CHAPTER – I

SOCIAL SECTOR

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SOCIAL SECTOR

1.1 Introduction

This Chapter of the Audit Report for the year ended 31 March 2014 deals with the findings on audit of the State Government units under Social Sector.

The names of the State Government departments and the total budget allocation and expenditure of the State Government under Social Sector during 2013-14 are given below:

Table No. 1.1.1

(₹ in crore)

Name of the departments	Total Budget allocation	Expenditure
School Education	1004.85	874.68
Technical Education	63.99	37.51
Higher Education	157.11	122.69
SCERT	28.12	15.52
Youth Resources and Sports	78.12	77.01
Art and Culture	18.95	18.38
Health and Family Welfare	308.78	303.90
Water Supply & Sanitation	82.06	81.86
Urban Development	248.92	127.06
Municipal Affairs	26.81	9.28
Information and Public Relations	22.59	22.57
Labour	8.87	8.97
Employment and Training	18.85	18.72
Social Security and Welfare	185.67	176.70
Women Welfare	10.44	10.28
Rajya Sainik Board	3.22	3.21
Total Number of Departments = 16	**2267.35**	**1908.34**

Besides the above, the Central Government has been transferring a sizeable amount of funds directly to the Implementing agencies under Social Sector to different departments of the State Government. The major transfers for implementation of flagship programmes of the Central Government are shown in the following table:

Table No. 1.1.2

(₹ in crore)

Name of the Department	Name of the Scheme/Programme	Implementing Agency	Amount of funds transferred during the year
School Education	Sarva Shiksha Abhiyan (SSA)	State Mission Authority	158.03
Health & Family Welfare	National Rural Health Mission (NRHM)	State Health Society	105.79
		State Blindness Control Society	0.83
	National Aids Control	Nagaland Aids Control Society	22.84
Water Supply and Sanitation	National Rural Drinking Water Programme	Public Health Engineering Department	50.78
Forest	National Aforestation and Eco Development	State Forest Development Agency	9.82

(Source: Central Plan Scheme Monitoring System of Controller General of Accounts)

1.2 Planning and Conduct of Audit

Audit process starts with the assessment of risks faced by various departments of Government based on expenditure incurred, criticality/complexity of activities, level of delegated financial powers, assessment of overall internal controls and concerns of stake holders.

After completion of audit of each unit on a test check basis, Inspection Reports containing audit findings are issued to the heads of the departments. The departments are to furnish replies to the audit findings within one month of receipt of the Inspection Reports. Whenever replies are received, audit findings are either settled based on reply/action taken or further action is required by the auditee for compliance. Some of the important audit observations arising out of the Inspection Reports are processed for inclusion in the Audit reports, which are submitted to the Governor of the State under Article 151 of the constitution of India for being laid on the table of the Legislature.

During the year, test check of audits involving expenditure of ₹ 3912.84 crore (including funds pertaining to previous years audited during the year) of the State Government under Social sector were conducted. This Chapter contains findings on Performance Audits of 'National Rural Health Mission' and 'Total Sanitation Campaign/Nirmal Bharat Abhiyan' and two compliance audit paragraphs.

HEALTH AND FAMILY WELFARE DEPARTMENT

1.3 PERFORMANCE AUDIT ON IMPLEMENTATION OF NATIONAL RURAL HEALTH MISSION

National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India (GoI) in all the States to bring about significant improvements in health system and health status of the people, especially those in rural areas. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable and responsive to the needs of the people. A performance audit on the implementation of NRHM in Nagaland brought out the following:

Highlights

Quality of health services to address the gap filling was not identified through facility survey during 2009 to 2013. The facility survey conducted during 2013-14, could not yield substantial result due to non-incorporation of the highlighted inputs in the State Programme Implementation Plan.

(Paragraph-1.3.8)

Government of Nagaland (GoN) committed financial assurances for ₹ 61.65 crore during 2009-14 against which only ₹ 53.20 crore was released to meet the commitments to enhance the facilities in health sector in the State.

(Paragraph-1.3.9.1)

Department provided an undue benefit of ₹ 10.25 crore to a local contractor for setting up of MRI at Naga Hospital Authority, Kohima.

(Paragraph-1.3.10.8 (a))

SHS diverted ₹ 8.76 crore for salary components of RCH/vertical programmes and ₹ 2.30 crore for furniture and fixing, deep bore well etc. against the upgradation of two DHs at Phek and Kiphire without any supporting vouchers.

(Paragraph-1.3.10.8 (b))

Due to non-procurement of generic drugs and equipment from the firms approved by GoI, the Department spent ₹ 1.03 crore which was avoidable.

(Paragraph-1.3.11.1(c))

Short receipt of medicines and equipment worth ₹ 1.53 crore was noticed in four District Hospitals, 8 CHCs and 12 PHCs out of the medicines and equipment issued by the SHS. Short receipt of equipment worth ₹ 1.66 crore was noticed with Central Store, NRHM during 2009-14.

(Paragraph- 1.3.11.1(e, f & i))

1.3.1 Introduction

The Mission aimed at providing accessible, affordable, accountable, effective and reliable health care services in the rural areas by converging various standalone disease control programmes. The components of NRHM includes bridging gap in healthcare facilities, facilitating decentralised planning in health centers and advocating convergence with the related social sector Departments. The major objectives of the Mission are to:

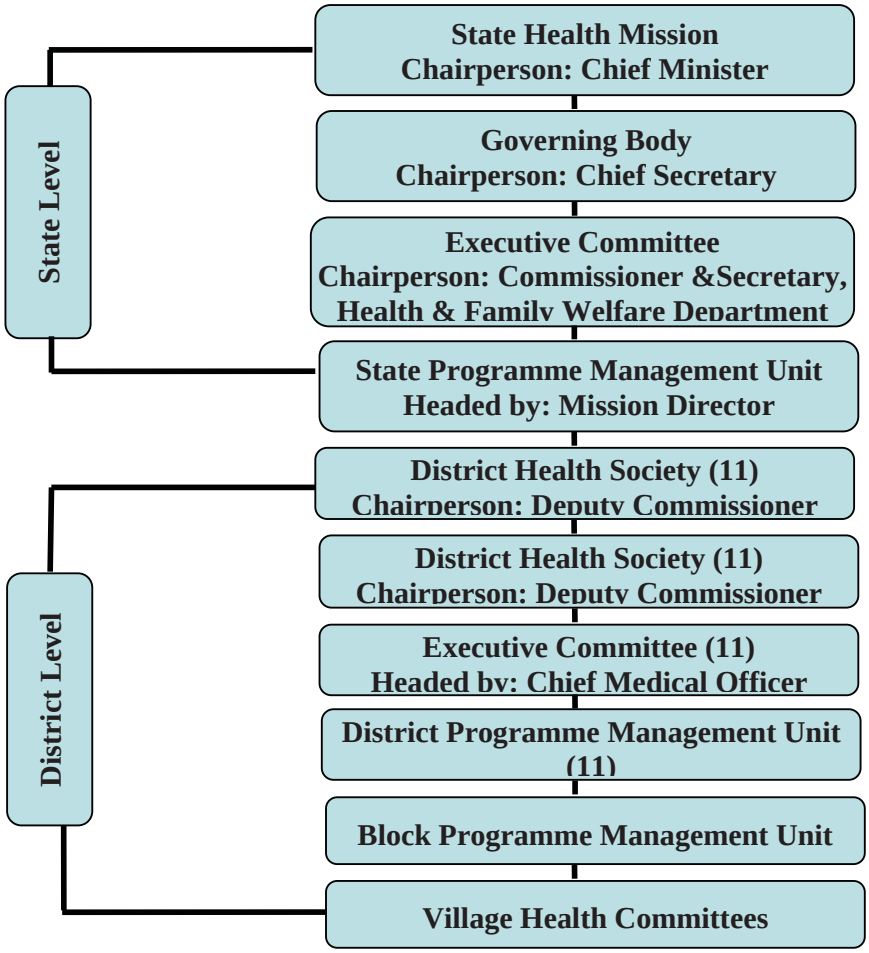
- Provide integrated comprehensive primary health care services with emphasis on universal immunisation to the rural people,
- Reduction of infant and maternal mortality rate,
- Prevention and control of communicable and non-communicable diseases,
- Promotion of healthy lifestyles.

The Mission was revised (October 2013) and renamed as National Health Mission (NHM) by merging NRHM and National Urban Health Mission (NUHM).

1.3.2 Institutional arrangements for NRHM

Institutional arrangements at the State and district levels of the mission are given below:

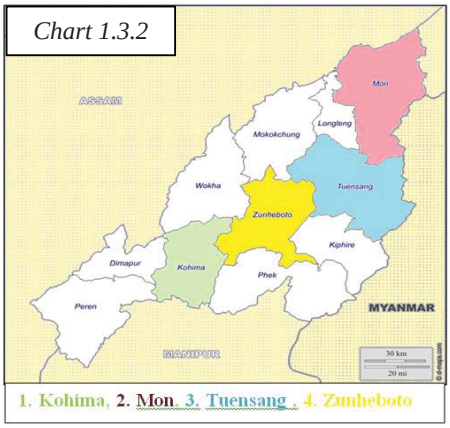
Chart 1.3.1



1.3.3 Scope of Audit

The Performance Audit (PA) covering various activities of NRHM and NHM[1] for the period from April 2009 to March 2014 was carried out between April and August 2014. Four Districts[2] out of 11 were selected by applying Simple Random Sample Without Replacement. Eight Community Health Centers (CHCs)[3] out of nine, 12 Primary Health Centers (PHCs)[4] out of 53 and 20 Sub-Centers (SCs)[5] out of 175 in the four sampled districts were selected using Probability Proportional to Size Without Replacement. In addition to this, four District Hospitals (DH)[6] in the four sampled districts were also covered.

Chart 1.3.2



1. Kohima, 2. Mon, 3. Tuensang, 4. Zunheboto

1.3.4 Audit Objectives

The objectives of the PA were to examine whether:

- Planning was oriented towards the Missions objectives; there was adequate community participation in planning, implementation and monitoring of the mission and there was convergence with the other departments, programmes and non-Governmental stakeholders to achieve the objectives of the Mission;
- Financial controls were in place to safeguard funds and assets of NRHM and the release of funds and their utilisation were prompt and adequate;
- Construction activities were undertaken to maximise the coverage in population, improve facilities and due procedures were followed while incurring expenditure thereof;
- The procedures and system of procurement of equipment, drugs and services, supplies and logistics management were cost effective and efficient;
- The performance indicators and targets fixed in respect of reproductive and child healthcare, Information, Education and Communication (IEC) programme, immunisation, and disease control programmes were achieved;
- Capacity building and strengthening of human resources at different levels was achieved as planned; and
- Monitoring mechanism and evaluation procedures were in place to ensure that the Mission's objectives were achieved.

[1]Though launched in October 2013, was not implemented till March 2014.
[2] Kohima, Tuensang, Mon and Zunheboto.
[3]Tsemenyu, Chiephobozou, Longkhim, Noklak, Aboi, Tobu, Pughoboto and Aghunato.
[4]Chunlika, Touphema, Tesophenyu, Noksen, Shamator, Thonokhnyu, Tizit, Phomching, Wakching, Satakha, Satoi and Suruhuto.
[5]Khuzama, AG Colony, Kitsebozou, Mima, Pfuchama, Hakchang, Chingmei, Tronger, Tonglongsor, Khudei, Longwa , Tanhai, Ngangching, Ukha, Yakshu, Aghuito, Gukishe, Chishilimi, Ghukovi and Hoshepu.
[6]Naga Hospital Authority Kohima (NHAK), Tuensang, Mon and Zunheboto.

1.3.5 Performance Indicators and Audit Criteria

Following performance indicators were used in performance audit:

- Increase in number of healthcare facilities in districts,
- Improvement in infrastructure, equipment, supply of medicines, diagnostic services of healthcare facilities at district level, and
- Increase in number of inpatient and outdoor patients seeking health services,

The findings were benchmarked against the audit criteria obtained from the following sources:

- Guidelines of the Government of India in respect of NRHM,
- Perspective and annual action plans,
- Conditions and norms for release of funds, and
- Prescribed monitoring mechanism.

1.3.6 Audit Methodology

The audit methodology comprised entry conference (April 2014) with the Commissioner & Secretary, Health & Family Welfare Department and the Mission Director, NRHM, Nagaland, requisition and examination of documents/records of State Health Society, four District Health Societies, four District Hospitals, eight CHCs, 12 PHCs and 20 SCs, communication/issue of audit observations, examination of responses to audit queries, joint physical verification, photographic evidence, beneficiary survey and exit conference (October 2014) at the end of audit.

1.3.7 Acknowledgement

We express our appreciation for the co-operation and assistance accorded to us at all levels during audit.

Audit Findings

Objective – 1: Planning for the achievement of the objectives of the Mission

1.3.8 Planning

Planning is an important tool to link various scheme components for successful implementation of the programme. Planning process involves identification of target groups by analysing the existing facilities and requirements to achieve anticipated output. In NRHM, the identification of health and facilities requirement were to be done through decentralised and community based approach by carrying out house hold survey, facility survey and baseline survey. The inputs received in respect of each district through these surveys form the District Health Action Plans (DHAPs) of that district which are integrated and form a State Programme Implementation Plan (SPIP). The approved SPIP forms the frame work for implementation of the programme for that State.

Examination of the records on planning process revealed the following:

(i) House hold survey.

To assess the availability, adequacy and utilisation of health services in the rural areas, household survey was required to be carried out. The deficiency in conducting household survey[7]and facility survey[8] were also highlighted in the Report of the Comptroller and Auditor General of India for the period ended 31st March 2008 and the Health and Family Welfare Department had reported in the Action Taken Report that household survey was completed in all 11 districts.

Examination of the Nagaland Family Health Assessment (NFHA) survey covering 1277 villages carried out during 2010 revealed that important parameters like assessment of availability, adequacy and utilisation of health services were not included in the survey. Thus, meaningful assessment of health care services in the rural areas remained unidentified to fill up the gaps for future course of interventions. The result of the beneficiary survey conducted in Kohima district also revealed that out of 457 responses received, 250 beneficiaries (55 *per cent*) stated that household survey was not conducted in their villages.

The Department accepted (October 2014) the observation and noted for future compliance.

(ii) Facility survey.

Facility survey was required to be conducted every year to identify the gaps required for delivering quality health services in Health Units (HUs)[9]. It was seen that during the period covered in this PA, the Department carried out only one facility survey[10] during 2013-14 covering all HUs in the State. Examination of the facility survey conducted in respect of 44 test checked HUs[11] revealed that though the requirement of the facilities were included in the DHAPs, the SPIP did not compile the required facilities such as medicines, equipment, infrastructure etc. projected through DHAPs. As a result, there were instances of unnecessary construction of HUs and residential accommodations of Medical Officers (MOs) and staff and unnecessary issue of medicines and equipment as detailed in paragraphs 1.3.10.2, 1.3.10.3, 1.3.10.4.1, 1.3.10.5 and 1.3.11.1. The facility survey was not carried out during 2009 to 2013.

(iii) Baseline survey.

Baseline survey is aimed to identify the core/deficient indicators to improve health services in the State. In Nagaland Mother Non-Government Organisations (MNGOs) were assigned to carry out base line surveys. As per the norms prescribed by the Ministry yearly grants-in-aid of ₹ 0.05 crore to ₹ 0.15 crore was to be allowed for the work. GoI approved (March 2008 and August 2009) 11 MNGOs in five districts for

[7] Survey was conducted in seven districts out of 11 districts but the data was not compiled.
[8] Facility survey was not conducted in three CHCs , 12 PHCs and 55 SCs.
[9] DHs, CHCs, PHCs and SCs
[10] Survey on special services, manpower, investigating facilities and equipment, infrastructure etc. with the health units.
[11] Four District Hospitals, eight CHCs, 12 PHCs and 20 SCs.

baseline survey and approved ₹ 5.98 crore[12] as grants- in- aid during 2009-2011[13]. It was observed that the Department had signed MOUs with 11 MNGOs with an annual allotment ranging from ₹ 0.20 crore to ₹ 0.22 crore per annum instead of ₹ 0.05 crore to ₹ 0.15 crore as prescribed by the Ministry. The Chief Medical Officers (CMOs) in four sampled districts however, stated (May-August 2014) that MNGOs did not carry out any baseline survey but the SHS released an amount of ₹ 1.11 crore to the four MNGOs in sampled districts. The beneficiary survey conducted in Kohima district also revealed that 386 beneficiaries out of 457 (84 *per cent*) reported that baseline survey was not conducted in their village which confirmed the reporting of the CMOs.

The Department stated (October 2014) that identification of underserved and unserved areas in two districts were carried out by MNGOs in June 2005. However, the CMOs categorically stated that no baseline surveys were carried out by the NGOs.

Objective – 2: Existence and adequacy of financial controls

The funding pattern of NRHM was in the ratio of 85:15 between the Centre and State for 2009-12 and 90:10 from 2012-13. The proportional State share was required to be deposited to the SHS within seven days of the releases made by GoI. The funds for the Mission components like untied funds, annual maintenance grants and grants for *Rogi Kalyan Samiti* (RKS) to DHs, CHCs, PHCs and SCs was to be transferred to the DHS within 15 days of receipt of funds from GoI.

The details of funds released by the GoI and the Government of Nagaland (GoN) and expenditure there against during 2009-10 to 2013-14 are shown in the table below:

Table No. 1.3.1

(₹ in crore)

Year	Opening Balance	Released by		Interest earned	Refunds from DHS	Total funds available for Programme Implementation (col. No. 2 + 3 + 4 + 5 + 6)	Expenditure	Closing Balance (col. 10-11)
		GoI	GoN					
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
2009-10	27.53	94.51	9.22	0.22	0	131.48	84.56	46.92
2010-11	46.92	77.45	12.62	0.80	0	137.79	97.64	40.15
2011-12	40.15	112.12	14.70	0.91	0	167.88	146.64	21.24
2012-13	21.24	95.04	10.08	1.10	2.73[14]	130.19	109.88	20.31
2013-14	20.31	95.13	6.58	0.51	0	122.53	93.30	29.23
Total		**474.25**	**53.20**	**3.54**	**2.73**		**532.02**	

(Source: Departmental figures)

Examination of the financial management revealed the following:

[12] 2009-10 (₹ 2.65 crore) + 2010-11 (₹ 3.33 crore)

[13] The programme was discontinued from 2011-12 onwards.

[14] Unutilised funds under RCH Flexipool (₹ 2.36 crore) and NRHM Flexipool (₹ 0.37 crore) refunded by the DHSs.

1.3.9.1 Short allocation/release of funds

The GoN proposed ₹ 946.22 crore[15] for NRHM activities for the period 2009-14, against which GoI released ₹ 474.25 crore. It was seen that the GoN committed financial assurances for ₹ 61.65 crore[16] as per the approved Records of Proceedings (RoP) for the period 2009-14 but released only ₹ 53.20 crore resulting in short release of ₹ 8.45 crore to meet the financial commitments to enhance the facilities in health sector in the State.

In reply the Department stated (October 2014) that GoI conveyed (May 2014) the shortfall of matching share of ₹ 0.90 crore. Further, the State share for 2013-14 had not been released by the State Government which is being pursued.

1.3.9.2 Delay in transfer of funds

As per clause 3.2.2 of Operational Guidelines of Financial Management (March 2012) of the Mission, funds should be transferred to the districts within 15 days of receipt of funds from GoI.

It was noticed that the State Government delayed release of State share ranging from eight to 15 months. There was also delay in transfer of funds to districts towards components like untied funds, annual maintenance grants and grants for RKS to DH, CHCs, PHCs and SCs ranging from two to 11 months. It was also observed that there was heavy retention of bank balance ranging from 25 to 83 *per cent* in respect of the funds released during the period 2009-14 with the SHS indicating poor financial management and deficient fund delivery mechanism. Due to this, there was shortfall in achievement of Routine Immunisation programme (*Paragraph 1.3.12.1*), Institutional Deliveries (*Paragraph 1.3.12.3*), eradication of leprosy (*Paragraph 1.3.13.1*), Annual Blood Examination Rate (*Paragraph 1.3.13.2.1*), conducting eye screening (*Paragraph 1.3.13.3*) and training under capacity building (*Paragraph 1.3.16.2*).

The Department while accepting (October 2014) the audit findings stated that funds are generally received at the end of the financial year which caused delay in transfer of funds.

