CHAPTER III : PERFORMANCE REVIEWS

HEALTH AND FAMILY WELFARE DEPARTMENT

3.1 National Vector Borne Disease Control Programme

National Anti-Malaria Programme, renamed as National Vector Borne Disease Control Programme (NVBDCP) during 2003, was one of the stand alone disease control programmes brought under the National Rural Health Mission with effect from April 2005. A performance review of implementation of the programme revealed that while in one district, there was some improvement in both the Annual Parasite Incidence (API) and death cases due to malaria during 2007 compared to the previous year, there was an increase in the incidence of malaria cases and deaths due to malaria in the four other districts selected for detailed scrutiny.

Highlights

The API and death cases due to malaria increased by 86 *per cent* and 524 *per cent* respectively during 2007 over 2003, despite an expenditure of Rs. 23.70 crore during the period.

(Paragraph 3.1.10.1)

Collection of blood samples of 12.41 lakh people with the utilisation of 5,17,700 micro-slides and 39,200 pricking needles by using these more than once could adversely affect the health of the people.

(Paragraph 3.1.10.2)

Shortfall in coverage of targeted population under spraying operations led to increase in API and malarial deaths during 2003-07.

(Paragraph 3.1.10.3)

Quality of spraying operations remained questionable because of non-availability of vehicles required for the purpose.

(Paragraph 3.1.10.5)

In the absence of proper infrastructure in the Entomological Cell, entomological observations and other activities of the Cell largely remained dormant, leading to considerable increase in the incidence of malaria.

(Paragraph 3.1.10.7)

3.1.1 Introduction

The National Malaria Eradication Programme (NMEP) was introduced throughout the country in 1958 as a Centrally Sponsored Scheme to control and eradicate the incidence of malaria. The NMEP was renamed (1999) as the National Anti Malaria Programme (NAMP) and subsequently (2004) as the National Vector Borne Disease Control Programme (NVBDCP). All the vector borne diseases, *viz.*, Malaria, Filaria, Kala-azar, Japanese Encephalities and Dengue were brought under the ambit of this programme. When the National Rural Health Mission (NRHM) was launched in April 2005, the NVBDCP was also brought under it.

Malaria has been a major public health problem in India and Meghalaya is among the States, where the number of cases reported is very high, compared to the size of the population in the State. Therefore, in respect of Meghalaya, only the activities under "Malaria" were undertaken as part of implementation of NRHM, since there was no incidence of other vector borne diseases in the State as reported by the programme implementing authority concerned.

The objectives of the NVBDCP were to reduce (i) the incidence of malaria, (ii) malaria mortality rate by 50 *per cent* by 2010 and (iii) malaria morbidity to 30 *per cent* by 2010.

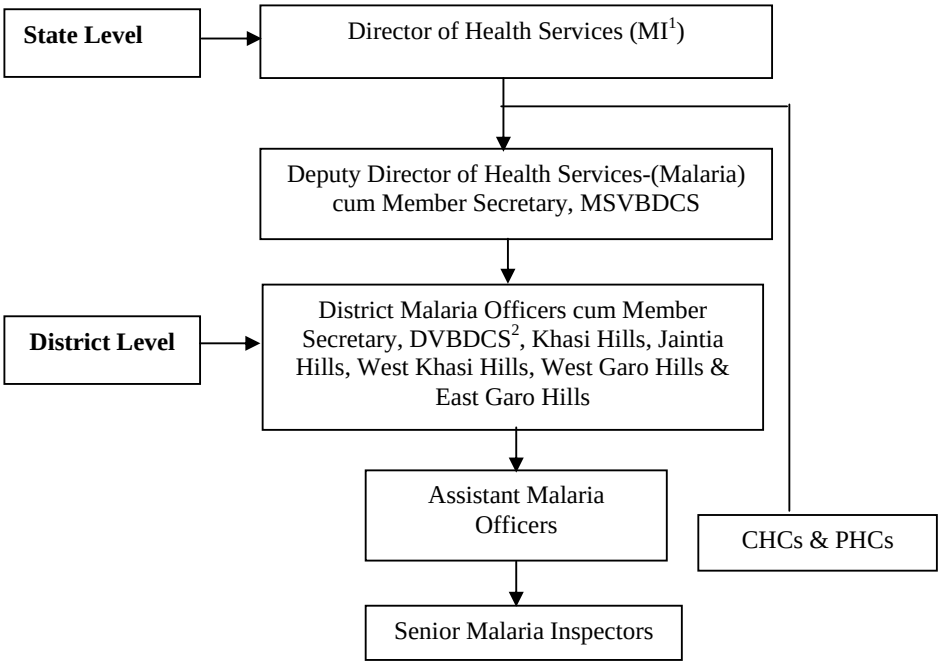
The guidelines of NRHM prescribed the following strategies to achieve the objectives of the programme:

- Increase Annual Blood Examination Rate to 10 *per cent* of the target population under surveillance;
- Indoor residual spray of insecticides;
- Free distribution of insecticides treated bed nets to below poverty line families; and,
- Establish Drug Distribution Centre/Fever Treatment Depot in each village in high-risk areas.

3.1.2 Organisational set up

The Principal Secretary/Commissioner and Secretary of Health & Family Welfare Department is responsible for overseeing the implementation of the programme. The State Malaria Control Society and Meghalaya State Vector Borne Diseases Control Society (MSVBDCS) were constituted in July 2002 and March 2005 respectively, by the State Government for prevention and control of malaria and other vector borne diseases in the State. The organisational structure for implementation of the programme in the State is detailed below:

Chart 3.1



3.1.3 Scope of Audit

Performance review of the NVBDCP covering the period 2003-08 was conducted (August - September 2008) through a test check of the records of the Director of Health Services (DHS)(MI), Deputy Director of Health Services (DDHS) (Malaria) cum Member Secretary, MSVBDCS, three out of five District Medical Officers (DMO)[3], nine out of 25 Community Health Centres (CHC) and 16 out of 101 Primary Health Centres (PHC) covering 68 *per cent* (Rs. 16.07 crore) of the total expenditure (Rs. 23.70 crore) incurred during the period.

3.1.4 Audit Objectives

The review was conducted with the objective of assessing whether:

- the objective of reducing the incidence of malaria was achieved;
- mortality rate due to malaria was reduced;
- adequate funds were provided by the Central/State Governments and funds were utilised for the intended purpose; and,
- implementation of the programme was effectively monitored and periodically evaluated.

[1] MI: Medical Institution. [2]DVBDCS: District Vector Borne Disease Control Society.
[3] Khasi Hills, Jaintia Hills & West Garo Hills.

3.1.5 Audit Criteria

Audit findings were benchmarked against the following criteria:

- Operational Manual for Malaria Action Programme (MAP)[4] and Guidelines of NRHM;
- Annual Work Plans;
- State Budget;
- Prescribed monitoring mechanism.

3.1.6 Audit Methodology

Before commencing the review, an entry conference was held (April 2008) with the Commissioner and Secretary of the Department, wherein the audit objectives, criteria and methodology were explained. Districts were selected on the basis of probability proportionate to size with replacement method. Utilisation of funds received from the GOI and the State Governments, adherence to scheme guidelines, implementation of various strategies, *etc.* were analysed to arrive at audit conclusions. Audit findings were discussed with the Deputy Director of Health Services (October 2008) in an exit conference and the replies of the Department have been incorporated in the report at appropriate places.

3.1.7 Audit Findings

The important points noticed in the course of review are discussed in the succeeding paragraphs.

3.1.8 Planning

NRHM emphasized the need for decentralised planning and implementation arrangements to ensure that need based and community owned district health action plans become the basis for intervention in the health sector. The districts were required to prepare perspective plans for the entire mission period (2005-12) as well as annual plans. The perspective plan was prepared by the State Mission Director of NRHM on the basis of information furnished by the district societies through the MSVBDCS.

Guidelines of NRHM envisaged achievement of targets of 50 *per cent* reduction of malaria mortality rate by 2010 and an additional 10 *per cent* by 2012. Further, the objectives of NVBDCP were to reduce the incidence of malaria and reduce mortality rate by 10 *per cent* during 2007-08. The DDHS (Malaria), however, stated (August 2008) that no intermediate target was fixed in respect of the activities under the programme. Due to non-fixation of targets with proper status indicators/baseline, achievement of the programme objectives remained unascertained.

