were provided supplementary nutrition (March 2018). Thus, large number of potential beneficiaries were deprived from the benefits of the scheme.

3.6.4.2 Pre School Education

Pre School Education (PSE) is one of the most important components of the ICDS and in many ways can be considered to be the backbone of the programme. The purpose of PSE is to provide sustained activities through joyful play-way method that helps to prepare the child for regular schooling. PSE, as envisaged in the ICDS, focuses on holistic development of children up to six years. Audit scrutiny revealed the following:

(i) Shortfall in coverage of beneficiaries

Scrutiny of records revealed that shortfall in achieving target of PSE during 2015-18 remained 40.27 to 41.99 *per cent* as detailed below in **Table 8.**

Table 8

Year	Targeted beneficiaries	Actual beneficiaries	Shortfall in targets	Percentage of shortfall
2015-16	16,69,117	9,68,244	7,00,873	41.99
2016-17	16,53,708	9,87,811	6,65,897	40.27
2017-18	16,53,708	9,64,295	6,89,413	41.69
Total	**49,76,533**	**29,20,350 (58.68 *per cent*)**	**20,56,183 (41.32 *per cent*)**	

[29] Bhilwara, Banswara, Bikaner, Barmer, Dungarpur, Sriganganagar, Jaipur, Jodhpur, Jhalawar and Udaipur.

[30] Sub scheme of Umbrella ICDS.

It can be seen from the above table that only 58.68 *per cent* of targeted beneficiaries were provided PSE during 2015-18. Further, it was observed during test check that out of 58 selected AWCs, 38 AWCs (65.52 *per cent*) in 2015-16, 47 AWCs (81.03 *per cent*) in 2016-17 and 45 AWCs (77.59 *per cent*) in 2017-18 did not provide PSE to all the registered children.

GoR stated (December 2018) that the efforts are being made to reduce the difference in target and achievements.

(ii) Shortfall in provision of PSE as per prescribed days

As per guidelines issued (July 2014) by GoI, PSE/Early Childhood Care and Education (ECCE) programme should be conducted for four hours daily for minimum 21 days in a month.

Scrutiny of records at Commissioner ICDS revealed that 325 AWCs out of 60,267 functional AWCs (0.54 *per cent*) in 2015-16, 196 AWCs out of 60,733 functional AWCs (0.32 *per cent*) in 2016-17 and 1,839 AWCs out of 61,029 functional AWCs (3.01 *per cent*) in 2017-18 (December 2017) did not provide PSE for prescribed 21 days in a month.

Further, during test check it was observed that out of 58 selected AWCs, in seven AWCs[31] in 2015-16, PSE was provided for days ranging from 85 to 249 days instead of prescribed minimum 252 days. However, in other AWCs, PSE was provided for prescribed days during 2015-18.

(iii) Non procurement of PSE kits

Pre-school education (PSE) is a crucial component of ICDS and imparted through a joyful play and activity based approach by the use of PSE kit containing local and culturally relevant play and learning material. As per guidelines (January 2014) of the scheme, the PSE kit was required to be provided for each year for all functional AWCs. PSE kits having suggested 14 items in prescribed quantities valuing ₹ 3000 per kit for AWCs[32] and ₹ 1500 per kit for mini AWC per annum were required to be provided. Sharp edge items were not to be included in PSE kits. Scrutiny of records revealed the following:

- GoR decided to procure fewer items in lesser quantities (valuing ₹ 1000 for AWCs and ₹ 500 for mini AWCs) than the prescribed items as mentioned above during 2016-17. Thus, seven items (as suggested by GoI) were not provided at all and three items were provided in lesser than prescribed numbers.

[31] Bhawarani Mini, Bithuda, Khoripada, Mandali-2, Muliyawas, Serawala and Udaipur Bada.

[32] Puppet/Dolls for role plays (4 No.), Building Blocks (set of 40) (1No.), Props for dramatic play (5 props), Strings and beads (coloured) (2 sets), Pad, paper, coloured, A4 size plain, 50 sheets (1 pack), Memory game (set of 32 cards) (2 packs), Slates (5 Nos.), Educational toys (lacking animals/Puzzles (human body, animals etc.)/Shape cut outs etc. (4 sets), Pre-reading/writing cards & flip books (set of 4) (1 set), Story Flash cards/Charts (5), Clay/Plasticine (5), Colours (water, sketch, wax) paint brushes (5 sets), Balls (5 No.), Local indigenous material as per requirement of activities planned.

- Contrary to prescribed guidelines, some sharp edge items, like pencil and pencil colour were procured. Moreover, extra items like gum and colour chalks were provided without any recommendation of specialists of ECCE/SCERT[33].

- Despite availability of funds ₹ 30.34 crore provided by GoI during 2017-18, no PSE kit of any type was procured by the department.

- Out of 58 test checked AWCs, PSE kits were not available in 19 AWCs in 2015-16, 20 AWCs in 2016-17 and 19 AWCs in 2017-18.

- Out of test checked 13 offices of Dy. Director ICDS, in three Offices (Banswara, Jaipur and Udaipur), PSE kits were not purchased for 9,483 AWCs during 2016-17 despite availability of funds (₹ 0.91 crore).

GoR accepted the facts and stated (December 2018) that the PSE kits were not procured during 2015-16 and 2017-18. Further, PSE kits in three districts were not procured during 2016-17 due to shortage of manpower/time for carrying out the tendering procedure. Further, items of PSE kits were decided by the GoR as per local requirement.

While the children were deprived of quality PSE due to non-availability of PSE Kits, the fact remains that they were also put at risk due to inclusion of sharp edge items in the kits that were made available.

(iv) Child Assessment Cards not maintained

As per guidelines, a Child Assessment Card was to be maintained to assess the child's learning and development needs. It helps to understand how the child is developing in terms of age and what he is able to do well and where he needs further help and support. The *Anganwadi* worker was required to assess and report the child's progress to his/her parents once in every three months.

Out of 58 test checked AWCs, child assessment cards were not maintained in 44 AWCs (75.86 *per cent*) in 2015-16, 43 AWCs (74.14 *per cent*) in 2016-17 and 40 AWCs (68.97 *per cent*) in 2017-18.

GoR accepted the facts and stated (December 2018) that in 2015-16 AWWs/AWHs were not trained for filling the Child Assessment Cards. Further, the cards were provided during 2018-19 only.

(v) Non enrolment of children in primary school

As per scheme, PSE provided at AWCs would enable easy transition of children from AWC to primary school. Accordingly, it was the duty of *Anganwadi* Worker (AWW) to maintain records for the transition to primary school, which should be monitored and analysed by the CDPO for shortfall in number of children joining primary school.

[33] State Council of Educational Research and Training.

Out of 58 test checked AWCs, 12 AWCs (20.69 *per cent*) in 2015-16, 10 AWCs (17.24 *per cent*) in 2016-17 and 11 AWCs (18.97 *per cent*) in 2017-18 did not enrol children ranging one to 30, in primary school after completion of Pre School Education (PSE).

GoR stated (December 2018) that efforts are being made for convergence with Education department to ensure 100 *per cent* enrolment in primary schools.

3.6.4.3 Nutrition and Health Education

(i) Nutrition and Health related education

One of the key roles of the *Anganwadi* worker and ASHA *Sahyogini* was to provide health and nutrition related education to all women in the age group of 15-45 years, ensure optimal uptake of services and entitlements and practice of recommended household behaviour through pictorial and audio visual aids.

It was observed that out of 58 test checked AWCs, necessary pictorial or interactive communication aids required to interact with the beneficiaries were not available in 53 AWCs (91.38 *per cent*) in 2015-16, 52 AWCs in 2016-17 (89.66 *per cent*) and 52 AWCs in 2017-18 (89.66 *per cent*).

(ii) Shortfall in organising Mother & Child Health Nutrition day (MCHN)

Monthly MCHN day is organised at each AWC on a predetermined date with the joint efforts of ICDS and Medical Department. MCHN day is organised once a month at each of the AWC and is attended by the ANM[34]. For effective implementation of MCHN days, the presence of ANM is a pre-requisite. The Medical Department ensures the presence of ANM along with the vaccines and medicines at the AWC to conduct immunization of children and pregnant women and to conduct their health check-ups. Nutrition Counselling through *Godbharai*[35] and *Annaprashan*[36] is imparted.

Audit scrutiny revealed that MCHN days were organised for less than specified period (12 days in a year) in 16 AWCs during 2015-16 ranging from 1 to 12 days , in 14 AWCs during 2016-17 ranging from 1 to 8 days and in 14 AWCs during 2017-18 ranging from 1 to 12 days. There was overall shortfall of 173 MCHN days in 58 test checked AWCs. Though presence of ANM on MCHN day was a pre-requisite, there was shortfall in participation of ANMs in 13 AWCs in 2015-16 ranging from 2 to 12 days, in 12 AWCs in 2016-17 ranging from 2 to 12 days and in 17 AWCs in 2017-18 ranging from 1 to 12 days. Overall, ANMs were absent for 318 MCHN days in these AWCs.

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[34] Auxiliary Nurse Midwifery: Works of ANM are include maternal and child health alongwith family planning services, health and nutrition education, efforts for maintaining environmental sanitation etc.

[35] *Godbharai* is a ceremony held in local communities to welcome unborn baby and bless the mother -to be.

[36] *Annaprashan* is a ceremonial beginning of solid food intake by the baby after attaining 6 months of age

GoR accepted the facts and stated (December 2018) that due to availing of long period leave by ANMs or vacant posts, MCHN days could not be organised. However, efforts are being made for alternative arrangements.

Thus, the services of immunization, health check-ups and Nutrition Counselling were hampered to the extent of shortfall in organisation of MCHN days and less participation of ANMs.

3.6.4.4 Immunisation and Referral services

Health check-up, immunisation, and referral services and treatment of common ailments were the health related services of ICDS. Health check-up service includes ante-natal care of expectant mothers, post-natal care of nursing mothers and care of new born babies and children below six years of age. The health check-up and medical care are to be rendered by the Auxiliary Nurse Midwifery under the guidance of the Medical Officers of the PHC. ICDS guidelines stipulate that during health check-up and growth monitoring, sick or malnourished children in need of prompt medical attention be referred to PHCs or their sub-centres.

(i) Immunisation

- ***Vaccinations:*** Under ICDS, for protection from six vaccine preventable diseases namely, poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles, children up to the age of one year were required to be administered the prescribed doses of BCG, DPT, OPV[37] and Measles vaccines with the help of Medical Department at AWCs.

Audit scrutiny of the 58 test checked AWCs revealed that 312 of the identified 3,766 beneficiaries (8.28 *per cent*) were not administered the prescribed vaccines. Further, five AWCs (8.62 *per cent*) in 2015-16, four AWCs (6.90 *per cent*) in 2016-17 and 4 AWCs (6.90 *per cent*) in 2017-18 did not even identify the beneficiaries for immunisation.

- ***IFA Tablets/Syrup:*** As per guidelines of Weekly Iron & Folic Supplementation Scheme (WIFS) weekly dose of 100 mg iron and 500 mcg folic acid was to be given to adolescent girls. Audit scrutiny however, revealed that Iron Folic Acid (IFA) tablets were not provided to 291 beneficiaries (4.56 *per cent*) of the identified 6,381 beneficiaries at 58 test checked AWCs. Further, 12 AWCs (20.69 *per cent*) in 2015-16, 13 AWCs (22.41 *per cent*) in 2016-17 and 15 AWCs (25.86 *per cent*) in 2017-18 did not even identify the beneficiaries.

Similarly under National Iron plus Initiative Program (NIPI), IFA syrup was to be given two days in a week to children of age group 6-60 months. Audit scrutiny however, revealed that IFA syrup was not provided to 551 beneficiaries (10.82 *per cent*) of the identified 5,092 beneficiaries at 58 test checked AWCs. Further, 22 AWCs (37.93 *per cent*) in 2015-16, 16 AWCs

[37] BCG: Bacille Calmette-Guerin, DPT: Diphtheria, Pertussis, Tetanus, OPV: Oral Polio Vaccine.

(27.59 *per cent*) in 2016-17 and 19 AWCs (32.76 *per cent*) in 2017-18 even did not identify the beneficiaries.

- ***Vitamin-A dose:*** As per instructions issued (November 2006) by Ministry of Health and Family Welfare, vitamin-A dose was required to be administered to all children of 9 months to 5 years of age at AWCs.

Audit scrutiny however revealed that dose of vitamin-A was not provided to 700 beneficiaries (6.63 *per cent*) of the identified 10,558 beneficiaries at 58 test checked AWCs. Further, 8 AWCs (13.74 *per cent*) in 2015-16, 4 AWCs (6.90 *per cent*) in 2016-17 and 3 AWCs (5.17 *per cent*) in 2017-18 did not even identify the beneficiaries.

This was indicative of lack of coordination & responsibility between ICDS (*Anganwadi* workers) and medical and health department (Auxiliary Nurse Midwifery).

(ii) Referral services

During health check-ups and growth monitoring sessions, sick/malnourished children as well as pregnant women and lactating mothers in need of prompt medical attention, were required to be referred to health facilities. The *Anganwadi* worker is required to facilitate the referrals and also detect disabilities in young children and refer to health facilities with a referral slip.

It was observed during test check of 58 AWCs, that two AWCs did not refer 29 out of 40 (72.50 *per cent*) severely malnourished children to health facilities in 2015-16. Similarly, four AWCs did not refer 13 out of 20 (65.00 *per cent*) severely malnourished children in 2016-17 and two AWCs did not refer 16 out of 23 (69.57 *per cent*) severely malnourished children in 2017-18. Thus, 58 children were deprived of specific treatment though identified at AWCs.

Further, no beneficiaries in need of prompt medical attention (other than the severely malnourished children) were referred to health facilities during 2015-18 by 50 out of 58 test checked AWCs.

Thus, due to lack of motivation among AWW and their inability to identify and counsel the target beneficiaries, the referral services were not as effective as desired.

3.6.5 Internal Controls

The monitoring and supervision of the ICDS Scheme is recognised as one of the essential requirements for the effective working of the scheme. Regular field visits to AWCs/ICDS Blocks by programme officials at different levels is essential to monitor the working at AWCs. Audit scrutiny however, revealed the following:

(i) Shortfall in stipulated supervision related field visits

As per norms, each CDPOs was to supervise at least 25 AWCs per month on a rotational basis and was to ensure coverage of 100 *per cent* AWCs in a

year. Supervisors were required to supervise all AWCs during a month in her sector and in case of holding additional charge, 50 *per cent* AWCs of each sector.

Year wise details of supervision/inspection conducted by CDPOs/Supervisors, as provided by the 12 test checked projects (out of 15 projects) is given in the **Table 9**.

Table 9

Years	CDPOs				Supervisors			
	Target	Achieve-ment	Shortfall	Shortfall (*Per cent*)	Target	Achieve-ment	Shortfall	Shortfall (*Per cent*)
2015-16	2,571	966	1605	62.43	30,852	10,336	20,516	66.50
2016-17	2,597	1008	1589	61.19	31,164	12,879	18,285	58.67
2017-18	2,607	930	1677	64.33	31,284	13,001	18,283	58.44
Total	**7,775**	**2,904**	**4871**	**62.65**	**93,300**	**36,216**	**57,084**	**61.18**

It can be seen from the table that there was a huge shortfall in supervisions/ inspections of the AWCs by CDPOs (62.65 *per cent*) and Supervisors (61.18 *per cent*). Further, out of 58 test checked AWCs, the Supervisors did not inspect 36 AWCs in 2015-16 (62.07 *per cent*), 35 in 2016-17 (60.34 *per cent*) and 34 in 2017-18 (58.62 *per cent*).

GoR accepted the facts and stated (December 2018) that shortfall in visits remained due to vacancy in supervisory posts. However, audit is of the view the government may revisit the feasibility of the norms set for supervision by CDPOs/Supervisors.

(ii) Incomplete data reported in Rapid Reporting System

GoI has been taking steps to revamp the Management Information System (MIS) under the ICDS programme. It is a web-enabled data entry system for use across all States/UTs for entry of revamped reporting formats at State/UT level.

Audit scrutiny revealed that 43.71 *per cent* (932 AWCs) of 2,132 AWCs of 10 test checked projects[38] did not upload their Monthly Progress Reports on Rapid Reporting System (RRS) MIS during March 2018.

Further, it was observed that in two (Chaksu and Jamawa Ramgarh) of these projects, despite provision of Android tablets, the Supervisors did not utilise them for uploading the same.

(iii) Monitoring committee not constituted at AWC level

As per instructions issued (March 2011) by GoI, an AWC level monitoring committee was to be constituted to review and take/suggest action to improve delivery of service at the AWC.

[38] Ahore, Anandpuri, Bakani, Buhana, Balotra I, Chaksu, Devgarh, Gangapur City, Jhadol and Jamawa Ramgarh.

Audit scrutiny revealed that out of 58 test checked AWCs, in 37 AWCs (63.79 *per cent*) such committee was not constituted. Though such committees were constituted in two AWCs, regular meeting were not held during 2017-18.

3.6.6 Conclusion

Anganwadi Centres are the first outpost for delivery of supplementary nutrition, pre-school education and other services under the ICDS programme to children in the age group of 6 months to 6 years, pregnant women and lactating mothers. Audit noticed that there were deficiencies in planning, availability of infrastructure, equipment and manpower in these Anganwadi centres. There was shortfall of 35.24 per cent and 41.32 per cent in coverage of targeted eligible beneficiaries for supplementary nutrition and pre-school education respectively. A substantial number (23.30 lakhs) of malnourished children were deprived of additional nutrition. None of the AWCs were able to provide micronutrient fortified supplementary nutrition as the Self Help Groups who supplied food did not have the capacity for fortification. Shortage of critical personnel like CDPOs/ACDPOs (52.47 per cent) and Supervisors (31.68 per cent) and shortage in prescribed trainings also affected various aspects of delivery of the programme. These deficiencies coupled with lack of regular supervision resulted in weaknesses in the delivery of services.