Objective – 3 Construction activities vis-à-vis coverage in population and improvement in facilities

1.3.10 Rural health infrastructure

NRHM aims to bridge gaps in existing capacity of rural health infrastructure by establishing functional health facilities through revitalisation of existing physical infrastructure such as health unit buildings and fresh construction or renovation

[15] 2009-10 (₹ 315.67 crore), 2010-11 (₹ 105.20 crore), 2011-12 (₹ 98.12 crore), 2012-13 (₹ 262.31 crore) and 2013-14 (₹ 164.92 crore) = ₹ 946.22 crore.

[16] 2009-10 (₹ 11.75 crore) 2010-11 (₹ 12.62 crore) 2011-12 (₹ 14.70 crore) 2012-13 (₹ 10.64 crore) 2013-14 (₹ 11.94 crore).

wherever required. The Mission also sought to upgrade available facilities to meet the requirement of Indian Public Health Standards (IPHS).

1.3.10.1 Sub-Centers

Sub Centre (SC) is the first point of contact between the primary healthcare system and the community. As per the norms, one SC for a population of 3000 in tribal and hilly areas was required to be established which should be located within the village for easy accessibility and no person should travel more than three kilometers to reach a SC. As the population density in the country is not uniform, it should also depend upon the case load of the facility and distance of the village/habitations which comprise the SCs.

The details of SCs in the State are given in the table below:

Table No. 1.3.2

Sl. No.	Particulars	Number of SCs	Approved cost (₹ in crore)
1	No of SCs in the State upto March 2013	397	-
2	No of SCs created during 2013-14	13	-
Total number of SCs in the State as of March 2014		**410**	
3	No. of SCs functioning in Government building as of March 2009	320	NA
4	No. of SCs approved and newly constructed under NRHM during 2009-11	75	9.25
5	No. of SCs created and approved for new construction under NRHM during 2013-14	13	2.86
6	**Total SCs approved for construction under NRHM during 2009-14**	**88**	**12.11**
Total SCs functioning in Government building (Sl. No. 3+ 6)		**408**	

(Source: Departmental figures)

Examination of the records on construction activities of SCs revealed the following:

1.3.10.2 Discrepancy in reporting the number of Sub-Centers

As per the record of SHS, only two out of 410 SCs in the State were functioning in rented buildings. Examination of the records in four districts [17] revealed that 19 SCs were functioning in rented buildings as detailed below:

Table No. 1.3.3

District	No of SCs in the district	SCs functioning in non-Government buildings against which proposals were made through DHAPs during 2009-2014	No. of SCs approved by the SHS and completed during 2009-2014	Excess/ Short	No. of SCs continued functioning in non-Government/private building as of June 2014
Kohima	40	4	7	(+) 3	Nil
Tuensang	39	13	7	(-) 6	6
Mon	50	14	7	(-) 7	7
Zunheboto	47	13	7	(-) 6	6
Total	**176**	**44**	**28**	**(-) 19**	**19**

(Source: Departmental figures)

[17] Mon, Tuensang, Zunheboto and Kohima.

It can also be seen from above table that three SCs[18] constructed at the cost of ₹ 0.37 crore in Kohima district were in excess and also not included in the proposals of DHAP (2009-13). An instance of unnecessary construction of SC Kijumetuoma is shown at ***Photograph 1.3.1.***

Photograph 1.3.1

Old (functioning) and new (closed) buildings of Kijumetuoma SC

The Department stated (October 2014) that necessary action would be taken for immediate occupation of the buildings constructed for the SCs and the old SC buildings would be used as staff quarters.

1.3.10.3 Expenditure without execution of work

Out of 408 SCs functioning in Government buildings, following eight SCs were again taken up for fresh construction under State Plan- Communitisation during 2013-14:

Table No. 1.3.4

(₹ in lakh)

Sl. No.	Name of SC proposed by the State plan during 2013-14	District	Amount sanctioned under Communitisation	SC already completed under NRHM on	Cost of construction under NRHM
1	Kitsubozou	Kohima	6.50	07.01.2008	6.80
2	Thakiye	Zunheboto	5.00	06.05.2012	12.33
3	Totok Chingkho	Mon	7.00	23.02.2012	12.33
4	Wangla	Mon	7.00	23.02.2012	12.33
5	Khensa	Mokokchung	9.00	18.08.2011	12.33
6	Yaongyimsen Model	Mokokchung	9.00	07.01.2008	12.33
7	Yachang (C)	Mokokchung	9.00	18.8.2011	12.33
8	Longya	Kiphire	8.00	07.01.2010	12.33
		TOTAL	**60.50**		**93.11**

(Source: Departmental figures)

Examination of the records of the Directorate of Health and Family Welfare (DH&FW) revealed that GoN sanctioned ₹ 0.61 crore for construction of eight SCs under "State Plan- Communitisation in convergence with Rural Development and Department of Under Developed Areas". It was seen that these eight SCs were already shown as constructed under NRHM for ₹ 0.93 crore during 2008-2012. However, the DH&FW approved (March 2014) new construction of these eight SCs under State Plan- Communitisation and released ₹ 0.50 crore. Further, out of the eight, two SCs (Sl. No. 1&2) in the test checked districts were physically verified along with Departmental Officers and it was noticed that both the SCs had not been constructed which implies that ₹ 0.19 crore shown as expenditure was fictitious.

The Department stated (October 2014) that since the works have not been completed the proposal would be revised to avoid duplication.

[18] Khuzama, Seyima and Kijumetouma @ ₹ 0.12 crore per unit.

Besides the above, three SCs[19] were shown as constructed in Zunheboto districts and an amount of ₹ 0.31 crore was released. Joint physical verification revealed that these were not actually constructed resulting in fictitious expenditure of ₹ 0.31 crore.

1.3.10.4 Primary Health Centers

As per IPHS norms, a PHC was to be created or upgraded from SCs to cover 20,000 population. A PHC should have its own building to facilitate comprehensive primary quality health care to the community and also be centrally located in an easily accessible area. PHC should have a minimum plinth area of 3566 sq. ft to accommodate 12 bedded capacities.

Examination of records revealed the following:

1.3.10.4.1 Creation of Excess Primary Health Centers

As per population criteria, the State should have 99 PHCs[20], whereas there were 126 PHCs resulting in excess 28 PHCs. Further scrutiny revealed that out of the 28 excess PHCs, 16 PHCs[21] (57 *per cent*) were created in Phek district alone without observing population criteria. Further, joint physical verification of PHC at Thetsumi revealed that the PHC constructed at the cost of ₹ 0.70 crore covering population of 1910 was defunct since up-gradation (during 2009-10) due to non-posting of MO.

The Department stated (October 2014) that the excess PHCs were constructed in Phek district as per the notifications issued by the GoN.

1.3.10.4.2 Deviation from IPHS norms

Scrutiny of records of four test checked DHs revealed instances of construction of PHCs in plinth area which was less than the required area, functioning of PHC in MO quarter and rented building, construction of PHC far away from the habitation and non-functional PHCs due to poor monitoring as given below:

(a) Two PHCs[22] in Zunheboto district constructed (May 2012) for ₹ 1.37 crore were in a plinth area of 3240 sq. ft each as against 3566 sq.ft. for which estimates were prepared and funds sanctioned. Joint physical verification (June-July 2014) of these two PHCs revealed that the in-patient bed capacity was limited to four beds each in male and female wards against the provision of six beds each in male and female wards.

(b) In PHC Tesophenyu, Kohima district, joint physical verification (July 2014) revealed that the PHC building was in dilapidated condition. It was observed that MOs quarter constructed during 2007-08 was being used as PHC which could accommodate only three beds to provide health services.

(c) In PHC Touphema, Kohima district, joint physical verification (July 2014) revealed that the PHC was located in the outskirts of the village. It was also seen

[19] ₹ 0.07 crore (Kivikhu Old) + ₹ 0.12 crore (Chisholimi)+₹ 0.12 crore (Kivikhu) in Zunheboto = ₹ 0.31 crore.
[20] 1980000 (2001 census)/20000=99
[21] Nine PHCs were created during 2008-09 and seven were created during 2009-10.
[22] PHC Suruhoto and PHC Satakha.

that as per Out Patient Department (OPD) register (30.7.2012 to 31.3.2014) the PHC was operational for 209 days only against the required 531 working days.

(d) Eight PHCs[23] in three test checked districts were functioning in rented buildings with inadequate health facilities since the creation of the PHCs.

(e) PHC Zeizou, in Kohima district was non-functional since 2002. Scrutiny further revealed that the PHC building constructed for healthcare services was not handed over to the Department by the contractor till August 2014. It was reported (August 2014) by the Sr. MO in-charge that the building constructed for health care services was occupied by Border Roads Task Force (BRTF).

In reply, the Department stated (October 2014) that the construction of two PHCs in Zunheboto district was completed as per the availability of fund. The Department assured the renovation as well as new construction of PHCs which were functioning in rented/dilapidated buildings. The Department added that the PHC at Touphema was constructed in the outskirts of the village due to availability of land in the outskirts of the village.

1.3.10.5 Construction of quarters for Medical Officers and Staff

The requirements for construction of quarters were being reported through DHAPs every year. Scrutiny of records in the four test checked districts revealed that DHs proposed construction of 18 MO quarters and 79 staff quarters during 2009-14, against which SHS approved construction of 22 MO quarters and 20 staff quarters (₹ 9.41 crore) out of the funds of NRHM, SPA and TFC (15 quarters for ₹ 3.25 crore under NRHM, 13 quarters for ₹ 3.07 crore under SPA and 14 quarters for ₹ 3.09 crore under TFC).

Examination of the records revealed the following:

- 11 MO Quarters[24] and 10 staff quarters[25] were constructed outside the proposals projected through the DHAPs.
- Construction of nine quarters for ₹ 2.06 crore[26] were in progress though the projects were approved during 2010-13.
- Seven quarters reported as completed for ₹ 1.57 crore[27] were not constructed at two CHCs, three PHCs and two SCs though the payments were released. The non-construction was authenticated during the joint physical verification.

[23] PHC at Chen, Naginimora, Wanching, Pessao, Yonkhao in Mon district, Tsadang in Tuensang district, Saptiqa and Gatashi in Zunheboto district.

[24] Aboi CHC (1 No), Tizit PHC (2 Nos), Wakching PHC (1 No), Shamator PHC (1 No), DH Zunheboto (1 No), Suruhoto PHC (1 No), Pughoboto CHC (1 No), DH Kohima (1 No), Touphema PHC (1 No) and Tseminyu CHC (1 No).

[25] Tobu CHC (1 No), Hakchang SC (1 No), Aghunato CHC (1 No), Satakha PHC (2 Nos), Suruhoto PHC (1 No), Pughoboto CHC (1 No), Touphema PHC (2 Nos) and Mima SC (1 No).

[26] MO quarters at DH Zunheboto , DH Kohima, CHC Tseminyu, CHC Aghunato, PHC Shamator, PHC Tizit, PHC Satakha and PHC Suruhoto @ ₹ 0.23 crore per quarter under NRHM during 2012-13 for ₹ 1.84 crore and Staff quarters at CHC Noklak (₹ 0.22 crore)= ₹ 2.06 crore.

- Four quarters constructed for ₹ 0.81 crore[28] were not occupied for residential accommodation till July 2014.
- Two quarters constructed for ₹ 0.42 crore[29] were occupied by the Programme Officer ICTC/ NVBDCP for official purpose.
- Two quarters constructed for ₹ 0.45 crore[30] under SPA fund were actually constructed under Backward Area Development Fund (BADF). This was authenticated by the Deputy CMO, Tuensang.

1.3.10.6 Electricity and water

Electricity and water are required to preserve medicines and equipment and for maintaining hygienic environment. Village Health Committee is responsible for maintenance and keeping the surrounding of HUs clean. It was observed that 36 HUs[31] in the four test checked districts were functioning without basic facilities of electricity and water. Beneficiary survey conducted in Kohima district also revealed that 149 beneficiaries (33 *per cent*) out of responses received from 457 beneficiaries stated that their HUs were without adequate water and electricity supply indicating the lack of basic facilities with the HUs.

Photograph 1.3.2

Unhygienic status of Ghokuvi SC due to poor sanitation with pigs roaming around.

It can be seen from the ***photograph 1.3.2*** that the SC at Ghokuvi under Zunheboto district was highly un-hygienic as seen during the joint physical verification (July 2014).

The Department accepted (October 2014) the audit findings and assured that the basic facilities would be provided in phased manner.

[27] CHC Pughoboto (₹ 0.22 crore) under NRHM during 2010-11, CHC Tobu (₹ 0.27 crore) under SPA, Hakchang SC (₹ 0.18 crore) under SPA, PHC Shamator (₹ 0.32 crore) under SPA, PHC Chunlikha (₹ 0.16 crore) under SPA, SC Mima (₹ 0.15 crore) under SPA and PHC Touphema (₹ 0.27 crore) under TFC during 2011-13 = ₹ 1.57 crore.

[28] One staff quarter at PHC Touphema during 2008-09 under NRHM for ₹ 0.17 crore, two quarters constructed for ₹ 0.46 crore under SPA during 2009-10 at PHC Wakching (₹ 0.25 crore) and PHC Touphema (₹ 0.21 crore) and One staff quarter, though constructed at CHC Longkhim under TFC during 2011-14 for ₹ 0.18 crore = ₹ 0.81 crore.

[29] MO Quarter constructed at CHC Aboi under SPA for ₹ 0.25 crore and Staff quarter constructed at CHC Aboi under TFC for ₹ 0.17 crore = ₹ 0.42 crore.

[30] One MO Quarter for ₹ 0.28 crore during 2009-10 and one staff quarter for ₹ 0.17 crore during 2010-11at CHC Noklak = ₹ 0.45 crore.

[31] CHC Tobu was made functional only since January 2014, Tsadang PHC and Chessore PHC in Tuensang district, Satoi PHC in Zunheboto district and SCs at Phirahir, Nokhu, Chokla, Tsuwao, Yimpang, Noksen village, Yokumsang, Sangdak, Chiphur, Pang, Peshu, Sanglao, Wui, Sangchen, Sotokur and Urban Health Center in Tuensang district, SCs at Lotisami, Shitsumi, Hokiye, Ghokhuvi, Thakiye, Asukiqa, Chishilimi, Mishilimi, Chisholimi, Hoshepu, Surumi, Aichi Saghemi, Yehemi, Yezami, Yemishe and Akuhaito in Zunheboto district.

1.3.10.7 Fictitious expenditure of ₹ 0.39 crore

SHS earmarked ₹ 0.39 crore for maintenance of DH Tuensang during 2011-2014. The Medical Engineering Wing (MEW) reported (August 2014) that re-wiring and replacement of internal electrification (₹ 0.07 crore), repair and renovation (₹ 0.14 crore), repair of sewage system and drainage (₹ 0.07 crore) and improvement of male ward, female ward and surgical ward at DH, Tuensang (₹ 0.11 crore) were completed during March 2011 to February 2014. Joint physical verification (May 2014) of the DH Tuensang revealed that the aforementioned works valued at ₹ 0.39 crore were not carried out and this fact was authenticated by the MO, DH Tuensang. The non-execution of repair and renovation could be seen from the photograph alongside ***(Photograph 1.3.3)***. The Operation Theatre had a single shaded light and it is surprising how the DH carried out 900 Minor operations during January 2011 to March 2014 in such pathetic condition.

Photograph 1.3.3

Present status of wiring, OT and condition of ceiling of DH, Tuensang

The Department accepted (October 2014) and assured that repair and renovation would be carried out in due course.

1.3.10.8 Construction under Forward Linkages Scheme

GOI, sanctioned ₹ 74.63 crore to set up State Family Welfare Training Centre (SFWTC) at Kohima (₹ 13.71 crore), setting up of MRI unit at Kohima (₹ 16.23 crore) up-gradation of DH, Phek (₹ 21.37 crore) and up-gradation of DH Kiphire (₹ 23.32 crore) during 2011-13 under Forward Linkage Scheme (FLS)[32].

Examination of the records of the above scheme revealed the following:

(a) ***Setting up of MRI unit at Naga Hospital Authority, Kohima (NHAK)***

Magnetic Resonance Imaging (MRI) scan facility is used as an accurate method of disease detection of aneurysms, stroke, tumors of brain, tumors or inflammation associated with the vertebral or intervertebral discs of the spine. In terms of GFR provision for propriety items procurement should be initiated as per Office Establishment Manual (OEM). However, for setting up of MRI unit at NHAK, the Department procured the same through a contractor instead of following the procedures as

Photograph 1.3.4

MRI installed with NHAK

[32] Additional assistance provided through NRHM

per OEM. The cost involved was ₹ 16.23 crore. Reasons for ignoring procedures under GFR were not on record.

The Department released ₹ 16.23 crore in two installments[33] including cost of civil work for ₹ 0.98 crore to the contractor on the basis of recommendations (September 2013) of the Technical Committee for installation of Seimens-Magnetom Essenza 1.5 Tesla with Tim + Dot MRI. The release was made without supporting bill/invoice of any agency. In the absence of supporting bills, the cost of the MRI of the same make was obtained from the manufacturer (Siemens Ltd, India) which was only ₹ 5.00 crore along with all supporting accessories including 60 KVA full system UPS with 15 minute back up. Thus, the SHS provided an undue benefit of ₹ 10.25 crore to a local contractor for MRI at NHAK.

Further, joint physical verification (July 2014) of MRI at NHAK revealed that MRI machine was installed and was operational only from June 2014. It was further seen that the civil work (₹ 0.98 crore) was not executed as per the approved lay out and seven supporting accessories required for composing, imaging and evaluating spectroscopy were not received. The substandard civil work constructed to accommodate the machine resulted in delay in obtaining the quality assurance certificate from M/s Siemens Ltd. to operate the MRI services by eight months.

The Department stated (October 2014) that the amount sanctioned was more than the normal cost of the MRI machine and hence the funds were provisioned for additional activities and comprehensive warranty period for five years.

(b) ***Misutilisation of the scheme funds***

Out of ₹ 74.63 crore, SHS incurred ₹ 13.71 crore for setting up of SFWTC, ₹ 16.23 crore for setting up of MRI unit at NHAK and transferred ₹ 26.82 crore to EE, MEW for construction of two DHs. By taking into account the bank interest of ₹ 1.20 crore accrued during the period, there should have been a balance of ₹ 19.07 crore with the SHS as of March 2014. It was observed that only ₹ 8.01 crore was available as closing balance in the Bank account[34] of SHS as of March 2014. It was seen that out of ₹ 11.06 crore, SHS diverted ₹ 8.76 crore for salary components of RCH/vertical programmes and ₹ 2.30 crore was stated as utilised for furniture and fixing, deep bore well etc. against the upgradation of two DHs at Phek and Kiphire which were under construction. However, the reported expenditure for ₹ 2.30 crore utilised in advance was without any supporting vouchers.

The Department stated (October 2014) that ₹ 2.30 crore was spent for furniture, fixing and construction of deep bore well at two locations without any supporting documents in this regard. As per the records of the MEW, both the upgradations of DHs were under progress and the MEW only received the funds against the first phase. Thus, the

[33] ₹ 12.91 crore in March 2013 and ₹ 3.32 crore in October 2013
[34] Operated with Bank of Baroda, Kohima (A/c No.10180100008732).

Department reported expenditure of ₹ 2.30 crore as utilised for furniture and fixing, deep bore well etc. against the incomplete projects without any supporting documents.

1.3.10.9 Construction of Drug Warehouse

SHS proposed to the Ministry of H&FW for construction of nine drug warehouses at nine district headquarters. GoI approved (2009-11) ₹ 13.44 crore[35] for construction of nine drug warehouses with a purpose to store medicines, equipment etc. for DHs and also to provide supply of medicines and equipment to inaccessible areas in the State. Examination of records revealed the following:

- SHS approved and constructed drug warehouse for ₹ 1.36 crore at Mokokchung in addition to the existing drug warehouse at same location. The newly constructed drug warehouse was not utilised till July 2014.
- Four drug warehouses at Zunheboto, Tuensang, Mon and Phek were approved for a total cost of ₹ 6.00 crore. Out of these, three drug ware houses (Zunheboto, Tuensang and Mon) were constructed in total plinth area of 19707 sq. ft. instead of 22872 sq. ft.[36] for which estimates were prepared and funds were sanctioned. Thus, the Department paid ₹ 0.46 crore[37] to the contractor for works not actually done by him for 3165 sq. ft.
- Joint physical verification of drug warehouse located at these four districts revealed that completed drug warehouses were utilised for running establishment of CMO and residential purposes etc. as given below:

i. The Drug warehouse constructed (2011) at Zunheboto for ₹ 1.42 crore was unoccupied till June 2014 due to non-construction of approach road[38].

ii. Two floors of the Drug warehouse constructed at Tuensang was un-authorisedly occupied by an Anesthetist of the DH, Tuensang for personal purposes.

iii. Two floors of the drug warehouse constructed for ₹ 1.52 crore at Mon was occupied by the staff of CMO office and only the ground floor was utilised for storage of equipment, medicines etc.