[4] The Operational Manual for Malaria Action Programme was prepared (March 1995) by the Union Ministry of Health & Family Welfare for use as broad guidelines by different tiers of workers involved in malaria control programme.

3.1.9 Financial Management

3.1.9.1 Funding Pattern

The expenditure on National Malaria Eradication Programme (NMEP) was borne by the Central and the State Governments on a 50:50 basis till November 1994. The total expenditure both on operations and cost of material and equipment is being met entirely by the GOI with effect from December 1994 and emoluments of multipurpose workers and existing sanctioned Plan/Non-Plan staff is being met entirely by the State. The same financial management procedure had been followed after introduction of NVBDCP (2004) and NRHM (2005). Assistance in kind is also being provided by the GOI in the form of anti-malarial drugs, DDT, rapid diagnostic kits and bed nets.

3.1.9.2 Budget and Expenditure

Budget provision and actual expenditure incurred during 2003-08 on implementation of the programme were as under:

Table 3.1

(Rupees in crore)

Year	Allotment				Expenditure				Saving (-) Excess (+)
	Non-Plan	Plan	CSS[5]	Total	Non-Plan	Plan	CSS	Total	
2003-04	1.88	1.02	0.79	3.69	1.80	1.09	0.87	3.76	(+) 0.07
2004-05	1.83	1.11	0.40	3.34	1.73	1.01	0.49	3.23	(-) 0.11
2005-06	2.03	1.34	0.73	4.10	1.94	1.38	0.61	3.93	(-) 0.17
2006-07	2.48	1.82	0.12	4.42	2.16	2.00	1.04	5.20	(+) 0.78
2007-08	2.43	1.70	Nil	4.13	2.63	1.58	0.20	4.41	(+) 0.28
Total	**10.65**	**6.99**	**2.04**	**19.68**	**10.26**	**7.06**	**3.21**	**20.53**	

Source: Information furnished by the DHS.

In addition to the above, financial assistance is being provided by the GOI directly to the MSVBDCS since 2005-06 for implementation of the programme, as detailed below:

Table 3.2

(Rupees in lakh)

Year	Opening balance	Funds released by the GOI to MSVBDCS	Total	Funds utilised by MSVBDCS	Unutilised funds (*Per cent*)
2005-06	…	45.81	45.81	35.76	10.05 (22)
2006-07	10.05	132.53	142.58	136.10	6.48 (5)
2007-08	6.48	155.77	162.25	145.44	16.81 (10)
Total		**334.11**		**317.30**	

Source: Information furnished by the MSVBDCS.

3.1.9.3 Non-reconciliation of Expenditure

According to the Budget Manual, reconciliation of Controlling Officer's figures of expenditure with those booked in the accounts of the Accountant General (Accounts & Entitlements) (AG) should be done periodically.

[5] CSS: Centrally Sponsored Schemes.

There was wide variation between the DHS's figures and those reflected in the Appropriation Accounts prepared by the AG for the period 2003-08. While the Appropriation Accounts showed Rs. 25.58 crore expenditure during 2003-08 under the programme, Rs. 20.53 crore was reflected in the records of the DHS. The discrepancy of Rs. 5.05 crore was due to non-reconciliation of expenditure during 2003-08 by the DHS with the records of the AG.

3.1.9.4 Variation between budget allotment and actual expenditure

T**able 3.1** above shows variation between the budget allotment and actual expenditure ranging from two *per cent* to 18 *per cent*, indicating poor budgeting and lack of internal control. During 2003-04, 2006-07 and 2007-08, expenditure exceeded the budget allotment by two *per cent*, 18 *per cent* and seven *per cent* respectively due to payment of wages and travelling expenses of DDT spray workers, which was stated to be met out of the allocation made under State fund.

3.1.9.5 Delay in release of Central funds

Under the NVBDCP, the GOI released Rs. 68.36 lakh and Rs. 68.39 lakh to the State in August/November 2005 and March 2006 respectively. Of this, the State Government released Rs. 68.39 lakh to the DHS (MI) during 2005-06. The balance amount of Rs. 68.36 lakh was released by the State Government to the DHS (MI) after a delay of two years in March 2008, who in turn released the amount to the DDHS (Malaria) in June 2008, thereby adversely affecting the implementation schedule of the programme.

3.1.9.6 Utilisation Certificates

Except for the year 2007-08, utilisation certificates against the funds received from the GOI by the Society have been furnished. Further, the separate accounts being maintained by the Society are got audited by the Chartered Accountants every year.

3.1.10 Programme Implementation

3.1.10.1 Increase in Malaria incidence

During 2003-08, the Department had spent Rs. 23.70 crore on the implementation of the programme (excluding value of material and equipment supplied by the GOI in kind). The incidence of malaria cases, however, remained high. Annual Parasite Incidence (API), i.e., number of positive cases detected per thousand population, which was 7.9 during 2003 reached a peak of 14.7 during 2007, an increase of 86 *per cent.* Also, the death cases due to malaria increased from 38 in 2003 to 237 in 2007, an increase of 524 *per cent*, thereby frustrating the objective of reducing the mortality rate by 10 *per cent* during 2007-08. The position of death cases in the State as well as in the three test-checked districts is given below:

Table 3.3: API and number of malarial deaths in the State

(in number)

Year	Positive cases	Plasmodium falciparum cases	API[6]	Death cases
2003	18,151	12,238	7.9	38
2004	18,082	15,576	7.8	29
2005	16,816	14,758	7.2	41
2006	29,924	25,907	12.9	167
2007	33,979	28,179	14.7	237

Source: Information furnished by the DDHS (Malaria).

Table 3.4: Position of API and number of deaths in three district Malarial Units covering five Revenue Districts

(in number)

Year	East Khasi Hills & Ri Bhoi			Jaintia Hills			West & South Garo Hills		
	Positive cases	API	Death cases	Positive cases	API	Death cases	Positive cases	API	Death cases
2003	Not available			3,154	9.86	2	9,907	14.60	27
2004	3,477	6.00	5	2,510	7.55	9	10,619	15.50	29
2005	3,727	5.57	16	2,477	7.11	35	9,641	14.00	23
2006	8,870	13.40	19	6,098	17.13	53	17,580	25.30	46
2007	5,547	23.03	42	4,235	11.53	10	23,774	32.60	114

Source: Information furnished by the DMOs of the respective districts.

While in Jaintia Hills District, there was some improvement in both API and death cases due to malaria during 2007 compared to the previous year, in East Khasi Hills and Ri-Bhoi Districts, the death cases increased by 121 *per cent* over the previous year. West and South Garo Hills Districts were mainly responsible for increase in the death cases in the State where the positive and death cases increased by 140 *per cent* and 322 *per cent* respectively, over the five-year period ending 2007. The increase was attributed by the DDHS (Malaria) to delay in detection and treatment of malaria cases through surveillance activities, which were not up to the mark, inadequate chemotherapeutic measures and non-provision or delayed provision of radical treatment[7] to falciparum cases.

Thus, despite an expenditure of Rs. 23.70 crore during 2003-08, the NVBDCP almost remained a non-starter and the entire expenditure remained largely unfruitful.

The DDHS (Malaria) stated (August 2008) that action had been taken to reduce the incidence of malaria through the use of RD kits, DDT spraying, intensifying IEC programme and involvement of NGOs. However, the fact remains that the action taken to reduce the incidence of malaria is yet to yield the desired results.

3.1.10.2 Collection and examination of blood smears

Surveillance covers collection of blood smear and its examination to detect the malaria parasite. According to the prescribed norms, one surveillance worker was to be provided for 4,000 persons and for every four workers, there was to

[6] API has been calculated on the base population figure of 2003 which is 23,06,069 as furnished by the DDHS (Malaria).

[7] Radical treatment ensures a complete cure from malaria in the positive case and makes the patient non-infective to mosquitoes.

be one Surveillance Inspector to supervise the surveillance activities. Against a minimum of 577 surveillance workers required for collection of blood smear of 23.06 lakh population of the State during the calendar years 2003 to 2007, only 184 workers were in position.