Recommendations:

GoR should

1. *Ensure that Annual Plans are prepared after taking inputs from villages and blocks.*

2. *Review the increasing percentage of 'wasted' children in the state in comparison to the national average and specific targets for reduction may be set so that this could be monitored effectively.*

3. *Ensure that all the identified beneficiaries including the malnourished children who have so far been excluded from the prescribed additional nutrition are provided fortified supplementary nutrition.*

4. *Ensure appointment and training of staff, especially of CDPOs and Supervisors so that implementation and supervision of ICDS programme is made more effective.*

5. *Ensure that all the identified beneficiaries are provided pre-school education with prescribed PSE kits and to mandatorily maintain Child Assessment Cards to assess the child's learning needs.*

Medical Education Department

3.7 Functioning of Mathura Das Mathur Hospital, Jodhpur

3.7.1 Introduction

Mathura Das Mathur (MDM) Hospital, Jodhpur is the largest hospital in the western region of Rajasthan and is attached to Government Medical College (Dr. SN Medical College) at Jodhpur. There are 18 departments[39], including seven Super-Specialty departments[40] and a separate Geriatric clinic[41] for senior citizens, in MDM hospital. They have inpatient facility of 1,111 beds. The hospital offers referral and tertiary healthcare services[42] to the patients. The Principal and Controller (P&C) of Dr. SN Medical College, Jodhpur is controller of the hospital and controls the budget of the hospitals. MDM Hospital, Jodhpur is headed by Superintendent, who is responsible for delivery of healthcare services in the hospital.

During the period 2013-17(calendar year), MDM Hospital provided healthcare services to 51.19 lakh patients and incurred revenue expenditure of ₹ 265.81 crore during 2013-18 (financial year). These funds were received from various sources[43]. Smaller portion of these funds were available for spending on medicines and repair & maintenance of the hospital assets during the period 2013-18 since majority were spent on salary, general establishment and contractual services (71.29 *per cent*).

With a view to assess the quality of inputs, efficiency and outcomes of the hospital processes, a thematic audit of the delivery of services by MDM Hospital Jodhpur, was conducted (May-September 2018) for the period 2013-18.

Audit Findings

Audit findings related to various aspects of the functioning of MDM Hospital have been discussed below.

3.7.2 Resource Management

Hospital resources include infrastructure, human resources, equipment and consumables and drugs. Audit scrutiny of the resources of MDM Hospital and their management revealed the following:

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[39] Dentistry; Dermatology, Venereology & Leprosy; Ear, Nose & Throat (ENT); General Medicine; General Surgery; Obstetrics & Gynecology; Ophthalmology; Orthopedics; Pediatrics; Psychiatry and Radio-Therapy.

[40] Cardiology, Cardiothoracic & Vascular Surgery, Gastroenterology, Nephrology, Neurology, Neurosurgery and Urology.

[41] Under National Programme for the Healthcare of the Elderly (NPHCE).

[42] Tertiary care is a specialized consultative healthcare provided for inpatients referred from primary and secondary level hospitals, in an institution that has personnel and facilities for advanced laboratory and imaging investigations.

[43] State General Budget, MNJY, MNDY (RMSCL), MNDY (MDM).

3.7.2.1 Building Infrastructure

MDM Hospital building comprises of four blocks accommodating 27 OPD units in 18 departments, one Geriatric Clinic, one Trauma Centre and one central laboratory.

The shortage in infrastructure with respect to standards of Medical Council of India (MCI), for providing quality healthcare services in various departments, operation theatres and wards are discussed in the following paragraphs.

(i) Infrastructure availability to meet increasing patient load: As per clause B.1.9 of 'Minimum Standard Requirements for the Medical College for 250 Admissions Annually Regulations, 1999' (Regulations), the teaching hospitals are required to have an attached 1,100 bedded facility for providing tertiary healthcare facilities. MDM hospital has 19 departments which have 28 OPD units[44] and 1,111 beds for patients' care and treatment. Scrutiny of records revealed that there was substantial patient load in the MDM hospital, the details of which are given in **Table 10.**

Table 10

Year	Number of OPD Patients (in lakh)	Number of IPD Patients (in lakh)	Patients load (in lakh)	*Percentage* increase as compared to 2012	Number of functional OPD units	Availability of beds
2012	7.08	0.30	7.38	-	17	NA
2013	8.70	0.37	9.07	22.90	23	703
2014	9.04	0.40	9.44	27.91	23	759
2015	9.25	0.46	9.71	31.57	25	936
2016	10.48	0.64	11.12	50.68	25	1,001
2017	11.12	0.73	11.85	60.57	28	1,111
Percentage increase in 2017 as compared to 2012	**57.06**	**143.33**	**60.57**			**58.03**

Source: information provided by MDM hospital, Jodhpur.

It can be seen from the above table that the number of OPD patients and IPD patients increased by 57.06 *per cent* and 143.33 *per cent* respectively during 2012-17. However, during this period, the number of beds increased only by 58.03 *per cent* which was not commensurate with the growth of IPD patients. Despite this, no planning for creation of additional/new units was done by the hospital during 2013-18 to cater for the increasing patient load, though, 10 units[45] were transferred from other hospitals to MDM Hospital during this period and one Geriatric clinic for senior citizens was established in August 2013.

GoR accepted the facts and stated (February 2019) that many units were transferred from other hospitals and seven super speciality departments and one Geriatric clinic were operationalised. To decrease the patient load from

[44] A unit is headed by either Professor or Associate Professor and generally have not more than 30 beds.

[45] Five units (one unit of General Medicine, two units of Obstetrics & Gynaecology, one unit of paediatrics and one unit of Cardiothoracic & Vascular Surgery) in 2013, two units of paediatrics in 2015 and three units (one unit of General Surgery, one unit of Gastroenterology and one unit of Urology) in 2017.

old building, a new OPD block was operationalised in 2017 and six OPD units were transferred to new OPD Block. The construction of first, second and third floors for remaining departments, Central Lab and Teaching Block was still pending.

(ii) Insufficient infrastructure in Wards

Norms prescribed by MCI provided that accommodation in a ward shall not exceed 30 patients. Further, the norms for infrastructure requirement for each ward include availability of Clinical Demonstration Room, Examination and Treatment Room, Residential Doctors and Student Duty Room, Nurses Duty Room/Nursing Station and Ward Pantry etc., in each ward.

Audit scrutiny of records and information provided for 33 wards revealed that Clinical demonstration rooms were not provided in 24 wards (72.73 *per cent*), Examination and treatment rooms were not provided in 19 wards (57.58 *per cent*), Resident doctors and Student duty room were not provided in eight wards (24.24 *per cent*) and Ward pantry was not provided in 22 wards (66.67 *p*er *cent*). Further, there was a high bed occupancy ratio in two out of three Pediatric wards. It was also noticed that bed occupancy ratio of these wards was 104 *per cent* in 2016, 113 *per cent* in 2017 and 117 *per cent* in 2018.

Facilities prescribed by MCI for wards are necessary to ensure that quality health services are provided efficiently and effectively. Thus, the delivery of quality health services have been impacted to the extent of shortage of these facilities.

GoR accepted the facts and stated (February 2019) that the old wards did not have prescribed infrastructure. In some wards, treatment room was being used as clinical demonstration room and wherever adequate space was available, Public Works Department had been instructed to construct clinical demonstration and treatment room in wards. It was also stated that to address the high bed occupancy ratio in paediatric wards, one neo natal ward of 20 bedded capacity was constructed and would become operational upon deployment of nursing staff and specialists.

However, the fact remained that a holistic view, of the current and future infrastructure needs, required to be taken in order to ensure continued infrastructure availability as per the prescribed norms.

(iii) Insufficient infrastructure for Operation Theatres

Norms prescribed by MCI in 1999 (revised norms w.e.f 03.11.2010) provides for minimum infrastructure for each Operation Theatre (OT) consisting of (i) waiting room for patients, (ii) pre-anesthetic/preparation room (for at least four beds), (iii) post-operative recovery room (for at least 20 beds), (iv) instrument room, (v) nurse room, (vi) washing room for Surgeon and Assistants and (vii) students washing up and dressing room etc.

Five OTs were operating under MDM hospital namely Cath laboratory OT (one table), Ophthalmology OT (four tables), Gynecology OT (three tables),

Main OT (seven tables)[46] and Cardiothoracic OT (three tables)[47]. Audit scrutiny revealed that:

- Pre-Anesthetic/preparation room was not provided in two (Gynecology and Cardiothoracic) out of five OTs and against the norm of four beds, only three beds were provided in Ophthalmology OT.

- Post-Operative Recovery Room was not provided in Cardiothoracic OT while other four OTs had less number of beds in Post-Operative recovery rooms.

- Soiled Linen Room was not provided in three OTs (Ophthalmology, Gynecology and Main OTs).

- Instrument Room was not provided in two OTs (Ophthalmology and Gynecology OT).

- Nurse Room was not provided in two OTs (Ophthalmology and Main OT).

- Surgeon and Anesthetist Room was not provided in three OTs (Ophthalmology, Main and Cardiothoracic OT).

- Observation gallery required for practical training of students was not provided in four OTs (Ophthalmology, Gynecology, Main OT and Cardiothoracic).

GoR while accepting the facts stated (February 2019) that instructions were being issued to provide sufficient space as well as upgrade infrastructure in Operation Theatres as per MCI norms. It was also stated that presently all the construction activities are being carried out in accordance with the MCI norms.

(iv) Non availability of Oxygen line and connections in wards

As per MCI norms, all the wards in Orthopedic, Surgery and Pediatrics Departments should have wall mounted suction lines along with piped wall mounted central Oxygen lines on all beds and at least five beds in Ophthalmology department should have the same arrangement.

Out of 319 beds in these four departments of Pediatrics, Surgery, Orthopedic and Ophthalmology, oxygen line was provided to only 38 beds (11.91 *per cent*).

GoR while accepting the fact stated (February 2019) that the tendering for installation of oxygen lines in the wards was under process.

[46] Includes Neurosurgery, Urology, ENT, Surgery and General Emergency.
[47] Includes Orthopedic, Dental and Cardiothoracic department.

(v) Insufficient infrastructure for Central Laboratory

As per MCI norms, there shall be well equipped and updated central laboratories preferably along with common collection for all investigations in pathology, microbiology and biochemistry and other specified works. Accordingly, there was a central laboratory for carrying out various investigations in pathology, biochemistry and microbiology. Scrutiny of records and physical verification of central laboratory revealed that there was no separate room for doctors (non-clinical) in microbiology laboratory. As a result, they had to sit with technicians and collected the samples of patients in the same room.

GoR while accepting the facts stated (February 2019) that the proposals for construction of well equipped laboratory building in new OPD block was pending for approval.

3.7.2.2 Human Resources: Shortage of medical specialists/medical staff

The details of sanctioned strength for various medical cadres in the hospital *vis-à-vis* person-in-position as on 31 March 2018 is given in the **Table 11**.

Table 11

Name of post	Sanctioned Strength	Persons in Position (Regular Staff)	Shortfall (in *per cent*)	Contractual staff/other staff	Total	Overall shortfall in PIP
Medical Officers	37	18	19 (51.35)	0	18	19
Staff Nurses	941	417	524 (55.69)	283	700	241
Para-medical staff	117	50	67 (57.26)	73	123	(+)6
Total	**1,095**	**485**	**610 (55.71)**	**356**	**841**	**254**

Source: information provided by MDM hospital, Jodhpur.

It can be seen from the table that as of March 2018:

- There was 51.35 *per cent* shortage (19 out of 37) of Medical Officers (Doctors).

- There was an overall shortage of 25.61 *per cent* of nursing staff (241 out of 941) including contractual nursing staff. It was also observed that despite shortage of nursing staff, 11 staff nurses were allowed to proceed on deputation and 11 staff nurses were deployed for tasks other than nursing.

Further, though there was an overall excess of 6 specialists[48] (Professors, Associate Professors and Assistant Professors) as per MCI norms. However, shortage of 1 or 2 specialists in departments of dentistry, obstetrics &

[48] Specialists include Professors, Associate Professors and Assistant Professors (teaching faculties). Department wise/hospital wise sanctioned strength of specialist was not provided though overall sanctioned strength for all constituent hospitals was available at medical college level. Comparison has been done between requirements of "Specialists" as per MCI norms for 28 units and actual deployment thereof.

gynecology, ophthalmology, radio-therapy, cardiothoracic & vascular surgery and nephrology was also noticed.

GoR accepted (February 2019) that there was shortage of medical officers and staff nurses. To address the acute shortage of staff nurses, 283 nurses were engaged on urgent temporary basis. Further, proposals are under consideration for repatriation of the nursing staff who were on deputation.

3.7.2.3 Equipment Management

As per norms prescribed by MCI, availability and management of Machinery and Equipment in a hospital and optimum utilisation thereof is essential for better delivery of healthcare services

The status of availability and utilisation of machinery & equipment for providing quality healthcare services in various departments and units of the hospital, as compared to standards prescribed by MCI, are discussed in the following paragraphs.

(i) Non-functional equipment in ICUs and OTs

Scrutiny of records of five OTs and six ICUs revealed that 33 to 100 *per cent* of essential machines and equipment were non-functional in one OT (Cath lab OT) and four ICUs (Pediatric, Surgical, Medical and Trauma), as detailed in **Table 12.**

Table 12

Name of ICU/ OT	Name of Machines/ Equipment	Total available	Functional	Non-functioning (*per cent*)	Period of non-function as of December 2018 (in months)
Pediatric ICU	Pulse Oximeter	4	1	3 *(75)*	16
	Baby Warmer	6	0	6 *(100)*	18
	Defibrillator	2	1	1 (*50*)	9
	ECG Machine	1	0	1 (*100*)	30
	Weighing Machine	3	2	1 (*33*)	16
	B.P. Instrument Mercurial	3	2	1 (33)	16
	Infusion Pump	21	7	14 (*67*)	16
Surgical ICU	Ventilator	15	8	7 (*47*)	18-48
Medical ICU	ECG Machine	3	1	2 (*67*)	9
	Defibrillator	4	2	2 (*50*)	16
	Ultrasonic Machine	1	0	1 (*100*)	23
Trauma ICU	Electric Suction Machine	5	2	3 (*60*)	24-48
	Advance ICU Ventilator	2	0	2 (*100*)	36-60
Cath lab OT	Fumigation Machine	2	1	1 (*50*)	23
	Artery Forceps	15	4	11 (*73*)	107
Total		**87**	**31**	**56 (*64.37*)**	

Source: Information provided by MDM hospital, Jodhpur.

Further, In-charge of Pediatric ICU also informed (May-July 2018) the Superintendent that various machines in Pediatric ICU were repairable, but no action for repairing these machines was initiated by the hospital.

GoR stated (February 2019) that repair of equipment and instruments was an ongoing process and in case they were not repairable under Annual Maintenance Contract (AMC) and Comprehensive Maintenance Contract (CMC), new equipment would be purchased.

The reply is not tenable as a large number of essential equipment in various OTs/ICUs were found non-functional for substantial period which was indicative of lapses in repair and maintenance of essential equipment.

(ii) Non-functional equipment in other departments/laboratories

Audit scrutiny of records of critical and costly medical equipment needed for specified treatments/diagnosis revealed the following:

- ***Cardiotocography (CTG) Machine:*** Scrutiny of records of labor room revealed that though there were five CTG machines available in labor room, all of them were inoperative since January 2017. In the absence of functional CTG machines, measurement of fetal heart beats was being done on an *adhoc* basis with the help of stethoscopes. Thus, specialized monitoring machines for investigation of fetal heart beats of patients could not be accessed. GoR assured (February 2019) that it would be repaired soon as work was under process.

- ***Clinical chemistry Analyzer:*** A fully automated Tulip coral 300 analyzer, for performing biochemistry and immune turbidimetry assays from blood, serum, plasma and body fluids was installed (August 2013) in biochemistry laboratory at a cost of ₹ 11.03 lakh. Scrutiny of stock register and records of machines revealed (June 2018) that the machine was not working properly since its installation and remained faulty since February 2014. Though the machine was under Comprehensive Maintenance Contract (CMC) but was not made good (June 2018) as damage done by rats was not covered in CMC. Thus, the patients had to be diverted to the Dr.SN Medical College, Jodhpur for these tests.

- ***ND YAG* and CO_2 *Lazer machines***: These machines were installed in Skin Department in February 2014 at a cost ₹ 9.98 lakh and ₹ 3.89 lakh respectively. It was observed that these machines were non-functional since October 2014 and April 2016 respectively due to faulty optical fiber cables damaged during shifting of machines from one room to another room. However, these machines were not repaired even as of July 2018. GoR assured (February 2019) that ND YAG laser machine would soon be repaired.

- ***Cobalt-60 machine:*** A Cobalt machine was installed in 2001 in the Radiotherapy Department for radiation therapy to treat 45-50 cancer patients per month. The Cobalt machine uses Co-60 radioactive source for therapy. It was observed that despite intimation by the dealing doctor (September 2011) to the head of the Department that the source was going to complete its active life and required replenishment, the order was placed only in December 2013. As a result, the machine became inoperative in June 2014 and remained so till January 2016 (19 months). Consequently, 850-900 cancer patients who could

have benefited from the services of the machine were deprived of access to radiation therapy.