Photograph 1.3.5

Unutilised old drug warehouse at Phek in good condition

Ware house at Phek. Only highlighted part used for storage

[35] Mokokchung (₹ 1.36 crore), Zunheboto (₹ 1.42 crore), Tuensang (₹ 1.54 crore), Mon (₹ 1.52 crore), Phek (₹ 1.52 crore), Longleng (₹ 1.37 crore),Kiphire (₹ 1.69 crore), Wokha (₹ 1.44 crore) and Peren (₹ 1.58 crore)

[36] Zunheboto (5456 sq ft.)Tuensang (6760 sq. ft) and Mon (7491 sq. ft.)

[37] 3165 Sq. ft. (₹ 1576.81 Ground floor + ₹ 1359.20 First floor)/2= ₹ 0.46 crore.

[38] No space to construct approach road to reach the drug warehouse as the warehouse was constructed behind the old hospital building.

iv. Though an existing storehouse in good condition was available with the CMO Phek, SHS resorted to new construction. It was observed that only two rooms in the ground floor of newly constructed drug warehouse (₹ 1.52 crore) was utilised for storage of equipment, linens and medicines out of the three floor building. Further it was noticed during physical verification of DH Phek that the medicines and hospital sundries and linens were kept in the corridor of the Regional Diagnosis Centre building of DH due to lack of space in the building though the drug warehouse was constructed for this purpose.

Photograph 1.3.6

Medicines stored in the corridor of RDC building due to insufficient space with the DH Phek.

Thus, the drug warehouses constructed in five districts for ₹ 7.36 crore were not utilised for intended purpose of storing medicines, equipment etc..

The Department accepted (October 2014) the audit findings and stated that the drug warehouse was being utilised to house CMO office and quarters. The compromise made in plinth area was due to the unavailability of required area of land.

1.3.10.10 Construction of Nursing Schools

The Indian Nursing Council authorises and prescribes requirement for setting up of nursing schools such as physical facilities, clinical facilities, hostel facilities etc. As per the prescribed norms, the teaching block should be constructed in 23720 sq. ft. and the hostel block should be with a plinth area of 30750 sq.ft. Laboratories, clinical facilities etc. should be provided within the Administrative block. GoI approved (2008-09) setting up of Nursing School at Dimapur for ₹ 8.74 crore.

Examination of records revealed the following:

- The Department constructed administrative and hostel block in plinth area of 15843 sq. ft. and 7284 sq. ft. respectively against the norms of 23720 sq ft. and 30750 sq. ft. respectively. By compromising the area of 31343 sq. ft.[39] EE, MEW utilised the project fund for construction of staff quarters, two quarters for Principal, one Dining hall-cum-kitchen, one quarter for Chowkidar and 26 items of supporting civil works.

- Joint physical verification revealed that though the cost of construction of two Principal's quarter, one Chowkidar quarter and sub-civil works with a total cost of

[39] Administrative block (23720 – 15843 sq ft.) + Hostel Block (30750 – 7284 sq. ft.) = 31343 sq. ft.

₹ 1.14 crore[40] was released to the contractor, the works were not actually executed to provide accommodation to Principal, Vice Principal and Chowkidar. The fact was authenticated by the Principal, Nursing School and the Assistant Engineer, MEW.

- Out of the total expenditure of ₹ 8.72 crore, Department incurred ₹ 1.11 crore for accessories and furnishing of the Nursing School, Dimapur. However, scrutiny of the stock register revealed that the items purchased by the SHS and the items in the stock register of Nursing School did not match. Non-availability of furnishing items and laboratory and study equipment with the Nursing school were confirmed during joint physical verification.

The Department appreciated (October 2014) the audit finding and assured that the contractor would be assigned to complete the unexecuted work.

1.3.10.11 Construction of Block Health Office (BHO)

SHS proposed (2011-12) for construction of Block Health Office (BHO) @ ₹ 0.05 crore per unit in 11 district headquarters to facilitate Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC) centers. The Ministry approved ₹ 0.55 crore for construction of 11 BHOs. The SHS issued (December 2011) sanction order to construct BHOs in 11 district headquarters and selected three contractors[41] as executing agency @ ₹ 0.05 crore per unit.

1.3.10.12 Payment made for works not executed

Examination of records revealed that the SHS did not maintain any Measurement Book in respect of the 11 BHOs constructed. However, a completion certificate stating that the works were completed satisfactorily was submitted. Payment of ₹ 0.55 crore was released (December 2011 to March 2012) to three contractors.

Joint physical verification (May 2014) of four DHS[42] revealed that in four BHOs the work reported as completed were not in existence and the fact was authenticated by the four CMOs.

Thus, the Department released ₹ 0.20 crore to three contractors against unexecuted four BHOs on false completion certificates signed by the Assistant Engineer, NRHM and approved by the Mission Director, NRHM.

The Department stated (October 2014) that the BHOs at Mon and Kohima were constructed and the BHOs at Tuensang and Zunheboto were not constructed. Fact

[40] Providing water supply & Sanitary installation i/c rain water harvesting for Con. of 3 bedded qtr (₹ 0.02 crore) + Site leveling & approach road for administration & classroom block Group A (₹ 0.05 crore) + Site leveling & approach road for administration & classroom block Group B (₹ 0.05 crore) + Site leveling & approach road for administration & classroom block Group C (₹ 0.02 crore) + Site leveling & approach road for hostel block (₹ 0.03 crore) + Site leveling & approach road for 3 bedded Qtr (₹ 0.02 crore) + Site leveling & approach road for 2 bedded Qtr (₹ 0.02 crore) + Providing water supply & Sanitary installation i/c rain water harvesting for Construction of Chowkidar Qtr NRHM (₹ 0.01 crore) + Providing water supply & Sanitary installation of Principal Qtr (₹ 0.03 crore) + Providing Marble stone flooring & tiles in Dining Hall & Kitchen (₹ 0.03 crore) + Construction of 3 bedded quarters for Principal of Nursing School (₹ 0.15 crore) + Providing granular Black filling, Protection wall & approach road (₹ 0.46 crore) + Construction of Chowkidar Qtr (₹ 0.05 crore) + 3 bedded Principal quarter (₹ 0.21 crore) = ₹ 1.14 crore.

[41] Shevohu Nienu (₹ 0.35 crore), Kiyehoto Sumi (₹ 0.10 crore) and Besupra Swuro (₹ 0.10 crore) =₹ 0.55 crore.

[42] Mon, Tuensang, Zunheboto and Kohima.

remained that the CMOs in the four districts authenticated the non-construction of BHOs for ₹ 0.20 crore.

Objective – 4 Procedures and system of procurement of equipment, drugs and services, supplies and logistics management

1.3.11 Medicines and equipment

Medicines and equipment are the integral part of the healthcare services. SHS formulated (December 2012) Nagaland Essential Drug list 2012-13 conveying a list of 282 essential drugs[43] to be issued to HUs. The drug list was required to be framed by April 2009 which was framed after a delay of 43 months. The SHS focused on 100 kinds of drugs (35 *per cent*) out of 282 as gap filling under NRHM and the remaining 182 (65 *per cent*) was to be provisioned through the State budget.

A purchase committee was formed with the DH&FW to analyse and scrutinise the bidding documents before awarding supply orders. As per Nagaland Drug & Diagnostics Policy 2013, the Committee was required to verify the manufacturer company-GMP certificate, company authorisation letter to stockist or supplier, company price list and valid wholesale drug licenses before awarding the supply orders to the suppliers for quality assessment of medicines and equipment. From the examination of records, the following was observed:

1.3.11.1 Deficiencies in procurement of medicines and equipment

It was observed that none of the suppliers furnished the documents as per Nagaland Drug & Diagnostics Policy 2013 whereas the Committee recommended the lowest quoted bidder for supply of medicine and equipment through limited tendering system without observing Nagaland Drug & Diagnostics Policy 2013. Para 19 of the Drugs (Price Control) Order 1995 envisages the provision of 16 *per cent* discount during the purchase of medicines directly from the Manufacturer. SHS purchased medicines worth ₹ 26.77 crore[44] from the local suppliers during 2009-14. Department could have saved ₹ 4.28 crore if the purchase had been made directly from the Manufacturer.

Scrutiny of the records of SHS, four DHS, four District Hospitals, eight CHCs, 12 PHC and 20 SCs revealed that:

(a) The four test checked districts received only 45 to 51 types (average of 83 *per cent*) of drugs every year against the list of 282 during 2012-14.

(b) The Department purchased expired medicines[45] valued ₹ 82,000 and the Committee also certified for issue to the HUs without verifying the quality.

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[43] Analgesic (19), Antibiotic (58), Anti-gastric ulcer (8), Anti-emetic(11), Anti diarrhea (2), Antispasmodic and purgative (8), central nervous system drugs (22), respiratory drugs (15), cardiovascular drugs (18), diuretics (6), antifungal (6), anti-allergy (16), local and general anesthetic drugs (23), anti-helminthic (6), vitamins and minerals (9), Antiseptics and disinfectant (6), electrolytes and acid based disturbances (11) skin/topical (10) eye/ear and nasal drops (16), anti- diabetic (4) and uterine drugs (8).

[44] 2009-10(₹ 4.67 crore), 2010-11(₹ 1.92 crore), 2011-12(₹ 10.08 crore), 2012-13(₹ 8.27 crore) and 2013-14(₹ 1.82 crore) =₹ 26.77 crore.

[45] 450 strips of Labetalol 100mg tablets @ ₹ 183 per strips purchased in December 2012 was expired in November 2012.

(c) Due to non-procurement of generic drugs and equipment from the firms approved by GoI, the SHS incurred an avoidable expenditure of ₹ 1.03 crore during 2013-14. ***(Appendix 1.3.1)*.**

(d) Department purchased 50 types of medicines and seven equipment above the Maximum Retail Price (MRP) for ₹ 0.75 crore ***(Appendix 1.3.2).***

(e) Short receipt of equipment worth ₹ 0.81 crore was noticed in four test checked districts from the equipment issued by SHS during 2009-14 ***(Appendix 1.3.3).***

(f) Short receipt of medicine worth ₹ 0.72 crore was noticed in two test checked DHS and NHAK out of the medicines issued by SHS ***(Appendix 1.3.4).***

(g) Idle and damaged equipment valued ₹ 0.77 crore was noticed with four DHs out of the issue made by the SHS and Directorate of Health and Family Welfare ***(Appendix 1.3.5).*** There were instances of rusted equipment noticed in the health units.

(h) Instances of expired medicines valued ₹ 0.10 crore stored with health units was also noticed in audit ***(Appendix 1.3.6)***.

(i) Short receipt of medicines and equipment worth ₹ 1.66 crore ***(Appendix 1.3.7)*** was noticed with central store of NRHM though full payment was released to the suppliers.

Thus, due to flaws in procurement process as well as issue of medicines to the HUs, 83 *per cent* of drugs did not reach the HUs. SHS incurred an excess expenditure of ₹ 1.78 crore due to non-adherence to the procurement policy. Due to surplus issue of medicine over and above the requirement, 42 types of medicines valued ₹ 0.10 crore was noticed as expired. Idle and damaged equipment valued ₹ 0.77 crore issued to the HUs failed to provide diagnosis facilities to the rural poor. Verification Committee failed to monitor the receipt and issue of medicine which resulted in short receipt of medicines and equipment worth ₹ 3.19 crore.

During beneficiary survey conducted in Kohima district, 233 beneficiaries out of 457 (51 *per cent*) stated that adequate medicines and equipment were not available in their HUs. Further, 143 beneficiaries (31 *per cent*) reported that they did not receive free medicines from their HUs. This points towards the inadequate supply of medicines to the HUs.

The Department stated (October 2014) that having realised the deficiencies, the Department had initiated streamlining the supply chain management system since December 2013.

1.3.11.2 Life-saving equipment

Life-saving equipment (blood gas analyser) is intended to diagnose important respiratory and metabolic indicators of acidosis[46] and alkalosis[47] in arterial blood. Electrolyte analyser, an important life-saving equipment is used to measure and evaluate the critical balance of electrolyte irons in the body fluids such as hot blood, serum, plasma and extra-cellular fluid etc.

[46] Acidosis: When body fluids contain too much acid (pH value below 7.35)
[47] Alkalosis: When body fluids contain excess base i.e.alkali (pH value above 7.45)

SHS proposed (April 2011) for purchase of life saving equipment for ₹ 4.79 crore in order to extend medical facilities to patients suffering from life threatening diseases like Cerebral Malaria, Swine Flu, Dengue, Meningitis etc. Blood gas analyser and electrolyte analyser was proposed for ₹ 1.48 crore to nine DHs and ₹ 3.31 crore was proposed for cost of consumables.

GoI sanctioned (June 2011) ₹ 4.79 crore for the purchase of life-saving equipment and medicines and released ₹ 4.23 crore being the share of GoI. GoN did not release the matching share of ₹ 0.56 crore.

The Department purchased (September 2011) seven blood gas analysers (₹ 0.56 crore), nine electrolyte analysers (₹ 0.66 crore) and consumables worth ₹ 2.80 crore from local suppliers and released (September 2011) ₹ 4.02 crore to the supplier and ₹ 0.21 crore was released towards taxes. During the joint physical verification of DHs, it was noticed that:

- Two blood gas analysers[48] (₹ 0.16 crore) and one electrolyte analyser[49] (₹ 0.07 crore) were not received in three DHs, though these were recorded as issued by the SHS.
- Two blood gas analysers[50] (₹ 0.16 crore) and three electrolyte analysers[51] (₹ 0.22 crore) in four DHs were not functioning since September 2011.
- The consumables valued ₹ 0.86 crore to support the life-saving equipment were not received in the test checked DHs. Non-functioning and non-receipt of life saving equipment and consumables were authenticated by the Medical Superintendents/ Managing Director.

Thus, the Department incurred ₹ 4.23 crore for 16 life-saving equipment, out of which three life-saving equipment (₹ 0.23 crore) and consumable (₹ 0.86 crore) were not received in the DHs though it was reported as issued by the SHS. Though the life-saving equipment worth ₹ 0.38 crore reached the DHs, they were not functioning due to damage as well as non-availability of consumables.

In reply, the Department stated (October 2014) that the procured blood gas analysers and electrolyte analysers were received and installed with the DHs. However, fact remained that the non-receipt of three equipment and consumables worth ₹ 1.02 crore and the non-functioning equipment with five DHs were authenticated by the officers-in-charge during the joint physical verification.

1.3.11.3 Waste management

In setting up bio-medical treatment facilities, sound environment management for bio-medical waste keeping in view of the techno-economic feasibility and viable operation of the facility to minimise impacts on human health and environment needs

[48] DH at Phek and NHAK
[49] DH Mon
[50] DH at Mon and Tuensang.
[51] DH at Phek and Zunheboto, NHAK

to be ensured. The Bio Medical Waste (Management and Handling) Rules 1998 envisages erection of stack for incinerator at a minimum height of 30 meters above the ground and the deep burial pits should be constructed at a distance far from habitation. The State Pollution Control Board should conduct inspection before providing pollution certificates. The Rules further envisages that the incinerator should be procured only from the manufacturing unit registered under the Factory Act 1948 and Company's Act 1956.

GoI, Ministry of H&FW, sanctioned (November 2011) ₹ 3.40 crore for setting up of Bio-medical Waste Plant (BWP) in four districts @ ₹ 0.85 crore per unit. The SHS selected four districts[52] for setting up of BWP and the work was awarded (December 2011) to M/s. Neile Enterprises, Dimapur which was not a manufacturing unit registered under Factory Act 1948 and Company's Act 1956.

Joint Physical verification of two BWPs in two districts (Phek and Kohima) revealed that:

1. The inspection was not carried out in two BWPs by the State Pollution Control Board for issue of pollution control certificate as the Department did not pursue for the same.

2. The heights of the stack of two incinerators erected with the BWPs were of eight meters only against the prescribed standard of 30 meters height which could cause health hazard due to the smoke emission.(***photograph 1.3.7).***

Photograph 1.3.7

BWP setup in front of Oncology Department at NHAK

3. The deep burial pits were constructed within the premises of the civil construction of the plants and the plants were also erected in prominent places[53] twithout considering the hazards to human health and environment.

4. The project at NHAK was not operational due to lack of technical manpower. The Managing Director, NHAK affirmed that on operation of BWP, the health hazard might arise due to short height of stack of the incinerator.

5. The incinerator machine set up at DH, Phek failed to burn during the test run (June 2013) and the plant remained non-operational till August 2014.

Thus, the Department awarded (December 2011) the erection of BWP to a contractor instead of manufacturing unit registered under Factory Act 1948 and Company's Act 1956 by violating the provisions of Bio Medical Waste (Management and Handling) Rules 1998. The plants setup were in inhabited areas and the stacks of incinerator were short in height by 22 meters which might result in human health hazard problem. BWPs were erected for ₹ 0.85 crore[54] in habitant area without adhering to the

[52] Kohima, Dimapur, Phek and Mokokchung.
[53] In front of eye OT and opposite to RDC Unit of the DH, Phek and in front of the Oncology Department at NHAK.
[54] Fifty *per cent* of ₹ 1.70 crore released to contractor.

specifications and without supporting accessories. The BWPs were also not operational due to technical problems as well as lack of manpower and was fraught with the risk of health hazards to the habitants. Due to non-utilisation of facilities provided under waste management for ₹ 0.85 crore, district hospitals continued with the disposal mechanism through District Municipal Councils (NHAK) and de-burial pits and open burning (DH, Phek) which subsequently resulted in wastage of NRHM funds.

The Department accepted (October 2014) the audit findings and assured that necessary corrective measures would be taken.

1.3.11.4 Waste management system with District Hospital, Tuensang

Photograph 1.3.8

Biomedical waste storage without any purpose.

During 2012-13, ₹ 0.04 crore was provisioned and utilised for construction of Biomedical Waste storage (₹ 0.03 crore) and deep burial pit (₹ 0.01 crore) at the DH, Tuensang. It was confirmed during the joint physical verification (June 2014) that biomedical Waste storage was constructed in the bushy jungle without any connectivity. The waste management continued in the landslide area behind the old building of the hospital.

Photograph 1.3.9

Dumping of waste behind the old hospital building.

The Department accepted (October 2014) the audit findings and assured that necessary corrective measures would be taken.

1.3.11.5 Quality Control

Nagaland Drug & Cosmetic Policy, 2013 envisage quality control at the time of tendering process subject to quality test by the laboratory empaneled in the State or outside the State. A Quality Control Committee, which is a support Committee to assist the verification board, should check the drugs and collect at least three samples randomly from 1/3 of the boxes from the supplies from each batch, decoded and dispatched to empaneled accredited laboratories for quality testing and control. No drugs should be distributed unless certified by the Quality Control Committee. As per the packing norms of the drug policy, all forms of packing of various drug formulations should be inscribed prominently with a logogram "Only Government of Nagaland Supply. Not for Sale".

Examination of records revealed the following:

- Verification Committee was performing verification of the quantity of the drugs received only and the quality control mechanism was not in place. Thus, the entire drugs purchased during the period covered in performance audit were distributed without the certificate of the Quality Control Committee.
- Further, joint physical verification of the four DHs and 40 HCs revealed that the drugs were not inscribed with the logogram "Only Government of Nagaland

Supply. Not for Sale" and also with short shelf life resulting in expiry of the drugs.

- The Drug Inspector, Tuensang seized 5200 Albendazole tablets (ABD-400) manufactured by M/s. G.S. Pharmaceuticals Pvt. Ltd, Roorke bearing Batch No T-1206147 out of the 15000 tablets issued (March 2013) by the SHS which did not conform to Indian Pharmocopy (IP). The seizure was made after confirming the laboratory tests from Regional Drugs Testing Laboratory (RDTL), Guwahati. Thus, 9800 sub-standard Albendazole tablets were issued to the school children for deworming.