According to the information furnished by the Deputy DHS, Malaria, during the years 2003 to 2007, blood collection and examination were done in respect of 12.41 lakh persons by utilising 5,17,700 micro-slides and 39,200 pricking needles. As per the MAP, one piece of micro-slide is required for collection of blood from one person. Therefore, the claim of the Deputy DHS is questionable.

The DDHS (Malaria) stated (October 2008) that micro-slides can be used for three or more times and the health workers are still using hagedorn needles after sterilization. The use of a micro-slide more than once is contrary to the MAP and as per the Operational Guidelines for Laboratory Technicians published by the Directorate of NVBDCP, auto disposable pricking needles are best suited for collection of blood smear and under the programme, sterile lancets are being supplied for malaria microscopy, which should be disposed/discarded after use.

Thus, lack of health education and awareness among the departmental officials could play havoc with the lives of people.

3.1.10.3 Shortfall in Indoor Residual Spray

Vector control for malaria and other vector borne diseases depend upon the use of Indoor Residual Spray (IRS), which is the easiest and most cost effective approach for breaking man vector contact. Under the modified plan of operation, spray operations are to be carried out in all areas with API2[8] and above with two rounds of insecticide (DDT 50% wettable powder) to prevent the transmission of parasites. The Environmental Management Plan also prescribed the requirement of two rounds of IRS with 75 tonnes of insecticide per million population per round. Spray operation in the State was conducted between March-May (first round) and August-October (second round) each year with a gap of around three months. The population targeted for spraying operations during the 2003-07 (calendar year) and coverage thereagainst is given below:

Table 3.5

(Population in lakh)

Year	Target		Coverage		Shortfall	
	First round	Second round	First round	Second round	First round	Second round
2003	13.87	13.28	9.37	8.72	4.50	4.56
2004	12.30	13.09	8.25	8.24	4.05	4.85
2005	13.84	6.13	9.46	3.89	4.38	2.24
2006	13.14	11.86	8.58	8.24	4.56	3.62
2007	12.89	12.89	7.53	9.08	5.36	3.81
Average per year	**13.21**	**11.45**	**8.64**	**7.63**	**4.57**	**3.82**

Source: Information furnished by the DDHS (Malaria).

[8] Number of two positive cases detected in an area per thousand population per year.

As can be seen from the above, during the period 2003-07, the annual average population targeted to be covered under spraying operations was 13.21 lakh. However, the target for the second round was reduced to 11.45 lakh leaving 1.76 lakh beyond the scope of spraying operations. Though the target was much below the total population of the State (23.06 lakh), this also could not be achieved because of shortfall in coverage of 4.57 lakh population per year in the first round of operations conducted during the period. The position of second round of spraying operations was also not encouraging, as the annual coverage (average) was only 7.63 lakh as against 8.64 lakh population covered in the first round.

Shortfall in coverage of 1.01 lakh population every year in the second round of spraying operations and 4.57 lakh targeted population under both rounds of operations, thus, indicates that the IRS was inadequate, which led to an increase in API and malarial deaths during 2003-07, thereby rendering the entire operation an exercise in futility. Besides, there is every possibility of malaria virus insects developing resistance and rendering the use of insecticide in the future useless.

3.1.10.4 Procurement of hand compression sprayers

Indoor Residual Spraying is an important component of integrated vector control strategy for control of vector borne diseases. Hand Compression Sprayers (HCS) were used by the spray workers in Meghalaya for spraying of DDT (50 % wp). As per NVBDCP guidelines, the discharge rate of HCS used in spraying should be between 750 and 850 ml per minute. The DDHS (Malaria) cum Member Secretary, MSVBDCS procured (August 2007) 150 Marut HCS from a Shillong based firm at a total cost of Rs. 7.57 lakh. The HCS were distributed to the District Malaria Units of the State. The District Malaria Officer (DMO), East Khasi Hills, however, had discarded these HCS on the ground that these did not have adequate discharge capacity (450 to 500 ml per minute) and that, with the use of these HCS, the spraying schedule would be disturbed and it would not be possible to cover the targeted population within the targeted period. The DMO, Jaintia Hills District stated (August 2008) that the shortfall in coverage in spraying operation with the HCS with inadequate discharge capacity was managed by spray workers working extra hours without additional wages.

The DDHS (Malaria) stated (October 2008) that the HCS were certified by the Entomologist and the Joint Director, NVBDCP and that no complaints were received from the districts other than East Khasi Hills. The reply is not acceptable because as per the tour report of the Consultant appointed by the MSVBDCS, the discharging capacity of the Marut HCS was 480-500 ml per minute compared to 750 ml per minute capacity of the old sprayer being used earlier and therefore, the Consultant commented that there would be optimal coverage with the older sprayer only.

Thus, procurement of HCS having less discharging capacity did not yield the desired result rendering the expenditure of Rs.7.57 lakh largely unproductive.

3.1.10.5 Inadequacy in checking of the quality of spray

The DMOs were responsible for achievement in coverage of spray operation in areas under their jurisdiction. They were to visit at least five to 10 villages every week to check the quality of spray. As per the norms, each district malarial unit was to be equipped with four vehicles and there were to be two van cleaners for each district malarial unit. In three test-checked districts (East Khasi Hills, Jaintia Hills and West Garo Hills), there were five vehicles on the road during 2003-08 against the requirement of 12. Availability of fewer vehicles than the requirement, thus, left the DMOs of these districts with little scope to check the quality of spray operations in the villages under their jurisdiction. In the absence of proper check by the DMOs, inadequacy in the quality of spray could not be ruled out.

3.1.10.6 Malaria unit and mobile malaria unit

As per the MAP, Meghalaya was considered a high risk area. There were, however, only five[9] District Malarial Units in the seven districts of the State. The District Malaria Officers (DMO), East Khasi Hills and Garo Hills were looking after the activities of the other two districts (Ri-Bhoi and South Garo Hills) in addition to their own, thereby giving little scope to focus on the activities of the programme in these two districts.

Further, as per the norms, there should be one mobile malaria control unit in every district in high risk areas. These mobile units were to be equipped with the prescribed equipment and staff. The duty of the medical officer in-charge of these units was to monitor the incidence of malaria in different PHC areas of the district. No such unit had, however, been created in any of the five district malarial units of the State. Consequently, the prescribed level of monitoring of the incidence of malaria could not be ensured, thereby leaving scope for increase in the incidence of malaria.

During the exit conference, the DDHS (Malaria) did not specify the reason for the shortfall of malaria units and non-creation of mobile unit, but stated that the mobile units provided to the District Medical & Health Officers under NRHM would monitor the incidence of malaria also. The reply is indicative of the fact that there was no effective measure to monitor or control the incidence of malaria prior to the establishment of mobile units.

3.1.10.7 Vector Control Measures

According to the MAP, an Entomological Cell was to be established in the State to evaluate the susceptibility of vector to insecticides. The existing Entomological Cell was established in the State during 1985 for (a) entomological observation, (b) imparting training on entomological investigation to the medical officers, technicians/microscopists, spray workers, (c) carry out awareness programme and (d) supervision and monitoring of spray operation. This Cell had, however, not been functioning properly since

[9] Khasi Hills, Jaintia Hills, West Khasi Hills, West Garo Hills and East Garo Hills.

its inception, due to the non-availability of the requisite manpower such as microscopist, technicians, *etc*. In the absence of proper infrastructure, entomological observations and other activities of the Cell remained largely dormant.

Stressing the need for a well equipped entomological Cell, the DDHS (Malaria) stated (October 2008) that the Government had been requested for providing proper infrastructure to the Cell and that response was awaited.

3.1.11 Monitoring and Evaluation

As per the MAP, the medical officers of the Public Health Centres and District Malaria Officers should keep a watch on the malaria incidence in the community. Further, the NRHM envisaged an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring.

According to the DDHS (Malaria), the programme was being monitored through the collection of various reports (surveillance, blood smear, incidence of malaria cases, *etc.*). He further, stated that community leaders were involved in creating awareness and that training was imparted to the medical officers, laboratory technicians, community volunteers and NGOs with the funds provided by the GOI under GFATM[10]. The veracity of the claim of the DDHS could not be ascertained in audit due to non-production of the relevant records. Absence of a well equipped entomological cell, mobile units and vehicles required to check the quality of spraying as mentioned in the foregoing paragraphs, however, indicated that the monitoring mechanism of the implementation of the programme in the State was ineffective. Evaluation of the programme was also not done to assess its impact on eradication of malaria and reduction of deaths due to malaria.