(iii) Equipment installed under Public Private Partnership

- ***Poor contract management of MRI machine:*** An MRI machine was installed (February 2009) under Public Private Partnership by M/s Satyam Diagnostic Centre, Jodhpur (Licensee). Accordingly, the licensee was required to perform the 26 types of imaging tests at their prescribed rate and for 20 *per cent* cases of the poor category patients, tests were to be performed free of cost. The number of free cases were to be evaluated on monthly basis and carried forward to next month. At the end of calendar year, if the number of cases remained less than 20 *per cent*, the licensee was liable to pay for the number of cases not performed at a fixed rate of ₹ 2,000 as per condition number nine. The receipt for MRI investigation was to be issued by licensee through computer on the receipt book provided by the hospital and reconciliation of accounts was to be done on quarterly basis as per condition number 17.

Scrutiny of records of the MRI machine and information provided by the hospital revealed that the receipt books were not provided to the licensee by the hospital and fee receipts were issued by the licensee at its own level. Further, reconciliation of accounts was also not done as a result it could not be verified in audit that 20 *per cent* of the patients were actually benefitted by free MRI tests as per the contract.

It was also observed that the tests were to be performed at the prescribed rates, however no mechanism was in place to ensure that the licensee was charging the fee as per agreement.

- ***PPP contract for Cancer Therapy Machine not finalized for 30 months:*** GoR in the budget announcement for 2016-17 proposed to establish Linear Accelerator and Gamma Camera machines on PPP mode in radiotherapy department of the hospital for upgradation of the available facilities for cancer patients.

Scrutiny of records revealed that the P&C prepared bid proposals and forwarded (May 2016) to the Director, Medical Education. Accordingly, e-tenders for installation of the machines were invited (October 2017) and a pre-bid meeting was held on 23 October 2017, wherein one of the bidders suggested certain changes to the terms and conditions of contract. Technical and Financial Committee forwarded (December 2017) the revised bid documents to the Directorate, Medical Education, Jaipur whose approval was not received despite repeated reminders.

As the Department failed (August 2018) to finalise the terms and conditions of installation of Linear Accelerator and Gamma Camera machines on PPP mode, the machines could not be installed even after lapse of more than two years and deprived the cancer patients from the benefits of an upgraded diagnostic facility. GoR stated (February 2019) that matter is pending for approval.

(iv) Monitoring of equipment through 'e-Upkaran'

'*e-Upkaran*', a web based application, was launched (October 2015)by Medical and Health Department, GoR for monitoring of usage and repair and maintenance of equipment and instruments installed at healthcare centres across the state from one platform. The application was available for utilization by all government health institutions including medical college attached hospitals. This application provides online status of Equipment Inventory, functionalities and maintenance status to the users.

Scrutiny of records, however, revealed that neither the Medical College nor MDM hospital was utilizing this application and did not upload any details on this software. Therefore, timely remedial action on many critical equipment could not be taken which deprived the patients of diagnostic services.

Only after being pointed out by Audit, GoR issued (February 2019) instructions to all HoDs and Unit Heads to provide information regarding procurement, installation, operation, repair, maintenance and upkeep of equipment on *e-Upkaran*. Further, computerisation of information was under progress.

3.7.2.4 Drugs, Consumables and Reagents Management

Drugs, sutures and surgical items are provided free of cost to all the patients visiting government hospitals in Rajasthan through the scheme *'Mukhyamantri Nishulk Dava Yojana' (MNDY)*. Under the scheme, more than 800 commonly used essential medicines, surgical and suture items (Essential Drug List) were to be made available to all visiting OPD and IPD patients at all Government Healthcare Institutions in the State.

In the MDM hospital, Jodhpur, the drugs were being distributed to patients through 14 Drug Distribution Counters (DDCs). In addition to drugs received from Rajasthan Medical Services Corporation Limited (RMSCL), the hospital also procured drugs locally of value ₹ 4.66 crore during 2013-18. Audit scrutiny revealed the following:

(i) Shortage of Essential Drugs

As per MNDY scheme guidelines, Drug Distribution Warehouses (DDWs) are to ensure continuous supply of drugs to the hospital sub store on receipt of requisitions as per availability of medicines and annual financial limit of the hospitals. Further, the drugs are issued to DDCs for distribution to the patients on presentation of the prescription of Medical Officer (MO).

Test check of records revealed that against the requisition of type of medicines included in Essential Drug List (EDL), 13.43 to 37.89 *per cent* drugs were not available for a period of more than four months during 2013-18. The details of requisition and availability of drugs is detailed in **Table 13**.

Table 13

Year	Types of essential Drugs required	Types of drugs unavailable for more than 4 months to 12 months	*Percentage*
2013-14	607	230	37.89
2014-15	745	172	23.09
2015-16	819	110	13.43
2016-17	801	127	15.86
2017-18	821	178	21.68

Source: Information made available by the hospital

GoR stated (February 2019) that the drugs and medicines which were not available/in short supply were procured as per availability of funds and it would be ensured that all indoor patients receive drugs.

(ii) Decline in beneficiaries of free of cost drugs

As per calendar year wise data available with the hospital, 8.70 lakh OPD patients had registered during the year 2013 which increased to 11.12 lakh during the year 2017. Thus, OPD patients under MNDY, increased substantially by 28 *per cent* during the period.

An analysis of total number of patients enrolled and benefited in MDM hospital during 2013-17, was conducted during Audit. The results of the analysis are detailed in **Table 14**

Table 14

Year	No. of outdoor patients enrolled during the year	No. of outdoor patients benefitted	*Percentage*
2013	8,70,164	7,64,932	87.91
2014	9,04,413	6,65,036	73.53
2015	9,25,369	7,43,683	80.37
2016	10,47,984	8,19,973	78.24
2017	11,11,686	8,60,930	77.44
Total	**48,59,616**	**38,54,554**	**79.32**

Source: Information made available by the hospital

Above data reveals that there was a gradual increase in number of outdoor patients enrolled during 2013-17 but the percentage of beneficiaries decreased. As a result, over the years, about 21 *per cent* of the registered patients failed to receive the requisite treatment/drugs prescribed.

Similar issue was also pointed out in paragraph 3.13.2.1 in the 'CAG's Audit Report on General and Social Sector for the year ending on 31 March 2015'. In this regard, the State Government assured Public Accounts Committee that efforts were being made to extend the benefits of the scheme to the maximum extent. However, in MDM hospital, the coverage of beneficiaries under MNDY consistently reduced to 78.24 *per cent* in 2016 and 77.44 *per cent* in 2017.

GoR stated (February 2019) that drugs and medicines were distributed for free to all patients under MNDY. The drugs and medicines which were not available/in short supply were purchased as per availability of fund to make

sure that all indoor patients received the drugs except those which were not in essential drugs list.

The reply is not acceptable as 68.12 *per cent* of the patients (188 out of 276 patients test checked) were not provided all the drugs prescribed by the doctors in the hospital and as many as 14.29 to 100 *per cent* medicines prescribed by doctors were not available in the hospital. This indicated that inspite of funds being available with RMRS as discussed in ***paragraph 3.7.4.3***, medicines were not made available and undue financial burden was put on the patients, which was against the objectives of the MNDY scheme.

(iii) Non availability of freezer in Sub Store/DDC

A physical inspection (July 2018) of sub store and the DDCs, revealed that all the drugs were kept at room temperature as no freezer was available in the store. The drugs and injectable items which were required to be kept at low temperature were kept either in Ice boxes or in paper cartons due to non-availability of freezer during 2013-18 despite the fact that Jodhpur city recorded significantly high temperatures during most parts of the year.

GoR stated (February 2019) that acquisition of WIC freezer (mobile freezer) was under progress.

(iv) Prescription of non-EDL drugs without reason

As per MNDY guidelines, in every prescription slip, as far as possible, doctor has to prescribe medicines from essential drug list as per standard treatment guidelines. If medicines are prescribed out of EDL, valid clinical reason and proper justification for use of a specific medicine should be specified.

Test check of 276 prescriptions revealed that out of 456 drugs, 80 (17.54 *per cent*) drugs were not included in EDL, which were prescribed. However, the medical officers did not mention the valid clinical reason for prescribing non EDL drugs. On being pointed out, P&C stated (November 2018) that instructions would be issued to the doctors in this regard.

(v) Inadequate monitoring through "e-Aushadhi" software

For online monitoring, RMSCL adopted a drug inventory management system *'e-Aushadhi'* which is a comprehensive online system capable of having detailed information about availability of medicines, from procurement point to consumption point, including Drug Distribution Counters.

Scrutiny of records of 14 DDCs in MDM hospital revealed that online ledger for issue of medicines was not updated in the software for a period ranging from four days to 10 months. As a result, there was mismatch in the number of available drugs as per software and actual availability at the DDCs. Further, only one out of 14 recruited Information Assistants (recruited in November 2013 for operation of DDCs under MNDY and MNJY) were posted at DDCs. Hence their utilization for real time updating of data was not being done and they were deployed for other clerical works. Similar issue was also pointed out

in paragraph 3.13.4.2 in the 'CAG's Audit Report on General and Social Sector for the year ending on 31 March 2015'. In this regard, the Public Accounts Committee also recommended (June 2017) to remove all the deficiencies as pointed out by Audit.

GoR while accepting the fact stated (February 2019) that to address the delay in updating of the system on daily basis, the necessary instructions were being issued.

3.7.3 Management of hospital services

Healthcare services provided by hospitals are broadly classified into line services (directly related to patient care), support services (indirectly related to patient care) and auxiliary services (facilitate delivery of healthcare services). The Audit findings related to management of these services are discussed below.

3.7.3.1 Line services

Line Services provided in a hospital are the various healthcare services which are directly related to patient treatment. These include Outdoor Patient Department (OPD) patients, Indoor Patient Department (IPD) patients, Emergency, Super Specialty, Maternity and other care services.

(i) Availability of Super Specialty Services: The detail of number of OPD and IPD patients, surgeries/procedures conducted by Super Specialty departments during 2017 are given in **Table 15.**

Table 15

S. No.	Name of Super Specialty Department (starting year)	Number of units	Number of beds	OPD days	Number of OPD patients in 2017	Number of IPD patients in 2017	Average OPD patients per OPD day in 2017	Surgery cases in 2017	OPD Patient per OPD day per Specialist
1	Cardiothoracic and Vascular surgery (January 2013)	01	25	01	2,834	1,031	55	215	55
2	Cardiology (2009)	01	37	04	43,797	7,422	211	3,018	105
3	Neurosurgery (1991)	01	73	03	9,167	3,077	59	1,004	59
4	Neurology (January 2017)	01	30	02	21,889	1,297	210	NA	70
5	Gastroenterology (January 2017)	01	30	02	7,052	1,134	68	4,759	34
6	Nephrology (IPD started from April 2018)	01	12	02	7,152	NA	69	NA	69
7	Urology (October 1987)	01	36	07	17,873	9,940	49	1,318	25

Scrutiny of records and information provided by the super specialty departments concerned, revealed the following:

- ***Neurosurgery:*** MCI norms prescribe that a unit[49] shall consist of not less than 20 and not more than 30 beds for super specialty. During 2013-17, though there were 73 beds in the department, it was being served by only one unit and number of operation cases also increased substantially by 18.40 *per cent* during 2013-17. Further, OPD was functioning for only three days in a week. As a result, the doctors were overburdened. Considering the high patient load, though an additional OT table was provided in the department but no additional units were planned to be established.

- ***Neurology:*** In this department, OPD was functioning only for two days despite average of 70 patients per doctor per OPD day during 2017. Audit analysis of average OPD per day and OPD duration during a day revealed that for each doctor in Neurology Department the average consultation time per patient[50] was only five minutes for examination of a patient as compared to 15 to 30 minutes in most other departments.

- ***Gastroenterology:*** In this department, OPD was functioning for only two days in a week and lengthy endoscopy procedures were being performed along with OPD. Further, this facility was not available in AIIMS, Jodhpur and other hospitals, hence the patients were being referred to MDM hospital.

- ***Nephrology:*** In the department, kidney transplant centre was inaugurated in 2015 but could not be started as of March 2018. Further, it was also noticed that 1,041 Chronic Renal Failure patients (546 in MDM hospital and 495 in MG hospital) requiring kidney transplant were registered during 2017-18. This indicates that large number of patients were deprived of the intended benefits of the Centre.

- ***Cardiothoracic and Vascular surgery:*** In this department, patients in OPD, IPD and surgeries increased by 50.50 *per cent*, 164.36 *per cent* and 35.22 *per cent* respectively during 2014-17. However, OPD unit was available only once in a week. Further, against sanctioned bed strength of 50 beds, only 25 beds were available as of March 2018. In violation of MCI norms, no full time Unit Head (Professor) and Assistant Professor were deployed/available in the department and the department was dependent on only one Associate Professor.

- ***Cardiology:*** In this department, patients in OPD, IPD and Cath Lab OT increased by 90.97 *per cent*, 46.97 *per cent* and 47.87 *per cent* respectively during 2013-17. Further, bed occupancy was 100 *per cent* throughout the year in IPD. However, the number of units/beds/cath labs were not increased during 2013-17.

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[49] As per Norms for minimum staff prescribed by MCI, each unit shall consist of (a) Professor/Reader-1 (b) Lecturer-1 (c) Senior Resident/Tutor/Registrar-1 and (d) Junior Residents 3 to 4.

[50] Consultation time per patient is a Quality Indicator for measuring clinical care in OPD as per National Quality Assurance Standards, 2016.

GoR stated that necessary action would be taken to address the deficiencies as pointed out in audit.

(ii) Services provided by other departments

The details of number of units, beds, days, number of OPD/IPD patients in the 12 non-super specialty departments are given in **Table 16**.

Table 16

S. No.	Name of Department	Number of units	Number of beds	OPD Days	Number of OPD patients in 2017	Number of IPD patients in 2017	Average OPD patient per OPD day in 2017	Surgery cases in 2017	Average OPD[51] patients per doctor
01	Dentistry	1	7	7	36,315	168	99	87	**99**
02	Dermatology, Venereology and Leprosy (Skin)	1	33	7	2,53,491	429	694	NA	**231**
03	Ear, Nose and Throat (ENT)	1	47	7	81,720	1,113	224	899	56
04	General Medicine	3	123	7	1,33,242	14,820	365	NA	**122**
05	General Surgery	3	97	7	32,699	3,809	90	2,666	30
06	Obstetrics and Gynecology	2	88	7	39,047	10,511	107	4,085	36
07	Ophthalmology	2	60	7	59,744	3,164	164	2,912	55
08	Orthopedics	2	63	7	49,953	3168	137	2,303	68
09	Pediatrics	3	117	7	53,211	6,747	146	NA	73
10	Psychiatry	1	105	7	52,374	2,547	143	NA	71
11	Radio-Therapy	1	35	7	11,478	1,554	31	NA	31
12	Geriatric	1	30	4	16,866	931	81	NA	81

It can be seen from the table that:

- Average OPD per doctor per OPD day was very high in Skin (231), General Medicine (122) and Dentistry (99) despite having OPD on all days. GoR accepted (February 2019) that there was requirement of faculties as well as more units.

- As per MCI norm, a unit shall consist of not more than 30 beds. In four departments (General Medicine, Obstetrics and Gynecology, Pediatrics and Psychiatry), number of beds were in excess of norms. The number of units was not increased to restrict the beds per unit to the prescribed norms. GoR accepted (February 2019) that in medicine, gynecology, pediatrics and psychiatry departments, number of beds were more as per MCI norms due to huge patient load which could be reduced by increasing number of units.

(iii) Denial of Services to Bhamashah Card Holders

Bhamashah Swasthya Bima Yojana **(**BSBY) was launched in December 2015 by GoR for providing cashless indoor medical treatment to those families which were covered under National Food Security Act (NFSA) and *Rashtriya*

[51] As per National Quality Assurance Standards 2016, OPD cases per doctor is an indicator for measuring efficiency of doctors in OPD.

Swasthya Bima Yojana. The scheme provides treatment up to ₹ 30,000 per family per year in general cases and upto ₹ 3.00 lakh for serious ailments which include packages for secondary and tertiary illnesses. A total of 21,051 patients were benefitted by free treatment under BSBY in the MDM hospital, Jodhpur during December, 2015 to March, 2018.

Scrutiny of records, however, revealed that during December 2015 to March 2018, free treatment under BSBY were denied to 12,945 card holders (38.08 *per cent*) as their Bhamashah Cards were not linked with National Food Security software.

GoR accepted (February 2019) that many of the Bhamashah card holders had not linked their Bhamashah card to the National Food Security Act. The fact, however, remained that a large number of BSBY card holders were deprived of the benefit of inpatient treatments at free of cost due to lack of awareness.

(iv) Emergency Services

MCI norms prescribed that each attached hospital should have Accident and Emergency Services, with distinct entrance for the emergency department. The emergency department should be equipped with lifesaving instruments such as Ventilator, Multi parameter monitor, Cardiac monitor with defibrillator, *etc.,* to treat accidental and emergency cases effectively.

It was however observed in Audit that:

- Against 30 beds in trauma unit, only 24 beds were provided.
- Against four fully equipped disaster trolleys (emergency trolleys), only one emergency trolley (crash cart) was available.
- Against four Ventilators, four Multipara Monitors, and four ECG machines, no Ventilators and Multipara monitors were available and only three ECG machines were available. GoR stated (February 2019) that construction of a 100 bedded dedicated trauma hospital as per MCI norms, was under progress and would address all the indicated deficiencies. Further, purchase of new ECG machines for Minor Operation Theatre was also under process.