- The Drug Inspector, Zunheboto collected samples of Iron Folic Acid (IFA) tablets, Oflogyl suspension, Ibugesic tablets and Ofoxo-oz suspension from the drug store of CMO/DH and forwarded (May 2013) to RDTL, Guwahati for laboratory testing. RDTL Guwahati confirmed that the samples were not of standard quality as defined in the Drug & Cosmetic Act, 1940. However, the Drug Inspector neither quantified the sub-standard IFA tablets, Oflogyl suspension, Ibugesis tablets and Ofoxo-oz suspension at the time of collection of sampling nor seized it after receiving the test report from the RDTL.

Thus, due to non-observance of the quality control by the verification board, the substandard drugs were supplied for consumption to school children and rural poor. In the absence of inscribed logogram on the drugs supplied to the DHs and further supplied to the HUs, possibility of sale of drugs to open market could not be ruled out.

The Department accepted (October 2014) the audit findings and assured to revise the procurement policy incorporating the quality control mechanism.

Objective – 5: Performance indicators and targets in respect of Reproductive and Child Healthcare (RCH), Information, Education and Communication (IEC) programme, Immunisation and disease control programmes

1.3.12.1 Routine Immunisation

Routine Immunisation (RI) is an important child survival strategy focusing on preventive aspects to reduce morbidity against six preventable diseases, namely tuberculosis, diphtheria, pertussis, tetanus, polio and measles and the vaccination was to be covered in seven stages to the age group of 0 to 1 years. The targets and achievements under the RI in the age group of 0-1 years are given in ***Appendix 1.3.8.***

The following was observed:

- Shortfall in achievement to targeted age groups in respect of Bacillus Chalmette Guerin (BCG) vaccination ranging from 14 to 37 *per cent* during 2009-14.
- Shortfall ranging from 33 to 44 *per cent* in respect of Oral Polio Vaccination (OPV) during 2009-14.
- Shortfall ranging from 26 to 71 *per cent* in Measles vaccination; and
- Short ranging from 39 to 52 *per cent* in full immunisation during 2009-14.

Short fall in full immunisation to age group 0-1 year was confirmed in the four sampled districts ranging from 26 *per cent* to 57 *per cent* and this was due to lack of storage facilities, electricity etc. for immunisation with the HUs and the fact was confirmed in 26 HUs[55] out of 40 test checked HUs during joint physical verification.

The Department accepted (October 2014) the audit findings and stated that shortfall in RI was due to poor health seeking behavior, inadequate equipment and inaccessibility owing to the difficult terrain etc. The Department assured that shortfall would be accelerated by up-scaling IEC activities, strengthening infrastructure and logistics and providing training to the health workers.

1.3.12.2 Cold chain facilities

As per the distribution norms, a CHC/PHC should be equipped with one Ice-lined Refrigerator (ILR) and one Deep Freezer (DF) for storage of vaccines for RI. The Department issued 93 ILRs and 83 DFs to 21 CHCs and 72 PHCs. Thus, there was shortfall of ILRs/ DFs with 54 PHCs[56].

Ministry allocated (November 2009) walk-in cooler (WIC) to the Department to store the vaccines in vast volumes around 27 cubic meter with the central store of State Immunisation Officer. Installation of WIC requires space more than 27 cubic meters in a separate building. The Department did not provide space for civil construction to commission the WIC and hence the WIC was kept uninstalled since June 2010. While requesting for commissioning of WIC by the Department, the Ministry replied (July 2010) that commissioning of WIC was not carried out by representative of M/s. Blue Star Pvt. Ltd due to non-availability of separate space for construction.

Further scrutiny revealed that Department purchased (December 2012) 50 ILRs for ₹ 0.13 crore and 43 DFs for ₹ 0.12 crore along with 93 voltage stabilisers for ₹ 0.04 crore from M/s. Neile Enterprises, Dimapur out of funds approved under NRHM during 2012-13. As per the stock register of the Central Store, Immunisation wing, against the above procurement there should be a balance of 39 ILRs, 32 DFs and 71 voltage stabilisers after the issue of the cold chain equipment to the HUs. However, joint physical verification (May 2014) revealed that only 10 ILRs valued ₹ 0.03 crore were available. Thus there was a pilferage of 29 ILRs (₹ 0.08 crore), 32 DFs (₹ 0.09 crore) and 71 voltage stabilisers (₹ 0.03 crore) noticed in audit which was authenticated by the officer in-charge of the Central Store, State Immunisation wing.

The Department stated (October 2014) that WIC was installed in June 2010 and also forwarded copies of the material verification report to support the receipt of cold chain equipment purchased in December 2012. However, fact remains that non-commissioning of WIC as well as the non-receipt of cold chain equipment worth ₹ 0.26 crore were authenticated by the officer-in-charge of Central Store, State Immunisation wing during the joint physical verification of the store.

[55] Cold chain facilities to store vaccines at CHCs at Tobu and Pughoboto were not functional due to lack electricity and damaged freezers, Cold chain facilities were not supplied to 4 PHCs (Satoi, Phomching, Tosephenyu and Touphema) and 20 SCs.

[56] 126 PHCs in the State-72PHCs=54 PHCs

1.3.12.3 Institutional and Home Deliveries

As per SPIP 2013-14 only 11 SCs (3 *per cent)* out of 396 SCs in the State have the facilities for deliveries in the State. Out of 11 SCs, only five SCs recorded more than two deliveries in a month. It was seen that four SCs (2 *per cent)* out of 175 SCs[57] in the four test checked districts were conducting deliveries. This indicated the poor institutional deliveries attended through the SCs

To achieve 109000 targeted deliveries in the State, Ministry allocated ₹ 12.63 crore during 2009-14 against which SHS incurred ₹ 9.26 crore. The birth rate[58] was reported as 16.8 per 1000 population. However, as per the targeted delivery in the State, the birth rate should be at an average of 21.8 per annum[59]. Out of the total allocation of ₹ 12.63 crore, SHS earmarked ₹ 8.17 crore and ₹ 2.08 crore for institutional and home deliveries respectively. Against this, the Department incurred ₹ 7.34 crore (90 *per cent*) and ₹ 1.33 crore (64 *per cent*) respectively towards institutional and home deliveries.

Department achieved 46862 deliveries (71 *per cent*) against the target of 69000 deliveries during 2011-14[60]. 40991 deliveries (87 *per cent*) were recorded as Institutional Deliveries (IDs) out of 46862 deliveries reported during 2011-14.
Scrutiny of the IDs and Home Deliveries (HD) in four test checked districts revealed that ID ranged from 55 *per cent* to 83 *per cent*, whereas HD ranged from 17 *per cent* to 45 *per cent* as detailed below:

Table No. 1.3.5

Year	Mon		Tuensang		Zunheboto		Kohima	
	ID	HD	ID	HD	ID	HD	ID	HD
2009-10	514 (63)	304 (37)	936 (62)	577(38)	NA	NA	1916(79)	507(21)
2010-11	519 (51)	497 (49)	1299 (72)	515(28)	650 (67)	325 (33)	1636(71)	661(29)
2011-12	743 (54)	625 (46)	1345(71)	561(29)	623 (59)	425 (41)	2232 (87)	337(13)
2012-13	921 (61)	592 (39)	895(46)	1060(54)	656 (49)	681 (51)	2223(88)	302 (12)
2013-14	951 (49)	998 (51)	642 (37)	1109(63)	744 (62)	456 (38)	2556(90)	281 (10)
Total	**3648 (55)**	**3016 (45)**	**5117(57)**	**3822 (43)**	**2673(59)**	**1887(41)**	**10563(83)**	**2088 (17)**

(Source: Departmental figures)

Thus, it is evident from the table that poor ID was noticed in the three test checked districts and ranged from 55 to 59 *per cent* only. This was due to poor health seeking behavior, shortage of adequate technical manpower for recruitment, inaccessibility owing to difficult terrain, scattered population, poor road condition and lack of proper public transport services.

It was also noticed during beneficiary survey conducted in Kohima district that 206 beneficiaries out of 457 (45 *per cent*) stated that HUs in their villages were not fit for institutional delivery.

[57] Mon (50), Tuensang(38), Zunheboto(47) and Kohima(40)
[58] Data published in SRS bulletin 2010-11
[59] (109000 targeted deliveries ÷ 5 years)÷1000 population = 21.8
[60] The data for ID and HD in separate format was not available for the period 2009-10 and 2010-11 with SHS.

The Department accepted (October 2014) the audit findings and assured that shortfall would be accelerated by up-scaling IEC activities, strengthening manpower and infrastructure and also providing training to the health workers.

1.3.12.4 Referral Transport

Ambulances with equipment are utilised for referral transport system during the medical emergency and disaster. Life-saving emergency medicines including oxygen should be made available in the ambulance and the ambulance should be kept in the HUs at all times whenever not on duty.

Department had only 22 ambulances for providing referral transport in the PHCs as of March 2009. During 2009-10 to 2013-14, the Department proposed purchase of 55 ambulances to provide referral transport to PHCs which observed 24 x 7 duty, against which the Ministry approved purchase of 45 ambulances[61] at a total cost of ₹ 3.20 crore @ ₹ 0.07 crore per unit against prioritised 45 PHCs in the State.

It was seen that the SHS purchased 45 ambulances at a total cost of ₹ 2.93 crore[62] to achieve the total fleet position of 67 ambulances.[63] It was observed that only 29 ambulances (64 *per cent*) were issued to the prioritised 24x7 PHCs out of 45 ambulances purchased during 2009-13. Ambulances (16) were issued to DHs and CHCs instead of issuing to PHCs in violation of the approval of the Ministry thus depriving the referral transport in 16 prioritised 24 x 7 PHCs[64].

The ambulance facilitating as referral transport should be equipped with minimum basic lifesaving emergency medicines including oxygen cylinder and other emergency equipment. Against the 26 ambulances purchased during 2009-10, the SHS procured equipment and medicines for ₹ 0.51 crore. However, in 10 ambulances[65] issued to four test checked districts it was seen that medicines and equipment were not provided with the ambulances which was authenticated by the four CMOs.

The Department stated (October 2014) that distribution of ambulances were prioritised in the district review meeting to accommodate the DHs and CHCs wherein referrals happen frequently. The Department, further accepting the non-receipt of medicines and equipment worth ₹ 0.51 crore stated that the CMOs authenticated without validating correct information from the Joint Director, NRHM. However, fact remained that the ambulances were issued to the DHs and CHCs instead of issuing them to the prioritised PHCs as approved by the GoI.

[61] 26 during 2009-10 (₹ 1.82 crore) + nine during 2010-11 (₹ 0.63 crore) +10 during 2012-13 (₹ 0.75 crore) = 45 ambulances (₹ 3.20 crore).
[62] 26 ambulances (cost of vehicle = ₹ 1.34 crore + cost of equipment = ₹ 0.51 crore) + 9 ambulances during 2010-11 (₹ 0.51 crore) + 10 ambulances purchased during 2010-11 (₹ 0.57 crore) = 45 ambulances (₹ 2.93 crore).
[63] 22 ambulances were available as of March 2009.
[64] PHCs located at Mezoma, Khonoma, Sabangya, Chen, Sungro, Chetheba, Tamlu, Satoi, Kuhuboto, Molvom, Poilwa, Likhimro, Sutsu, Chessore, Yachem and Naginimora.
[65] Kohima (1 Nos.), Mon (2 Nos.), Tuensang (4 Nos.) and Zunheboto (3 Nos.).

1.3.13 Vertical disease control programmes

Out of six communicable disease programmes,[66] three programmes viz. National Leprosy Eradication Programme (NLEP), National Vector Borne Disease Control Programme (NVBDCP) and National Programme for Control of Blindness (NPCB) were covered and the audit findings are as under:

1.3.13.1 National Leprosy Eradication Programme (NLEP)

The National Leprosy Eradication Programme (NLEP) is aimed to ensure leprosy prevalence rate of less than one patient per ten thousand population in the State and sustain the level thereof. The objectives of the programme are to improve quality services to leprosy affected persons, enhance activities in urban areas with migratory cases etc.

The status of leprosy cases in the State during 2009-10 to 2013-14 is tabulated below:

Table No. 1.3.6

Year	Population (in ten thousands)	New cases detected	Prevalence Rate
2009-10	198	81	0.41
2010-11	198	84	0.42
2011-12	198	90	0.45
2012-13	198	85	0.43
2013-14	198	113	0.57
TOTAL	**990**	**453**	

(Source: Departmental figures)

It could be seen from the table that the number of persons affected with leprosy had increased during the years 2009-10 to 2013-14 inspite of the fact that Nagaland State was the first State in the country which declared eradication of leprosy in the year 1998. As of March 2014, a total of 238 leprosy cases were reported as continuing treatment out of which 94 patients were released from treatment (cure rate of 39 *per cent)*. Out of 238 cases noticed, 150 cases (63 *per cent*) were reported in Dimapur district alone.

The Department stated (October 2014) that all leprosy related activities would be executed with renewed impetus.

1.3.13.2 National Vector Borne Disease Control Programme (NVBDCP)

Vector Borne diseases are major public health problem in the State and malaria death cases are also being reported ranging from 4 to 14 every year. The SPIP prioritised pre-elimination of malaria in phased manner every year.

[66] National Iodine Deficiency Disorders Control Programme (NIDDCP), Integrated Disease Surveillance Programme (IDSP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Eradication Programme (NLEP), National Programme for Control of Blindness (NPCB) and Revised National Tuberculosis Control Programme (RNTCP).

1.3.13.2.1 Annual Blood Examination Rate (ABER)

Annual Blood Examination Rate (ABER)[67] is the key indicator to regulate epidemiological situation in the State. The State targeted 10 *per cent* of ABER in 2011. The target was set at 11 *per cent* from 2012 aiming to sustain the national target of 10 *per cent.*

Scrutiny revealed that ABER was not achieved in three districts[68] in the State and the ABER ranged from 5.37 to 7.9 *per cent* only. Non-achievement of target was analysed and it was observed that this was due to non-availability of consumables for examination of ABER. Joint physical verification of DH, Mon and PHC, Tizit revealed that though the laboratories were equipped with microscopes, blood examination could not be carried out in the HUs due to non-availability of consumables.

In reply, the Department stated (October 2014) that non-achievement of ABER rate was due to poor laboratory network and non-availability of consumables in the districts. The Department also stated that the targeted ABER rate at 11 *per cent* was achieved in Tuensang district. However, fact remained that ABER rate in Kiphire and Mon was not achieved.

1.3.13.2.2 Long Lasting Insecticidal Nets

GOI, Directorate of NVBDCP decentralised (May 2009) the procurement policy of bed nets through NRHM funds and also stated that during 2007-08 the Directorate of NVBDCP allocated 140000 bed nets to Nagaland for prevention of malaria in the remote areas. During 2009-10, GoI allocated ₹ 1.44 crore towards decentralised policy on procurement of Long Lasting Insecticidal Nets (LLINs). The Department purchased (June 2009) 67823 bed nets @ ₹ 213/- per bed net[69] at a total cost of ₹ 1.44 crore.

As per the SPIP for 2009-10, tribal populations of 940266 were to be covered under High Risk areas in 672 villages in the State. In the SPIP, the status of households in possession of 107500 bed nets only was reported. However, the Directorate of NVBDCP had already issued 140000 bed nets during 2007-08 which point towards the fact that there was a short delivery of 32500 bed nets to the households residing in the high risk villages in the State.

Scrutiny of the SPIP 2010-11 further revealed that the household survey made by the Department reported the possession of 108700 bed nets as available with the households. This point towards the fact that a total of 99123 bed nets[70] valued ₹ 2.11 crore[71] had not reached the households in the high risk areas of the State to prevent malaria cases. Non-receipt of bed nets was ascertained in 40 villages during the joint physical verification. The beneficiary survey conducted in Kohima district also

[67] Total blood examined per total population x 100 in percentage.
[68] Kiphire= 6.35 *per cent*, Mon= 7.9 *per cent*, Tuensang = 5.37 *per cent*.
[69] DGSD approved rate.
[70] (32500 – 1200) = 31300 supplied by the GoI + 67823 purchased by SHS = 99123 bed nets.
[71] 99123 x ₹ 213 = ₹ 2.11 crore

revealed that 346 beneficiaries out of 457 (76 *per cent*) stated that they did not receive any mosquito nets.

In reply, the Department stated (October 2014) that 67823 bed nets purchased during 2009-10 were delivered directly to Dimapur Store office and on verification, it was noticed that 32500 bed nets pertaining to 2007-08 were issued to various HUs. However, fact remained that the SPIP could disclose only 108700 bed nets issued against the allocation/purchase of 207823 bed nets resulting in non-delivery of 99123 bed nets valued ₹ 2.11 crore to the households in the high risk areas.

1.3.13.3 National Programme for Control of Blindness (NPCB)

The National Programme for Control of Blindness (NPCB) is aimed to reduce prevalence of blindness from 1.1 *per cent* to 0.3 *per cent*, establish eye care facilities for every five lakh population and develop human resource of eye care services at PHCs, CHCs and DHs. Cataract surgery and school eyes screening are the important areas of scheme implementation. During 2009-14, the Department proposed ₹ 16.66 crore for NPCB activities against which the Ministry approved ₹ 11.53 crore. Out of the approved programme ₹ 8.56 crore was earmarked for the following objectives to reduce the prevalence of blindness by establishing eye-care facilities in the State:

Table No.1.3.7

(₹ in crore)

Approved programme	Ear marked during					
	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Procurement of Ophthalmic Equipment	0	0.40	0.41	0.40	0	1.21
Eye ward and Eye OT.	0.75	0.75	0.75	0.75	0	3.00
Mobile Ophthalmic Units with Tele-Ophthalmology.	1.20	0	0	0.60	0.30	2.10
Grants-in-Aids for strengthening DH, Tuensang	0	0	0	0	0.40	0.40
Construction of eye-ward and eye OT, DH Peren	0	0	0	0	1.00	1.00
Grants-in-Aids for strengthening two DH	0	0	0	0.40	0	0.40
Construction	0.45	0	0	0	0	0.45
TOTAL	**2.40**	**1.15**	**1.16**	**2.15**	**1.70**	**8.56**

(Source: Departmental figures)

While considering the sanction for allotment of funds during 2012-14, the Ministry curtailed ₹ 2.14 crore[72] as the State was unable to spend the previous equivalent balances sanctioned for the programme. Thus, due to slow implementation of blindness control programme, the State lost funding of ₹ 2.14 crore.

Though ₹ 8.56 crore was earmarked during the period 2009-14, the Department received only ₹ 7.02 crore (82 *per cent*) from SHS for blindness control programme implementation. Scrutiny revealed that:

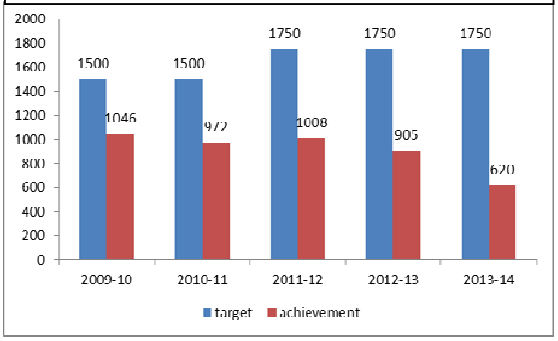
[72] ₹ 0.95 crore during 2012-13 and ₹ 1.19 crore during 2013-14 = ₹ 2.14 crore..

- During 2009-10 and 2012-13, SHS released ₹ 1.10 crore[73] for establishing of mobile ophthalmic units in the State. However, the Department did not establish mobile ophthalmic units. Instead the funds of ₹ 0.83 crore was diverted for procurement of ophthalmic equipment out of ₹ 1.10 crore.

- During 2009-14, SHS released ₹ 2.25 crore for construction of eye ward and eye OT. Out of ₹ 2.25 crore, the Department constructed two eye wards and eye OT at Tuensang and Phek for ₹ 1.50 crore and kept ₹ 0.75 crore with the bank as unutilised.