3.1.12 Conclusion

The overall impact of the programme was far from satisfactory because of the failure of the Department in reducing the mortality rate due to malaria. Despite expending a substantial amount, death cases due to malaria had increased over the five year period ending March 2008. Deficiency in collection and examination of blood smears and shortfall in spraying of DDT led to increase in the death cases. Sharp increase in malaria morbidity (86 *per cent*) and malaria mortality (524 *per cent*) during the current year compared to 2003 indicates that the possibility of achieving the objective of reducing the malaria morbidity and mortality by 30 *per cent* and 50 *per cent* by 2010 is remote.

[10] The GOI signed a Grant Agreement with the Global Fund for AIDS, TB & Malaria (GFATM) in 2005.

3.1.13 Recommendations

On the basis of the shortcomings pointed out in the foregoing paragraphs, the following recommendations are made for streamlining the implementation of the scheme:

- **Timely release of funds should be ensured for effective implementation of the programme.**

- **Efforts should be made to reduce the mortality rate due to malaria by 50 *per cent* as envisaged under the programme.**

- **Requirement of insecticides, microslides and pricking needles should be properly assessed and procured on a timely basis to avoid resurgence of malaria.**

- **Proper infrastructure should be created for effective implementation of the programme.**

- **Monitoring mechanism needs to be strengthened and accountability should be fixed at various levels for effective implementation of the programme to serve the objective of controlling and eradicating of the incidence of malaria.**

Audit findings were reported to the Government in September 2008; reply had not been received (November 2008).

SOCIAL WELFARE DEPARTMENT

3.2 Integrated Child Development Services Scheme

Integrated Child Development Services (ICDS) scheme, launched in 1975-76 by the GOI aimed at improving the nutritional and health standard of children in the age group up to six years of age and enhancing the capability of mothers to look after the normal health and nutritional needs of their children. The State was able to achieve the envisaged objectives only to a limited extent. Performance review of the scheme revealed shortfall in implementing various components of the scheme. Though the quantity of the foodstuff provided was as per the norms, the nutritive value of the food was not ensured. Health check-up was not provided to the desired extent and inadequate infrastructure and lack of supervision further affected the working of anganwadis.

Highlights

The Department failed to provide supplementary nutrition to 40 to 83 thousand children of 0-6 years age during 2003-08.

(Paragraph 3.2.10.1)

In the ICDS Project, Rongram, poor quality of milk powder and ready to eat food was distributed to 4,081 children and 736 pregnant/lactating mothers, thereby adversely affecting their health.

(Paragraph 3.2.10.3)

There was a shortfall in administering different vaccines to the children and women.

(Paragraph 3.2.11)

The Nutrition Programme for Adolescent Girls was not implemented by the Department despite the release of Rs. 49.36 lakh by the GOI.

(Paragraph 3.2.14)

There was a shortfall in coverage of rural children and mothers by the anganwadi centres by 13 *per cent.*

(Paragraph 3.2.15.1)

Around 4.48 lakh rural populace of the State were deprived of the benefit of anganwadi centres due to non-construction of 1,492 centres.

(Paragraph 3.2.15.2)

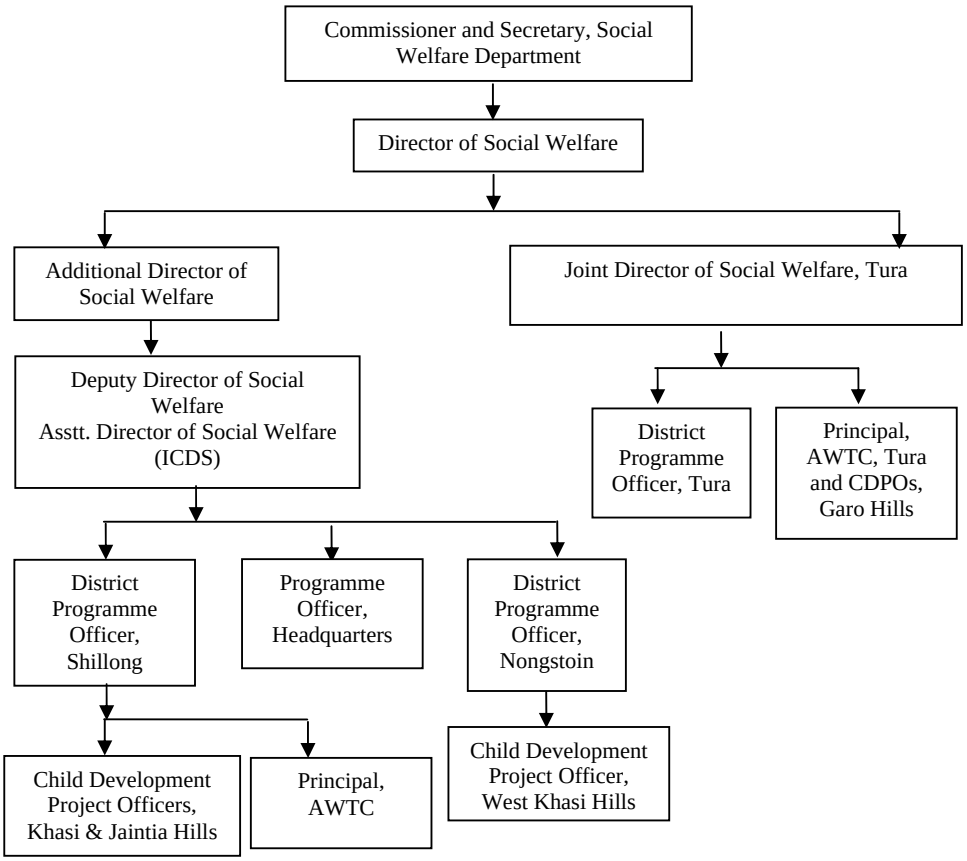
3.2.1 Introduction

Integrated Child Development Services (ICDS) Scheme, launched in 1975-76 by the GOI, aimed at improving the nutritional and health standard of children up to six years of age and enhancing the capability of mothers to look after the normal health and nutritional needs of their children. For this purpose, supplementary nutrition, immunization, health check-up, health education to women and non-formal pre-school education to children of 3-6 years of age were to be provided. The focal point for delivery of these services at the community level is the Anganwadi, to be set up in each village. In Meghalaya, the scheme was taken up for implementation in 1975-76.

3.2.2 Organisational Set Up

At the Government level, the Commissioner and Secretary of the Social Welfare Department is responsible for overseeing the implementation of the scheme. The organisational structure for implementation of the scheme is detailed below:

Chart 3.2



3.2.3 Scope of Audit

Performance review of the scheme covering the period 2003-08 was conducted (June-August 2008) through a test-check of the records of the Director of Social Welfare (Director), District Programme Officers (DPO), East Khasi Hills, Shillong and West Garo Hills, Tura, two Anganwadi Training Centres (AWTC), 14[1] out of 39 Child Development Project Officers (CDPO) in three districts (East Khasi Hills, Jaintia Hills and West Garo Hills) and 56 out of 3,195 Anganwadi Centres (AWCs) covering 50 *per cent* (Rs. 95.83 crore) of the total expenditure (Rs. 192.57 crore) during the period.

3.2.4 Audit Objectives

The main objectives of the performance review were to assess whether:

- The objectives envisaged under the scheme were achieved, i.e., whether the scheme has resulted in improvement in nutrition and health standard of children;
- adequate funds were provided by the Central/State Governments and funds were utilised for the intended purpose;
- various components of the scheme were implemented economically and effectively and as per the prescribed guidelines; and,
- implementation of the scheme was effectively monitored and periodically evaluated.

3.2.5 Audit Criteria

Audit findings were benchmarked against the following criteria:

- Scheme guidelines issued by the GOI;
- Sanction orders of the GOI;
- Norms prescribed for identification of beneficiaries;
- Procurement procedure prescribed;
- Quality assurance norms of food; and,
- Monitoring mechanism prescribed.

