CHAPTER I: SOCIAL SECTOR

CHAPTER I: SOCIAL SECTOR

1.1 Introduction

This Chapter of the Audit Report for the year ended 31 March 2016 deals with the findings on audit of the State Government units under Social Sector.

The names of the State Government departments and the break-up of the total budget allocation and expenditure of the State Government under Social Sector during the year 2015-16 are given in the table below:

Table No: 1.1.1

(₹ in crore)

Name of the departments	Total budget allocation	Expenditure
Education (Higher) Department	190.04	126.91
Education (School) Department	1,548.49	1,400.45
Education (Social) Department	417.69	294.87
Education (Sports and Youth Programme) Department	93.28	49.50
Food, Civil Supplies and Consumer Affairs Department	113.21	84.26
Family Welfare and Preventive Medicine	432.30	218.43
Health Department	286.89	239.93
Labour Organisation	19.65	18.30
Panchayati Raj Department	368.07	210.49
Public Works (Drinking Water and Sanitation) Department	215.07	206.98
Relief and Rehabilitation Department	30.59	30.44
Rural Development Department	638.40	498.77
Tribal Welfare (Research) Department	2.68	2.45
Tribal Welfare Department	3,606.02	2,139.57
TRP and PVTG Department	22.70	22.21
Urban Development Department	355.61	183.62
Welfare for SC and OBC Department	1,490.66	789.34
Welfare of Minorities Department	98.47	33.84
Welfare of OBC	46.35	18.63
Total number of departments = 19	**9,976.17**	**6,568.99**

Source: Appropriation Accounts – 2015-16.

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, etc.

After completion of audit of each unit, Inspection Reports (IRs) containing audit findings are issued to the heads of the departments. The departments are requested to furnish replies to the audit findings within one month of receipt of the IRs. Whenever replies are received, audit findings are either settled or further action for compliance is advised. The important audit observations arising out of those IRs are processed for inclusion in the Audit Reports, which are submitted to the Governor of Tripura under Article 151 of the Constitution of India for being laid in the State Legislature.

The audits were conducted during 2015-16 involving test check of an expenditure of ₹ 9,347.18 crore (including expenditure pertaining to previous years audited during the year) of the State Government under Social Sector. This Chapter contains one Performance Audit on "Implementation of National Rural Health Mission" relating to Health and Family Welfare Department, audit of "Management of State Disaster Response Fund" relating to the Revenue Department and one Compliance Audit paragraph.

HEALTH AND FAMILY WELFARE DEPARTMENT

1.3 Implementation of National Rural Health Mission

The National Rural Health Mission (NRHM) was launched in April 2005 in the country with a view to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections of the society. The key strategy of NRHM was to support and supplement the efforts of the State for strengthening health system through the provision of financial and technical assistance.

Highlights

The State Government did not conduct household surveys to identify the local needs of health care. Village Health Action Plans were not prepared.

{Paragraph 1.3.7.1(B)}

Lack of proper assessment by the State Health Society (SHS) led to short release of ₹ 273.46 crore by Government of India (GoI). Even out of the funds provided by GoI, SHS could utilise only 51 to 69 *per cent* during 2011-16. ₹ 1.51 crore advanced to 116 officials was lying outstanding.

(Paragraphs 1.3.7.3, 1.3.7.4 & 1.3.7.6)

The number of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) were below the prescribed level by 12, 47 and 56 *per cent* respectively in the State. In the three test checked districts, there was a shortage of SCs, PHCs and CHCs by 11, 42 and 53 *per cent* respectively. 69.57 *per cent* test checked SCs were running without water supply and electricity and 34.78 *per cent* without toilets.

(Paragraph 1.3.7.8 & 1.3.7.9)

There were no specialists in CHCs and Sub Divisional Hospitals. In 279 SCs there was no Auxiliary Nursing Midwife/Female health worker. Four test checked CHCs did not have facilities for Caesarean Section delivery and none of the 23 test checked SCs had facilities for institutional delivery.