- Cataract surgery conducted during the period from 2009-14 showed a descending trend (1046 to 620). The target fixed ranged from 1500 to 1750 as shown in the graph (*1.3.1*) alongside:

Graph 1.3.1



- Only 256 cataract surgeries were carried out in two DHs in Mon (124) and Tuensang (132) during 2009-14. No cataract surgeries were carried out in Zunheboto district during 2009-14. The deficiencies in conducting cataract surgeries were due to non-deployment of eye surgeons with the three DHs.

- During 2009-14, Department conducted eye screening of 81806 students against the target of 154000 students in the State. Out of 81806 students screened, 13136 students (16 *per cent*) were detected with refractive errors. Though Department targeted to issue 6500 spectacles to the students having refractive errors during 2009-2014, only 1154 spectacles (18 *per cent*) were issued to the 1154 students having refractive errors.

The Department stated (October 2014) that equipment valued ₹ 0.83 crore for Tele-Ophthalmology in fixed type was purchased and installed with three DHs instead of establishing mobile ophthalmic unit. While accepting the descending trend in cataract surgery and eye screening in the State, the Department stated that this was due to engagement of three senior eye surgeons to the administrative capacities out of the eight cataract surgeons posted in the State. The Department also accepted the deficiency in issue of spectacles to the students with refractive errors and stated that this was due to delay in delivery of prescribed glasses to the school students @ ₹ 275 per spectacle as the amount was too low.

1.3.13.3.1 Non-receipt and idling of ophthalmic equipment

In order to carry out cataract surgeries and school eyes screening programmes, Department procured ophthalmic equipment worth ₹ 2.58 crore during 2009-14.

[73] 2009-10 (₹ 0.50 crore) and 2012-13 (₹ 0.60 crore) = ₹ 1.10 crore.

Scrutiny of the records of SHS and three test checked DHs revealed that 14 ophthalmic equipment worth ₹ 0.13 crore was not received at DH Tuensang and Zunheboto (***Appendix 1.3.9***) though it was reported as issued as per the stock register of Programme Officer, NPCB. Further, seven ophthalmic equipment worth ₹ 0.10 crore though issued to DH, Mon were idle (***Appendix 1.3.10)*** since October 2010 in the absence of eye surgeon or any trained technical person to operate the equipment**.**

The Department stated (October 2014) that eye equipment were received by the Nodal officer in charge of Tuensang and Zunheboto districts and the ophthalmic equipment in Mon district was idle due to non-availability of eye surgeon.

1.3.13.3.2 Construction of Eye Operation Theatre at Tuensang and Phek

GoI approved ₹ 1.50 crore during 2009-10 for construction of Eye OT at Tuensang (₹ 0.75 crore) and Phek (₹ 0.75 crore) as per the proposal made by the SHS.
It was observed that:

- The completed (July 2011) Eye OT building at Tuensang district was not handed over to the Medical Superintendent, DH by the MEW till July 2014. Meanwhile, eye surgeon posted with the DH Tuensang was transferred (December 2011) to Dimapur.

- Eye OT constructed at Phek district was functional from February 2011 and 121 minor and 31 major cataract surgeries were carried out. The only eye surgeon posted with Phek district was transferred (December 2012) to Dimapur which made the eye OT defunct after his/her transfer.

The Department accepted (October 2014) the audit findings and stated that shortage of trained ophthalmic surgeons and frequent transfer and posting of eye surgeons affected the eye screening and cataract surgeries in the districts.

1.3.14 Health Sector funded through Thirteenth Finance Commission

The guidelines for implementation of 13th Finance Commission (TFC) Award for local rural bodies in the State stipulated each village to open a bank account[74] to boost the Communitised flagship programmes[75] through the communitised bodies (VEW, VDB, VHC, WATSAN etc.). The action plan of the flagship programmes should be initiated invariably from the village level and was required to be scrutinised by the line Departments for technical feasibility and admissibility which shall enable 'Bottoms-up' approach to be furnished to the GoN through Deputy Commissioners (DC) of the districts. During 2011-13, GoN released ₹ 1.84 crore to the bank accounts of 236 village councils against the proposals of ₹ 1.86 crore made by the DCs to boost health activities through TFC. Details are given below:

[74] Jointly operated by the Chairman, Village Council and Deputy Commissioner.
[75] Health (NRHM), Education (SSA), Social Welfare (ICDP) and Public Health Engineering Sectors.

Table No. 1.3.8

(₹ in crore)

Name of the sampled districts	Proposal made by the Dy. Commissioner for health activities	Released by the Commissioner, Nagaland			No of VC accounts	Utilised for
		1st Installment	2nd Installment	Total		
Mon	0.37	0.36	0	0.36	99	Purchase of equipment such as BP instruments, Glucometer, Rapid diagnostic kits, power microscope, Boyls Machine, portable Ultrasound machine etc.
Tuensang	0.80	0.40	0.40	0.80	50	
Zunheboto	0.69	0.32	0.36	0.68	87	
Total	1.86	1.08	0.76	1.84	236	

(Source: Departmental figures)

Scrutiny revealed that:

- DC, Mon utilised ₹ 0.36 crore for purchase of equipment as per the utilisation certificate furnished to Commissioner, Nagaland, On query regarding the utilisation of equipment sponsored under TFC, the Nodal officer, Health sector (CMO), Mon stated (June 2014) that the equipment were not issued to the 50 SCs in the district by the DC, Mon. This was ascertained in the Facility Survey Report (2013) of the HUs. Non-availability of equipment purchased under TFC was ascertained in 10 HUs during the joint physical verification. The fact was reported (May 2014) to DC, Mon.
- DC, Tuensang utilised ₹ 0.80 crore for purchase of equipment for 50 SCs in the district. Out of equipment purchased for ₹ 0.80 crore, it was found during joint physical verification that equipment valued ₹ 0.38 crore were issued to six HUs. It was noticed that the equipment (₹ 0.14 crore) issued to the five HUs[76] were lying in the custody of the Village Chairman. The equipment worth (₹ 0.24 crore) issued to CHC Noklak was not installed since the date of issue[77] to the CHC. The nodal officer for health sector in Tuensang district stated (June 2014) that purchase of the equipment were not brought to their notice for verification and installation in order to put it into use.
- DC Zunheboto purchased equipment worth ₹ 0.68 crore and issued the equipment to 87 Village Councils in the district. The Nodal Officer, Zunheboto stated that the equipment issued were kept with 47 SCs and 40 Village Councils. Joint physical verification of 10 SCs in the district revealed that the SCs were not equipped with the equipment provisioned under TFC.

Thus, due to poor coordination with the health Department, the funds provided against the medical sector under the Thirteenth Finance Commission did not boost the health sector in three test checked districts.

[76] Equipment worth ₹ 0.07 crore at Noksen PHC , ₹ 0.02 crore at Thonoknyu PHC, ₹ 0.03 crore at Shamator PHC, ₹ 0.01 crore at Chingmei SC and ₹ 0.01 crore at Tronger SC = ₹ 0.14 crore.

[77] The purchase details of equipment and date of issue of equipment to HUs were not furnished to audit by the DC, Tuensang.

1.3.15 National Health Mission (NHM)

National Health Mission (NHM), launched in October 2013, consist of five parts viz. National Rural Health Mission (NRHM) plus Reproductive Maternal Neonatal Child Health+Adolescent (RMNCH+A) Flexipool[78], National Urban Health Mission (NUHM) Flexipool, Flexipool for disease Control Programmes, Flexipool for non-communicable diseases including injury and trauma and Infrastructure Maintenance.

On launching of new mission, the Department of H&FW, Nagaland restructured[79] the ongoing NRHM into NHM to address the above five parts of newly introduced scheme to cover both rural and urban areas in the State. However, perspective plan[80] though initiated (October 2013) by the ministry of H&FW was not prepared by the Department. Instead the Department proposed (January 2014) ₹ 5.10 crore through a separate SPIP-NHUM to implement the health programme in urban sector in three districts (Kohima Dimapur and Mokokchung) wherein ₹ 3.45 crore was proposed for strengthening health services in urban sector through infrastructure development and ₹ 1.65 crore was proposed for other programme management. The GoI approved (February 2014) ₹ 1.04 crore (20 *per cent*) to implement NHUM in two districts (Kohima and Dimapur) and released (February 2014) ₹ 0.94 crore to the Department in two installments but the funds released were not utilised as of March 2014. Thus, the Department did not implement any health activities in the urban sector due to the delay in approval followed by subsequent delay in release of funds by the GoI.

The Department stated (October 2014) that the funds released during 2013-14 would be utilised during 2014-15 in two districts.

Objective – 6 Capacity building and strengthening of human resources at different levels

1.3.16.1 Human Resource Management

As per IPHS norms prescribed for HUs, there should be 2385 manpower in different categories. The requirement as per IPHS norms and men-in-position are given in the ***Appendix 1.3.11.***

The following were observed:

- General/Auxiliary Nursing Midwiferies (G/ANM) was disproportionately deployed in SCs and PHCs resulting in shortages of 36 GNMs/ANMs with CHCs.
- 649 Health Workers (male) required to be deployed in 397 SCs and 126 PHCs as per IPHS standards were not deployed in 523 health units.
- 38 Pharmacists were deployed in SCs beyond the IPHS norms resulting in shortage of pharmacists with PHCs and CHCs

[78] The erstwhile RCH, Mission flexi pool and immunisation components of PIPs.
[79] By issuing office memorandum dated. 27.3.2014.
[80] 2014-15 to 2016-17.

- There was a shortage of 92 lab technicians with PHCs (81) and CHCs (11) as per IPHS standards.
- By deploying 10 MOs with PHCs over and above the norms of IPHS, CHCs remained short of MOs to that extent. It was also found that the only Senior Medical Officer (SMO) posted to CHC Noklak was absent from duties. It was noticed from the IPD register of CHC Noklak that three patients admitted[81] with the CHC for the treatment of diarrhea, chest infection and fever during March and April 2011 were attended to by the staff nurses but the lives of the three patients could not be saved[82].
- In Yangkhao PHC in Mon district, no manpower was provided. Similarly three SCs[83] were also functioning without any manpower.

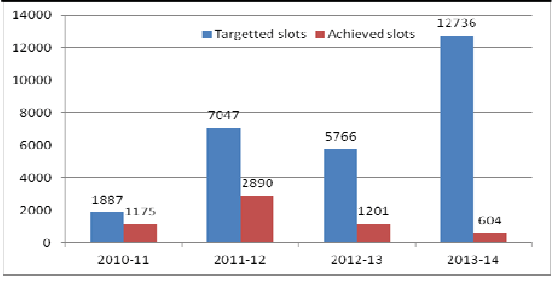
The beneficiary survey conducted in Kohima district also revealed that out of 457 responses received from the beneficiaries, 294 beneficiaries (64 *per cent*) stated that HUs were staffed with insufficient manpower, 74 beneficiaries (16 *per cent*) stated that the working hours ranged from 1 to 3 hours in a day and 14 beneficiaries stated that HUs were opened on a weekly basis instead of on a daily basis.

The Department stated (October 2014) that most of the HUs do not conform to the IPHS and hence the State took a conscious decision not to propose manpower according to the IPHS norms.

1.3.16.2 Capacity building

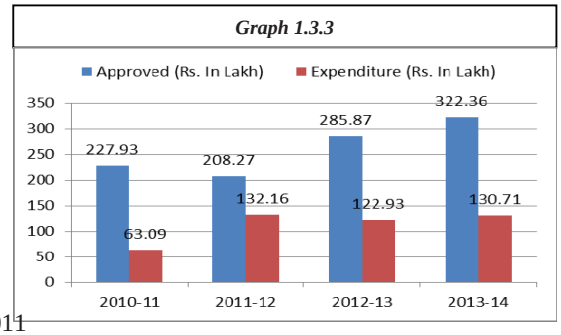
The Department aimed to strengthen public health management system by conducting various in service training programmes with assured quality.

Graph 1.3.2



The GoI while approving the SPIP targeted to carry out training on Skilled Birth Attendance (SBA) to ANMs, Emergency Obstetric Care (EOC) to MOs, Infection Management and Environment Plan (IMEP) to MOs and ANMs, Adolescent Reproductive and Sexual Health (ARSH) to MOs and ANMs and Intra-uterine Contraceptive Device (IUCD) insertion.

Graph 1.3.3



The SHS targeted 27436 trainings for ₹ 10.44 crore against which only 5870 trainings (21 *per cent*) were imparted to MOs and supporting staff for ₹ 4.49 crore (43 *per cent*) during 2009-14.

[81] Admitted on 21.3.2011, 28.4.2011 and 20.7.2011
[82] Expired on 30.3.2011, 28.4.2011 and 20.7. 2011.
[83] Khetsokhuno (Phek District), Pongkong and Tankong (in Mon district).

The physical and financial targets and achievements are depicted in the graphs above.

Scrutiny of records of SHS revealed that:

- The calendar of programme for the training for MOs and midwifery staff were neither framed at State level nor at District level to impart training to them.
- It was noticed that ₹ 0.23 crore was booked against the slots. However, slots utilised were found as 'nil' in respect of 12 training programmes.

Scrutiny of the records of four test checked DHS revealed that physical achievement of the training ranged from 2 to 6 *per cent* in various courses as detailed in the ***Appendix 1.3.12***.

It would be seen from appendix that:

- Training on Skilled Birth Attendant (SBA) was imparted to 18 GNMs/ANMs (2 *per cent*) in three test checked districts. No GNM/ANM in Tuensang district was trained in SBA.
- Only one MO in Zunheboto district was trained in EmOC out of 132 MOs in four test checked districts.
- 20 MOs were only trained in BEmOC out of 132 MOs in four test checked districts.
- MOs posted in Tuensang district were not trained in HBNC, IUCD Insertion, ARSH and IMEP.
- 30 GNMs/ANMs (4 *per cent*) was imparted training in IMNCI in four test checked districts. No GNM/ANM in Zunheboto district was trained in IMNCI.
- 10 GNMs/ANMs (4 *per cent*) in Kohima district were only trained for HBNC. No GNM/ANM posted in Mon, Tuensang and Zunheboto district was trained in HBNC.
- 47 GNMs/ANMs (6 *per cent*) in three districts got trained for IUCD insertion. No GNM/ANM posted in Kohima district was trained in HBNC.
- ARSH training was imparted to 12 GNMs/ANMs posted with Kohima district only. No GNM/ANM posted in Mon, Tuensang and Zunheboto district was trained in ARSH.
- No GNM/ANM posted in Kohima district was trained in WIFS.

Thus, it is evident from the above that though the GoI approved for carrying out the important trainings and even after spending ₹ 4.49 crore towards training programmes around 94 *per cent* medical staff remained untrained.

The Department stated (October 2014) that low performance in carrying out the training programme was due to inability to spare manpower from the HUs, limited training schools and hospitals with low intake capacity to impart training etc.

1.3.16.3 Accredited Social Health Activist (ASHA)

As per NRHM guidelines one married/widowed/divorced woman in the age group of 25-45 years possessing formal education upto Class-VIII was to be appointed as

ASHA in a village to render healthcare services. One ASHA is to be provided in each village against 1000 population or one ASHA per habitation (village) depending on the workload. As per number of recognised villages, the provision of ASHAs should be 1324. However, the State selected 1700 ASHAs. The status was further increased to 1854 during 2013-14.

(a) ASHA Drug Kits:

Every year ASHAs were to be provided with drug kits consisting of 15 sets of basic medicines and contraceptives for maternal and child health care services in rural areas. Out of ₹ 8.85 crore[84] approved during 2009-14, SHS released only ₹ 6.63 crore[85] for ASHA activities. Out of ₹ 6.63 crore, the SHS incurred ₹ 0.81 crore[86] for purchase of medicines to replenish 1700 ASHA drug kits and ₹ 2.84 crore[87] was utilised for four modules of ASHA training.

Scrutiny of records of four sampled DHs revealed that the ASHA drug kits worth ₹ 0.34 crore issued for replenishment during 2009-14 were not received in the four sampled districts. Thus, 714[88] ASHAs in four test checked districts performed their duties without any drug kits in rural areas. The beneficiary survey conducted in Kohima district revealed that 190 beneficiaries out of 457 (42 *per cent*) stated that ASHAs were not functioning in the villages.

The Department furnished (October 2014) copies of indents regarding the issue of ASHA drug kits. However, the non-receipt of ASHA drug kits were authenticated by the CMOs and the non-delivery of ASHA drug kits to the villages was also ascertained through the interactions with the ASHAs during the joint physical verification of health units.

Objective – 7 Monitoring mechanism and evaluation procedures and involvement of the community in monitoring as envisaged in the guidelines

1.3.17 Monitoring and Evaluation

NRHM envisage robust accountability framework through prolonged mechanism of internal monitoring, community based monitoring and external evaluation. The composition and functions were defined in the guidelines in order to monitor the NRHM activities at State, District and Block level.

[84] 2009-10 (₹ 1.70 crore), 2010-11(₹ 1.70 crore), 2011-12(₹ 1.70 crore), 2012-13(₹ 1.26 crore) and 2013-14 (₹ 2.49 crore) = ₹ 8.85 crore.
[85] 2009-10 (₹ 1.00 crore), 2010-11(₹ 1.31 crore), 2011-12(₹ 1.70 crore), 2012-13(₹ 0.82 crore) and 2013-14 (₹ 1.80 crore) = ₹ 6.63 crore.
[86] 2009-10 (₹ 0.27 crore), 2010-11(₹ 0.34 crore), 2011-12(₹ 0.20 crore) = ₹ 0.81 crore.
[87] 2009-10 (₹ 0.43 crore), 2010-11(₹ 0.67 crore), 2011-12(₹ 0.98 crore), 2012-13(₹ 0.27 crore) and 2013-14 (0.49 crore) =₹ 2.84 crore.
[88] Mon(227), Kohima (120), Tuensang(176) and Zunheboto(191) = 714 ASHAs.

1.3.17.1 Shortfall in conducting meetings

NRHM guidelines prescribed (June 2005) the constitution of a State Health Mission (SHM) and a State Health Society (SHS) with the task of scrutiny and approval of the annual State plans, monitoring the status of the follow-up action on decision of SHM, review of expenditure and implementation, approval of the accounts of the district and other implementing agencies and execution of approved action plans including release of funds for the programme. At the district level, the DHS is headed by Deputy Commissioner. The CMOs as head of the Executive Committee (EC) is responsible for planning, monitoring, evaluation, accounting, database management and release of funds to health centers. Periodicity of meetings to be conducted and the nature of business to be transacted in the meetings were also prescribed as per the guidelines. It was observed that there were shortfall in conducting meetings of the SHM, SHS Governing Body (GB) and Executive Committee (EC) at the State level during 2009-14 as indicated below:

Table No. 1.3.11

Name of the Committee	Periodicity of meeting	Date of Registration of SHS	To be held during 2009-14	Actually held during 2009-14	Shortfall (Percentage)
SHM	Twice in a year	17.02.2006	10	01	09 *(90)*
SHS-GB	Twice in a year	-	10	01	09 *(90)*
SHS-EC	Once every month	-	60	16	44 *(73)*

(Source: Departmental figures)

The SHM met only once during 2009-10 though 10 meetings were to be held during 2009-14. The GB of the SHS was convened only once as against ten prescribed meetings and the EC met 16 times against 60 prescribed meetings during 2009-14.

The shortfall in conducting meetings of the DHS in the four test checked districts were also noticed as given below:

Table No. 1.3.12

Name of the DHS	Name of the Committee	Periodicity of Meeting	To be held during 2009-14 in respect of four sampled districts	Actually held during 2009-14	Shortfall (Percentage)
Kohima	DHS-GB	Twice in a year	10	0	10 *(100)*
	DHS-EC	Once every month	60	0	60 *(100)*
Mon	DHS-GB	Twice in a year	10	10	0
	DHS-EC	Once every month	60	36	24 *(40)*
Tuensang	DHS-GB	Twice in a year	10	10	0
	DHS-EC	Once every month	60	20	40 *(67)*
Zunheboto	DHS-GB	Twice in a year	10	10	0
	DHS-EC	Once every month	60	10	50 *(83)*

(Source: Departmental figures)

It would be seen from the table above that neither Governing Body Meeting nor EC Meeting was convened in DHS Kohima during 2009-14. Shortfall in EC meeting was also observed in the remaining three DHS and the deficiency ranged from 40 to 83 *per cent*.

Thus, non-convening of SHM meetings and the shortfall in conducting GB/EC meetings of SHS defeated the very objective of having meaningful deliberations on policy issues, implementation and monitoring.