3.2.6 Audit Methodology

For conducting the performance review, an entry conference was held (June 2008) with the Commissioner and Secretary of the Department, wherein the audit objectives, criteria and methodology were explained. Districts and ICDS Projects were selected on the basis of probability proportionate to size with replacement method and AWCs were selected by simple random sampling without replacement method. Audit findings were discussed with the

[1] Mylliem, Mawsynram, Mawryngkneng, Pynursla, Shella-Bholaganj, Laitkroh, Thadlaskein, Khliehriat, Selsella, Betasing, Zikzak, Tikrikilla, Gambegre and Dalu

Commissioner and Secretary of the Department (September 2008) in an exit conference and the replies of the Government have been incorporated in the report at appropriate places.

3.2.7 Audit Findings

The important points noticed in the course of the review are discussed in the succeeding paragraphs.

3.2.8 Financial Management

3.2.8.1 Funding Pattern

The GOI provided 100 *per cent* funds for implementation of the scheme except for the cost of supplementary nutrition, which was to be met by the State up to 2004-05. With effect from 2005-06, the GOI extended assistance for this component also at the rate of half of the financial norms laid down for various categories of beneficiaries or 50 *per cent* of the actual expenditure on supplementary nutrition, whichever was less.

3.2.8.2 Receipts and Expenditure

Funds released by the Central and the State Governments during 2003-08 for implementation of the scheme and expenditure incurred thereagainst, were as under:

Table 3.6

(Rupees in crore)

Year	Revenue/ Capital	Opening balance	Grants-in-aid received from		Total fund available	Expenditure	Unutilised funds Savings (-)/ Excess (+) (*Per cent*)
			GOI[2]	State[3]			
2003-04	Revenue	3.36	8.82	16.30	28.48	28.80	+ 0.32 (01)
	Capital[4]	6.81	-	-	6.81	4.37	- 2.44 (36)
2004-05	Revenue	-	9.80	22.97	32.77	33.22	+ 0.45 (01)
	Capital	2.44	4.87	-	7.31	2.44	- 4.87 (67)
2005-06	Revenue	-	18.50	17.91	36.41	33.48	- 2.93 (8)
	Capital	4.87	8.17	-	13.04	8.00	- 5.04 (39)
2006-07	Revenue	2.93	23.60	15.71	42.24	34.82	- 7.42 (18)
	Capital	5.04	8.41	-	13.45	7.99	- 5.46 (41)
2007-08	Revenue	7.42	25.84	13.61	46.87	39.45	- 7.42 (16)
	Capital	5.46	-	-	5.46	-	- 5.46 (100)
Total	**Revenue**		**86.56**	**86.50**		**169.77**	
	Capital		**21.45**	**-**		**22.80**	

Source: Information furnished by the Research Officer, Directorate of Social Welfare.

As can be seen from the above table, there were huge savings year after year, especially in the capital head. This was due to the failure of the State Government to undertake the construction of AWCs as discussed in paragraph 3.2.15.2. Also, there were delays in release of funds by the State Government

[2] 2003-05: ICDS; 2005-08: ICDS including SNP.
[3] SNP only.
[4] For construction of buildings for AWCs.

to the Department/implementing agencies, affecting the implementation schedule of the scheme, as brought out below.

- The GOI released (March 2003) Rs. 2.44 crore to the State Government for the Construction of 390 AWCs with the instruction to utilise the fund during 2003-04. The State Government, however, released the amount to the Director after a delay of one year in March 2004, thereby leaving no scope for utilisation of the amount during 2003-04.

- Central fund of Rs. 7.99 crore, released by the State Government to the Director in March 2007, was initially parked by the Director in "8443 Civil Deposit" in March 2007 with the approval of the State Finance Department. The amount was withdrawn from the Civil Deposit in June 2007 and has been lying unutilised in the form of Deposit at Call as of August 2008. This was contrary to the State Treasury Rules, 1985, which prohibit drawal of money in anticipation of requirement.

The Government stated (October 2008) that delay was due to delay in obtaining concurrence from various levels. The action of the Government was contrary to the instructions of the GOI and shows lack of urgency in implementing socio-economic developmental schemes.

3.2.9 Programme Implementation

3.2.9.1 Schematic Criteria

The ICDS scheme provided for the following:

- All children in the 0-6 years age group and pregnant/nursing mothers are to be provided with supplementary feeding for additional nutrition, through AWCs for 300 days in a year at different prescribed rates[5] per day.
- Food provided to the children should contain the required nutrient value of 300 calories and 10 grams of proteins per child, 500 calories and 20-25 grams of proteins per pregnant woman/nursing mother and 600 calories and 20 grams of proteins per severely malnourished child.
- Proper survey should be carried out for identification and registration of malnourished children.
- Economic and efficient procurement should be made keeping in view the quality of food.
- Growth monitoring of all the children in the age group 0-6 years by weighing is to be undertaken monthly/quarterly at the AWC.

[5] Prescribed rate per day per beneficiary in an AWC:

	Up to 2003-04	With effect from 2004-05
	(Rupees per day)	
Ordinarily malnourished children	0.95	2.00
Severely malnourished	1.35	2.70
Pregnant women and nursing mothers/adolescent girls	1.15	2.30

- AWCs should be set up in every village having a population of 300 or more.
- Monitoring, evaluation and impact assessment machinery should function effectively.

3.2.10 Supplementary Nutrition Programme

Under SNP, all the children up to the age of six years and pregnant women and nursing mothers belonging to landless agricultural labourers, marginal farmers, scheduled castes/scheduled tribes and other poor sections of the community (where the total income of all the members of the family did not exceed Rs.15,000 per year) were to be enlisted. The anganwadi workers are responsible for conducting a survey of the villages and identifying and enlisting the children up to six years, pregnant and nursing mothers and adolescent girls of 11-19 years age for providing supplementary nutrition. In accordance with the directions (October 2004) of the Supreme Court, the Union Ministry of Human Resource Development informed (February 2005) the State Governments that the supplementary nutrition under ICDS should not be confined to the beneficiaries from the low income group families. The following shortcomings were noticed in the implementation of this programme:

3.2.10.1 Coverage

Details of the coverage of eligible beneficiaries with supplementary nutrition during 2003-08 are given below:

Table 3.7

(Beneficiaries in lakh)

Year	Beneficiaries	Eligible beneficiaries	Beneficiaries provided with supplementary nutrition	Shortfall in providing supplementary nutrition (*per cent*)	Days on which supplementary nutrition was provided against the requirement of 300 days (Shortfall)
2003-04	Children	2.29	1.84	0.45 (20)	300 (Nil)
	Expectant and nursing mothers	0.37	0.33	0.04 (11)	
2004-05	Children	2.28	1.88	0.40 (18)	300 (Nil)
	Expectant and nursing mothers	0.38	0.33	0.05 (13)	
2005-06	Children	2.74	1.91	0.83 (30)	300 (Nil)
	Expectant and nursing mothers	0.41	0.34	0.07 (17)	
2006-07	Children	3.53	2.88	0.65 (18)	175 (125)
	Expectant and nursing mothers	0.60	0.54	0.06 (10)	
2007-08	Children	3.43	2.94	0.49 (14)	300 (Nil)
	Expectant and nursing mothers	0.58	0.54	0.04 (7)	

Source: Information furnished by the Research Officer, Directorate of Social Welfare.

As can be seen from the table, although the Department was successful in providing supplementary nutrition to the beneficiaries during all the 300 days (except during 2006-07) as specified under the scheme, this achievement was

at the cost of a significant number of beneficiaries (40 to 83 thousand children and four to seven thousand expectant/nursing mothers) who were denied the benefit of supplementary nutrition. During 2006-07, supplementary nutrition was not provided for five months (October 2006 to February 2007) in eight ICDS projects of East Khasi Hills District and three projects of Ri-Bhoi District and for three months (October, December 2006 and January 2007) in five ICDS projects of Jaintia Hills District. Consequently, 1.53 lakh beneficiaries of these districts were deprived of the benefit of supplementary nutrition.