{Paragraphs 1.3.7.15(A) & (B) & 1.3.7.18 (A)}

Although there was a high prevalence rate of Anaemia amongst pregnant women (54.4 *per cent)* in the State, 36 *per cent* of pregnant women did not receive three Ante Natal check ups, and 40 *per cent* did not receive 100 Iron & Folic Acid tablets.

{(Paragraph 1.3.7.18(B)}

State Quality Assurance Committee had not met even once till June 2016. Internal assessment and patient satisfaction survey was not done in any of the test checked facilities. Health Management Information System lacks data integrity. Hence internal control, supervision and monitoring were inadequate.

(Paragraphs 1.3.7.24, 1.3.7.25, 1.3.7.26 & 1.3.7.27)

1.3.1 Introduction

The National Rural Health Mission (NRHM) was launched on 12 April 2005 throughout the country. The NRHM seeks to provide accessible, affordable and quality health care to the rural population. The State Government signed a Memorandum of Understanding (MoU) with Government of India (GoI) in January 2006 for implementation of NRHM in Tripura.

Components of NRHM

NRHM is an umbrella programme subsuming the existing programmes of health and family welfare and comprises of the following components:

- Reproductive and child health
- Emergency and trauma care
- Control of communicable diseases
- Non-communicable disease

Framework of Implementation

The Ministry of Health and Family Welfare in its 'Framework of Implementation (2005-2012 and 2012-2017)' had laid down some anticipated outcomes to be achieved by the end of XII Five Year Plan (2012-17). The three main expected outcomes to be achieved at the end of 31 March 2016 is indicated below (details in **Appendix-1.3.1**).

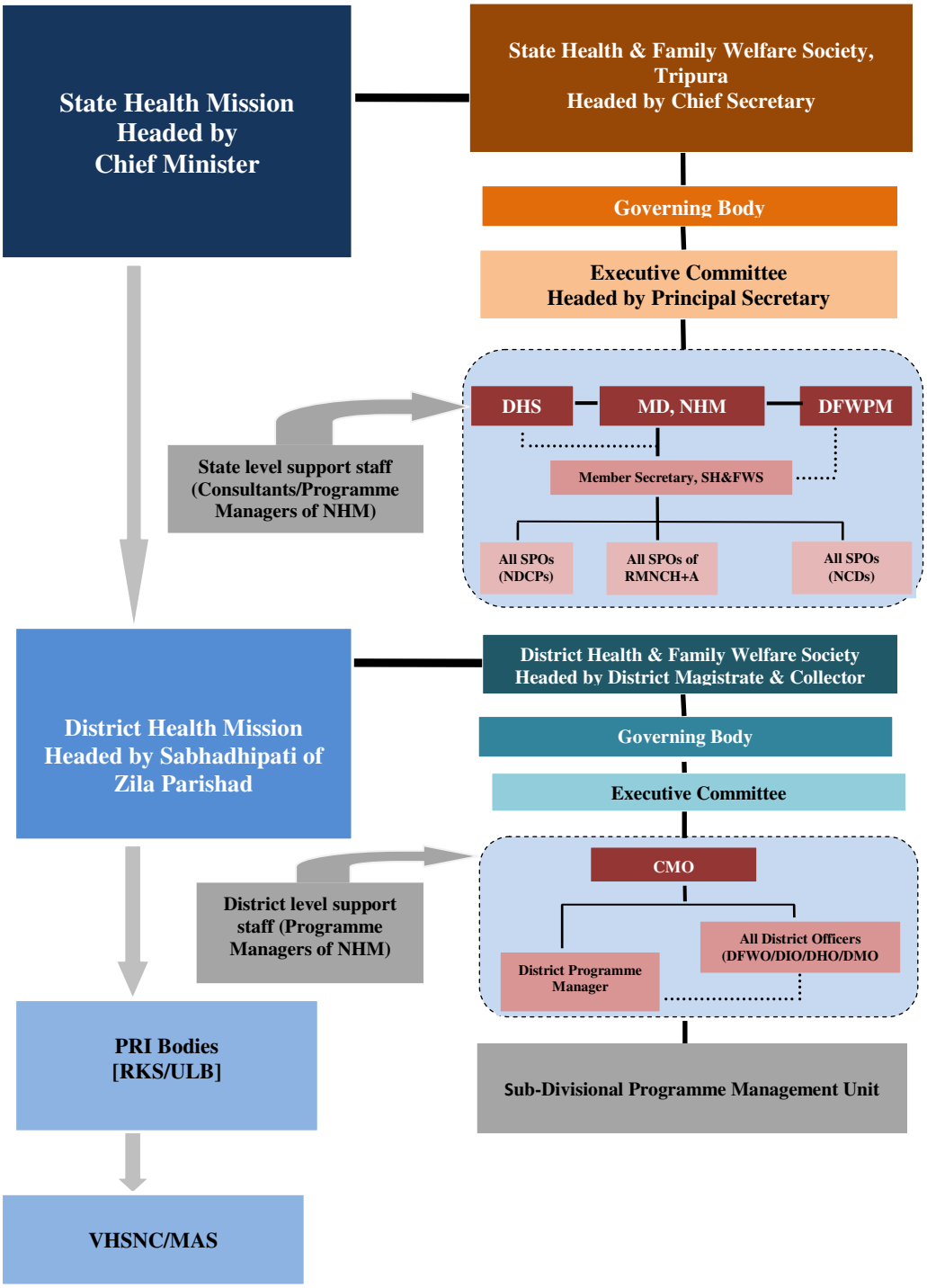
- Reduce Infant Mortality Rate (IMR) to 26/1,000 live births
- Reduce Maternal Mortality Ratio (MMR) to 100/1,00,000 live births
- Reduce Total Fertility Rate (TFR) to 2.1