While admitting the audit findings, the Department stated (October 2014) that shortfall in conducting of meetings was due to engagement in other official duties and also assured that the meetings would be convened on a regular basis in future.

1.3.18 Conclusion

The inadequate conduct of various surveys to assess the requirements of healthcare facilities in the rural areas led to partial assessment of the quality of prevailing healthcare services in the State. The financial management was not streamlined and there were instances of financial commitments not being honoured and delays in release of funds which impacted the achievement of Mission objectives. It was noticed that there were various deficiencies in construction activities and purchase of quality medicines and equipment. The targets set in respect of various healthcare programmes were not achieved. Monitoring of the implementation of the mission activities was not carried out as envisaged in the Mission guidelines. This resulted in inadequate translation of the Mission's objectives to tangible benefits in the State.

1.3.19 Recommendation

- *The Department should undertake comprehensive surveys at all levels and incorporate the inputs in the plan documents to make the planning meaningful.*
- *Government of Nagaland should honour financial commitment and also avoid delays in release of funds.*
- *The Department should bridge the gap of rural health infrastructure by observing population criteria as well as case load reported in the Health Units.*
- *The Department should ensure proper staffing pattern with the Health Units and also should provide capacity building to the staff to improve the health services.*

PUBLIC HEALTH ENGINEERING DEPARTMENT

1.4 PERFORMANCE AUDIT ON IMPLEMENTATION OF TOTAL SANITATION CAMPAIGN/NIRMAL BHARAT ABHIYAN.

Performance audit of Total Sanitation Campaign (TSC)/Nirmal Bharat Abhiyan (NBA) was taken up in the State of Nagaland from May 2014 to September 2014 covering the period from 2009 -10 to 2013-14. The major observations are highlighted below:-

Highlights

There was short fall in release of matching share amounting to ₹ 9.12 crore during 2009-14 from the Government of Nagaland.

(Paragraph 1.4.9.2)

Joint physical verification revealed that there was short receipt of IHHL construction materials valued at ₹ 0.58 crore by 27 villages.

(Paragraphs 1.4.11.1)

Joint physical verification of three Community Sanitary Complexes (CSC) revealed that one CSC constructed under Kohima district was physically not available and two CSC constructed at Dimapur District deviated from approved drawing.

(Paragraph 1.4.11.2)

Joint physical verification of 29 schools revealed that only 8 schools had functional toilets, five toilets were dismantled for land development, six toilets were not in use and 10 schools did not have water facility. None of the school toilets had provision for children with special needs.

(Paragraph 1.4.11.3.1)

Joint physical verification of 34 Anganwadi toilets revealed that only 11 Anganwadis had functional toilets. 10 were dismantled due to land development, four were defunct toilets and nine did not have toilet facilities. All the toilets provided are "normal toilets" and not "baby friendly toilets".

(Paragraph 1.4.11.3.2)

Monitoring and evaluation of various activities undertaken under TSC/NBA in the State was inadequate. Evaluation of the implementation of the scheme in the State were not conducted.

(Paragraph 1.4.14)

1.4.1 Introduction

The Total Sanitation Campaign (TSC) launched by the Government of India (GOI) in 1999 aimed at providing sanitation to all rural communities by 2012 (extended to 2017) and renamed as Nirmal Bharat Abhiyan (NBA) in 2012. The objectives of TSC/NBA are to accelerate sanitation coverage in rural areas, generate demand for sanitation facilities through intensive awareness and health education, promotion of sanitation in schools and anganwadis and to reduce/eliminate water borne diseases that spread through sewage contamination.

The TSC/NBA guidelines envisage that the programme will be implemented by the Panchayati Raj Institutions. However, the provisions of the Act[89] were not applicable in the State of Nagaland. Therefore, the Government of Nagaland through the "Nagaland Village Council Act 1978" empowered every recognised village to have

[89] 73rd Constitution Amendment Act, 1992 relating to Panchayat Raj

"Village Council" with duties and powers which includes among others, formulation of Village Development Schemes, supervise proper maintenance of water supply, roads, forest, sanitation, education and other welfare activities.

In Nagaland, Communitisation Programme for Rural Water Supply and Sanitation System started from 2005-06 under the Communitisation of Public Institutions and Services Act, 2002 (Act No.2 of 2002) through funding from the Twelfth Finance Commission. The Public Health and Engineering Department (PHED) which is the nodal department for implementation of TSC/NBA therefore adopted the Communitisation policy by way of handing over the completed Rural Water and Sanitation schemes to the Water and Sanitation (WATSAN) Committees.

WATSAN Committees headed by a Chairman and 4-9 members including one female representative under the Village Councils were formed as per the guidelines and norms laid down under the Government Notification[90]. A WATSAN Committee is formally recognised and empowered by way of signing a Memorandum of Undertaking (MOU)/Deed of Agreement with the PHED, to participate in planning, design, implementation and subsequent take-over of the schemes for Operation and Maintenance.

Though the scheme guidelines envisaged formation of Block Resources Centres (BRCs) in all the districts, the State of Nagaland was exempted by GOI being a small State. IEC Consultants, Sanitation and Hygiene Consultant and a Chemist appointed in each district by the Department under the scheme National Rural Drinking Water Programme (NRDWP) assist the DWSM for successful implementation of the TSC/NBA scheme.

1.4.2 Scope of audit

The Performance Audit covered all components of TSC/NBA and Nirmal Gram Puraskar for the period 2009-14. Out of the 11[91] districts in the State, four[92] were selected by Probability Proportional to Size With Replacement Sampling method. Two[93] Blocks in each district, 53[94] Villages from eight selected Blocks, 520 Individual Household Latrine beneficiaries, 29 Schools, 34 Anganwadis and four Community Centres were selected by Systematic Simple Random Sampling Without Replacement method.

[90] No. PHE/WORKS/REFORMS/7/2003 dated 22nd October 2003
[91] Kohima, Mokokchung, Tuensang, Mon, Wokha, Zunheboto, Phek, Dimapur, Peren, Longleng and Kiphire.
[92] Tuensang, Zunheboto Dimapur and Kohima
[93] Noksen, Thonoknyu, Tokiye, Satakha, Niuland, Medziphema, Jakhama and Chiephobozu
[94] Yali, Sangtak, Noksen, Litem, Thonoknyu, Pang, Chilliso, Viyilho, Thokihimi, Satami, Ngozubo, Melahumi, Luvishe-old, Luvishe-New, Lukikhe, Khetoi, Xuivi, Vishepu, Sukhai, Momi, Kiyekhu, Kivukhu, Kilo Old, Aqhuito, Kiyezu B, Kuhuxu (Muhumi), Muhumi/Kuhoxu, Nihokhu, Zuheshe, Hovukhu, Hezheto, Henito, Hakhezhe, Ghotovi, Tsiepama, Tsuma, Seithekiema-A, Razaphema, Piphema Old, Molvon, Medziphema Village, Medziphema Kirha, Phesama, Mima, Kigwema, Kezoma, Chakhabama(Kezo town), Rusoma, Dihoma, Thizama, Nerhema and Ziezou.

1.4.3 Audit Methodology

The performance audit comprised of an Entry Conference with the Secretary and other officers of the PHED on 02 May 2014 wherein the audit objectives, scope and methodology were explained, requisition and examination of records, issue of audit observations, examination of responses to audit observations and joint physical verification carried out along with officers and staff of PHED. An Exit conference was held with the Secretary, PHED on 17 October 2014 wherein Government's views/replies were obtained and incorporated at appropriate places.

1.4.4 Audit Objectives

The objectives of the performance audit were to assess whether:

- The planning of the implementation of the Scheme at different levels was adequate and effective and was aimed towards achievement of objectives of the Scheme;
- Funds were released, accounted for and utilised in compliance with the guidelines issued under the Scheme;
- The targets set in terms of number of units under various components of the Scheme were sufficient to achieve and sustain the vision of Nirmal Bharat by 2022 with all GPs attaining Nirmal status;
- The system of selection of beneficiaries was transparent and construction and upgradation of infrastructure under various components of the Scheme was in compliance with the financial and quality parameters set out in the scheme guidelines;
- The information, education and communication strategy under the Scheme was effective in generation of demand of TSC/NBA services through community mobilisation;
- The convergence of the NBA activities with other programmes/stakeholders as envisaged was effectively achieved; and
- The mechanism in place for monitoring and evaluation of the outcomes of the programme was adequate and effective.

1.4.5 Audit criteria

The audit criteria were derived from the following sources:

- TSC guidelines 2007, 2010 and 2011 and NBA Guidelines 2012; notifications and circulars issued by Ministry of Drinking Water and Sanitation;
- IEC guidelines 2010 issued by the Ministry;
- State Government orders relating to implementation of the TSC/NBA;
- Guidelines for engagement of Swachchhata Doot/Prerak;
- Guidelines for engagement of skilled and unskilled workers from MGNREGS;
- Guidelines for the Nirmal Gram Puraskar;
- Provisions of Financial Hand Books; and
- Physical and financial progress reported under Management Information System available on website of the Scheme (tsc.gov.in).

1.4.6 Organisational setup

The Chief Secretary is the Chairman of State Water and Sanitation Mission (SWSM) with the Secretary to the Government of Nagaland, PHED as Member Secretary and Director WSSO, PHED as State Coordinator at the State level. District Water and Sanitation Mission (DWSM) is headed by the Deputy Commissioner as Chairman and Executive Engineer, PHED as member Secretary and at the Village level/GP a WATSAN is responsible for implementation of TSC/NBA Scheme.

1.4.7 Acknowledgement

We acknowledge the cooperation and assistance extended to us at all levels during the conduct of audit.

Audit findings

1.4.8 Audit objective-1: Planning of the Scheme at different levels

As per the TSC/NBA guidelines, the programme was to be implemented with a demand driven approach. A preliminary survey and base line survey were to be undertaken as start-up activity for preparation of Project Implementation Plan (PIP). The Annual Implementation Plan (AIP) was to be prepared based on demand raised from the Village Councils and these demands would then be consolidated into a Block plan. Subsequently Block plans would merge into a district plan. District plan is submitted to State Government for consolidation as State Plan which is submitted to GoI for approval.

It was observed that in three[95] out of the four test-checked districts preliminary and baseline surveys were not conducted for preparation of PIPs. It was further observed that the Water and Sanitation Support Organisation (WSSO) prepared district-wise AIPs without assessing the requirement of the villages as all the interviewed WATSAN Committee members stated that no demands were made by the villagers for incorporation in the District PIP and AIP. This defeated the objective of bottom-up approach and demand driven strategy in planning process.

The Department stated (October 2014) that all AIPs were prepared at State level on the basis of proposals received from the district level DWSM. Normally, the DWSMs also prepare such proposals for incorporating in the AIPs only after verification as well as after conducting Participatory Rural Appraisal (PRA) exercises. Hence, the bottom up and demand driven approach have been normally followed barring certain stray cases. Further, no district TSC project was sanctioned by the GOI without the Department having carried out the baseline survey for which sanctions were accorded as early as in the year 2000-01.

The reply of the Department was not acceptable as the supporting documents such as district level proposals, verification reports, baseline survey reports, etc. were not furnished to audit. Further, the Project Director, DRDA Kohima stated (August 2014)

[95] Zunheboto, Dimapur and Kohima

that baseline survey conducted by DRDA was incomplete when the scheme was transferred to PHED.

1.4.9 Audit Objective-2: Release and utilisation of funds.

As per the guidelines, the SWSM was required to open a single Savings Bank Account in a Nationalised Bank or a bank authorised by the State Government. The funds including Central, State, Beneficiary share or any other receipt were to be transferred directly to the savings bank account. The State Government was required to release the central grants received along with the matching State share to the District Implementing Agency within 15 days of the receipt of Central grants. The District Implementing Agency was required to transfer the funds for the works to the Village Councils (WATSAN Accounts) within 15 days of receipt of funds.

Table No.1.4.1

(₹ in crore)

Year	Opening balance		Funds received		Expenditure		Closing balance		
	Central	State	Central	State	Central	State	Central	State	Total
2009-10	0.29	0.07	10.59	1.69	10.59	0.00	0.29	1.76	2.05
2010-11	0.29	1.77	12.29	1.76	1.12	3.02	11.46	0.51	11.97
2011-12	11.46	0.51	1.74	4.26	12.92	0.65	0.28	4.12	4.40
2012-13	0.29	4.12	23.03	0.00	3.96	4.06	19.36	0.06	19.42
2013-14	19.35	0.06	0.00	0.00	19.06	0.00	0.29	0.06	0.35
Total			**47.65**	**7.71**	**47.65**	**7.72**			

Source: Departmental records and sanction orders

Examination of the records on financial management revealed the following:

1.4.9.1 Delay in release of funds

It was seen that there were delays in receipt and release of funds at various levels during 2009 to 2014. The delay in release of matching State share to the SWSM ranged from six months to 14 months from the date of receipt of Central grants. The delay in releasing the funds by SWSM to the DWSMs ranged from 22 days to 249 days as shown in **Appendix 1.4.1**. It was also noticed that no funds were released to the village WATSAN Committee by DWSMs for implementation of the scheme at the village level.

It was further observed that out of the State share of ₹ 4.26 crore sanctioned during 2011-12, the Finance Department kept an amount of ₹ 4.05 crore in Civil Deposit (CD) for 88 days. This impacted the scheme implementation to that extent.

1.4.9.2 Short release and parking of funds

As per the funding pattern of TSC/NBA, the Government of Nagaland was required to release an amount of ₹ 16.83 crore as State share against the release of ₹ 47.65 crore

by Central Government during the five years period. The State Government released only an amount of ₹ 7.71 crore resulting in short release of State share by ₹ 9.12 crore. It was further noticed that out of the State share, the Finance Department deducted an amount of ₹ 0.21 crore as work charged component during 2011-12.

1.4.9.3 Non-accountal of interest accrued from the bank account

As per guidelines the interest accrued on TSC/NBA funds shall be treated as part of the resources. Examination of records revealed that SWSM earned an amount of ₹ 0.38 crore as interest during the period from August 2010 to July 2013 from savings bank account[96] maintained for operating TSC/NBA funds. This amount was not reflected in the audited accounts of SWSM.

The Department stated (October 2014) that all GOI's scheme funds under NBA, Support, Water Quality Monitoring and Surveillance and National Rural Drinking Water Programme were credited in the said SWSM account. There was a problem in segregating the interest accrued for many years. As a result, the interest accrued amount could not be reflected in audited accounts of SWSM. Action Plan for the interest amount on TSC/NBA funds worked out by audit is being prepared by WSSO for carrying out sanitation activities in the State.

1.4.9.4 Delay in conduct of Statutory Audit by the Chartered Accountant

As per NBA guidelines, the SWSM will ensure that the accounts are audited by a Chartered Accountant selected from a panel approved by the Comptroller & Auditor General of India, within six months of the close of the financial year and submit the audited statement of accounts to the Ministry.

Scrutiny of records revealed that there was delay ranging from two to five months in conducting audit of accounts of the SWSM for the years 2009-14 by the Chartered Accountant.

1.4.10 Audit Objectives-3: Targets and achievements

In order to achieve Nirmal Bharat by 2022, the targets proposed by the SWSM was approved by GOI. The targets set and achievements thereof under various components as of March 2014 are shown in the table below:

Table 1.4.2:

Sl. No	Components	Project target (2000 to 2022)	Cumulative Project achievement	Percentage of achievement
1	IHHL(BPL & APL)	278859	170206	61
2	Community Sanitary Complex	976	232	24
3	School toilet	6090	2831	46
4	Anganwadi toilet	2351	1288	55

Source:- AIP 2014-15 and departmental records.

[96] *SBI Lerie Branch, Kohima*

It is seen from above table that the achievements in the last 15 years ranged from 24 *per cent* to 61 *per cent*. As the programme funding is only upto 2019, if the trend of implementation and funding of the scheme continue at the pace of last 15 years, it is unlikely that the State will achieve the proposed target especially community sanitary complex component where the achievement is only 24 *per cent*. It was also observed that Solid and Liquid Waste Management, one of the components of TSC/NBA was not taken up in project mode in the State.

The Department stated (October 2014) that the project target figures reflected are the revised figures of 2013 which is the reason why the percentage of achievement is less. The GoI has also revised the targets for full coverage to October 2019 under Swachh Bharat Mission. The proposal for implementing the Solid and Liquid Waste Management was recently approved which will be taken up shortly.

Objective-4: Selection of beneficiaries and up gradation of infrastructure under various components of the Scheme.

1.4.11.1 Construction of Individual Household latrines (IHHL)

The programme aimed to cover all the rural families with completed household latrines to eliminate open defecation (OD). According to the guidelines of TSC/NBA the start-up activities which included conducting of preliminary survey and baseline survey to assess the status of sanitation and hygiene practices, people's attitude and demand for improved sanitation, etc., was to be carried out. A duly completed household sanitary latrine shall comprise of a toilet unit including a super structure. The construction of household toilets was to be undertaken by the household itself and on completion and use of the toilet, cash incentive was to be given in recognition of its achievement. However, instead of giving incentive in terms of cash, the beneficiaries were provided toilet construction materials in violation of the scheme guidelines.

Examination of the records in four test checked districts revealed the following:

(j) Against AIP targets for construction of 98413 IHHLs, only 51690 IHHLs (53 *per cent*) were constructed at a cost of ₹ 16.78 crore during 2009-14 as shown in the table below.

Table 1.4.3:

Sl. No	Name of District	Annual Implementation Plan (AIP) Target			Actual number of IHHL constructed	Achievement (in percentage)	Expenditure there-against (₹ in crore)
		IHHL-APL	IHHL-BPL	Total Target			
1	Tuensang	0	16203	16203	7759	48	2.59
2	Zunheboto	0	24460	24460	14433	59	4.80
3	Dimapur	2036	29149	31185	19756	63	6.47
4	Kohima	12737	13828	26565	9742	37	2.92
	TOTAL	14773	83640	98413	51690		16.78

Source: Departmental Records

(ii) It was noticed from the records of the four DWSMs in the four test checked districts that they procured IHHL construction materials worth ₹ 1.23 crore and supplied to 27 villages during the period from 2009-14. However, it was seen from the records of the WATSAN that they received materials worth only ₹ 0.65 crore. Thus, there was a short receipt of IHHL construction materials worth ₹ 0.58 crore in 27 villages as detailed in **Appendix-1.4.2.**

(iii) In all the four test-checked districts, the list of eligible BPL and APL households were not identified by DWSM for implementation of IHHLs. Instead, random beneficiary list was submitted by WATSAN/Village Councils. This resulted in difficulty in segregating the BPL and APL beneficiaries by audit besides selection of ineligible beneficiaries by the Department as discussed in subsequent paras.

(iv) The WATSAN/Village Councils of two test-checked villages[97] confirmed that seven selected beneficiaries do not belong to the villages which indicated that the records of the DWSM were not reliable. It was also observed that 25 beneficiaries from seven test checked villages[98] of three districts did not receive IHHL construction materials under TSC/NBA from respective WATSAN Committee.

(v) It was seen that in three out of the four test-checked districts, 48 beneficiaries from 21 villages did not utilise the IHHL materials provided under TSC/NBA as 28 beneficiaries[99] already had sanitary toilets prior to implementation of the scheme and 20 beneficiaries[100] preferred to use traditional pit latrine. It was also found that 14 beneficiaries from four villages[101] in three test checked districts still practice OD.

Thus, due to faulty selection of beneficiaries by WATSAN committees, ineligible beneficiaries were selected which resulted in non-utilisation and wasteful expenditure of ₹ 0.13 crore[102].

The Department stated (October 2014) that target could not be achieved due to non-release of funds from GoI during 2013-14 and State share during 2012-14. Till 2012-13, the Department followed the BPL list as provided by the State Rural Development (RD) Department, based on which bifurcation of APL/BPL was made. Thereafter, from 2013-14, the Department is adopting the records of 2011 Census.