Government stated (October 2008) that supplementary nutrition was discontinued during October 2006 to February 2007 due to the time taken for identifying the Self Help Groups (SHGs) required to be engaged for the supply of foodstuff in compliance with the Supreme Court order. Reasons for the shortfall in coverage during 2003-08 were, however, not furnished.

3.2.10.2 Calorific and protein value

The main aim of SNP was to supplement the nutritional intake by 300 calories and 10 grams of protein per child, 500 calories and 20-25 grams of proteins per pregnant woman/nursing mother and 600 calories and 20 grams of proteins per severely malnourished child[6] for a period of 300 days in a year as mentioned in paragraph 3.2.9.1. For providing foodstuff with adequate nutritive value, the GOI also prescribed the following financial norms:

Table 3.8

(Rupees per child per day)

Categories of beneficiaries	Rate prior to March 2007	Revised rate effective in Meghalaya from March 2007
Malnourished children	1.20	2.00
Severely malnourished children	2.40	2.70
Pregnant/nursing mothers	1.50	2.30

Source: Information furnished by the Director.

During 2003-08, the Department spent Rs. 108.97 crore for providing foodstuff to different categories of beneficiaries. But in none of the test-checked projects, any laboratory test was conducted to ascertain the requisite calories/protein value of the food provided under the scheme. According to the report furnished (November 2005) to the State Government by the Director, nutritive value of the foodstuff in respect of the children in the age group of 0-3 years was maintained during 2003-07. The Director, however, did not clarify how he was satisfied about the fulfillment of the nutritive value of foodstuff without laboratory test of the food.

The Government stated (October 2008) that considering the escalation of prices of all food items, it was impossible to meet the required nutritive value at the revised rates prescribed by the GOI. The reply is an admission of the State Government's failure in providing food with adequate nutritive value to the children and pregnant woman and lactating mothers. As such, the

[6] Severely malnourished children are to be given therapeutic nutrition.

expenditure of Rs. 108.97 crore incurred was able to achieve the objective of the scheme only to a limited extent.

3.2.10.3 Quality of food

To meet the required calorific and protein content as per norms, the State Government decided to distribute ready to eat (RTE) food and milk powder fortified with minerals and vitamins to the malnourished children of 0-6 years, pregnant and lactating mothers and adolescent girls. The CDPO, ICDS Project, Rongram, West Garo Hills received 2,401 kg of milk powder and 16,500 kg of RTE food valued at Rs. 8.65 lakh on 24 February 2004 and 12 April 2004 respectively, from the suppliers engaged by the Director, which was distributed to 4,081 children of 0-6 years age group and 736 pregnant and lactating mothers under the project. The performance report of the DPO, however, showed that the milk powder and RTE food were of bad quality. The parents complained about constipation and acidity of their children after consuming the milk powder and they did not want that their children consume the poor quality RTE food. The report also showed that some children developed worm infection after consuming the milk powder. Thus, distribution of poor quality food items not only frustrated the objective of the scheme but also affected the health of the beneficiaries adversely.

The Government stated (October 2008) that taking into consideration the report of the DPO, the samples of the relevant food items were sent to the Quality Control Laboratory (QCL) of the Food and Nutrition Board, Kolkata and the laboratory tests did not indicate that these food items were of bad quality. Laboratory test report enclosed in support of the reply, however, showed that the samples of milk powder and RTE food were sent on 13 February 2004 to the QCL, i.e., before the receipt of these items by the DPO and thus, the food items sent for laboratory tests were different from those reported by the DPO to be of poor quality.

3.2.10.4 Adulteration of foodstuff

During 2006-07, the Director procured 1,697.49 tonnes of RTE food valued at Rs. 4.82 crore for distribution to the beneficiaries of different projects. Of this, 43,769 kg (value : Rs. 12.43 lakh) meant for 15,534 beneficiaries under Mylliem, Dalu and Thadlaskein projects was seized by the police due to the complaints alleging adulteration of food. The entire quantity of the RTE food was lying in the godown of the respective projects as of August 2008 and lost its utility, as the shelf life of the RTE food was only six months. Consequently, the targeted beneficiaries were deprived of the benefit of the foodstuff. The matter needs to be investigated and responsibility fixed.

3.2.11 Immunization

Under the scheme, the following immunization schedule was prescribed for children up to six years of age and pregnant women to protect them against specific diseases:

Table 3.9

Age	Schedule for immunization
Children of age six weeks or one and a half months	(i) Diphtheria, Whooping cough and Tetanus (DPT) : First dose (ii) Oral Polio Vaccine (OPV): First dose (iii) Tuberculosis (BCG)
Children of age 10 weeks or two and a half months	(i) DPT: Second dose (ii) OPV: Second dose
Children of age 14 weeks or three months	(i) DPT: Third dose (ii) OPV: Third dose
Children of age nine months	Measles
Children of age between 16 and 24 months	(i) DPT: Booster (ii) OPV: Booster
Children of 5 to 6 years of age	Booster dose for Diphtheria and Tetanus (DT) and two doses of typhoid vaccination.
Pregnant women	Tetanus toxoid: Two doses at an interval of eight to twelve weeks, the second dose being given four weeks before expected date of delivery.

Source: Information furnished by the Research Officer, Directorate of Social Welfare.

The Department did not fix any targets for immunization during 2003-08. However, based on the information[7] available with the Director, the position of immunization of children of 0-3 years (DPT & OPV), 3-6 years (DT) and pregnant women is given in the table below:

Table 3.10

(in numbers)

Year	Vaccine	Children who completed the				Children who did not complete the doses (*per cent*)	Pregnant women who completed the		Pregnant women who did not complete the doses (*per cent*)
		First dose	Second dose	Third dose	Booster dose		First dose	Second dose	
2003-04	DPT	16,316	13,309	11,061	7,183	9,133 (56)	7,455	4,244	3,211 (43)
	OPV	15,905	13,309	11,147	7,083	8,822 (55)			
	DT	5,695	3,425	-	3,294	2,401 (42)			
2004-05	DPT	21,454	17,730	11,988	8,876	12,578 (59)	9,858	6,368	3,490 (35)
	OPV	23,225	18,463	16,643	9,669	13,556 (58)			
	DT	7,816	5,807	-	5,772	2,044 (26)			
2005-06	DPT	24,215	20,104	16,517	11,235	12,980 (54)	12,185	7,089	5,096 (42)
	OPV	43,887	20,184	16,525	11,025	32,862 (75)			
	DT	10,078	6,753	-	6,626	3,452 (34)			
2006-07	DPT	30,158	26,310	22,620	13,903	16,255 (54)	15,810	9,327	6,483 (41)
	OPV	33,602	28,662	22,670	13,729	19,873 (59)			
	DT	13,679	9,203	-	8,848	4,831 (35)			
2007-08	DPT	28,801	24,785	21,244	13,961	14,840 (52)	15,725	9,815	5,910 (38)
	OPV	29,278	24,246	20,720	13,490	15,788 (54)			
	DT	11,106	8,142	-	7,867	3,239 (29)			

Source: Information furnished by the Director.

Although the ICDS scheme was being implemented in the State since 1975-76, the immunization programme had not gathered momentum despite the availability of sufficient funds from GOI, as only a portion of the children (25 to 74 *per cent*) and mothers (57 to 65 *per cent*) could be provided with all the vaccinations on a timely basis. Apart from the first dose of immunization, the remaining doses of immunization were not completed by 52 to 75 *per cent*

[7] Information regarding administering typhoid vaccine was not furnished to Audit.

children of 0 to 3 years age, 26 to 42 *per cent* children of 3 to 6 years age and 35 to 43 *per cent* pregnant women. The shortfall was attributed by the Research Officer of the Directorate of Social Welfare to non-supply of vaccines to the centres by the State Health & Family Welfare (H&FW) Department and non-attendance of beneficiaries to the centres, for immunization. The reply highlights the failure of the Department to obtain the required vaccines and also educate the beneficiaries about the importance of immunization.

3.2.12 Health check-up

3.2.12.1 Health check-up

Under the scheme, health check-up was to be given to all the expectant and nursing mothers by the H&FW Department. A minimum of four physical examinations during pregnancy and at least one visit after delivery was prescribed in the guidelines. In order to detect diseases and other evidence of malnutrition *etc.*, general check-up of all children under the age of six years after every three to six months was also to be done.