1.3.2 Organisational structure

At the State level, there is a State Health Mission (SHM) headed by the Chief Minister. The activities of the SHM are carried out through the State Health Society (SHS) headed by the Chief Secretary. The Executive Committee of the Society is headed by the Principal Secretary, Health and Family Welfare Department. The State Programme Management Unit (SPMU) acts as the Secretariat to the SHM and is headed by the Mission Director.

At the District level, the District Health Mission (DHM) is headed by the *Sabhadipati* (President of Zila Parishad) and the District Health Societies (DHSs) are headed by the respective District Magistrate & Collectors. The Executive Committee is headed by the Executive Secretary (Chief Medical Officer). An organogram showing the organisational structure of NRHM in the State is shown below:

Organogram of NRHM



1.3.3 Scope of audit

A Performance Audit on implementation of NRHM in the State of Tripura was conducted during April-August 2016, covering the implementation of the programme for the period from 2011-12 to 2015-16 through test check of the records of the SHS, three[1] out of eight DHSs and District Hospitals (DHs), two blocks of each selected

[1] West Tripura, Dhalai and North Tripura District.

district, all six Sub-Divisional Hospitals (SDHs)/Community Health Centres (CHCs) under the sampled two blocks of each selected district, nine Primary Health Centres (PHCs) linked to the sampled blocks and 23 Sub Centres (SCs) linked to sampled PHCs. They were selected through statistical sampling using Simple Random Sampling Without Replacement (SRSWOR) method.

In addition, 69 Accredited Social Health Activists (ASHAs) and 230 beneficiaries[2], selected through SRSWOR method[3] under each selected SC[4] were interviewed. A list of selected units is available in **Appendix-1.3.2**.

Out of the outcome indicators specified in **Appendix-1.3.1** as per framework of implementation, we have selected Reproductive and Child Health (RCH) for analysis in this Report due to importance of these indicators in achievement of the Millenium Development Goals (2015). Further, out of the six National Disease Control Programmes, one item *i.e.* Intensified Malaria Control Project under National Vector Borne Disease Control Programme (NVBDCP) was also covered as Tripura is a Malaria prone zone.