(v) Maternity Services

- ***Incentives under Janani Suraksha Yojana not provided:*** *Janani Suraksha Yojana* (JSY), a centrally sponsored scheme was launched in September, 2005 for reducing the infant mortality rate (IMR) and maternal mortality rate (MMR) by encouraging and incentivizing the institutional deliveries. A financial aid of ₹ 1,400 to rural and ₹ 1,000 to urban pregnant women was to be given under this scheme. Director, Medical Health and Family Welfare Services, Jaipur also issued instructions (July 2015) that it was responsibility of the hospital to encourage opening of bank accounts of pregnant women at the time of registration.

Scrutiny of records revealed that out of 21,124 eligible women, cash incentive was not provided to 2,848 eligible women (13.48 *per cent*) during August

2015 to March 2018 due to non-availability of bank account details. Thus, the hospital failed to adhere to these instructions.

- ***Incentives under Mukyamantri Shubhlaxmi Yojana not provided***: The scheme was started from 1 April 2013 to encourage girl child birth, to reduce the death rate of girl child and mothers and to make sure that there is no discrimination on the basis of gender of the child. Under this scheme, financial assistance of ₹ 7,300 (₹ 2,100 on discharge from hospital, ₹ 2,100 after one year of birth and ₹ 3,100 after completion of five year of birth) was to be provided to the mother of the girl child. Further, the scheme was modified in June 2016 to increase the positive attitude towards the girl child and to improve their educational and health status. The scheme was also renamed (June 2016) as *Mukyamantri Rajshree Yojana* and financial assistance[52] of ₹ 50,000 was to be provided.

Scrutiny of records revealed that out of 5,070 cases, financial assistance was not provided in 364 cases (7.18 *per cent*) under *Mukhyamantri Shubhlaxmi Yojana* during August 2015 to May 2016. Further, out of 7,287 cases, financial assistance was not provided in 1,238 cases (16.99 *per cent*) under *Mukhyamantri Rajshree Yojana* during June 2016 to March 2018 due to non-availability of pass book or the fact that the beneficiary belonged to other state.

GoR while accepting the facts stated (February 2019) that some of the patients did not produce their bank account details and some patients belonged to other states. The fact however remained that a substantial number of women were deprived of incentive for institutional delivery and giving birth to girl child, as envisaged in the Government schemes.

(vi) Indicators for measuring quality of service

Norms prescribed by MCI regarding provision of healthcare services are based on number of MBBS/Post graduate (PG) seats sanctioned in the medical college. Further, the National Quality Assurance Standards, developed by National Health Systems Resource Centre (Ministry of Health and Family Welfare, GoI) provides a list of service quality indicators to assess the performance of public health facilities in the delivery of healthcare services. However, no such indicators have been adopted by the government tertiary care hospitals in Rajasthan. GoR stated (February 2019) that decision of adopting the service quality indicators are yet to be finalised.

3.7.3.2 Support Services

(i) Diagnostic Services

- ***Non-registration of laboratories:*** GoR issued instructions (June and September 2015) for registration of all the hospitals having capacity of 50 beds or more, under Section 11 of the Clinical Establishments (Registration & Regulation) Act, 2010, by 30 September 2015. It was observed that the hospital was not registered under the Act as of March 2018. GoR stated

[52] ₹ 2,500 at the time of discharge from the hospital to mother and ₹ 47,500 in the name of girl for her education up to class XII in any government school in phases.

(February 2019) that no Government laboratory was registered in the state under the Act. The reply was not tenable as Government laboratories were also required to adhere to the provisions of the Act.

- ***Non-obtaining of quality certification from NABL:*** In accordance with Indian Council of Medical Research (ICMR) guidelines, the department decided (May 2014) for accreditation of Medical College attached Hospitals with National Accreditation Board for Testing and Calibration Laboratories (NABL). It was observed in Audit that the hospital was not accredited with NABL as of March 2018. GoR stated (February 2019) that pathology laboratory of the hospital was accredited by NABL. However, no reply was furnished for accreditation of biochemistry and microbiology laboratories.

- ***Diagnostic tests not conducted due to non-availability of reagents:*** Scrutiny of records of Central Laboratory of the hospital revealed (June 2018) that blood culture tests could not be conducted in microbiology laboratory for 15 months (from 05 November 2016 to 05 February 2018) due to non-availability of reagents (Antibiotic discs). The hospital, while accepting the facts, stated (June 2018) that alternate arrangement for conducting these tests was done in the Dr. SN Medical College. On being pointed out Principal & Controller stated (November 2018) that availability of reagents would be ensured.

- ***Patients charged for free diagnostic tests:*** MNJY scheme was launched in April 2013 with the objective of reducing high 'out of pocket' expenses borne by the patients for diagnostic tests and to provide all healthcare services in the Hospital free of cost. It was, however observed in Audit that during 2013-18, MDM Hospital irregularly charged ₹ 15.90 lakh[53] from the patients for various diagnostic tests which were to be offered free of cost. No specific reasons for charging the fee for these tests were intimated by the hospital, though called for during Audit. GoR stated (February 2019) that no fees was charged for tests under MNJY. Only few special tests which were not covered under MNJY were charged. The reply is not tenable because the accounts reflect charging of tests which were free under MNJY.

(ii) Bio Medical Waste Management

Bio Medical Waste (BMW) is generated by hospitals and other health providers during diagnosis, treatment, immunization of human beings. BMW consists of discarded drugs, waste sharps, microbiological and biotechnological waste, human anatomical waste, etc. Scrutiny of records in MDM Hospital, Jodhpur revealed the following:

- ***Improper segregation, storage, transportation and disposal:*** Rule 8 (1) of BMW Rules, 2016 provides that no untreated BMW shall be mixed with other wastes, while Rule 8 (2) provides that BMW shall be segregated into containers or bags at the point of generation in accordance with Schedule I of Rule 8 prior to its storage, transportation, treatment and disposal. It was,

[53] X-Ray: ₹ 12.00 lakhs, ECG: ₹ 0.16 lakh, Dialysis: ₹ 3.67 lakh, Sonography: ₹ 0.07 lakh.

however observed that segregation of BMW at the point of generation as per color coding was not done properly. BMW was kept in open spaces outside the dumping station in common containers without prescribing the color coding. Being in open space, there was no restriction on contact with BMW by stray animals or unauthorized persons entering the vicinity, increasing the risk of contamination. It was also found that BMW was being mixed with Municipal Solid Waste (MSW). GoR stated (February 2019) that a committee was formed to govern the segregation, storage and transportation of bio medical waste. At present, bio medical waste after segregation was being sent to Keru dumping station. The contention of GoR was not found correct as the waste was not being segregated even as of 11 January 2019.

- ***Improper arrangement for autoclaving of sharp waste:*** According to Schedule I of the Rule 8, needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades or any other contaminated sharp object that may cause puncture shall be stored in white (Translucent) disposal bag and autoclaved. It was, however observed that sharp waste was not being segregated at generation point (Ward, laboratory, and Operation theaters etc.) due to absence of white containers/bags. As a result, sharp waste was not being treated despite the availability of an Autoclave. Thus, it was lying idle and not being utilised for treatment of sharp waste as prescribed in rules.

- ***Absence of Effluent Treatment Plant (ETP):*** As per BMW Rules, 2016, ETP was to be established in a hospital for treatment of liquid wastes. However, it was not established in MDM hospital as of March 2018. As a result the infected sewage generated in the hospital consisting of three kinds of contamination, bacterial, nuclear and chemical wastes, was being discharged directly into the public sewer system. A similar issue was also pointed out in paragraph 2.4.1 the 'CAG's Audit Report on General and Social Sector for the year ending on 31 March 2013'. Public Accounts Committee recommended (June 2015) that all the deficiencies pointed out by Audit may be rectified. GoR stated (February 2019) that the matter was under process. However, the fact remained that despite instructions of PAC, the deficiencies have not been addressed for more than three and a half years.

(iii) Poor Ambulance Services

Indian Public Health Standards for district hospitals prescribe at least four ambulances fully equipped with basic life support equipment (oxygen cylinder, ventilator, defibrillator etc.) for hospital having 301 to 500 beds. Further, serviceability and availability of equipment and drugs in the ambulance needs to be ensured through checking on daily basis.

Though eight ambulances were available in MDM hospital as of March 2018, none of the ambulances were equipped with life saving equipment. Thus, none of the available ambulances were able to extend life saving support to the patients in emergency and were being used merely as a transport vehicle.

GoR stated (February 2019) that new advanced life support (ALS) ambulance has been purchased and will be delivered to hospital soon. However, it was not delivered as of March 2019.

(iv) Mortuary services

A Mortuary unit of the Department of Forensic Medicine and Toxicology is functioning in the hospital which attends to medico legal cases including postmortem on dead bodies. Five cold storages for accommodation of 24 dead bodies were provided in the mortuary. Joint physical inspection of the mortuary revealed the followings:

- Building was below the road level due to which there was stagnation of rain water.
- Demonstration gallery for students was found in dilapidated condition increasing the risk of injury for students entering the gallery.
- Three out of five cold storage units (12 chambers) were found to be out of order.
- Unit Head in a letter to the Superintendent, stated that the viscera shelf needed to be repaired and a separate viscera room for keeping viscera samples was required.

GoR accepted the facts and stated (February 2019) that renovation work of Mortuary was under progress and Viscera room was also under construction.

(v) Dietary Services

As per norms prescribed by MCI, central kitchen should be commodious (spacious), airy, sunny and clean with proper flooring and with exhaust system. It should be provided with proper and clean working platforms. The services trolleys should cater for hot food and should be covered and made of stainless steel. It is also stated that services of qualified dietician are essential to prescribe diet on scientific lines for different types of patients.

Scrutiny of records revealed that sufficient utensils, trolley, staff etc., were not available in the hospital kitchen to provide meals to the patients. The meals were not served with due hygiene as the cook/serving staff did not wear head masks and gloves etc., during cooking/serving of food to the patients. Further, during 2013-18, no dietician was posted to prepare diet chart for the patients.

Cook/serving staff not wearing masks and gloves etc. in the hospital

GoR accepted (February 2019) that the post of dietician was vacant. However, the cook maintained hygiene of the food. The reply was not tenable as the instruction regarding wearing of head masks and gloves by the cook/serving staff at the time of cooking/serving of food to the patients, was not found adhered to during physical inspection by Audit.

(vi) Laundry Services

As per MCI Norms B 2.5 (Amended up to August 2017) for 250 P.G. Seats, the Central Mechanical laundry shall be provided with bulk washing machine, Hydro-Extractor, flat rolling machine. Further, laundering of hospital linen shall satisfy two basic considerations, namely, cleanliness and disinfection. The Principal & Controller of the Medical College, also directed (May 2017) to use different colour bed sheets on different days of the week to ensure that bed sheets are changed every day. Physical inspection of 33 wards (June-July 2018) revealed that bed sheets were being changed according to prescribed color. During patients survey IPD patients also confirmed the cleanliness of bed sheets and there was no complaint in this regard.

3.7.3.3 Auxiliary services

Auxiliary Services in a hospital are those services which are not directly related to healthcare but contribute to facilitate the delivery of healthcare services. Services such as patient registration, patient safety, transportation, stores etc., are generally included under auxiliary services. Audit scrutiny of delivery of these services revealed the following:

(i) Patient registration

- ***Insufficient registration counters for Patients:*** Registration of patients is the first step for getting healthcare facilities in hospitals. In 2017, on an average 3,250 patients visited the hospital daily. Scrutiny of records revealed that there were ten counters in the hospital for registration of patients. Further, a patient survey of 142 patients was conducted wherein 74 patients reported waiting time of 15 minutes, 29 patients reported waiting time of 15 minutes to 30 minutes, 28 patients reported waiting time of 30 minutes to one hour and 11 patients reported waiting time of one hour to two hour. Further, complete information i.e., age, gender, address, category, occupation, status, mobile number etc., of patients was not being noted at the registration counter. These facts indicated that the number of counters were not sufficient to handle the volume of work.

GoR accepted (February 2019) the facts and stated that registration counters would be increased as per availability of staff. Further, implementation of integrated Health Management System (iHMS) was under process, which would enable the patients to register themselves online and to access the reports personally on computer/mobile.

- ***Drug Distribution Counters not increased with increasing patient load:*** 14 Drug Distribution Counters (DDCs) were established in the hospital to distribute the medicines free of cost to the patients under *Mukhyamantri*

Nishulk Dava Yojana (MNDY). The scheme was started in October 2011. Scrutiny of records revealed that the total number of patients increased from 7.38 lakh to 11.85 lakh during 2012-17. Also, 42 (29.58 *per cent*) out of 142 patients surveyed, reported that they had to wait for more than 30 minutes to get the medicines from DDCs. However, the Hospital did not plan to increase the number of DDCs to cater for the increasing patient load. GoR stated (February 2019) that proposals for additional DDCs would be taken up.

(ii) Patient safety

- ***Legal requirements for laboratory equipment:*** Safety code issued by Atomic Energy Regulatory Board (AERB) stipulates that to operate diagnostic X-Ray/X-Ray equipment, the hospital would obtain the license for operation and provide radiation protection devices such as protective lead glass viewing window, barrier, apron, goggles and thyroid shields, ceiling suspended glass, couch hanging flaps, gloves etc.

It was, however observed that 9 out of 11 X-Ray machines (81.82 *per cent*) were operating without obtaining AERB registration. However, these nine machines got AERB registration in October 2018 at the instance of audit. Further, Radiology department neither had protective lead glass viewing window nor protective door in the X-ray rooms. Thus, radiology laboratories are functioning without adherence to AERB safety codes thereby exposing the patients and technicians to harmful radiations. GoR assured (February 2019) that lead goggle and lead thyroid shield would soon be procured by the hospital.

- ***Fire Safety Certificate of Hospital not obtained:*** As per instructions of Ministry of Health and Family Welfare, Government of India issued in November 2016, 'No Objection Certificate/Fire Safety Certificate' should be obtained from the Local Authorities/Fire Department in public interest. Scrutiny of records revealed that the MDM hospital did not initiate any action to obtain Fire Safety Certificate from fire department though fire extinguishers were installed in various wards/departments. Further, eight out of 44 test checked wards did not have fire extinguishers including Emergency Medical ward where an incident of fire occurred in 2016. It was also observed that no staff in wards were provided training to operate the firefighting equipment during 2013-18. GoR assured (February 2019) that fire extinguishers would be procured and provided to all departments and fire safety certificate would also be obtained.

3.7.4 General Administration and Financial management

The Principal and Controller (P&C) of Dr. SN Medical College, Jodhpur is controller of the hospital and is responsible for planning and budgetary controls of the hospital. MDM Hospital, Jodhpur is headed by Superintendent, who is responsible for delivery of healthcare services in the hospital. In addition, Rajasthan Medicare Relief Society (RMRS) has been formed in every government hospital to strengthen and modernise the healthcare services and provide them at nominal cost to the patients.

3.7.4.1 Financial management

To meet the general administrative expenses of the hospital and for implementation of various schemes[54], funds are allotted annually from the state budget to the teaching hospitals through controlling Medical colleges. During 2013-18, funds to the tune of ₹ 265.00 crore were allocated to MDM Hospital through Dr. SN Medical College, Jodhpur under various heads[55] and ₹ 265.81 crore were incurred on the items as detailed in **Table 17**.

Table17

(₹ in crore)

Year	Allotment	Total Expenditure	Salary and General Establishment (*per cent*)	Contractual Services[56] (*per cent*)	Repair and Maintenance (*per cent*)	Drugs and Medicine (*per cent*)	Diagnosis/ Investigations (*per cent*)
2013-14	34.15	35.31	22.63(*64.09*)	3.34(*9.46*)	0.70(*1.98*)	7.97(*22.57*)	0.67(*1.90*)
2014-15	39.49	39.95	25.41(*63.60*)	4.22(*10.56*)	0.74(*1.85*)	7.94(*19.88*)	1.64(*4.11*)
2015-16	54.56	55.16	34.46(*62.47*)	5.22(*9.46*)	1.00(*1.81*)	11.61(21.05)	2.87(*5.21*)
2016-17	62.62	62.11	38.41(*61.84*)	5.79(*9.32*)	1.07(*1.72*)	13.79(*22.21*)	3.05(*4.91*)
2017-18	74.18	73.28	43.70(*59.63*)	6.30(*8.60*)	1.21(*1.65*)	18.79(*25.64*)	3.28(*4.48*)
Total	**265.00**	**265.81**	**164.61(*61.93*)**	**24.87 (*9.36*)**	**4.72(*1.77*)**	**60.10 (*22.61*)**	**11.51(*4.33*)**

Source: information provided by MDM hospital, Jodhpur

It can be seen from the above table that:

- A major portion of budget allocation was incurred on 'Salary, General Establishment and contractual services' during 2013-18, which constituted 71.29 *per cent* of total expenditure.

- There was only a marginal increase in expenditure on drugs & medicines whereas decrease on repair and maintenance of hospital assets during 2013-18, as compared to increase in patient load by 60.57 *per cent.*

Under Capital head, ₹ 47.56 crore was allotted for 17 works[57] of which 13 works were completed at expenditure of ₹ 48.91 crore during 2013-18. Four works[58] were in progress as of March 2019.

Audit observed that only two proposals of major civil works were sent by the hospital to the college during 2015-16 and those works that were announced in annual budgets were undertaken. Though, seven works were undertaken for improvement of hospital facilities but they were on the basis of directions of the High Court (May 2013 to March 2015) regarding a public interest

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54 *Mukhyamantri Nishulk Janch Yojana* (MNJY) and *Mukhyamantri Nishulk Dava Yojana* (MNDY).