The Director neither fixed the targets for health check-up nor maintained any record indicating the number of expectant and nursing mothers. In the absence of such information, it was not possible to assess whether the health check-up activities were adequately covered or not. The position of health check-up of the child population in the age group of 0-6 years is given below:

Table 3.11

Year	Children (0-6 years)	Number of health check-ups		Shortfall	Percentage of shortfall
		Required to be conducted	Actually conducted		
2003-04	2,29,012	4,58,024	1,27,593	3,30,431	72
2004-05	2,27,760	4,55,520	2,08,157	2,47,363	54
2005-06	2,74,187	5,48,374	2,44,684	3,03,690	55
2006-07	3,53,495	7,06,990	2,70,152	4,36,838	62
2007-08	3,43,016	6,86,032	2,48,045	4,37,987	64

Source: Monthly Progress Report and information furnished by the Research Officer, Directorate of Social Welfare.

Note: Number of health check-ups required to be conducted was arrived at, by multiplying the total child population with minimum number of check-ups (two) required.

Shortfall in health check-up, which ranged between 54 and 72 *per cent* during 2003-08, indicated the apathy of the Department towards the health care of the children.

3.2.12.2 Weight of children

The health care of the children under six years of age included recording of their weight at periodical intervals to keep a close watch over their health and nutritional status. In order to classify the nutritional status, the Anganwadi workers were to weigh all children up to three years of age every month and children of 3-6 years of age every three months.

The consolidated monthly progress reports of various activities showed that there was a significant shortfall in weighing of children ranging between 24 and 55 *per cent***.** Scrutiny of records of the 14 test-checked projects revealed that there was a shortfall in weighing the children in seven of these projects due to the non-availability of weighing scales. Consequently, nutritional status of a significant number of the children remained unassessed, thereby depriving them of the benefits envisaged under the scheme.

The Government admitted the fact and stated (October 2008) that due to shortage of fund, the old weighing scales could not be replaced. The reply is not acceptable considering that there were huge savings every year during the review period, as brought out in paragraph 3.2.8.2.

3.2.12.3 Supply of medicine kits

As a vital input to health check-up, each AWC was to be provided every year with a medicine kit consisting of easy to use and dispensable medicines to remedy common ailments like cough and common cold, skin infections, *etc.* If the ailment required specialised treatment, the case was to be referred to the nearest health centre. To prevent the outbreak of common seasonal diseases among children especially in tribal and hilly areas, the Union Ministry of Human Resource Development stressed (March 2000) the need for procurement of medicine kits within the first six months of each financial year and supplying them to the AWCs before the monsoon break.

Scrutiny revealed that the Director procured medicine kits after delays ranging between four and eight months of the stipulated period**.** Consequently, the kits could not be supplied to the AWCs before the outbreak of monsoon, thereby depriving the children of timely treatment of common ailments during the monsoon.

The Government stated (October 2008) that the delay was due to the observance of procurement procedures. The reply highlights the need to streamline the procurement procedures so that the essential items are procured on time. Delays in procurement obviously deprived the children of timely treatment of seasonal ailments.

3.2.12.4 Growth chart

To assess the impact of the health and nutritional status of the children, each child in the AWCs was to be provided with an individual growth chart. Records of the 14 test-checked ICDS projects, however, showed that the required growth charts were not maintained during 2003-08 by 15 AWCs under eight[8] of these projects. Consequently, the impact of the health and nutritional schemes on the status of the children under these AWCs remained unassessed.

[8] Mawryngkneng, Khliehriat, Thadlaskein, Selsella, Tikrikilla, Dalu, Betasing and Mawsynram.

The Government stated (October 2008) that the growth chart was not maintained due to the non-functioning of the weighing scales. Appropriate action should have been taken to provide the required weighing scales for the benefit of the children.

3.2.13 Pre-school Education

Under the scheme, children of 3-6 years were to be provided with pre-school education through AWCs to make them capable of joining the main stream of school children.

Scrutiny of records of the 14 projects revealed that against the minimum strength of 40 children in each AWC, the average enrolment of children for pre-school education during 2003-08 in seven[9] of these projects ranged between 26 and 39. While the position in two (Pynursla and Betasing) of these seven projects improved in 2007-08 because of enrolment of 39 and 30 children against 31 and 29 in 2003-04, enrolment of children in the remaining six projects declined significantly during 2007-08 as compared to 2003-04 and 2004-05.

The Government stated (October 2008) that the shortfall was due to the accessibility of nursery schools run by missionaries and private organisations.

3.2.14 Implementation of scheme for adolescent girls

The Planning Commission launched a pilot project, *viz.* Nutrition Programme for Adolescent Girls (NPAG), initially for two years from 2002-03. The GOI approved the implementation of the scheme thereafter from 2005-06. Under this scheme, 6 kg of foodgrains per month are given to under-nourished adolescent girls, after determining the eligibility on the basis of their weight. As per the instructions (July 2005) of the Ministry of HRD, the scheme was to be restricted only to adolescent girls from 2005-06, as pregnant women and lactating mothers were separately covered under ICDS. Funds for implementation of the scheme are released by the GOI as 100 *per cent* additional Central assistance under the ICDS Scheme.

For implementation of the scheme during 2003-04 in the East Khasi Hills District of the State, the GOI released (March 2004) Rs. 15 lakh. The amount had, however, not been released by the State Government to the implementing authority as of August 2008. Similarly, for implementation of the scheme during 2005-07, the GOI released (July 2005 and May 2006) Rs. 34.36 lakh. The State Government released the amount to the Director after a delay of 10 months in March 2006 and February 2007 for providing foodgrains to 14,661 adolescent girls. Though the Director released the amount (Rs. 34.36 lakh) to the DPO, Shillong (implementing authority) for providing the required foodgrains to the beneficiaries, the entire amount had been lying unutilised

[9] Pynursla, Thadlaskein, Mylliem, Mawryngkneng, Khliehriat, Betasing and Zikzak.

with the DPO as of August 2008, thereby depriving the targeted girls of the benefit envisaged under the scheme.

3.2.15 Anganwadi Centres (AWC)

The Anganwadi is the focal point for delivering the package of services to the children and mothers right at their door step. AWCs should be set up in every village having a population of 300 or more.

3.2.15.1 Establishment of Anganwadi Centres

The table below details the ICDS Projects, AWCs sanctioned by the GOI, projects actually in operation and coverage of population during 2003-08:

Table 3.12

(Population in lakh)

Year	Number of ICDS projects (as of March)		Number of AWCs (as of March)		Total population		Population not covered (*per cent*)
	sanctioned	in operation	sanctioned	in operation	to be covered	covered	
2003-04	32	32	2,218	2,217	2.66	2.17	0.49 (18)
2004-05	32	32	2,218	2,218	2.66	2.22	0.44 (17)
2005-06	32	32	3,179	2,265	3.15	2.26	0.89 (28)
2006-07	39	39	3,179	3,162	4.14	3.42	0.72 (17)
2007-08	39	39	3,388	3,195	4.01	3.48	0.53 (13)

Source: Monthly progress reports maintained by the Directorate.

As of March 2003, 2,206 AWCs were in operation in the State. During 2003-08, 989 more AWCs were set up thereby increasing the number of operational AWCs to 3,195 as of March 2008. The coverage of rural population under ICDS at the end of 2007-08 was 3.48 lakh against the rural population of 4.01 lakh. Shortfall in coverage of population by the AWCs, thus, deprived 13 *per cent* of the children and mothers in the rural areas of the benefit of the scheme.

The Assistant Director (ICDS) stated (August 2008) that the shortfall was minimal and effort would be made to avoid such shortfall in future. The Government further stated (October 2008) that more ICDS projects and AWCs were made operational as of August 2008 to reduce the shortfall in coverage.