1.3.4 Audit objectives

The Performance Audit was conducted to assess whether:

- planning was adequate, effective and in accordance with the requirements of the NRHM;
- the funds allotted were being utilised in an efficient and economic manner;
- the capacity building and strengthening of physical infrastructure and augmentation of human resources were achieved as planned and targeted;
- the performance indicators and targets fixed were achieved;
- the quality assurance, monitoring and reporting were effective.

1.3.5 Audit criteria

Audit findings were benchmarked against the following criteria:

- NRHM framework for implementation (2005-12 and 2012-17);
- NRHM operational guidelines for financial management;
- Indian Public Health Standard (IPHS) guidelines (2012) for PHCs, CHCs, SDHs and DHs;
- Operational guidelines for quality assurance in public health facilities, 2013;
- State Programme Implementation Plan (PIP) approved by National Programme Co-ordination Committee (NPCC).

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2 women who have given birth within the last 24 months.

3 SRSWOR is a method of selection of n units out of the N units one by one such that at any stage of selection, anyone of the remaining units have same chance of being selected, *i.e.* 1/ N.

4 Three ASHAs and 10 beneficiaries under each SC were selected through SRSWOR.

1.3.6 Audit methodology

The Performance Audit commenced with an entry conference on 12 April 2016 with the Principal Secretary to the Government of Tripura, Heath and Family Welfare Department, wherein the audit objectives, criteria and audit scope & methodologies were discussed. The draft Report was issued to the State Government in September 2016. The audit findings, conclusion and recommendations were discussed with the Principal Secretary in an exit conference held on 7 October 2016 and the views of the Department during exit conference have been duly incorporated in the report, where appropriate.

Audit findings

1.3.7.1 Planning

An overall perspective plan for five year period and PIP for each year were to be prepared on the basis of District Health Action Plan (DHAP). It envisaged a decentralised and participatory planning process from village level to the State level by carrying out household surveys, facility and baseline surveys.

(A) Perspective plan

According to NRHM framework, the districts would be expected to prepare Perspective Plans (PPs) for the entire Mission period outlining the year wise resource and activity needs of the district. The DHAP is the key strategy for integrated action under NRHM.

The PPs for the period under audit could not be produced to audit at the State level though called for repeatedly. The same could also not be produced in any of the test checked districts as the same were not prepared. This was confirmed by the test checked districts when asked specifically. Consequently, gaps in services, areas requiring intervention, probable investment in each area as well as requirement and availability of resources were not identified. Moreover, no baseline data had been determined against which improvements were to be benchmarked.

The absence of perspective planning had resulted in failure to effectively identify gaps in health facilities and areas of intervention.

(B) Programme Implementation Plan

Under NRHM, financing to the State is based on the State's PIPs. The annual State PIPs were to spell out key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

According to the operational guidelines for financial management of NRHM, a 'bottom up' approach should be followed for planning and budgeting. The process should begin with the preparation of Village Health Action Plans (VHAPs) for ensuring access to health services at the village level. At the next level, Block Health Action Plans (BHAPs) were to be prepared based on village level plans. The BHAPs were to be aggregated to form an integrated DHAP which was to be sent to the State

level. The DHAPs of all districts were to be compiled and aggregated at the State level for framing the State PIP.

Test check of records revealed the following:

(i) The State PIPs were being prepared by the directorate on the basis of DHAPs. However, DHAPs were not prepared on the basis of formal plans of the lower formations. None of the villages, PHCs and CHCs in the State had prepared health plans during 2011-16 pointing towards lack of participation/involvement of the community in preparation of plans. Thus, it could not be ensured whether State PIPs were need based and these adopted a participatory approach.

(ii) As per the framework, facility and household surveys were to be conducted to identify the core/deficient indicators in order to identify areas and improve health services in the State. The NRHM household surveys were to be conducted through ASHAs and Anganwadi Workers in order to allow effective convergent action. However, scrutiny by audit revealed that in Dhalai District (one of the three test checked districts) no health facility surveys were conducted. It was further noticed that habitation/village based household surveys were not conducted in any of the three test checked districts to identify the local needs and gaps in health care facility.

Thus, the underserved areas in the districts remained unidentified. Further, due to absence of household surveys, core/deficient indicators in the locality/villages were not identified.