[97] Dimapur district-Piphema old (5) and Kohima district-Ziezou (2)
[98] Dimapur district-Kirha (6), Razaphema (4), Medziphema (2)/ Kohima district-Ziezou(4), Mima (6), Kigwema (2) and Zunheboto district- Khetoi (1)
[99] Zunheboto district- Kivikhu (9), Kiyekhu (3), Viyilho (3), Vishepu (1), Xuivi (1), Sukhai (1), Aghuito (1)/ Kohima district- Ziezou (2), Kigwema (1)/ Dimapur district- Henito (1), Zuheshe (2), Hezheto (3)
[100] Zunheboto district- Ngozubo (1), Luvishe old (1), Melahumi (1)/ Dimapur district- Tsuuma (1), Khaibung (5), Kirha (3), Seithekima (1), Ghotovi (3), Hezheto (2)/ Kohima district- Chakhabama (2)
[101] Dimapur district-Medziphema(1)/ Zunhebot district-Ngozubo(9) and Kohima district-Chakhabama(3), Kezoma(1).
[102] 48 IHHL beneficiaries at `2700.00 per IHHL

1.4.11.2 Community Sanitary Complex (CSC)

The Community Sanitary Complexes comprising of appropriate number of toilet seats, bathing cubicles, washing platforms, Wash basins etc. was to be set up in a place acceptable and accessible to all in the village. However, the ultimate aim was to ensure construction of maximum IHHLs and construction of CSCs were to be resorted to only when IHHLs cannot be constructed. The maximum unit cost prescribed for a community sanitary complex is up to ₹ 0.02 crore. The sharing pattern amongst Central Government, State Government and the community was in the ratio of 60:30:10 (TSC guidelines June 2010).

Examination of the records of four test checked districts revealed that against AIP targets for construction of 106 CSCs, only 31 units (29 *per cent*) were constructed at a cost of ₹ 0.36 crore during 2009-2014 due to inadequate funds as shown in the table below:

Table 1.4.4:

Sl. No	Name of District	Number of CSC to be constructed	Actual number of CSC constructed	Percentage of achievement	Expenditure there-against (₹ in lakh)
1	Tuensang	13	2	15	3.00
2	Zunheboto	40	2	5	2.00
3	Dimapur	24	11	46	14.00
4	Kohima	29	16	55	16.73
	TOTAL	106	31	29	35.73

Source: Departmental Records

It was found that all the CSCs constructed in the three[103] out of four test-checked districts were funded entirely from the GOI fund. Thus, the sharing pattern of CSC as envisaged in the TSC/NBA guidelines was not followed.

Out of three CSCs selected for joint physical verification in two test checked districts, it was found that one CSC at Rusoma village (₹ 0.01 crore) under Kohima district was physically not available. The approved drawing for two seated CSC consists of two toilets, two urinals, water tanks and wash basin. However, it was noticed that the two seated CSCs constructed, one each at Nihokhu Village and Medziphema Town under Dimapur District was not as per the approved drawing. It was also noticed that provision for water was not made. The CSC at Medziphema town consists of two toilets only while CSC at Nihokhu village consists of one common toilet and two urinals as shown in the following picture:

[103] Tuensang (2), Zunheboto (2) & Dimapur (11)

Photgraph No 1.4.1

Medziphema CSC

Approved drawing of CSC

Nihokhu CSC

Thus, the CSCs constructed by the contractors did not adhere to the approved drawing and specification due to lack of monitoring by the Department. The CSCs lack sanitation facilities. Proper upkeep and maintenance of the CSCs was poor mainly due to lack of water facility.

The Department stated (October 2014) that the shortfall in construction of CSC was due to the fact that more weightage was given to IHHL and receipt of funds far below the allocation of funds as per AIP. The inability to adhere strictly to the fund sharing patterns for CSC was due to untimely release of State share.

1.4.11.3 Institutional Toilets

1. School Toilet

Rural school sanitation is an entry point for the wider acceptance of sanitation by the rural people. Realising that children play an effective role in absorbing and popularising new ideas and concepts, this programme intended to tap their potential as the most persuasive advocates of good sanitation practices in their own households and schools. Two toilet units, one each for boys and girls with urinals were to be constructed in each school under this programme.

Examination of the records of SWSM revealed that against the project targeted construction of 6090 school toilet units for the entire State, only 2831 (46 *per cent*) could be constructed during 1999-2014 due to fund constraint. Further, examination of records in four test checked districts revealed that against AIP targets for construction of 1158 school toilets, only 488 units (42 *per cent*) were constructed at a cost of ₹ 1.91 crore during 2009-2014 as shown in the table below:

Table 1.4.5

Sl. No	Name of District	Number of toilets to be constructed in Schools	Number of toilets constructed in Schools	Achievement (in percentage)	Expenditure there-against (₹ in lakh)
1	Tuensang	50	130	260	56.21
2	Zunheboto	434	120	28	46.54
3	Dimapur	578	150	26	53.55
4	Kohima	96	88	92	34.82
	TOTAL	1158	488	42	191.12

Source: Departmental Records

It was observed that all the School toilet units constructed in the four districts test-checked were funded entirely by the GOI. The rate prescribed for construction of School toilet was ₹ 38500 (maximum limit for hilly area) for each unit. However, it was seen that an amount of ₹ 0.58 crore was incurred for construction of 116 school toilets as against admissible amount of ₹ 0.45 crore resulting in excess expenditure of ₹ 0.14 crore.

Joint physical verification (between May to August 2014) further revealed that out of 29 school toilets in 24 villages, only 8 (28 *per cent*) schools[104] had functional toilets. The toilets in one school (Government High School, Kigwema, Kohima) was common for both boys and girls. One pre-fabricated school toilet block was diverted to Anganwadi Centre at Ngozubo Village under Zunheboto District. Five toilets[105] were dismantled due to site development and construction of approach road and 10 schools[106] did not have water facility. It was also found that six school toilets[107] constructed by the Department was not usable due to non-maintenance by the school authorities. It was also noticed that none of the school toilets constructed had made the required provision for children with special needs.

Defunct toilet at GMS Ziezuo

[104] Dimapur district: Kuhuxu/ Kohima district: GMS Rusoma, GPS Kezoma, GPS Thizama, GMS Phesama and Tuensang district: Noksen, GPS Litem

[105] Kohima district- GPS Chakhabama/ Tuensang district-GPS B Noksen/ Zunheboto district- GMS Kivukhu, GMS Xuivi/ Dimapur district- GPS Molvom

[106] GMS Rusoma, GMS Phesama, GPS Litem, GPS B Noksen, GPS Molvom, GPS Yali, GMS Ziezou, GMS Medziphema, GPS Sangdak, GMS Dihoma.

[107] Tuensang district- GPS Litem, GPS Yali, GPS Sangdak/ Kohima district- GMS Ziezou/ Dimapur district- GMS Medziphema, GPS Zuheshe

Interviews with the teachers in the 29 schools in four test checked districts revealed that the teachers in 11 schools (38 per cent) did not receive training on hygiene education from the DWSM/ WSSO/SWSM. Thus, the objective of training school teachers on hygiene education for promoting hygiene and sanitary habits among students was not fully achieved.

As per NBA guidelines, a toilet unit consists of a toilet and minimum of two urinals. However, it was observed that during 2013-14 the WSSO purchased 814 units of pre-fabricated school toilet block at the cost of ₹ 2.43 crore from M/s Dhariwal Steel Pvt. Ltd. It was seen that the pre-fabricated school toilet block did not have urinal facility as seen in the photograph of Government Primary School (GPS) Litem village, Tuensang district as shown below:

Photograph No.1.4.2

Toilets without urinals at Litem

Thus, 814 units of school toilets constructed/installed during 2013-14 were without urinal facilities and the objective of promoting good sanitation practices among students was defeated to that extent.

The Department accepted (October 2014) the audit observation and assured necessary remedial action. The Department further stated that training was being given to school teachers and WATSAN members every year by DWSM. To ensure 100 per cent construction and also to avoid duplication, the Department had opted for pre-fabricated school toilet block. However, due to high cost of transportation to carry the materials to various destinations, no other facilities could be provided with the meagre amount of ₹ 38,500 per unit.

2. Anganwadi Toilet

Children could be a good channel to influence parents to adopt proper sanitary habits as children are more receptive to new ideas. Anganwadis are appropriate institutions for changing the behavior, mindset and habits of children from open defecation to the use of lavatory through motivation and education.

Examination of the records of SWSM revealed that against the targeted construction of 2351 Anganwadi toilet units for the entire State, only 1288 (55 *per cent*) could be constructed during 1999-2014 due to fund constraint.

Examination of the records in four test checked districts revealed that against AIP targets for construction of 907 Anganwadi toilets, only 420 units (46 *per cent*) was constructed at a cost of ₹ 0.29 crore during 2009-2014 as shown in the table below:

Table 1.4.6

Sl. No	Name of District	Number of toilets to be constructed in AWCs	Number of toilets constructed in AWCs	Achievement (in percentage)	Expenditure there-against (₹ in lakh)
1	Tuensang	330	69	21	6.90
2	Zunheboto	118	85	72	4.75
3	Dimapur	326	182	56	12.35
4	Kohima	133	84	63	4.65
	TOTAL	**907**	**420**	**46**	**28.65**

Source: Departmental Records

It was seen that all the Anganwadi toilet units constructed in the four districts test-checked were funded entirely from the GOI's fund. Thus, the sharing pattern between Central and State (70:30) as envisaged in the TSC/NBA guidelines was not followed.

Joint physical verification of 34 Anganwadis in 24 villages revealed that only 11 Anganwadis[108] had functional toilets. Out of the remaining, 10 Anganwadi[109] toilets were dismantled due to land development or construction of approach road, toilets in four Anganwadis[110] were defunct/not in use, nine Anganwadis[111] did not have toilet facilities and one[112] toilet was far from the centre and difficult to access by the children. Further, out of the 11 functional toilets, six toilets (55 *per cent*) were un-hygienic as the concerned authorities did not maintain the toilets as shown in the picture below.

Photogrpah No.1.4.3

Anganwadi Satami (Zunheboto) Unhygienic

Defunct Anganwadi Litem (Tuensang)

Anganwadi Noksen (Tuensang) not baby freindly

[108] Kohima district- Rusoma (1), Mima (1)/ Zunheboto district-Khetoi (2), Satami (2), Momi (1), Lukikhe (1), Vishepu (1)/ Tuensang district- Yali (1) and Dimapur district-Hovukhu (1)

[109] Kohima district- Phesama (1), Mima (2), Chakhabama (1)/ Tuensang district- Thonoknyu (1)/ Zunheboto district- Xuivi (1), Sukhai (1), Kilo Old (1), Melahumi (1)/ Dimapur district- Nihokhu (1)

[110] Tuensang district- Litem (1), Sangdak (1), Noksen (1) and Dimapur district- Ghotovi (1)

[111] Tuensang district- Thonoknyu A, Chilliso, Pang/ Dimapur-Henito, Hezheto/ Kohima- Phesama (2) and Zunheboto district-Kiyekhu, Zuheshe.

[112] Zunheboto district-Satami

It was also seen that out of 34 Anganwadis, 12 Anganwadi centres[113] (35 *per cent*) did not have water facility. All the toilets provided in Anganwadis were "normal toilets" and not "baby friendly toilets".

Further, out of 34 Anganwadis in four test checked districts, only 26 (76 *per cent*) Anganwadi workers/helpers received training on hygiene education from the DWSM/ WSSO/SWSM. Thus, the objective of training Anganwadi workers/helpers on hygiene education for promoting hygiene and sanitary habits among children was not fully achieved.

It was also observed that there was no system of handing over of Anganwadi toilets constructed under the scheme by DWSM to the authority concerned of the Anganwadi centres. Further, no assurance was obtained from the Department concerned for their maintenance.

While admitting (October 2014) the Joint physical verification report, the Department stated that necessary steps would be taken for detailed verification of the matter. The Department faced difficulty in construction of Anganwadi toilets as majority of the Anganwadi Centres are housed at private buildings where GoI does not permit construction of a toilet.

The reply was not acceptable as the NBA guidelines at para 5.8.5 allows construction of toilets in Anganwadi centres operating in private buildings.

1.4.11.4 Solid and Liquid Waste Management

Under this component, activities like compost pits, vermin composting, common and individual biogas plants, low cost drainage, soakage channels/ pits, reuse of waste water and system for collection, segregation and disposal of household garbage etc. can be taken up.

As per TSC guidelines, upto 10 *per cent* of the project cost can be utilised for meeting capital costs incurred under this component. The fund sharing pattern would be in the ratio of 60:20:20 between the Centre, State and the Community. SLWM can also be implemented by dovetailing funds from other RD programmes like MNREGS etc.

Examination of the records in four test checked districts revealed that an amount of ₹ 1.14 crore was spent during 2009-2014 for implementation of SLWM in 140 villages. It was also observed that the entire SLWM expenditure was funded from the GOI. The targets and achievement of SLWM for the four test checked districts are shown in the table below:

[113] Kohima district-Rusoma, Mima, Chakhabama/ Tuensang district- Litem , Noksen, Yali, Sangdak, Thonoknyu/ Zunheboto district- Vishepu, Khetoi, Kiyekhu/ Dimapur district- Henito

Table 1.4.7

Sl. No	Name of District	Number of villages where SLWM was implemented	Expenditure there-against (` in lakh)
1	Tuensang	22	11.61
2	Zunheboto	34	36.42
3	Dimapur	59	42.89
4	Kohima[114]	25	22.93
	TOTAL	140	113.85

Source: Departmental Records

The following was also observed:

- SLWM was not taken up in a Project Mode as envisaged in the scheme guidelines which resulted in defeating the objective of ensuring proper drainage facility, safe disposal of household waste and overall clean environment in the village.
- Collection, segregation and disposal of household garbage are inter-related activities in the Solid Waste Management System. However, it was observed that provision for only collection of household waste was taken-up, their segregation and disposal into bio-degradable & non-biodegradable waste were not considered.
- It was seen that during 2011-12, DWSM Zunheboto diverted an amount of ₹ 0.80 lakh from SLWM component of the scheme funds for payment of honorarium to officers and staff of the establishment of the Executive Engineer (PHED) Zunheboto Division. Similarly, in Dimapur district, DWSM diverted (2011-12) an amount of ₹ 1.50 lakh for construction of Community Sanitary Complex at Darogapathar.

The WSSO, Nagaland stated that SLWM was not taken up in a project mode as a result of which no significant development, impact, etc. had been achieved or observed in the State. It was expected to be taken up in the coming years for which a Detailed Project Report on SLWM had been prepared and approval from the Ministry was awaited.

The Department accepted (October 2014) the audit findings and assured necessary remedial action. The Department also stated that so far only household liquid waste management system involving collection of solid waste through waste bins, disposal of liquid waste through kitchen garden and soak pits were taken up. Community level Waste Management System was to be implemented from the year 2014-15 with the approval of AIP by GoI.

[114] Number of villages where SLWM was implemented during 2010-11 was not made available.

1.4.11.5 Rural Sanitary Marts and Production Centre

The Rural Sanitary Mart (RSMs) is an outlet dealing with the materials, hardware and designs required for the construction of sanitary latrines, soakage and compost pits, vermi-composting, washing platforms, certified domestic water filters and other sanitation and hygiene accessories. The Production Centres (PCs) are the means to produce cost effective affordable sanitary materials at the local level. PC can be independent or part of the RSMs. RSMs and PCs were required to be established as commercial ventures with social objective.

Scrutiny of DWSM records of four test checked districts revealed that against the project objective/target for establishment of 11 RSMs/ PCs, only 5 (45 *per cent*) RSMs/PCs could be established as of March 2014 which is detailed in **Table No.1.4.8**. However, no RSM/PC was established during the period of audit (2009-14) in any of the four test checked districts.

Table 1.4.8

Sl. No	Name of district	Projective objectives (sanction by GoI)	Project performance (cumulative as of March/2014)	Status of RSM/PC
		RSM/ PC		
1	Tuensang	3	1	Discontinued since 2007-08
2	Zunheboto	2	1	Discontinued from 2009-10
3	Dimapur	3	1	Discontinued since 2007-08
4	Kohima	3	2	Discontinued since 2007-08
Total		11	5	

Source: Departmental Records

The Department stated that PCs were set up in all the TSC districts and beneficiaries mostly represented by WATSAN Committee members were trained to make Commodes and Squatting plates using locally available materials. But the results were not forthcoming as in most cases WATSAN Committee members in return failed to train the beneficiaries. Accordingly, the Department decided to manufacture Commodes and Squatting plates at the respective District Headquarters and carried it to the beneficiary villages. However, due to poor road connectivity, bad road conditions, difficulty of travelling during certain seasons, the heavy weight of Commodes and Reinforced Concrete Cement (RCC) Squatting plates etc. almost 50 to 60 *per cent* of the materials got damaged on reaching the destination. Another problem was the high cost involved in transportation. Therefore, the Department finally decided to go for readymade Rotto moulded plastic Squatting plate assembly which is light in weight, durable and can easily be carried by head load to any place in the hilly terrain of the State. The Department is responsible for supplying all essential

materials for construction of IHHL and the beneficiary takes care in erecting their own latrines as part of the beneficiary contributions.

1.4.11.6 Provision of Revolving Fund in the District

A Revolving Fund may be given to Cooperative Societies or Self Help Groups whose credit worthiness is established, for providing cheap finance to their members. Loan from this fund should be recovered in 12-18 installments. This revolving fund can be accessed by APL households not covered for incentives under the guidelines and the owners of the households where Anganwadi Centre is located for construction of baby friendly toilets. 5 *per cent* of the District Project outlay subject to a sum of up to ₹ 0.50 crore can be used as revolving fund.

It was observed that Revolving fund was not operated in any of the eleven districts of the State. The Department stated that taking into account the failure of loan recovery as experienced by many departments in the State and the mindset of the people, the Department from the beginning decided not to encourage Revolving fund.

1.4.11.7 Nirmal Gram Puraskar (NGP)

The NGP award is given to those Nirmal Gram Panchayats, Blocks and Districts which have become fully sanitised and open defecation free. The prize money is to be released in two equal installments. Organisations and officials are given citations and mementos in recognition of their efforts.

Examination of the records of SWSM revealed that the State Level Scrutiny Committee for NGP was not set up in the State. It was however, observed that out of 449 applications received for NGP award, only 82 (18 *per cent*) villages were selected for the award and an incentive of ₹ 0.86 crore was paid during 2009-14.

Further examination of the records in the four test checked districts revealed that against 189 numbers of applications received (13 applications pertaining to 2013-14 under process) for NGP award, only 53 villages (30 *per cent*) were selected for the award during 2009-2013. It was also seen that 70 *per cent* of the applications were rejected after verification as these did not meet the prescribed criteria. An incentive amount of ₹ 0.39 crore were disbursed to awarded villages as detailed in the table below:

Table 1.4.9

Sl. No	Name of District	Number of applications received.	Number of Villages awarded	Percentage	Incentive amount disbursed (₹ in lakh)
1	Tuensang	16	2	13	1.50
2	Zunheboto	70	29	41	18.00
3	Dimapur	86	15	17	11.50
4	Kohima	17	7	41	7.50
	TOTAL	**189**	**53**	**28**	**38.50**

Source: Departmental Records

The following was also observed:

(i) Year-wise target was not fixed by DSWMs for achieving Nirmal Status to the GPs/villages. It was noticed that out of 653 villages in the four test-checked districts only 60 villages (9 *per cent*) had attained the Nirmal status as of August 2014. The details of the status of villages in the test checked districts are shown below:

Table 1.4.10

Sl. No	Name of District	No. of villages (Rural) in the district as per Census 2011	No. of NGP villages (since implementation of the scheme) in the district	Achievement (Percentage)
1	Tuensang	138	2	1
2	Zunheboto	191	29	15
3	Dimapur	219	21	10
4	Kohima	105	8	8
	Total	653	60	9

Source: 2011 Census and Departmental Records

(ii) DWSM and SWSM did not verify the facts/information contained in the applications of villages before forwarding the same to DDWS. Thus, the procedure for recommending the applications of villages as stipulated in the guidelines was not followed in the State.

The procedure for payment of incentive amount as envisaged in the NGP Guidelines 2010 and sanction orders of the GoI was not followed. The SWSM Nagaland disbursed the entire award money to respective NGP villages in lump sum. Therefore, the mandatory random checks by the DWSMs after six months in all the awarded villages to ascertain Nirmal Gram and ODF status for release of second installment was not followed.

Joint physical verification of two NGP villages in Dimapur district revealed that toilet facility was not available in Anganwadi Centre (Tsuuma village) and OD was still practiced in Razaphema village as shown in the picture.

Photograph No.1.4.4

Open defecation

Further, there were no random checks by the SWSM/DWSM to ensure that NGP villages maintain their OD free status.