55 State general budget: ₹ 189.24 crore, MNJY: ₹ 27.86, MNDY (RMSCL): ₹ 40.00 crore and MNDY (MDM): ₹ 7.90 crore.

56 Outsourcing of security guards and contract for housekeeping and cleanliness.

57 Three works sanctioned prior to 2013-14, two works announced in annual budget 2013-14, seven works undertaken in 2014-15 under public interest litigation, two works (2015-16) and three works under budget announcement (2017-18).

58 Development work for renal transplant facilities, new building of cath lab, extension of mother and child wing and construction of trauma centre.

litigation. On being enquired, department stated (January 2019) that, due to budget ceiling, proposals for new works were not sent during 2015-18.

3.7.4.2 Non approval of Master Plan

Planning in respect of expansion, upgradation of existing facilities and other requirements of the hospital is essential to ensure continuous and improved access to quality healthcare services to all the persons visiting the hospital.

It was, however observed that no short term or long term plan was approved for expansion of MDM Hospital (under Dr. SN Medical College) during 2013-18, especially in view of the continuously increasing patient load. Accepting the facts that extension of Medical College and all attached teaching hospitals had been done on *ad hoc* basis and expansion of various departments was done without any prior planning. The Government of Rajasthan (GoR) in Budget 2015-16 announced that all future expansion of Medical Colleges and teaching hospitals would be through a Master Plan.

MDM hospital prepared and sent (December 2015) the proposal to Dr. SN Medical College. Though Dr. SN Medical College submitted (October 2016) its Master plan for all attached hospitals for approval of GoR, however, the approval was awaited as of February 2019.

3.7.4.3 Management of revenue generating services

Rajasthan Medicare Relief Society (RMRS) collects the user charges like patients registration fee and diagnosis charges for high end diagnostic services (MRI and CT Scan etc.) from the patients. RMRS also maintains the assets (Shops, Canteen and Parking spaces) of the hospitals and leases them on rent. Funds collected by RMRS are utilised where the budget allocated by the GoR is insufficient or the budget is not available, as an additional amount for procurement of x-ray films, CT films, kits and chemicals; repair, maintenance and purchasing of various machines and equipment; construction, renovation and repair of building etc., as per the RMRS Revised Rules, 2007.

Two important schemes i.e. *Bhamashah Swasthya Bima Yojana* and *Mukhyamantri Jeevan Raksha Kosh* are also implemented through RMRS. During 2013-17, total income and expenditure of RMRS was ₹ 14.11 crore and ₹ 12.90 crore respectively, leaving an accumulated surplus of ₹ 1.21 crore. The Management of RMRS did not draw a plan to utilize this surplus accumulated during 2013-17.

Further in following cases, RMRS was not realizing the revenue from the assets leased/rent out.

- Two shops established for OPD registration in hospital premises were let out for *e-Mitra* centres to private operators in 2011 without an agreement. Though the operators were conducting commercial activities but no rent was charged from them since 2011.

- A private chemist shop was also running in the premises of hospital without any agreement and no rent was recovered from the shopkeeper during 2013-18.

- A piece of land was allotted by GoR during 1985 to a trust for construction and operation of a Dharamshala without any Memorandum of Understanding. However, the trust let out three shops to the chemists in the Dharamshala without any approval of the hospital management. The trust was not depositing the rent realized from the chemists to the hospital.

GoR stated (February 2019) that notices have been issued to all shopkeepers to vacate the shops. The fact remains that RMRS was not able to collect potential revenue from the various hospital assets which could have been utilised for betterment of hospital services.

3.7.4.4 Incomplete implementation of 'Arogya Online'

Hospital Management Information System (HMIS) also known as 'Arogya Online' project was initiative by GoR for better delivery of healthcare through automation. The Arogya Online software was to manage critical health related data of Hospital operations including vital records of patients and providing solution to support the Hospital administration through sharing of information. The project was planned (September 2011) to be implemented in two phases and a total of 28 modules (13 core clinical modules[59], 11 Back office modules[60] and four miscellaneous modules[61]) were required to be developed within 12 months i.e. by August 2012.

It was however noticed that two out of 13 core clinical modules, eight out of 11 back office modules and three out of four miscellaneous modules were not developed even as of March 2018. Due to non-development of these modules, hospital operations scheduled for computerisation in respect of these modules were done manually.

GoR stated (February 2019) that Arogya Online project was planned in 2011 and as of now a higher version i.e. iHMS in place of Arogya online has been taken up which is under process of implementation.

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[59] (i) Registration (ii) Emergency (iii) Out Patient Management (iv) Pharmacy Management (v) Billing (vi) Investigation (vii) In patient Management (viii) Operation Theatre (ix) Patient Medical Record (x) Diet Kitchen (xi) Blood Bank (xii) Enquiry and (xiii) User Management.

[60] (i) Store Management System (ii) Procurement & Purchase (iii) Central Sterile Services (iv) Personnel Information System (v) Finance Management System (including RMRS and Lifeline) (vi) Bio Medical Waste/Housekeeping (vii) Transport (viii) Linen/Laundry (ix) Bio Medical Engineering Department (x) Administrative Module and (xi) Appointment and Roster Management.

[61] (i) Right to Information Module (ii) Health Portal (iii) File Tracking System (FTS) and (iv) Library Management System.

3.7.4.5 Patient Feedback Mechanism

For improvement in the healthcare services, it is necessary to maintain mechanism to get feedback from patient regarding satisfaction and suggestions.

It was observed that no mechanism to get feedback from patients regarding satisfaction, grievances, redressal thereof etc., for further improvement in the healthcare services provided by the hospital, was in existence. It was also observed that no complaint register was maintained in the hospital during 2013-18. In the absence of any record regarding feedback from patient, Audit could not ascertain the response of hospital administration to resolve the patient specific issues and grievances. GoR stated (February 2019) that instructions to get feedback from patients about hospital services have been issued. Further, a complaint box and complaint register were being kept at main enquiry of the hospital.

3.7.4.6 Physical verification of stores not conducted

As per rule 12(1) of General Financial and Accounts Rules (GF&AR) Part-II, physical verification of all stores is required to be conducted at least once in a year. Scrutiny of records however, revealed that physical verification of the stores was not conducted during 2016-18. Further, reconciliation of items (Machinery, Equipment, Tools and Plants) as per stock register with the items actually installed in various departments/wards was also not done. Accordingly, physical availability and disposal of unserviceable articles could not be verified by Audit. GoR stated (February 2019) that instructions for physical verification of stores had been issued in December 2018.

3.7.4.7 Prescription Audit

An Audit of one *per cent* of the total prescriptions issued by the doctors in the hospital was to be conducted by a committee at the medical college level. It was however observed that neither was a committee constituted by the medical college nor was the prescription audit carried out in the hospital during 2013-18. Only after being pointed out by Audit, GoR constituted (December 2018) a three member committee for prescription audit.

3.7.5 Conclusion

Mathura Das Mathur (MDM) Hospital, Jodhpur is the largest hospital in the western region of Rajasthan providing referral and tertiary healthcare services. Though, the number of patients increased from 7.38 lakh to 11.85 lakhs during 2012-17, the augmentation of its facilities was not commensurate to the increasing load of patients. Resource management was weak as Operation Theaters (OTs), Intensive Care Units (ICUs) and wards suffered from many infrastructural deficiencies and shortages of Medical Officers and nursing staff. Beneficiaries were deprived of free drugs as all the essential drugs were not available. Due to insufficient resources, various important hospital services like number of OPD days in a week, consultation time per patient and diagnostic services suffered. The hospital was not following the

legal/regulatory requirements regarding management of bio-medical waste, patient safety and hospital safety.

Thus, mismanagement of resources of the hospital coupled with weaknesses in planning and monitoring resulted in deficiencies in the services being provided to the beneficiaries.

Recommendations:

GoR should

1. *Take adequate initiatives to increase the number of units in the departments wherever necessary, to address the increasing patient load.*

2. *Ensure adequate availability, timely repair and maintenance of prescribed medical equipment in ICUs, OTs, wards and laboratories so that equipment downtime is minimized and services are rendered to the patients without any hindrance.*

3. *Ensure effective inventory management to maintain adequate and regular supply of essential drugs and reagents through stores and Drug Distribution Counters so that no beneficiary is deprived of free medicines and diagnostic tests.*

4. *Adopt defined service quality indicators and benchmarks so that healthcare outcomes can be measured and assessed for future improvements.*

5. *Increase the awareness amongst the beneficiaries of the Janani Suraksha Yojana, Mukyamantri Shubhlaxmi Yojana and Mukyamantri Rajshree Yojana so that they are able to avail of all benefits (by providing complete bank details etc.) under these schemes.*

Animal Husbandry, Gopalan and Co-operative Departments

3.8 Activities for Dairy Development in Rajasthan

3.8.1. Introduction

After agriculture, animal husbandry is the most important source of livelihood in the state. Animal husbandry which includes cattle and other livestock, contributes over 11 *per cent* to the gross state domestic product. Rajasthan has the second highest livestock population and contributes 12.72 per *cent* of all milk production making it the second largest milk producer state in India. During 2017-18, 1.65 crore milch animals produced 2.24 crore tonnes of milk in the state. During the year 2017-18, Rajasthan had 834 gram per capita per

day availability of milk against 375 gram per capita per day availability of milk in India.

Animal Husbandry Department (AHD) in co-ordination with Rajasthan Livestock Development Board[62] (RLDB), *Gopalan* Department and Rajasthan Co-operative Dairy Federation[63] (RCDF), implements the schemes for livestock and dairy development. As regards the activities of the dairy sector, the milk is procured, processed and marketed through a three tier Co-operative structure i.e. RCDF at apex level, 21 milk unions[64] at district level and 14,496 dairy co-operative societies at the village level.

The main scope of Audit was to examine the efficiency and effectiveness of the schemes/activities implemented for dairy development in the state over the period 2013-18. Seven[65] districts were selected for examination using Simple Random Sampling without Replacement method. Records of the offices of Joint Director (AHD), veterinary hospitals, regional/district disease diagnosis laboratories, cattle feed plants, semen banks, milk unions and control mechanism of the Registrar of Co-operative Societies were examined during the period April to August 2018.

3.8.2 Audit Findings

The results of Audit are discussed in the succeeding paragraphs:

3.8.2.1 Inadequate planning and financial support from GoR

(i) Inadequate planning: Government of Rajasthan (GoR) formulated (March 2010) Livestock Development Policy, which underlined a vision to procure and market 50 lakh kgs of milk per day by the year 2020. RCDF separately approved (February 2014) Vision Document 2020 aimed at achieving a collection of 40 lakh litre of milk per day and marketing of 35 lakh litre of liquid milk per day by the year 2020.

In this regard, it was observed that:

- The targets set by RCDF was not in consonance with that of livestock policy of 2010 as RCDF prepared its vision document independently without consulting the AHD. Further, the targets set were also inadequate in terms of the surplus milk production in the state and also in terms of the national average procurement achieved by co-operatives

[62] RLDB is the designated State Implementing Agency for implementing the centrally sponsored schemes for dairy and livestock sectors like the National Programme for Bovine Breeding, National Mission for Bovine Productivity and Risk Management & Insurance under National Livestock Mission.

[63] RCDF set up in 1977 as the implementing agency for dairy development programmes in Rajasthan and registered as a society under the Rajasthan Co-operative Societies Act, 1965.

[64] Milk union is a middle level co-operative society one each for one or more district. They procure, process and market the milk supplied by the dairy co-operative societies (village level) situated in their jurisdiction.

[65] Ajmer, Bharatpur, Bikaner, Jaipur, Jhalawar, Jodhpur and Udaipur.

across the country (10.40 *per cent* of the production) during the year 2017-18.

- Further, study/market survey was also not carried out either by AHD or by RCDF for finalising the procurement targets and for planning and implementation of projects/schemes for dairy development.

(ii) Inadequate financial support: With regard to financial resource management required for achievement of livestock policy, scrutiny of Five year plan, Annual plan and budget documents revealed that GoR did not make significant financial contribution for growth of dairy sector as detailed below.

- Scrutiny of the details of total grants received from GoR as well as from GoI under various schemes[66] and expenditure thereon during 2013-18 ***(Appendix 3.3)*** for livestock and dairy development revealed that against a grant of ₹ 883.64 crore, ₹ 573.25 crore (64.87 *per cent*) was contributed from GoI under various Centrally sponsored schemes through various heads of budget[67]. The contribution from GoR was only ₹ 310.39 crore (35.13 *per cent*) which included subsidy for incentivising milk producers under *Mukhya Mantri Dugdh Sambal Yojana* (₹ 157.05 crore), development of infrastructure under RKVY (₹ 83.56 crore), production and allied activities (₹ 32.66 crore) and livestock health & disease control (₹ 30.62 crore). An amount of ₹ 6.50 crore was allocated under *Devnarayan Yojana* for establishing a dairy plant at Khetri, Jhunjhunu. Thus, expenditure on creation of dairy infrastructure in the state was not significant. During 12th plan period (2012-17) the financial provision from GoR for dairy sector was a token provision of only ₹ 5000.

- Further, as per budget speech of 2012-13 and 2013-14, ₹ 133 crore was to be released as 'grant' to RCDF for creation of infrastructure[68] under dairy development initiative. However, it was observed that only ₹ 79 crore was released as an 'interest free loan' for five years to RCDF/Milk Unions. As a result, only one Cattle Feed Plant in Pali, one Powder Plant in Jaipur and 262 Bulk Milk Coolers (BMCs) could be established/taken up. Other infrastructure projects (one Chilling Plant, one Milk Plant, one Powder Plant and 238 BMCs) could not be established/taken up due to shortage of funds. As a result, the development of infrastructure required for enhanced procurement of milk was hampered.

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66 National Dairy Plan-I (NDP-I), *Rashtriya Krishi Vikas Yojana* (RKVY), National Programme for Bovine Breeding (NPBB), National Programme for Dairy Development (NPDD), Clean Milk Production (CMP), National Livestock Mission (NLM), Livestock Health & Disease Control (LH&DC), *Dugdh* Subsidy and *Devnarayan Yojana*.

67 2401-Crop Husbandry, 2403-Animal Husbandry, 2404-Dairy Development and 4225-Capital Outlay on Welfare of Scheduled Castes, Scheduled Tribes, Other Backward Classes and Minorities.

68 Cattle Feed Plant in Pali: ₹ 25.00 crore, Powder Plant in Jaipur: ₹ 40.00 crore, Chilling Plant in Ghadsana: ₹ 4.00 crore, 500 Bulk Milk Coolers: ₹ 40.00 crore, Milk Plant in Barmer: ₹ 4.00 crore and Powder Plant in Bhilwara: ₹ 20.00 crore.

From the above, it can be seen that GoR did not provide adequate financial support for creation of infrastructure and schemes of dairy development which was necessary in the light of lack of adequate existing capacities with the milk unions to handle the surplus production.

GoR's reply (January 2019) was silent on the facts mentioned above.

3.8.2.2 Inadequate growth in milk procurement and marketing

(i) The details of milk production, processing capacity, procurement and marketing in the state during 2013-18 are given below in **Table 18**:

Table 18

Year	Number of Registered DCSs	Number of Functional DCSs (*per cent*)	Production of milk (lakh kgs per day)	Milk processing capacity in lakh kgs per day (lakh litre[69] per day)	Target for procurement (lakh kgs per day)	Procurement of milk against the target in lakh kgs per day (*per cent*)	Marketing of milk lakh kgs per day (lakh litre per day)
2013-14	12,875	8,298 (*64.45*)	399.26	19.53 (19.00)	22.70	22.45 (*98.90*)	18.09 (17.60)
2014-15	13,492	8,777 (*65.05*)	463.95	20.10 (19.55)	26.94	25.45 (*94.47*)	19.08 (18.56)
2015-16	13,878	8,778 (*63.25*)	506.85	20.92 (20.35)	29.23	26.01 (*88.98*)	19.35 (18.82)
2016-17	14,193	8,725 (*61.47*)	571.22	20.92 (20.35)	30.45	25.68 (*84.33*)	19.63 (19.10)
2017-18	14,496	8,804 (*60.73*)	614.44	20.92 (20.35)	35.17	28.45 (*80.89*)	20.66 (20.10)

It can be seen from the above table that:

- Milk production in Rajasthan increased from 399.26 lakh kgs per day in 2013-14 to 614.44 lakh kgs per day in 2017-18 i.e. 53.89 *per cent*. However, the milk procurement by RCDF and its milk unions grew only by 26.73 *per cent* during 2013-18 i.e. from 22.45 lakh kgs per day in 2013-14 to 28.45 lakh kgs per day in 2017-18.

- The achievement of milk procurement against the annual target set by RCDF also declined from 99 to 81 *per cent* during 2013-18.

It was further noticed in audit that the percentage of milk procurement to milk production in fact fell from 5.62 to 4.63 *per cent* during 2013-18. Interestingly, procurement of milk to milk production during 2013-18 was even less than the level of 6.44 *per cent* which RCDF achieved during 2004-05. This was mainly due to low processing capacity of the milk unions as can be seen from the **Table 18** that the milk processing capacity of all the milk unions combined remained almost stagnant between 19.53-20.92 lakh kgs per day during 2013-18.