It was further noticed that:

(i) PIPs (2011-16) did not mention the extent of utilisation of existing and new infrastructure which was required as per the guidelines. PIPs stated physical and financial achievements of previous years, however, there was no mention about the quality of interventions and their outcomes.

(ii) In all the PIPs, physical and financial progress of the previous year (upto December) was mentioned. However, reasons for shortfall in achievements and need, if any, to change strategies/interventions were not analysed. As a result, subsequent PIPs did not contain remedial measures.

(iii) In PIP 2015-16, proposals involving convergence with other departments to control Malaria and other vector borne diseases were made. However, it was noticed that the concerned PIP did not elaborate on data sharing, planning for physical and human resources, mechanism for joint monitoring, coordination, etc.

Thus, the state planning process was not comprehensive and it failed to put in place the horizontal and vertical linkages required for effective implementation of the scheme in the State.

The Department stated (October 2016) that VHSNCs were present in each Gram Panchayat (GP)/Autonomous District Council (ADC) village where Panchayati Raj Institutions (PRIs) representative was a member along with health staff. Any required activities were sent to PHC before incorporation in the district plan.

But the fact remained that the VHAPs were not prepared.

1.3.7.2 Utilisation of funds

The National Health Policy 2002 recommended that State Governments should allocate 8 *per cent* of the budget to the Health Sector by 2010. According to NRHM framework, the State Government should maintain a minimum of 10 *per cent* annual increase in budgetary outlay on Health Sector. The year wise details of total public spending during 2011-16 are as under:

Table No.1.3.1: Details of funding in Health Sector in the State

(₹ in crore)

Year	Expected population *(in lakh)*	Total spending including NRHM on Health Sector	GSDP[5]	Spending to GSDP on Health Sector	State spending on health care through budget (excluding CASP[6])	Total budget of the State	*Percentage* of spending on Health Sector on total budget	Yearly increase in State spending *(per cent)*	Per capita spending on Health Sector *(in ₹)*
2011-12	36.71	339.12	18795.53	1.80	296.54	7054.72	4.20	31.56	924
2012-13	37.25	311.62	21289.38	1.46	288.28	8282.37	3.48	-2.79	837
2013-14	37.80	408.83	25039.40	1.63	381.40	9642.30	3.96	32.30	1082
2014-15	38.36	646.43	29113.19	2.22	462.37	12399.45	3.73	21.23	1685
2015-16	38.92	610.33	33189.03	1.84	410.74	12993.10	3.16	-11.16	1568

(**Source:** Quarterly Review Report of the Finance Minister for the 3rd Quarter of 2015-16, Annual Financial Statement of 2012-13 to 2016-17, Budget at a Glance of 2011-12 to 2016-17 and Finance Accounts 2015-16)

It was observed that:

- During 2011-16, spending on health sector was in the range of 3.48 to 4.20 *per cent* of the State budget which was below the recommended 8 *per cent*.
- State spending on Health Sector showed a mixed trend. It decreased in 2012-13 by 2.79 *per cent*, showed an increasing trend in 2013-14 & 2014-15 and again decreased in 2015-16 by 11.16 *per cent*.

According to the Health and Family Welfare Statistics in India (2015)[7], every fifth resident of Tripura (20 *per cent*) does not use Government health facilities and prefers private medical sector. Among the various reasons mentioned in the publication brought out by the Ministry, nearly half (47.10 *per cent*) gave 'poor quality of care' as a major reason. Distance of the public sector facility (29.40 *per cent*), long waiting time (23.80 *per cent*) and inconvenient hours of operation (20.40 *per cent*) were other significant reasons cited. This shows that despite Government efforts, health facilities have not gained the confidence of a significant percentage of the population.

5 Gross State Domestic Product.
6 CASP-Central Assisted State Plan.
7 Published by Ministry of Health & Family Welfare, Government of India.