The Department accepted (October 2014) that year wise targets were not made for achieving Nirmal Gram status for GPs/villages. The Department also stated that the State level NGP verification committee was constituted which scrutinised the cases to be recommended to the DDWS. However, the committee constitution notification could not be made available during the period of audit. Further, the Department stated that as the NGP cash award was not substantial (₹ 50,000) and the award distribution ceremonies were attended by the Hon'ble Chief Minister of the State, as the chief guest, the idea of releasing the award money in two installment was considered not suitable. Besides, as some awardees/villages were required to come from long distances involving great hardships and expenses the award was given in one installment.

The reply is not justifiable as it is clearly mentioned in the GOI sanction order[115] that the award money upto ₹ 0.50 lakh was to be given in one installment and above that in two installments. However, in 27 cases, awards of more than ₹ 0.50 lakh were paid in one installment.

Further, while accepting the fact, the Department stated that some households in NGP awarded villages have reverted to the practice of OD as IHHL constructed were of very low cost and temporary in nature. However, the Department is trying to address these issues through IEC campaign and other measures.

The reply is not acceptable as this indicates the failure of proper monitoring by the DWSM and lack of awareness on sanitation.

[115] No.W-11045/13/2009/CRSP dated 30.12.2009.

1.4.12 Audit Objectives-5: Information, Education and Communication.

Information, Education and Communication (IEC) was a key component of the TSC/NBA scheme which was intended not only to trigger the demand for sanitary facilities, but also for use, maintenance and up-gradation of the sanitary facilities through behavioral change, so that sanitation and hygiene become an integral part of life and thereby sustainable. Each district was required to prepare a detailed IEC Annual Action Plan by February of the preceding financial year with defined strategies to reach out to all sections of the community. The Annual IEC Action Plan should be duly approved by the DWSM. The IEC funds should be broadly divided into Pre-Nirmal and Post-Nirmal phase so as to have funds for sustaining the movement.

The TSC/NBA guidelines do not have provision for earmarking of certain part of IEC funds for carrying out State level IEC activities. However, NBA guidelines were modified (July 2013) by inserting new provisions in Para's 5.2.1 & 5.2.8 mentioning that "IEC should be conducted at all levels i.e. State/UT, District, Block & Gram Panchayat" whereby out of 15 *per cent* total project cost of the district, 5 *per cent* can be utilised by the State/UT for State level IEC activities and funding will be in the ratio of 80:20 between GoI and the State Government.

Examination of the records of SWSM revealed that during 2009-14, all the eleven DWSMs transferred ₹ 7.34 crore to the SWSM/WSSO Nagaland towards 15 *per cent* IEC component in violation of the provisions of the scheme guidelines. At the State level, an amount of ₹ 4.20 crore (57 *per cent*) was spent for IEC activities including production of IEC materials worth ₹ 2.68 crore while all the eleven districts of the State incurred an expenditure of ₹ 3.14 crore (43 *per cent*). No funds were provided to Village level implementing agencies for IEC activities. There was short release of State matching share towards IEC component amounting to ₹ 1.59 crore. The sharing pattern and utilisation of IEC funds as envisaged in the TSC/NBA guidelines were therefore, not followed. The details of IEC funds received and its utilisation is shown in the table below:

Table 1.4.11

(₹ in lakh)

Year	Source of IEC funds-TSC-NBA			Expenditure	
	Central	State	Total	State level	District level
2009-10	158.88	0.00	158.88	127.88	31.00
2010-11	16.80	19.51	36.31	26.71	9.60
2011-12	193.73	0.00	193.73	165.73	28.00
2012-13	59.45	0.00	59.45	3.12	56.33
2013-14	285.94	0.00	285.94	96.62	189.32
Total	**714.80**	**19.51**	**734.31**	**420.06**	**314.25**

Source: Departmental Records

It was observed that no detailed IEC Annual Action Plan was prepared by DWSM in any of the four districts test-checked. However, IEC Action Plan for all the eleven districts was prepared by the WSSO Nagaland. The actual year-wise IEC activities in the districts were taken up as per instructions and funds released by the WSSO Nagaland. Therefore, the IEC activities were not carried out as per the requirements of the districts/grassroots level. It was also noticed that the IEC Annual Action Plans did not have a provision for Post-Nirmal IEC activities in NGP villages for sustaining the movement.

As per IEC guidelines, the IEC activities were to be carried out throughout the year. It was observed that the activities were not conducted throughout the years due to insufficient funds. Examination of the records in four test-checked districts revealed that against the initial allotment of IEC funds amounting to ₹ 3.26 crore, DWSMs received only ₹ 0.91 crore. The details are shown in the table below:

Table 1.4.12

(₹ in lakh)

Sl. No	Name of District	Total funds returned by DWSM to WSSO	Actual funds received by DWSM	Funds received by DWSM (in percentage)
1	Dimapur	122.50	38.34	31
2	Zunheboto	93.25	26.95	29
3	Tuensang	48.14	13.82	29
4	Kohima	61.85	11.40	18
Total		325.74	90.51	28

Source: Departmental Records

It was observed that out of the total expenditure of ₹ 7.34 crore, an amount of ₹ 2.68 crore was incurred on material component of IEC activities during 2009-14. The Department did not maintain Stock account of the IEC materials and therefore, the actual quantity issued/utilised to and by various divisions/programmes could not be ascertained and the value of the materials lying (September 2014) in the store could also not be quantified. Joint physical verification of stores revealed huge number of unutilised IEC materials as shown in the picture below:

Photograph No.1.4.5

Un-utilised IEC materials

The TSC guidelines issued by the Ministry of Rural Development, Department of Drinking Water Supply provided for engagement of Swachchhata Doots/ Sanitation Messengers to strengthen communication machinery at the village level with participatory social mobilisation. They were to be paid suitable incentive based on their performance from funds earmarked for IEC. The responsibilities of Swachchhata Doots are:

- To create awareness in community towards safe sanitation by personal household contact, organising meetings and events.
- Collection of habitation-wise detailed information of each Household of the village.
- Coordinating with Panchayat Members for monthly meeting of Gram Sabha (Sanitation Day).
- To visit School and the Anganwadi at regular intervals for discussion on cleanliness, maintenance and use of toilets.
- Mobilising schools for Health Walk, Rally in the village, Focused Group Discussions and door-to-door drive by students.
- To encourage Households to go for construction of IHHL themselves.

It was noticed that Swachchhata Doots/Sanitation Messengers were not engaged in any of the four test-checked districts by the DWSM for interpersonal communication and door to door contact. Even the financial provision for door-to-door contact drives were not made in the IEC Action Plan of DWSM.

It was further observed that out of 52 villages in four districts test-checked, the village level implementing agency i.e WATSAN committee of 49 villages (94 *per cent*) did not receive IEC materials from the DWSM/WSSO. Also, no funds were provided to the village level implementing agency for conduct of IEC activities and other components of the scheme. It was also observed that during 2009-2014, out of 52 villages test-checked in four districts, members of the Village Council/ WATSAN Committee from 35 villages only received training. Further, Hoardings/Banners on TSC/NBA were not placed in the Villages premises, Village Council Hall etc. of any of the test checked villages thus reducing the effectiveness of creating awareness to the rural masses on sanitation.

Thus, IEC which was intended not only to trigger the demand for sanitary facilities, but also for use, maintenance and up-gradation of the sanitary facilities through behavioral change failed to change the mindset of the people.

The Department stated (October 2014) that each time funds were released by the GoI, the whole amount of IEC fund which is 15 *per cent* of the released amount were placed at the disposal of the DWSM/PHE division at district level for incurring expenditure through them. In the interest of giving an effective IEC campaign all over the State, the IEC Action Plans were formulated for all TSC districts after thorough discussion and consultation with the divisional officers. Further, the works of IEC campaign is a continuous process where, apart from IEC materials already given to divisions, some IEC materials are required to be kept in stock for distribution at various functions in the State and at district level from time to time. This is even more necessary as the fund release remain always uncertain whereas IEC activities must go on. The IEC materials were always distributed to the participants in TSC/NBA functions held at State, district and village levels instead of distributing the materials through WATSAN committees on account of limited availability of resources.

1.4.13 Objectives-6: Convergence of the NBA activities with other programmes/stakeholders.

The GoI directed (June 2012) the convergence mechanism with MNREGS to facilitate the rural households with fund availability for creating their own IHHLs. Accordingly, the incentive amount of ₹ 4600 available under NBA could be further increased by ₹ 4500 through expenditure on skilled and unskilled components of the work done through MNREGS. The IHHLs, Institutional toilets as well as CSCs could be constructed through use of MNREGS resources.

It was observed that there was no convergence of TSC/NBA schemes with MGNREGS or any other scheme implemented in the State.

The Department stated (October 2014) that despite the provision for convergence of MGNREGS and TSC/NBA, there were practical difficulties for convergence in the State as these two programmes are being implemented by two separate departments. However, the new guidelines under Swachh Bharat Mission has done away with the need for convergence.

1.4.14. Objective-7: Monitoring and Evaluation.

Regular field inspections by officers from the State and district level were essential for effective implementation of the programme. The TSC/NBA guidelines emphasised that project authorities were to constitute a team of experts in the district, who were to review the implementation in different blocks. Such reviews were to be held at least once in a quarter. Similarly, the State Government was to conduct a review of projects in each district once in a quarter. For this purpose, they were to constitute a panel of experts available in the State. In addition, GoI was to send review missions to the State periodically to assess the quality of implementation.

Examination of the records revealed the following:

The functions of SWSM included coordination with various State Government departments, convergence of water supply and sanitation activities, monitoring and evaluation of physical and financial performance of the schemes, maintaining accounts and carrying out the required audits of the accounts. These activities were to be implemented and evaluated through regular meetings at least once in six months. It was found that against the minimum requirements of 10 SWSM meetings, no meetings were held during 2009-14. Further, it was mandatory to hold meetings of DWSMs at least once in a month to prepare the implementing strategies, sanction expenditure and monitor the progress and quality of work. It was however, observed that no formal DWSM meetings were held in the four test-checked districts during 2009-14. However, the Member Secretary and the Chairman DWSM meets from time to time for approval of Action Plans of the respective District. Thus, due to non-conduct of prescribed meetings at regular intervals, the DWSM were unable to discharge their responsibilities of overseeing the implementation of the schemes in their respective districts.

It was also noticed that teams of experts for review of TSC/NBA as envisaged in the guidelines had not been constituted in the State. The TSC/NBA guidelines and GoI instruction (December 2011), also prescribe "Evaluation study" on the progress of implementation of TSC in the State to be undertaken periodically to validate the progress made and reported. However, it was found that no evaluation study on TSC/NBA was carried out by the State as of September 2014.

While admitting (October 2014) the fact, the Department stated that the prescribed number of SWSM and DWSM meetings in the guidelines could not be strictly followed. However, the Member Secretary and the Chairman DWSM meet from time to time for approval of Action Plan of the respective district and accordingly works are being executed.

1.4.14.1 Sanitation Day and Social Audit

NBA will provide a central role to 'social audits' as a means of continuous and comprehensive public vigilance. Each GP/VC was to earmark a particular day of the Month to be named as 'Swachchhata Diwas' (Sanitation Day) in an open public space, with ample provision for proactive disclosure of information and thoughts. A Gram Sabha/Village Council will be convened every six months to undertake mandatory review of progress made under various Month Plans and proceedings of Swachchhata Diwas that were held in the GP/VC. This will be used as a means to strengthen the elements of transparency, participation, consultation and consent, accountability and grievance redressal in the implementation of NBA. It was observed that Sanitation Day/Village cleaning day was observed ranging from one to four times in a year but activities (Swachchhata Diwas/ Sanitation Day) as envisaged in the guidelines were not followed by the villages.

Social Audit was conducted for other funds under Village Council (VC). However, no audit was under taken for Total Sanitation Campaign/ Nirmal Bharat Abhiyan as per

the scheme guidelines in any of the 52 villages of four test checked districts. This was due to lack of fund allocation to the villages under TSC/NBA though toilet construction materials were received by the Villages from the Department.

The Department accepted (October 2014) the audit observation and assured necessary remedial action.

1.4.14.2 Online Monitoring

The Ministry of Drinking Water and Sanitation has developed an online monitoring system for TSC/NBA. All project districts are to submit the physical and financial progress reports through this online software. Progress reports in hard copy are discouraged except an Annual Performance Report which is to be submitted to MDWS.

It was seen that none of the four test-checked districts carried out online entry of TSC/NBA data as envisaged in the guidelines. All the four DWSMs have stated lack of facilities and network problem the reasons for non-compliance. The Department stated that online data entry was done from State level. However, the source documents based on which data entry was made in the Integrated Management Information System (IMIS) was not made available to audit.

Discrepancy between IMIS Report and actual achievement of four test-checked districts on different components of the scheme for the period 2009-2014 is detailed in table 1.13.

Table 1.4.13

Component	Dimapur		Zunheboto		Tuensang		Kohima	
	Actual	IMIS	Actual	IMIS	Actual	IMIS	Actual	IMIS
IHHL (APL+BPL)	9756	21641	4433	5113	7759	8364	9742	20671
CSC	11	10	2	1	2	3	6	17
School Toilet	150	252	120	385	130	87	88	88
Anganwadi Toilet	182	204	85	123	69	69	84	114

Source: Departmental Records and website-tsc.gov.in

The above discrepancies indicate unreliability of data maintained on IMIS which is expected to be the key tool for monitoring and evaluation of the programme.

Conclusion

The process of planning was devoid of comprehensive assessment of beneficiaries/requirement of the rural needs, non-availability of reliable baseline data and lack of community participation in the preparation of PIPs. Funds were not released in time and the sharing pattern between GOI and State for various components as envisaged in the scheme guidelines was not followed. There was short release in State's matching contribution. There was lack of proper assessment for identification of IHHL beneficiaries and upkeep of the same by the beneficiaries. Open Defecation was practiced even in Nirmal Gram Puraskar awarded villages. Institutional toilets were dismantled or defunct due to land development, improper

maintenance and lack of water facilities. The school toilets lack provision for children with special needs. The Anganwadi toilets were unhygienic and not "Baby friendly". Deficient IEC activities at the lower levels led to lack of awareness and non-generation of demand. Therefore, the supply driven approach adopted in the State could not achieve the desired results. There was lack of regular meetings at all levels for preparing the implementing strategies, monitoring the progress and ensuring quality of work. Specific Evaluation Study and Review of TSC/NBA by involving reputed organisations/institutions in the field of sanitation were not done. Social Audit was not conducted in any of the test checked villages.

Recommendations

- Planning should be based on "bottom up approach" in order to ensure community participation and generation of demand for sanitary facilities.
- Timely release of funds and sharing pattern of various components as envisaged in the scheme guidelines should be strictly adhered to.
- Proper assessment for identification of IHHL beneficiaries and monitoring to secure construction of latrine and upkeep of the same should be ensured.
- Intensive IEC activities should be taken up at all levels laying emphasis on Interpersonal communication and Community mobilisation.
- State specific Evaluation Study/ Review on TSC/NBA may be conducted by involving reputed organisations and institutions in the field of sanitation for taking further corrective measures.

TECHNICAL EDUCATION DEPARTMENT

1.5 Unfruitful expenditure

The Technical Education Department incurred an unfruitful expenditure of ₹ 99.87 lakh due to non-incorporation of specific clause in the agreement for obtaining bank guarantee against advance payments and clauses on penal action for failure in execution of the works. Besides, the objective of setting up Pilot Training Academy in Nagaland could not be achieved.

Rule 159 of General Financial Rules (GFR) 2005 stipulates that ordinarily payments for services rendered or supplies made should be released only after the services have been rendered or supplies have been made. However, if it becomes necessary to provide advance payments in certain cases such advance payments should be released after obtaining adequate safeguards in the form of bank guarantee, etc. from the firm.

The work for setting up of pilot training academy at Dimapur, Nagaland was awarded to Carver Aviation Private Limited (CAPL), Baramati, Pune without inviting tenders or expression of interest in contravention of procedures stipulated in the GFR. It was observed that an agreement was signed (8 December 2009) between the Government of Nagaland represented by Commissioner & Secretary, Department of Higher and Technical Education (H&TE), Kohima and CAPL.

As per the agreement, the entire scope of work for setting up of pilot training academy was spread in three phases. However, the present agreement was executed for Phase – I valid from July 2009 to December 2011. The activities to be taken up by CAPL during phase-I were:

(i) Obtain all relevant permission from respective Ministries for the project, (ii) set up infrastructure such as hangar, offices, fuel depot, etc. (iii) relocate Aircraft, (iv) induct technical, operations and marketing staff, (v) recruit students and (vi) train students.

As per the agreement, the Department was required to release the estimated cost of ₹ 6.63 crore (Phase-I) in four installments, i.e. 25 *per cent* on signing the agreement, 25 *per cent* on arrival of three aircrafts, 25 *per cent* on completion of hangar and related construction activity and the balance 25 *per cent* on receipt of approval from Director General of Civil Aviation (DGCA) for commencement of flying institute at Dimapur. However, the agreement did not mention anything about submission of Bank Guarantee against which the advance payments were to be released. Further, the agreement did not also stipulate anything about the penal action for non-performance of the agreement.

Examination of records revealed that the Department paid an amount of ₹ 99.87 lakh to CAPL (February 2010). However, the CAPL did not take up any of the activities stipulated in the agreement till the date of audit (February 2013). The Department wrote to CAPL in June 2011 (just before completion of tenure of the agreement) regarding utilisation of the amount paid. In reply CAPL clarified (June 2011) that they spent ₹ 69.56 lakh towards salary, travelling expenses and training of CAPL staff and the balance amount of ₹ 30.31 lakh was spent for purchase of two aircrafts[116]. The aircrafts purchased were registered in the name of CAPL and were lying in Baramati, Pune.

Thus, due to non-incorporation of specific clause in the agreement for obtaining bank guarantee against advance payments and clauses on penal action for failure in execution of the works, the Department incurred unfruitful expenditure of ₹ 99.87 lakh. Besides, the objective of setting up Pilot Training Academy in Nagaland remained unachieved.

The Government stated (July 2014) that ₹ 99.87 lakh was released as advance payment as per the agreement. Though the project had been badly delayed due to the cumbersome procedure in getting necessary clearance from the AAI/Civil Aviation Ministry, the Department was trying its best to set up the Institute to train youth from Nagaland and other North Eastern states as pilots and maintenance engineers.

[116] Out of the cost of the aircrafts (₹ 116.16 lakh), an amount of ₹ 30.31 lakh was paid from the amount received from the department and the remaining amount of ₹ 85.85 lakh was borne by CAPL.

The reply confirmed the fact that the amount spent had not yielded any benefit to the Department and in the absence of any bank guarantee and clause for liquidated damages in the agreement, the scope to recover the amount was remote.

URBAN DEVELOPMENT DEPARTMENT

1.6 Non-remittance of toll to Municipal Account

Advisor in-charge of Revenue, Dimapur Municipal Council failed to remit toll amounting to ₹ 78.83 lakh collected from consignees against goods transported through Railway wagons during 2011-12.

Dimapur Municipal Council (DMC) Advisory Committee while deciding (March 2011) the modalities for collection of various taxes and fees to be levied under Section 120 of the Municipal Act 2001 entrusted the Revenue wing of the DMC to collect the toll on items such as cement, edible oil, etc. transported by Rail. Accordingly, instructions were also issued to the Station Master NF Railway by the Chief Executive Officer (CEO), DMC not to clear any goods brought by rail without the clearance from the DMC.

Examination (July 2014) of records of the DMC, revealed that the Advisor In-charge of Revenue (ACR) deposited an amount of ₹ 17 lakh during 2011-12 on account of toll from goods transported through Rail. Since no receipt books, etc. were furnished to audit in support of the collection and remittance of toll in respect of goods transported through rail for scrutiny, audit collected details of goods (cement, Rice, etc) transported through wagons during 2011-12 from Commercial wing, NF Railway, Dimapur. Examination thereof revealed that 4831 wagons were unloaded at Dimapur and the toll thereagainst worked out to ₹ 95.82 lakh which was to be collected from the consignees before releasing the material/items.

Thus, there was a short remittance of toll tax amounting to ₹ 78.82 lakh to the DMC by the Advisor-in-charge of revenue wing during 2011-12.

The matter was reported to the DMC (July 2013) and the Government (August 2014). Replies had not been received (December 2014).