3.2.15.2 Non-construction of Anganwadi Centres

GOI sanctioned Rs. 33.16 crore (February 2006: Rs. 16.34 crore; February 2007: Rs. 16.82 crore) for construction of 1,895 AWCs (Rs. 1.75 lakh for each centre). The first instalment of Rs. 16.58 crore was released by the GOI to the State Government in February 2006 (Rs.8.17 crore) and February 2007 (Rs. 8.41 crore) with the condition that the balance amount would be released during the succeeding financial year, taking into account the pace of construction and utilisation of funds. Funds released in the first instalment were sufficient for construction of 947 AWCs. Of Rs. 16.58 crore, the State Government released (March 2006 and March 2007) Rs. 11.11 crore to the

Director, retaining Rs. 5.47 crore in the Government account. In turn, the Director released Rs. 7.99 crore (out of Rs. 11.11 crore) to the CDPOs for construction of AWCs and the balance amount of Rs. 3.12 crore was kept in "8443-Civil Deposit" as mentioned in Paragraph 3.2.8.2 above. As of September 2008, construction of only 298 AWCs was completed and construction of 105 AWCs was in progress. Funds released for the purpose amounting to Rs. 9.53 crore were parked at different levels (State Government: Rs. 5.47 crore; Department: Rs. 3.12 crore; CDPOs: Rs. 0.94 crore), which could have been utilised to establish 545 more AWCs. Due to non-utilisation of funds released in the first instalment, the GOI did not release the second instalment, which could have facilitated construction of 947 AWCs. Thus, around 4.48 lakh rural population had been deprived of the benefit.

During the exit conference, the Additional Director, Social Welfare stated (September 2008) that in the absence of buildings, the AWCs were functioning from the community hall or private houses. Government also endorsed (October 2008) the views of the Additional Director. The reply is an attempt to deflect the failure of the State Government to construct the buildings for housing the AWCs in a time bound manner by utilising the funds provided by the GOI, which also led to non-release of second instalment of Rs. 16.58 crore.

3.2.16 Position of staff

Field level functionaries are the back bone of the ICDS scheme. They comprise of Anganwadi Workers (AWWs), Anganwadi Helpers (AWHs) Supervisors and CDPOs. In large sized projects, Assistant CDPOs are also added to the field level functionaries. The CDPO is responsible for implementation and administration of the ICDS programme and provides the link between the ICDS functionaries and the administration. Any shortage of field level functionaries adversely affects the implementation of the scheme.

Scrutiny of records disclosed that during 2003-08, there was no shortage in the cadre of AWWs and AWHs. However, there was a shortage of CDPOs and Supervisors, as detailed below:

Table 3.13

(in number)

Year	Sanctioned strength		Men-in-position		Shortage (*Per cent*)	
	CDPO	Supervisor	CDPO	Supervisor	CDPO	Supervisor
2003-04	32	124	28	122	4 (12)	2 (2)
2004-05	32	124	28	124	4 (12)	…
2005-06	32	124	28	123	4 (12)	1 (0.81)
2006-07	39	162	27	124	12 (31)	38 (23)
2007-08	39	171	24	121	15 (38)	50 (29)

Source: Information furnished by the CDPOs.

Shortage of the CDPOs and Supervisors became more acute from 2006-07 due to the increase in the number of sanctioned posts. As a result of non-filling up of the vacant posts of CDPOs and Supervisors, the implementation and administration of the programme suffered to an extent.

The Government stated (October 2008) that the vacancies were due to the delay in the process of recruitment procedure by the Meghalaya Public Service Commission/District Selection Committee and the posts of CDPOs were filled up in July 2008. Action taken to fill up the vacant posts of Supervisors had not been stated.

3.2.17 Training

Achievement of the objectives of the ICDS scheme depends mainly on the effectiveness of the frontline workers like AWWs. In order to increase the working efficiency of the AWCs, the scheme provides for imparting job training to the AWWs for three months duration on joining the service followed by a refresher course on completion of two years service. The CDPOs and Supervisors are also imparted job/refresher training. Two Anganwadi Workers Training Centres had been functioning in Shillong and Tura under the supervision of DPOs for imparting the required training courses to the AWWs and orientation and refresher courses to AWHs.

Out of Rs. 1.54 crore received from the GOI during 2003-08 for training of ICDS functionaries, only Rs. 1.29 crore was spent. All the eligible AWWs and AWHs were not targeted for imparting training in various courses during 2003-08. The status of training was alarming at Shillong Training Centre particularly during the year 2007-08. Of the 814 and 1,265 AWWs eligible for job training and refresher training respectively, only 140 and 210 AWWs were targeted for training. The AWWs actually trained were only 187 and 192 respectively.

Likewise, AWHs eligible for job training and refresher training were 639 and 899 respectively. The number targeted for training during the year was 400 and 350, and those actually trained were only 280 and 139 respectively. Information regarding the training of the CDPOs and supervisors was not on record.

The Government stated (October 2008) that the shortfall was due to non-filling up of the posts of CDPOs/lady supervisors. Thus, the deficiency in imparting training is bound to have an adverse impact on the quality of service provided by the AWCs.

3.2.18 Field visits and supervision

The CDPOs are required to undertake field visits to the anganwadis for at least 18 days a month with 10 night halts outside the headquarters and Supervisors are expected to visit at least one anganwadi once in a week to inspect its activities.

It was seen that during 2003-08, there was 18 *per cent* to 74 *per cent* shortfall in field visits of CDPOs and 77 *per cent* to 99 *per cent* by Supervisors in 11 out of the 14 test-checked ICDS projects. In the remaining three test-checked projects, the quantum of field visits by CDPOs/Supervisors was in accordance with the prescribed norms.

The Government stated (October 2008) that the shortfall was due to non-filling up of the posts of CDPOs/lady Supervisors. The shortfall in supervision of the AWCs by the designated officers had denied the AWWs the guidance to improve the functioning of AWCs and the quality of service delivered.

3.2.19 Monitoring and Evaluation

As per the scheme guidelines, there should be a State Coordinator to ensure smooth flow of the services under the ICDS. Besides, a Senior Adviser with wide experience in nutrition, child development and ICDS was to be engaged. Two to three Survey Consultants were also to be engaged for conducting survey of severely malnourished children and any other specific parameters assigned to them. Data pertaining to training, survey and monitoring were to be analysed at the first level by the individual officer and then sent to the State Coordinator. Though, Coordination Committees at the block/project, district and State levels were set up, there was no recommendation from these Committees to overcome the shortfall/deficiencies in the area of immunization, training and distribution of foodstuff, *etc*. The overall impact of implementation of the scheme was also not evaluated at any level.

The Assistant Director, ICDS stated (August 2008) that the scheme had been monitored regularly and the task for evaluation study had been entrusted to the North Eastern Hill University during 2007-08. The reply is an admission that the impact of the scheme so far implemented, remained unassessed.

3.2.20 Conclusion

The overall impact of implementation of the scheme was far from satisfactory because of significant shortfall in implementing various components of the scheme. Health check-up of a significant number of children was not conducted to detect diseases and other evidence of malnutrition. Fund management was poor and the Director failed to utilise 36 to 100 *per cent* of funds released by the GOI during 2003-08 for construction of buildings for AWCs. Forty to 83 thousand children of 0-6 years age were deprived of the benefit of supplementary nutrition during the review period and poor quality of food was supplied to children and pregnant/lactating mothers in certain projects. There was a shortfall in completion of the prescribed doses of immunization of different vaccines to the children and women. The objectives of improving the nutritional and health standard of the children and enhancing the capability of mothers to ensure the nutritional and health standard of their children as envisaged under the scheme, thus, remained largely unachieved.

3.2.21 Recommendations

On the basis of the shortcomings and deficiencies pointed out in the foregoing paragraphs, the following recommendations are made for streamlining the implementation of the scheme:

- **Adequate funds should be released on a timely basis and utilised for the intended purpose.**

- **Anganwadi centres should be set up as per norms to bring all the targeted children and women under the purview of the scheme.**

- **Effective steps should be taken for immunization through vaccination of the children and pregnant women as per the prescribed schedule to protect them against various diseases.**

- **Steps should be taken to ensure that the foodstuff provided is of acceptable quality and contains the prescribed calorific and protein value.**

- **Regular training should be imparted to the CDPOs, Supervisors, AWWs and Anganwadi helpers as per norms, to upgrade their knowledge in the area of their operation.**

- **Prescribed level of supervision and visit of the AWCs by the CDPOs and Supervisors should be enforced to improve their functioning.**