GoR stated (January 2019) that the level of milk procurement has reached 28.45 lakh kgs per day in 2017-18 from 22.45 lakh kgs per day in 2013-14, which shows that 27 *per cent* positive growth was recorded despite having constraints of processing facilities. It also stated that the total milk handling

[69] One litre of milk=1.028 kg milk

capacity would increase to 43.48 lakh kgs per day {42.30 lakh litre per day (*llpd*[70])} by 2019-20.

The reply is not convincing as growth of 27 *per cent* by milk unions during 2013-18 did not keep pace with growth in milk production (53.89 *per cent*) during this period as well as with the expected levels in consonance with national average (10.40 *per cent* of the production of milk). Even assuming the achievement of procurement of 43.48 lakh kgs per day by the year 2020, the procurement would still be substantially lower (only 7.08 *per cent*) even in comparison to the production of milk in 2017-18.

(ii) The Dairy Co-operative Societies (DCSs), at the village level, form the last mile collecting points for milk procurement. During 2013-18, RCDF had set targets to establish 5,864 new DCSs and register 2.79 lakh new members. However, it could establish only 1621 (27.64 *per cent*) DCSs and register 1.03 lakh (36.92 *per cent*) new members. Further, against target of 1000 women DCSs as announced in budget 2017-18, only 248 new women DCSs were established. Moreover, an average of 37.07 *per cent* of the total DCSs registered in the state remained non-functional during 2013-18 mainly due to their operational/financial non viability and conflict/dispute within the DCSs.

Thus, RCDF and milk unions failed to take effective measures to expand the number of registered as well as functional DCSs and to increase the number of milk producing members. This affected the procurement of milk from the DCSs and the overall procurement in the state.

RCDF stated (November 2018) that targets for establishment of new DCSs were fixed on higher side, hence the achievement are less. The target for 1000 new woman DCSs could not be achieved due to newly introduced system of online registration and villagers are facing constraint in registering new women DCS. However, the fact remains that GoR/RCDF could not expand the number of registered as well as functional dairy co-operatives to the expected levels in consonance with higher production of milk in the state.

3.8.2.3 Inadequate capacity expansion and marketing against milk procurement

Para 3.6 of National Livestock Policy (April 2013) stated that major share of marketable surplus of milk and other livestock products were not being handled adequately by organized processing industry, resulting in reduced price realization by farmers and post production losses and wastages. In this regard, scrutiny of milk processing capacity, marketing and procurement pricing followed in the state, revealed the following:

(i) ***Processing capacity:*** A detailed analysis of procurement, processing and marketing of milk by the largest dairy i.e. Jaipur milk union, during 2013-18 is given in **Table 19**.

[70] After the enhancement of the processing capacity of milk unions at Jaipur (10 *llpd*), Ajmer (8 *llpd*), Pali (2.4 *llpd*), Udaipur (0.9 *llpd*) Chittorgarh (0.4 *llpd*) and Sikar (0.25 *llpd*).

Table 19

S. No.	Year	Existing Processing Capacity of Plant (litre per day)	Average Milk Collection/ Procurement (kg per day)	Average Milk Collection/ Procurement (litre per day)	Capacity Utilization (*per cent*)	Average Milk Marketing (litre per day) except Milk Products
1.	2013-14	5,00,000	9,06,000	8,81,323	176.26	8,08,000
2.	2014-15	5,00,000	9,58,000	9,31,907	186.38	8,41,000
3.	2015-16	5,00,000	10,26,000	9,98,054	199.61	8,57,000
4.	2016-17	5,00,000	10,61,000	10,32,101	206.42	8,66,000
5.	2017-18	5,00,000	11,36,000	11,05,058	221.01	8,99,000

It is evident from above table that annual procurement of milk of Jaipur milk union grew from 8.81 lakh litre per day (*llpd*) in 2013-14 to 11.05 *llpd* in 2017-18 (25.39 *per cent*). During the period, Jaipur Dairy marketed 8.08 *llpd* to 8.99 *llpd* of milk. However, during this period the annual capacity to process the milk procured remained static at 5 *llpd*. Neither RCDF nor the milk union took measures to expand the processing capacity of milk. Due to significantly low processing capacity of Jaipur Dairy, RCDF had to make arrangements from time to time for outsourcing facilities for packing of milk, conversion of milk to Skimmed Milk Powder (SMP) and ghee. Only in December 2014, efforts were taken by Jaipur milk union to add an additional processing capacity of 10 *llpd*, which was still under progress (September 2018) (elaborated in ***paragraph 3.8.2.5(i)***).

Similarly, milk unions of Ajmer, Alwar, Ganganagar, Kota, Sikar and Udaipur had capacity utilization ranging between 130 to 313 *per cent* during the years 2013-18. However, proposals to enhance the capacity of dairy plants for these milk unions were not submitted to GoR/GoI by RCDF. This shows that they were outsourcing the handling of milk without taking measures to expand their capacity. GoR's reply was silent on the facts mentioned above.

(ii) Marketing: Indian Council of Medical Research (ICMR) recommended 280 grams for per capita per day consumption of milk. This implied that there was a minimum average demand of 280 grams per day per capita in urban areas which get their milk supply from rural areas and this should have been tapped by the milk unions to market packaged milk.

A comparative analysis of performance of milk unions established in seven test checked divisional headquarters ***(Appendix 3.4)*** shows that no milk unions could market milk to the level of per capita basic consumption needs despite having enough milk production in their jurisdiction. Only Jaipur milk union could come nearer (226 to 252 grams per capita) in terms of procurement and marketing milk in consonance with minimum per capita demand of milk. Milk unions of Bharatpur, Jodhpur, Kota and Bikaner could market only less than 100 grams of milk per capita per day despite having adequate production in their jurisdiction.

GoR stated (January 2019) that the dairy development could not be equal in all the districts of the State. However, the fact remained that the milk unions

failed to tap into the existing demand despite having surplus milk production in their jurisdictions.

(iii) Pricing: RCDF's bye law 26.16 prescribed for preparation of pricing policy by the Board. It also provided for the programming committee to recommend prices of raw materials and/or finished products and review them periodically. It was observed that there was no pricing policy prepared by RCDF as discussed in ***paragraph 3.8.2.4(i)***. Scrutiny of procurement pricing followed by each milk union for the last five years in the month of March is given in **Table 20**.

Table 20

(Amount in ₹ per kg)

S.No.	Milk Union	March 2014	March 2015	March 2016	March 2017	March 2018
1	Ajmer	39.00	32.45	33.09	39.60	35.01
2	Alwar	39.40	34.56	33.75	40.25	33.19
3	Banswara	32.94	30.17	28.41	36.93	35.07
4	Barmer	28.03	25.59	25.01	27.89	24.03
5	Bharatpur	38.58	30.12	31.19	38.72	31.50
6	Bhilwara	28.68	27.58	26.82	30.39	25.35
7	Bikaner	24.99	20.88	18.86	25.56	**20.01**
8	Chittorgarh	30.32	30.74	29.73	34.47	32.21
9	Churu	28.94	25.13	23.63	29.15	25.00
10	Ganganagar	30.51	24.58	24.12	30.54	23.89
11	Jalore	31.83	30.86	28.25	35.85	32.47
12	Jaipur	34.98	31.35	30.99	36.11	33.75
13	Jhalawar	31.67	28.57	27.56	31.86	31.56
14	Jodhpur	26.61	26.28	25.84	28.08	27.18
15	Kota	31.57	31.48	28.90	34.47	32.22
16	Nagaur	31.11	28.82	27.74	35.32	27.15
17	Pali	31.38	33.50	30.29	35.74	33.36
18	Sikar	34.86	29.29	26.60	31.58	26.88
19	Sawaimadhopur	34.32	32.00	33.81	37.08	34.87
20	Tonk	36.63	34.38	34.68	41.97	**37.15**
21	Udaipur	30.65	30.99	29.15	34.87	32.20

It can be seen from table above that there was significant difference in procurement price of milk in milk unions during the same period. For instance in March 2018, the price of milk per kg varied from ₹ 20.01 in Bikaner to ₹ 37.15 in Tonk.

Further, the procurement prices of milk in Ajmer, Alwar, Barmer, Bharatpur, Bhilwara, Bikaner, Churu, Ganganagar, Jaipur, Jhalawar, Nagaur and Sikar were on lower side in March 2018 in comparison to prices of March 2014 inspite of the fact that wholesale price index for milk increased by 20.43 *per cent* from 116 points in 2013-14 to 139.7 points in 2017-18. Thus, it appeared that there was no consistency and pattern visible in the pricing followed by the unions due to which neither did the dairy farmers get remunerative prices for their milk nor could the milk unions increase procurement to the expected levels.

GoR accepted (January 2019) the fact that there was no fixed pricing policy being followed by RCDF and its member unions. It also stated that the milk procurement price was being fixed by the milk unions at their own level as per

budget provisions, availability of milk, financial status of the milk union and marketing trend in the milk shed area and hence, the milk procurement prices were different for different milk shed areas. RCDF was just examining their proposals and giving consent for implementation.

However, the fact remained that the cost of production of milk was not taken into consideration which should have been considered to incentivize economic development of milk producers and the procurement prices of many milk unions remained lower than March 2014 prices.

3.8.2.4 Inadequate institutional and co-ordination mechanism

(i) Inadequate institutional mechanism

Dairy related activities in Rajasthan are mainly implemented by Rajasthan Co-operative Dairy Federation and its milk unions in co-ordination with the Animal Husbandry Department. Department of Co-operatives enforces control over RCDF and its unions through the Co-operatives Act. RCDF is run by a Board and executive functions are carried out by a Managing Director (MD) appointed by GoR. In this regard, it was observed in Audit that:

(a) Bye-law 26 of RCDF stipulated that the Board would decide policies for the functioning of RCDF including pricing policy for the dairy and allied products supplied by the members. Bye-law 27 stipulated that the Board would frame subsidiary rules for conduct of the business. Further, Bye-law 31.1 of RCDF also provided that a Programming Committee, consisting of MD of RCDF and MDs of 21 affiliated milk unions, would recommend for pricing of raw-materials & finished products, set terms & conditions for procurement, processing & marketing and also review them periodically.

It was observed that there was no subsidiary rules framed for day to day functions and no policy for fixing of price of raw materials and finished products. It was also observed that no recommendation was made by the Programming Committee during 2013-18 for prices of procurement of milk and processed products (except for occasionally deciding price of ghee). In the absence of such policies and subsidiary rules, it was left to the MD of RCDF to take critical decisions on procurement of milk & other raw materials; machineries & equipment; marketing milk & milk products and cattle feeds. Such important decisions were being taken on the basis of recommendations made by a General Manager Level Committee of RCDF in violation of bye-laws 31.1, which stipulated for decision making through a Programming Committee consisting of MD of RCDF and MDs of the 21 affiliated milk unions.

(b) Section 29 of the Rajasthan Co-operative Societies Act, 2001 provided that GoR would nominate three members to the management committee of the co-operative society. Further, two additional members having expertise in the fields of production, marketing, management etc., would also be nominated to the apex society i.e. RCDF. Bye-law 20.1 of RCDF also stipulated that maximum of two members from banking, management, finance or related fields would be co-opted by RCDF.

It was, however observed that neither GoR nor RCDF appointed two additional members having expertise in the related fields to the Board of RCDF. The fact that during 2013-18, RCDF did not pass any resolution to enhance dairy activities in the professional way {discussed in ***paragraphs 3.8.2.1, 3.8.2.3 and 3.8.2.5 (iii, vi-ix)***} needs to viewed in the light of the facts that RCDF lacked the necessary professional support in its Board of Directors.

GoR accepted the facts and stated (January 2019) that a proposal to this effect would be put up before the forthcoming meeting of Board of RCDF for decision and it also admitted that the polices and subsidiary Rules were not formulated which would be taken up in near future.

(ii) Inadequate co-ordination between AHD and RCDF

During course of audit all the audit requisitions and observations issued to GoR pertaining to long term policy/programme, perspective plan, five year plan, livestock survey, planning, schemes etc., for dairy development in Rajasthan were directed to RCDF. On the other hand, RCDF replied that they pertained to the domain of GoR.

It was also observed that except for the Secretary, AHD and the Deputy Secretary, Gopalan, there was no personnel posted in AHD to co-ordinate with RCDF on issues relating to dairy activities and therefore the Secretary was depending entirely on MD, RCDF to oversee dairy activities.

This shows that there was inadequate co-ordination between AHD and RCDF with regard to duties and responsibilities pertaining to dairy sector. It also raises question mark over their responsibility/ownership towards dairy sector development.

3.8.2.5 Implementation of schemes and activities of dairy/livestock development

(i) Deprival of central assistance of ₹ 56.25 crore under Rashtriya Krishi Vikas Yojana (RKVY)

A plant study of Jaipur Dairy was carried out (August 2014) by Jaipur milk union through National Dairy Development Board (NDDB), wherein it was proposed to enhance the plant capacity from existing 5 *llpd* to 15 *llpd* by installation of a new milk processing plant of 10 *llpd* capacity at an estimated project cost of ₹ 174.93 crore. The study envisaged payback period of five and half years even without any grant/support from GoI/GoR.

Accordingly, a proposal was submitted (January 2015) to GoR by Chairman, Jaipur milk union at their own level for sanctioning grant under RKVY as the RCDF did not take any initiative[71] for it. Subsequently, GoR forwarded the proposal to RCDF for examination. RCDF examined and resubmitted (May 2015) the proposal to GoR for an amount of ₹ 174.93 crore. The funding

[71] In consonance with basic objective to carry out activities for promoting the production, procurement, processing and marketing of milk and milk products for economic development of the animal husbandry/farming community.

pattern under RKVY was in the ratio of 60:40 between centre and state during 2015-16.

It was observed that the State Level Sanctioning Committee (SLSC) downgraded (June 2015) the project proposal into half to a cost of ₹ 87.46 crore without recording any justification. Due to this downgrade, Jaipur milk union was deprived of the benefit of central assistance under RKVY of ₹ 52.48 crore[72].

Similarly, two other projects of ₹ 9.50 crore and ₹ 3.06 crore for strengthening of Tonk Dairy Plant and Rehabilitation of Jhalawar Milk Union respectively were also halved and approved (2015-16) by SLSC for ₹ 6.28 crore (50 *per cent* of proposed amount) and thereby it deprived the benefit of central assistance of ₹ 3.77 crore to the concerned milk unions.

Thus, central assistance of ₹ 56.25 crore could not be availed for improvement of dairy sector under RKVY. No specific reply has been furnished by GoR.

(ii) Non establishment of Gokul Grams and In-Vitro Fertilization labs

GoI launched (December 2014) Rashtriya Gokul Mission (RGM) for development and conservation of indigenous breeds with an outlay of ₹ 2,025 crore for three years on basis of 100 *per cent* grants-in-aid to the states. The mission envisaged establishment of integrated indigenous cattle centres '*Gokul Grams*'. It was observed that proposals for establishment of *Gokul Grams* were not prepared and submitted to GoI by GoR, which resulted in deprival of central assistance necessary for development of indigenous breed in the state.

Similarly, under a sub mission of RGM 'National Mission on Bovine Productivity', GoI envisaged establishment of 50 labs for In Vitro Fertilization (IVF)/Multiple Ovulation Embryo Technology (MOET) including two in Rajasthan. Each lab was to be established at the cost of ₹ 5 crore. However, no proposal for establishment of IVF/MOET labs was prepared by GoR and submitted to GoI and it resulted in deprival of central assistance of ₹ 10 crore from GoI which could have been utilized to develop super elite animals from super embryos. GoR accepted the facts (January 2019).

(iii) Non completion of dairy plant at Khetri

RCDF submitted a proposal to Social Justice and Empowerment Department (SJED) for establishment of a dairy plant with a capacity of 25,000 litres milk per day at Khetri (Jhunjhunu district) at a cost of ₹ 6.50 crore[73] within a period of 30 months under *Devnarayan Yojana*[74] of GoR. Accordingly, SJED approved (June 2011) the proposal and AHD issued (August 2012 and March 2013) Administrative & Financial sanction of ₹ 6.50 crore and the amount was

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72 60 *per cent* of ₹ 87.46 crore.

73 Civil work: ₹ 2.00 crore, plant & machinery: ₹ 3.30 crore and working capital: ₹ 1.20 crore.

74 *Devnarayan Yojana* was implemented through SJED for welfare of Special Backward Classes.

released to RCDF. Subsequently, RCDF executed (November 2012) a MoU for ₹ 2 crore with Rajasthan Avas Vikas and Infrastructure Limited (RAVIL) for civil work with scheduled completion by February 2014.

It was observed that RAVIL completed the civil work with a delay of three years in July 2017 at a cost of ₹ 2.21 crore. Consequent upon increase in cost due to delay in completion of civil works, RCDF demanded (September 2017) additional funds of ₹ 3.40 crore from GoR for completion of dairy plant. However, additional amount was not sanctioned by GoR as of August 2018. RCDF also did not make efforts to supplement the shortfall from its own funds. As a result, the milk plant could not be made operational even after lapse of four and half years from the proposed completion period of the plant. Further, remaining amount of ₹ 4.29 crore was lying unutilized with RCDF for more than five years.

GoR while accepting the facts stated (January 2019) that RAVIL could not complete the work timely and due to which the cost involved to complete the project was escalated. Accordingly, RCDF decided to withdraw the work from RAVIL and recovered 10.48 lakh by imposing penalty as per MoU. It also stated that the work order for remaining civil work was awarded in September 2018, which is still under progress (March 2019) and supply order for machinery has also been issued.