1.3.7.3 Availability of funds and expenditure

The details of availability of funds *vis-à-vis* expenditure and the contribution of Central and State share thereof under NRHM from 2011-12 to 2015-16 are shown in **Table No. 1.3.2.**

Table No. 1.3.2: Availability of funds and expenditure figure of State Health Mission

(₹ in crore)

Year	Opening balance	Funds received		Bank interest received	Total availability of funds	Expenditure incurred (*per cent* in bracket)		Refund to GoI	Closing balance
		GoI share transferred to SHM	State share						
2011-12	125.53	62.32	28.75	1.38	217.98	115.56	(53)	0	102.42
2012-13	102.42	75.38	0.33	1.33	179.46	123.78	(69)	0	55.68
2013-14	55.68	134.92	21.41	1.59	213.60	107.94	(51)	10.37	95.29
2014-15	95.29	109.77	14.17	2.05	221.28	133.58	(60)	0	87.70
2015-16	87.70	107.64	12.35	1.11	208.80	118.89	(57)	0	89.91
Total		**490.03**	**77.01**	**7.46**		**599.75**		**10.37**	

(**Source**: Information furnished by the State Health Society, NRHM)

During 2011-16, against total availability of ₹ 700.03 crore, actual utilisation was ₹ 599.75 crore with percentage of utilisation ranging from 51 to 69 *per cent*. Poor utilisation of funds was mainly noticed due to delay in procurement of medicine, equipment, construction and huge vacancies in human resources, which are discussed in ensuing paragraphs.

The Mission Director, NRHM accepted (August 2016) the audit findings.

1.3.7.4 Sanction and release of Central and State share

NRHM funds were to be provided by the Central and State Government in the ratio of 85:15 upto 2011-12 and thereafter in the ratio of 90:10. The outlays approved as per annual approved plans from 2011-12 to 2015-16 and proportionate share of Central and State Government are shown in **Chart Nos. 1.3.1 & 1.3.2** below:

Chart No. 1.3.1

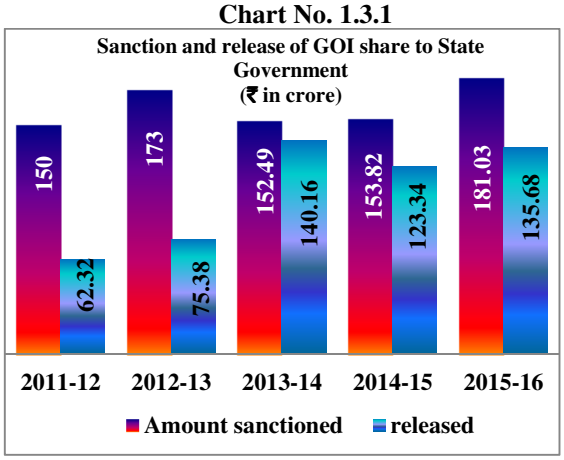
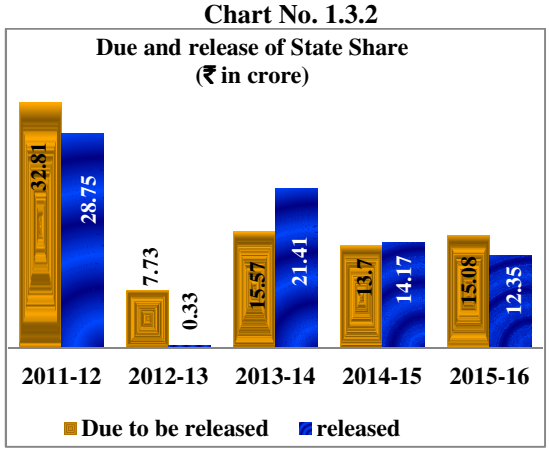


Chart No. 1.3.2



(**Note**: 1. State share due for the year 2011-12 is calculated taking due of ₹ 21.74 crore upto March 2011.
2. GoI share released to State Government during 2013-14, 2014-15 and 2015-16 is not matching with corresponding figures of data provided by SHM (**Table No. 1.3.2**) because of delay or non-release of some funds by State Government to SHM).
(**Source**: Information furnished by the State Health Society, NRHM)

Audit observed that during 2011-16, out of the total sanctioned amount of ₹ 895.23 crore, only ₹ 613.89 crore *i.e.* 68.57 *per cent* was released. Of the total sanctioned amount, the share of GoI was ₹ 810.34 crore out of which only ₹ 536.88 crore (66.25 *per cent*) was released resulting in short release of ₹ 273.46 crore (33.74 *per cent*). The reason was attributed entirely to non-utilisation of funds in the previous years. There was a short release of State share by ₹ 7.88 crore, the reason for which was not found on record.