(iv) Implementation of Brucellosis Control Programme

Brucellosis is second most important zoonotic disease after *Rabies* which poses bigger threat to human life. Brucellosis in humans occurs when a person comes into contact with an animal or animal product is infected with the *Brucella* bacteria. It had a prevalence of 3 to 5 *per cent* in Rajasthan. Brucellosis is also a serious disease of livestock and it causes decreased milk production, weight loss, infertility and physical deformities.

To contribute to the National Vision of " Brucella Free India", GoR submitted (July 2011) a project proposal to GoI under *National Control Program on Brucellosis for Surveillance & Vaccination* of ₹ 9.99 crore for five years. GoI released (September 2012) ₹ 0.90 crore for the year 2012-13 as first installment. The Brucellosis Control programme was to be run across the State in all 33 districts. In this regard, it was observed that:

- AHD utilized only ₹ 0.86 crore out of the sanctioned amount and that too, over four years during 2013-17 after getting revalidation of the sanction each year. As a result, it could not get subsequent installments from GoI.

- AHD carried out only 3.18 lakh (2.65 *per cent*) vaccinations of female calves against a bovine population which averaged 1.20 crore (between 1.06 to 1.34 crore) during 2013-18.

- While incurring expenditure under this programme, AHD did not take provision for procuring Lateral Flow Assay (LFA) kits to be used for detection of the disease among dairy farmers at their site. Only 90 such kits were procured in 2017-18, out of which 40 kits were used for testing

and 18 (45 *per cent*) samples were found to be positive indicating the importance of the test. In addition, the control strategy of obtaining a small sample from milk tanks of district dairies two to four times a year for evidence of brucellosis was also ignored in each district.

On enquiring by audit of the actual methodology/operational strategy adopted, AHD submitted (July 2018) figures of only 2017-18 wherein it was stated that 3458 samples of milk ring was tested, out of which 214 samples found positive. 9929 samples of rose bengal plate agglutination was tested, out of which 386 samples found positive.

Thus, there was ineffective and deficient implementation of Brucellosis Control Program in Rajasthan.

GoR stated (January 2019) that out of 10 components proposed in project, four components amounting to ₹ 3.70 crore were approved by GoI and only ₹ 0.90 crore was released. Hence, the expected physical and financial targets could not be achieved. The reply is not acceptable in view of GoR's inability to spend the released amount within a year and hence the subsequent installment was not released by GoI. Furthermore, despite being requested to specify the actual methodology/operational strategy adopted by AHD, the reply was silent on the issue. This also shows initial diagnostic strategy was weak.

(v) Irregularities in Frozen Semen Bank, Bassi

RCDF submitted (November 2013) a proposal to National Dairy Development Board (NDDB) for strengthening the capacity of semen production at FSB Bassi under National Dairy Plan-I. The project envisaged (i) making animals disease free within an area of 10 kms radius of frozen semen production area and (ii) increase in production of semen. NDDB approved (February 2014) the project for increase in semen production at FSB Bassi and released ₹ 11.12 crore. The project was completed in March 2017.

- It was observed that RCDF proposed to increase the number of bulls from existing 69 to 131 by 2016-17 to increase the semen production to 35 lakh straw. Though the number of bulls increased from 69 to 106 by 2017-18, however, FSB Bassi could not procure the targeted number of 131 bulls and the target of increase in semen production was not achieved even after incurring an expenditure of ₹ 10.53 crore. In fact, the semen production decreased from pre-project level of 27.27 lakh (2013-14) to 22.09 lakh semen straw in 2017-18.

- The project envisaged vaccination of animals around 10 kms radius of frozen semen production area and 9.74 lakh vaccinations for five diseases by AHD for control of diseases like Foot & Mouth disease, Hemorrhagic septicemia, Black quarter, Brucellosis, Theileriosis and Anthrax. RCDF was to co-ordinate with AHD for vaccination. However, only 4.41 lakh (45.28 *per cent*) vaccinations were carried out during 2014-18. Further, no vaccinations for Brucellosis and Theileriosis diseases were carried out.

Thus, RCDF could not achieve the goals of the project of increasing the production of semen. Further, prescribed quality standards for hygiene for frozen semen production could not be achieved thereby compromised the quality of frozen semen.

GoR replied (January 2019) that the bulls allotted by NDDB were not mature and it takes 1-3 years' time for them to yield semen and the number of bulls could not be increased due to change in the policy for including the indigenous breeds which slowed down the induction. Currently, the project was almost completed and the semen production was expected to increase. Further, the vaccination around 10 kms radius of FSB is being carried out on regular basis in co-ordination with AHD, GoR.

The reply is not acceptable as the policy changes had already taken place in 2014-15accordingly indigenous bulls could have been inducted during 2015-17 for strengthening the capacity of semen production. Further, the vaccinations were essential to maintain the quality of the semen production.

(vi) Non synchronized execution of work in Milk Powder Plant, Jaipur

GoR released (October 2013) an amount of ₹ 35 crore to RCDF as interest free loan for establishment of Milk Powder Plant of 30 MT capacity in Jaipur. Audit scrutiny of records of RCDF revealed that the tenders for procurement and installation of plant and machinery were invited in May 2013. However, despite the funds being available, the Notice Inviting Tender for civil work was issued only in April 2015 with a delay of one and half years. The civil work was awarded (August 2015) at ₹ 16.34 crore with scheduled completion by February 2018. Though the plants and machinery were supplied by May 2017, the civil works were not yet completed as of July 2018. As a result, plants and machinery could not be installed and it was lying idle. With regard to procurement of plant & machinery, MD approved the rate of M/s GEA at ₹ 21.71 crore on single tender basis, which needed approval of the Board of RCDF in accordance with the Rule 68 (2) of Rajasthan Transparency in Public Procurement (RTPP) Rules 2013. For the civil works, RCDF also approved additional works of ₹ 1.15 cores (executed by 8 February 2018) in respect of 22 items, each item ranging from 51 to 515 *per cent* in excess of that in the schedule 'G'. This was in violation of Rule 73 of the RTPP Rules 2013 which prevents any authority from approving excess quantity of items beyond 50 *per cent*. This also shows that the estimates for the above work were not prepared on realistic manner.

Thus, imprudent decision of RCDF in awarding the civil work after the order for plant and machinery, led to hurried procurement of plant & machinery and delay in completion of civil work. As a result, the powder plant was not yet commissioned even after lapse of five years. Further deterioration of plant & machinery lying idle could not be ruled out.

GoR stated (January 2019) that the civil structure for plant building could not be finalized before finalizing the tender for powder plant machineries, as there are various technologies for setting up powder plant. The additional civil work of ₹ 1.15 crore was executed after due approval from the concerned authority.

The reply is not convincing as after finalising the suitable prevailing technology and layout for plant and machinery, the civil construction work should have been carried out accordingly.

(vii) Undue benefit to distributors of ghee

Programming Committee of RCDF recommended (July 2015) for disposal of 2,689 MT (produced in January 2015: 1,100 MT and February 2015: 1,589 MT) of old stock of ghee by incentivising the distributors. Distributors were allowed 18 tins (of 15 kgs) free for every purchase of minimum 600 tins. The distributors lifted 1,46,667 tins ghee (2,200 MT) under this incentive scheme from 1 August 2015 to 19 August 2015 at the rate of ₹ 323 per kg. Consequently, they were provided 4,400 tins (66 MT) free of cost under the scheme. The scheme was closed on 20 August 2015.

Audit scrutiny revealed that incentive was given to the distributors without ultimate revision of Maximum Retail Price (MRP) of ghee. This amounted to undue benefit of ₹ 2.13 crore to distributors without passing on the benefit to consumers by reducing the MRP of ghee. Interestingly, after 14 days of the closure of the scheme, RCDF increased the MRP of ghee from 323 per kg (during the scheme period) to ₹ 333 per kg on 3 September 2015. Thereafter, RCDF again increased the MRP of ghee to ₹ 348 per kg on 5 October 2015 (45 days after closure of the scheme). Thus, RCDF revised MRP of ghee by ₹ 10 per kg and ₹ 15 per kg respectively within a short span of time (14 days and 45 days) which provided an opportunity to the distributors to sell ghee at the increased rates, thereby giving an advantage of upto ₹ 3.97 crore[75] to distributors.

Thus, RCDF passed on a undue benefit of up to ₹ 6.10 crore to distributors by incentivising distributors and increasing MRP in a short span of time. This decision taken by RCDF needs to be viewed in the light of the fact that there were no policies available for either procurement or marketing of milk and milk products.

GoR stated (January 2019) that the expiry period of ghee was nine months and stock of January and February 2015 was expiring in September and October 2015 which otherwise needed reprocessing for further use. Therefore, ₹ 10 per kg benefit was given as quantitative sale promotion without revising MRP in order to avoid higher reprocessing cost.

The reply is not convincing as there was sufficient demand (10,896 MT) during January to July 2015 just before introduction of the incentive offer. As such the balance stock (2,689 MT) of January and February 2015 could have been disposed of by July 2015 if the first in first out (FIFO) method was adopted for sale of ghee since it was a perishable commodity.

[75] 2,266 MT * (333 per kg+348 per kg)/2 (-) 2266 MT * 323 per kg = ₹ 3,96,55,000 (say ₹ 3.97 crore).

(viii) Unfruitful expenditure on capacity expansion of Cattle Feed Plant

During 2013-14, the production and sale of Cattle Feed Plant (CFP) Ajmer was 71,096 MT and 72,917 MT respectively with a daily capacity of 150 MT. Meanwhile, another cattle feed plant of 150 MT daily capacity was established at Lambiyakalan in November 2014, for the catchment area of Bhilwara district which earlier used to receive supplies from CFP, Ajmer.

Despite knowing this fact, CFP, Ajmer went for additional capacity expansion in March 2015, of another 150 MT per day. Notably, after enhancement of the capacity of CFP, Ajmer, the production during 2016-17 and 2017-18 declined to 56,304 MT and 66,026 MT respectively with corresponding sale of 57,170 MT and 65,793 MT. Thus, the capacity of Cattle Feed Plant was enhanced without need, resulting in an unfruitful expenditure of ₹ 6.28 crore.

GoR stated (January 2019) that in 2013-14, all the four CFPs of RCDF were running beyond their capacities and RCDF was facing problem in catering to the demand of milk unions and dealers network. Therefore, new CFP with 150 MT daily production capacity was established at Lambiyakalan (Bhilwara) in November 2014. Further, it was decided to expand the capacity of four existing old CFPs from 150 MT daily to 300 MT daily. The transportation cost for catering the demand of Bhilwara milk union has been reduced by establishment of new CFP at Lambiyakalan. The expansion of capacity at CFP, Ajmer was an asset for future use.

The reply is not convincing in view of fact that the demand of CFP, Ajmer was not re-assessed after establishing another plant in its catchment area and it could have been expanded at a later stage after demand analysis instead of enhancing capacities of all the CFPs.

(ix) Undue benefit to the advertising agency

M/s Proactive In & Out Advertising Pvt. Ltd., approached (July 2017) RCDF for display of advertisement of *Saras* brand on the side panels of 1,000 'Blue Line' buses of Rajasthan State Road Transport Corporation (RSRTC). The firm claimed that it was the sole licensee by virtue of an agreement with RSRTC. Advertising Agency also submitted a letter issued by Directorate of Advertising & Visual Publicity (DAVP), GoI, in which the Director General, DAVP had approved the rates in favor of them. RCDF awarded the work to the firm in September 2017 for 800 buses for two months. Consequently, the firm was paid ₹ 58.04 lakh (including ₹ 44.80 lakh rental, Vinyl cost ₹ 4.38 lakh and ₹ GST 8.86 lakh) during November-December 2017.

In this regard, it was observed in Audit that the firm was not registered with DAVP for category of multimedia advertising, based on which the work was awarded. The firm had an agreement with RSRTC for display sizes of 115.6 sqft (14′x1.6′ size each side of bus and other spaces) on the buses with a license fee of ₹ 485 per bus per month. But it sought ₹ 2,800 per bus per month for display size of 56 sqft (14′x2′ size each side of bus) on side panels of each bus.

Thus, the offer submitted by the firm was not reliable on the following grounds:

- The firm was not registered with DAVP for category of multimedia/ outdoor advertising.
- The size of display submitted by the firm was not in consonance to the size mentioned in the agreement with RSRTC as well as the space of specific size available on buses.
- The price submitted by the firm was higher by 1,191 *per cent*.

However, RCDF awarded the work to the firm without verifying the facts with RSRTC. This led to undue benefit of ₹ 58.04 lakh to the advertising agency.

GoR stated (January 2019) that the information about the firm was available on the website of DAVP and all the details were verified before issuing the work order to the firm. The display of *Saras* products was done on 56 sqft area as per DAVP approved terms & conditions.

The reply is not convincing as neither was the firm registered with DAVP for multimedia/outdoor advertising nor was the size of 14′x2′ on each side panel of bus possible on RSRTC buses.

(x) Non utilization of co-operative funds

Section 48 of the Rajasthan Co-operative Societies Act, 2001 provided that co-operative societies would contribute to the Co-operative Education and Training Fund. Section 111 also mandates the Registrar for preparation of a working plan for education and training and implement it through co-operatives. Rule 55 of the Rajasthan Co-operative Societies Rules, 2003 also provided that the Co-operative Education & Training Fund Regulations would be made for administration of the fund and allocation & distribution of fund for co-operative education and training in order to carry out the working plan and distribution amongst various district co-operative unions.

RCDF contributed one *per cent* of its net profit each year to Co-operative Education & Training Fund. It also contributed three *per cent* to State Co-operative Renewal Fund and two *per cent* to Co-operative Revitalization Fund being operated by the Registrar, Co-operative Societies. Accordingly, RCDF alone contributed ₹ 5.64 crore[76] during 2013-18 to these three funds.

However, it was observed that no training and educational activities were undertaken for the benefit of dairy farmers from this fund inspite of the fact that milk unions were conducting training programmes. There was also no evidence of having undertaken activities from the other two funds for benefiting dairy co-operative members. As such, dairy co-operative

[76] ₹ 94.02 lakh in Co-operative Education & Training Fund, ₹ 2.82 crore in State Co-operative Renewal Fund and ₹ 1.88 crore in Co-operative Revitalization Fund.

members/employees were denied benefits of training and other activities for which these funds were created.

3.8.2.6 Inadequate internal control mechanisms

Internal controls are the activities and safeguards that are put in place by the management of an organization to ensure that its activities are carried out in prescribed manner.

It was observed in Audit that:

- No internal control manual was formulated by RCDF to safeguard its resources.
- RCDF did not carry out any inspections/vigilance activities in compliance of procedures/norms devised by it.
- RCDF did not prepare Annual Receipts and Disbursements Account. This raised the risks of misappropriations of funds. Moreover, during 2013-18, statutory auditors also reported that RCDF was not following the accounting principles.
- RCDF did not formulate the Accounting Manual to establish effective accounting system.
- Cash book/bank book of all the bank accounts (except current account) were not maintained as per fundamental accounting principles and non-cash transactions were also being entered in the cash book.
- Cashier of cattle feed plant, Jodhpur misappropriated ₹ 94.55 lakh by manipulating the figure in carbon copy of receipt of sale of cattle feed. This could not be noticed for three years due to non-reconciliation of the amount of gate pass cum challans and cash receipts. The misappropriation came to notice only in March 2018 after which the cashier deposited ₹ 95.00 lakh but no criminal action was initiated against him.
- No human resources policies and practices were adopted by RCDF and the manpower was deployed at the same position for long periods thereby increasing the risk of error, manipulation and misappropriation.
- Though Section 55 of Rajasthan Co-operative Societies Act provided for the Registrar to hold inquiries into the constitution, working and financial condition of RCDF, it was observed that no such inquiry/investigation was conducted.

Thus, internal control and inspection mechanisms were inadequate in RCDF due to which misappropriation of co-operative funds of milk producer members cannot be ruled out.

3.8.3 Conclusion

Rajasthan having the second largest livestock population and milk production in the country has high potential for development of dairy sector. Although GoR set out a vision of achieving a target of 50 lakh kg/day of milk procurement by the year 2020, it did not support this with necessary planning and financial assistance. No market survey was carried out either by GoR or RCDF for increasing procurement, processing and marketing of milk. RCDF and the milk unions did not expand their capacities. RCDF's execution and monitoring of dairy sector schemes and its internal control mechanisms were also inadequate.

Thus, lack of planning, inadequate financial and institutional support by GoR combined with RCDF's failure to expand capacities and business activities has led to the dairy sector in Rajasthan not being exploited to its full potential.

Recommendations

GoR should

1. *Conduct a detailed survey/study of the dairy sector to assess the potential of the sector, identify demand supply gaps, resource gaps, plan for capacity expansion and devise necessary policies for procurement and marketing for the future.*

2. *Take initiative for expansion of dairy sector by committing financial resources required to achieve targets set in its policy.*

3. *Establish a functional wing within the AHD for dairy development, with clearly delineated responsibilities to co-ordinate and monitoring of dairy activities in the state.*

4. *Conduct regular inspections so that the schemes for dairy sector are implemented more effectively.*

Medical and Health Department

3.9 Non utilization of District Training Centre with hostel constructed for Women's Health Workers

District Training Centre with hostel facility for Women's Health Workers, Wazirpura, Tonk was not utilized for 15 years since its completion and this resulted in unfruitful expenditure of ₹ 1.51 crore on its construction.

The Reproductive and Child Health (RCH) Programme was launched in October 1997 with objective to reduce infant, child and maternal mortality

rates. Under the programme, a five year sub-project of ₹ 10 crore for the period 1998-2003 was approved for Tonk district. This included construction of a District Training Centre (DTC) with hostel facility for Auxiliary Nurse Midwives (ANMs) at Wazirpura, Tonk at a cost of ₹ 0.65 crore.

The construction work was assigned (June 2000) to Rajasthan Housing Board (RHB) with stipulated date of completion in December 2001. RHB completed[77] the work of DTC comprising training halls and hostel rooms for 60 girls at a cost of ₹ 1.23 crore[78] and handed over to the Department in June 2003.

Test check (December 2017) of records of District Reproductive and Child Health Officer (DRCHO), Tonk revealed that the DTC building was not being utilized for ANM training and hostel purposes even after lapse of 15 years of its completion. The ANM training center and hostel is still being operated in the old building of Saadat Hospital, Tonk, where total 174 trainees[79] were imparted training during the period 2013-18 in the old hospital premises which is insufficient as the classes are running only in two rooms.

Further, two *Chowkidars* engaged for watch and ward of DTC building were paid ₹ 0.28 crore during 2012-18. A joint inspection conducted by audit (April 2018) with the DRCHO, Tonk revealed that the DTC was situated eight kms away from the city and the area was uninhabited even as of June 2018. The ANM training centre and hostel was being operated in the old building of Saadat Hospital, Tonk instead of DTC as it was difficult for girls to reside in the hostel and approach daily to Saadat Hospital, Tonk for training.

GoR stated (August 2018) that DTC was not being utilized due to non-availability of transport facility and inadequate security for women trainees as it is situated at remote location. CMHO, Tonk was directed to shift the training centre and hostel at DTC building. In pursuance of the direction, CMHO, Tonk intimated (August 2018) that the training centre and hostel would be transferred to DTC building after rectification of deficiencies and provision of electricity and water connections.

The reply is not found correct because the building was uninhabitable for girls as the girls were reluctant to shift there in absence of proper facilities and DRCHO submitted (August 2018) requirements for family quarter for warden, appointment of cook and arrangement of emergency power back up. DRCHO further intimated (November 2018) that the training centre and hostel would only be transferred after budget allotment for additional guards and transport

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77 Construction work of DTC was completed in June 2002 and other development works such as approach road, electric connection, drinking water, plinth protection, boundary wall, drainage, etc., were completed in June 2003.

78 Building work: ₹ 0.71 crore; Development works: ₹ 0.32 crore and furniture, equipment and goods: ₹ 0.20 crore.

79 2013-15: 87, 2016-18: 42 and 2017-19: 45.

facility. Further, the training centre and hostel was not shifted to DTC building as of November 2018. Thus, an expenditure of ₹ 1.51 crore[80] incurred on construction of DTC remained unfruitful as the building was not being utilized for intended purpose for 15 years.

Public Health Engineering Department

3.10 Unfruitful expenditure on installation of Reverse Osmosis Plants

In the absence of Operation and Maintenance work, installed RO plants became non-functional rendering expenditure of ₹ 1.53 crore incurred by PHED unfruitful.

Additional Chief Engineer (ACE), Jodhpur issued (May 2013) work order of ₹ 2.02 crore on the lowest bidder M/s Doshion Veolia Water Solutions Private Limited, Ahmedabad (contractor) for installation of 15 Reverse Osmosis (RO) plants[81] in Jodhpur region with liability for seven years Operation and Maintenance (O&M). The contractor was to be paid 65 *per cent* after installation and commissioning of RO plants and remaining 35 *per cent* in seven installments i.e. five *per cent* per year for seven years for which O&M was to be provided. The works of installation of these 15 RO plants were completed between August 2013 and January 2015 and an amount of ₹ 1.53 crore[82] was paid to the contractor.

Test check (December 2017 and January 2018) of the records of Executive Engineer (EE), District Division-III, Jodhpur and District Division, Phalodi revealed that the contractor completed the work of installation of 15 RO plants between August 2013 and January 2015. However, the contractor did not carry out O&M for any of these plants after their installation. As a result, all the installed RO plants became non-functional as of December 2017. A joint physical verification of 10 RO plants[83] conducted with engineers of department in December 2017 and January 2018 also revealed that RO plants were in damaged condition *viz.* broken tanks, missing water tank, burnt panel, missing Ion Exchanger, chocked TDS meter, missing complete structure of plant etc., as can be seen in the picture below:

[80] Including ₹ 0.28 crore paid to *Chowkidars*.
[81] District Division-III, Jodhpur: eight RO plants and Division, Phalodi: seven RO plants.
[82] Installation of RO plant: ₹ 1.31 crore and power connection: ₹ 0.22 crore.
[83] Seven RO plants in District Division-III, Jodhpur and three RO plants in District Division, Phalodi.

Missing complete structure at Tekra

Broken tank at Chandrakh

Missing taps at Thob

Though the department repeatedly issued notices to contractor for carrying out O&M work of RO plants since their installation, it neither initiated action to recover compensation for delay under clause 2 of the contract nor awarded the O&M work to other contractors on risk and cost of the original contractor under clause 3 of agreement.

Thus, in absence of O&M work of installed RO plants, the expenditure of ₹ 1.53 crore incurred on installation of these RO plants remained unfruitful. Further, the department also failed to provide safe drinking water to these severely quality affected habitations as envisaged.

Non-functioning of 124 RO plants (costing ₹ 15.45 crore[84]) out of 193 plants[85] installed in Barmer, Jaisalmer and Jalore due to not carrying out O&M work by the contractor was also highlighted in paragraph 2.2.13.1 (Performance Audit on 'Drinking Water Management in Rajasthan') of Audit Report (G&SS) 2016-17.

GoR accepted (November 2018) the facts and stated that the department has now rescinded the work and issued (July 2018) direction for carrying out O&M work on the risk and cost of the contractor under clause 3 of the agreement.

Social Justice and Empowerment Department

3.11 Unfruitful expenditure on hostel building

Non-utilisation of hostel building constructed at Bikaner and Pali for students of Specially Backward Class for over two to four years resulted in unfruitful expenditure of ₹ 1.89 crore.

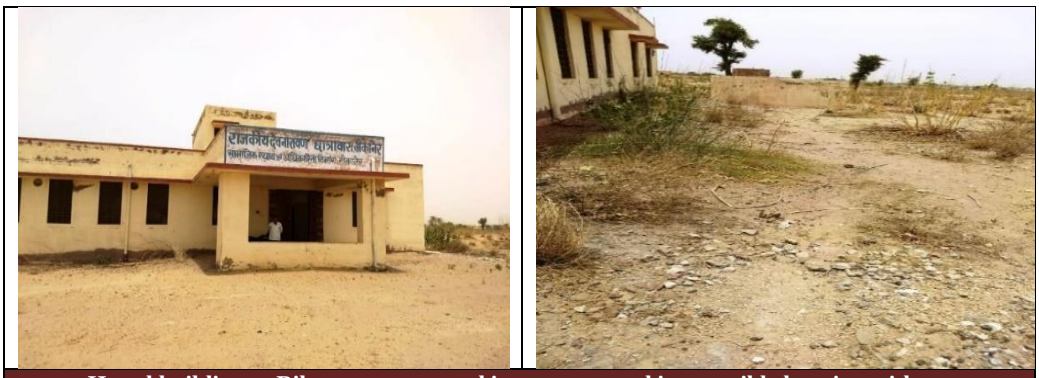
Social Justice and Empowerment Department (SJED) approved construction of model hostels under *Devnarayan Yojana* as per a special package announced in 2011-12 for the welfare of persons belonging to Specially Backward Class.

[84] Barmer: 75 (₹ 9.48 crore), Jaisalmer: 25 (₹ 3.04 crore) and Jalore: 24 (₹ 2.93 crore).
[85] Barmer: 113, Jaisalmer: 40 and Jalore: 40.

SJED issued (November 2011) Administrative and Financial sanction of ₹ 0.96 crore for construction of each model hostel building at Bikaner and Pali district to accommodate 50 students each. The construction work was completed by Public Works Department (PWD) at a cost of ₹ 0.96 crore at Bikaner (March 2013) and ₹ 0.93 crore at Pali (October 2014). Subsequently, PWD handed over the hostel to SJED, Bikaner in January 2014 and to SJED, Pali in October 2016.

Test check (January 2018) of records of Deputy Director, SJED, Bikaner and information gathered (September 2018) from Assistant Director, SJED, Pali revealed that no student was admitted to the newly constructed hostels even after a lapse of two to four years since its handing over. It was also noticed that the hostels were constructed 15 kms and 13 kms away from the city at Bikaner and Pali respectively. During joint inspection conducted (June 2018) with the Deputy Director, SJED, Bikaner that arrangement for supply of water and electricity was not made in the hostel. Deputy Director, SJED, Bikaner confirmed (June 2018) that the sanction was issued without obtaining any proposal from the district. It was also stated that the hostel was not connected with an approach road. This indicated that the department constructed the hostels in a remote and inaccessible location, which resulted in deprival of intended benefits to students belonging to Specially Backward Class.

Deputy Director, Bikaner (January 2018) and Assistant Director, Pali (September 2018) accepted the facts and intimated that due to remote location of hostel and lesser population of Specially Backward Class, students could not be admitted in the hostel.



Hostel building at Bikaner constructed in a remote and inaccessible location without civic facilities.

Hostel building at Pali constructed in a remote and inaccessible location.

GoR accepted the facts and stated (April 2018) that the process of inviting applications in Bikaner has been initiated during 2018-19 session and efforts are being made continuously to get the hostel operational. However, the reply of GoR on model hostel at Pali, was awaited (October 2018).

The facts remains that the hostel building was constructed at a remote and inaccessible locations which resulted in deprival of intended benefits to the targeted section of the community rendering the expenditure of ₹ 1.89 crore unfruitful.

Urban Development and Housing Department

3.12 Unfruitful expenditure on incomplete Sewerage project

Non-completion of Sewerage Project in Kota city approved under National River Conservation Plan and Urban Infrastructure Development Scheme in Small and Medium towns, even after lapse of more than five years, resulted in unfruitful expenditure of ₹ 77.78 crore.

Ministry of Urban Development (MoUD), Government of India (GoI) accorded sanction (May 2008) for ₹ 51.22 crore under Urban Infrastructure Development Scheme in Small and Medium Towns (UIDSSMT) for development of sewerage system in the areas of Kota city, where the sewerage was being draining into the Chambal river. Similarly, Ministry of Environment and Forest (MoEF), GoI approved (November 2009) *'Environmental Improvement Plan for River Chambal, Kota'* and accorded sanction for ₹ 149.59 crore under National River Conservation Plan (NRCP).

Accordingly, Rajasthan Urban Infrastructure Finance and Development Corporation Limited (RUIFDCO) sanctioned (December 2008 and December 2009) one package for ₹ 51.22 crore under UIDSSMT[86] and three packages[87] for ₹ 136.57 crore under NRCP for the sewerage project with Sewage Treatment Plants (STPs). Urban Improvement Trust, Kota was the executing agency for the works under NRCP and UIDSSMT.

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[86] **UIDSSMT/Sewerage/02:** For the works of providing, laying, jointing, testing and commissioning of lateral branch trunk and out fall sewers and all ancillary works including construction of manholes and restoration of roads at various area of Kota city.

[87] **(i) NRCP/LB/01:** Lateral, branch and main sewers and all ancillary works including construction of manholes and restoration of roads etc., **in area downstream of Kota barrage left bank and trunk sewer along the river bank.**
(ii) NRCP/RBS/01: Lateral, branch and main sewers and all ancillary works including construction of manholes and restoration of roads etc**., in area upstream of Kota barrage right bank.**
(iii) NRCP/RBN/02: Lateral, branch and main sewers and all ancillary works including construction of manholes and restoration of roads etc., **in inner city gravity zone right bank and outfall sewer along Kaithun road upto Raipura and construction of water tight retaining wall along Kishor Sagar Talab.**

Test check (October 2016) of records of Urban Improvement Trust (UIT), Kota revealed that four packages were awarded (May and July 2010) to two different contractors with stipulated dates of completion between November 2012 to July 2013. It was, however, noticed that the sewerage project in Kota city, has not been completed, even after lapse of more than five years of stipulated date of completion and lying standstill as of June 2018. Package-wise details of the works under UIDSSMT and NRCP are given in **Table 21**.

Table 21

(₹ in crore)

S. No.	Package No.	Name of contractor	Stipulated date of commence-ment of work	Stipulated date of completion of work	Work order amount	Total length of pipeline to be laid (in Kms)	Total length of pipeline Actually laid (in Kms)	Work executed as of August 2016 (*per cent*)	Cost of balance work	Compen-sation recovered
1.	UIDSSMT/ Sewerage/02	M/s Shriram EPC Limited, Chennai	July 2010	July 2013	42.05	137.63	54.58	19.42 (46.18)	22.63	4.21
2.	NRCP/RBN/02			January 2013	39.64	61.09	18.34	16.82 (42.43)	22.82	3.96
3.	NRCP/LB/01	M/s SMS Paryavaran, New Delhi	May 2010	November 2012	22.87	27.33	5.04	8.01 (35.02)	14.86	2.29
4.	NRCP/RBS/01			May 2013	59.82	72.57	9.09	33.53 (56.05)	26.29	5.98
	Total				**164.38**	**298.62**	**87.05**	**77.78 (47.32)**	**86.60**	**16.44**

The above table indicates that the contractors executed only 47.32 *per cent* works even after lapse of more than five years of stipulated dates of completion. Subsequently, the contractors left these projects incomplete. It was noticed that against the scope of work of construction of two STPs, three lifting stations, 22 drains and laying of 160.99 kms sewer line in three packages of NRCP, the contractors did not complete the work of one STP, one lifting station, 12 drains and laying of 128.52 kms sewer line. Further, out of 137.63 kms sewer line to be laid under UIDSSMT, only 54.58 kms line was laid by the contractor.

Scrutiny also revealed that the project area had substrata of hard rocks, therefore application of advanced technologies such as 'mechanized excavation', 'micro tunneling' was recommended in the Detailed Project Reports[88] (DPRs) to overcome the hazards of rock blasting in a populated city. UIT, instead of specifically identifying the appropriate technology for excavation and including the use of that technology in the 'Instruction to Bidders', made the contractors responsible for visiting and examining the site of work before preparing the bid for the contracts.

[88] Prepared (October 2009 and November 2009) for the packages under UIDSSMT and NRCP.

It was also observed that neither was the application of advanced technologies for excavation clarified by UIT with the bidder before finalizing the contract nor verified during execution of the works. This resulted in the contractor facing hurdles during execution of work due to inability to blast rocky reaches. The contractor had to then resort to cutting of rock manually with compressors, which resulted in poor output. Besides, the contractors also found obstacles due to existing utilities along the alignment like potable water rising main of large diameter, power cables, communication cables and existing drainage system, which also caused delay in work. This also indicated that alignment of sewer lines had hindrances and UIT did little to clear the hindrances after award of the works to the contractors.

Subsequently, after three years of stipulated date of completion UIT rescinded (August 2016) the works at the risk and cost of the contractors and recovered (August 2016) compensation of ₹ 16.44 crore for not maintaining prorata progress. Thereafter, UIT did not award the remaining works to other contractors (as of June 2018) at the risk and cost of the previous contractors.

Later, UIT submitted (September 2017) a revised proposal for ₹ 200.48 crore[89] to the Department for completing the balance works under both the schemes, which was ₹ 36.10 crore in excess over the initial work order amount (₹ 164.38 crore). This indicated that the balance work of both the schemes was estimated to be done at a cost of ₹ 122.70 crore[90]. However, the recovery of excess amount of ₹ 36.10 crore required to complete the works at the cost of the contractors, was remote as UIT did not have any deposit from the contractor when the contracts were rescinded.

GoR stated (September 2018) that looking to difficulties in excavation, the items of hard rock excavation were included in H-Schedule[91]. Accordingly, the contractors made excavation work with the help of mechanical equipment but in narrow lanes, micro-tunneling technique for rock excavation was very much costlier and required lot of time which was not estimated by the consultant and the bidders. Further, it is general practice not to specify any specific technique for excavation work in general work.

The reply is not acceptable as the DPR consultants suggested application of advanced technologies such as 'mechanized excavation', 'micro tunneling' was recommended in DPRs, to overcome the hazards of rock blasting in a populated city having substrata of hard rocks. Further, UIT neither clarified the application of advanced technologies for excavation to the bidder before finalizing the contract nor verified during execution of the work sand made the contractors responsible for visiting and examining the site of work before

[89] Excluding connections to property (₹ 85.02 crore) and Operation and Maintenance (₹ 2.66 crore) for five years, which were not included in the original sanctions.

[90] Cost of Balance work ₹ 86.60 crore + cost overrun₹ 36.10 crore.

[91] H Schedule is prepared for items which either not covered by BSR or required additional cost due to use of advance technology.

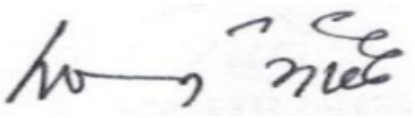
preparing the bid for the contracts. Moreover, UIT undertook the works as general practice even though it required special technology for execution.

The fact remains that UIT did not assess the difficulties of the work owing to hard rock strata and did not provide hindrances free sites to the contractors. Resultantly, the works were incomplete after incurring an expenditure of ₹ 77.78 crore on sewerage project under both the schemes even after lapse of more than five years of stipulated date of completion. Besides, the purpose to improve the water quality of the Chambal river under NRCP, was also defeated.

JAIPUR,
The 25 September, 2019

(R. G. VISWANATHAN)
Principal Accountant General
(General and Social Sector Audit), Rajasthan

Countersigned



NEW DELHI,
The 03 October, 2019

(RAJIV MEHRISHI)
Comptroller and Auditor General of India