Thus, it appears that during preparation of PIPs the capacity of the SHS to utilise the funds was not considered. As a result, despite availability of funds SHS could not utilise it due to shortage of resources. This is indicative of lack of proper assessment prior to implementation of the scheme and poor execution.

The Department stated (October 2016) that pending State share of ₹ 7.85 crore had been released by the Finance Department.

(A) Short release of funds (GoI share) by the State Finance Department to the Mission

Audit observed that in 2015-16, GoI released ₹ 135.68 crore[8] but against this amount Finance Department released only ₹ 130.43 crore resulting in short release of ₹ 5.25 crore to the SHS till July 2016. Reason for delay in release of the balance Central share was neither found on record nor stated to audit.

(B) Loss of interest due to delayed release of funds by the State Government.

It was noticed that there was delay in release of funds by the State Finance Department. During 2014-16, it took 50 to 100 days for release in 31 cases, 100 to 199 days in 98 cases, and 226 to 437 days in 18 cases. Reasons for delay in release of funds were not found on record.

[8] Cash - ₹ 125.58 crore and kind - ₹ 10.10 crore.

Further, it was noticed that due to delay in release of funds by the Finance Department, SHS suffered a loss of interest[9] of ₹ 2.55 crore during 2014-16.

1.3.7.5 Programme funds remained unutilised

(A) State level

During scrutiny of records, it was noticed that out of ₹ 89.91 crore remaining unspent as of March 2016, ₹ 67.15 crore was lying with the SHS and rest ₹ 22.76 crore was lying unspent with DHSs. The details of unutilised funds against major programmes at the close of last five years up to March 2016 are shown below:

Table No. 1.3.3: Unutilised funds against major programmes at the close of last five years up to March 2016

(₹in crore)

Sl. No.	Name of the programme	2011-12	2012-13	2013-14	2014-15	2015-16
1	RCH-II/RCH-Flexi Pool	33.72	24.06	33.63	42.46	46.19
2	Additionalities under NRHM	62.21	24.14	49.87	28.56	29.89
3	Immunisation					
	Routine Immunisation	0.62	0.16	0.06	(-) 1.60	(-) 0.8
	Pulse Polio Immunisation	0.72	0.26	0	(-) 1.08	(-) 0.37
4	NIDDCP					0.34
5	**National Disease Control Programme**					
	Integrated Disease Surveillance Project (IDSP)	0.19	0.02	(-) 0.09	(-) 0.24	(-) 0.13
	National Leprosy Eradication Programme (NLEP)	0.01	0.15	0.11	0.08	(-) 0.07
	National Vector Born Disease Control Programme (NVBDCP)	2.04	1.43	6.28	11.05	11.80
	Revised National Tuberculosis Programme (RNTCP)	0.06	0.19	0.28	(-) 0.39	(-) 0.34
6	**Non Communicable Disease Control Programme**					
	National Programme for Control of Blindness (NPCB)	0.95	4.06	0.33	1.38	(-) 0.07
	National Mental Health Programme(NMHP)	0.13	0.11	0.07	0.85	1.64
	National Programme for prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)	-	-	2.01	2.00	3.28
	National Programme for Prevention and Control of Deafness (NPPCD)					0.22
	National Tobacco Control Programme(NTCP)	-	-	0.58	0.50	0.90
7	**Infrastructure Maintenance**	0.00	(-)1.47	0.60	(-) 0.87	(-)11.63
Total		**100.65**	**53.11**	**93.73**	**82.70**	**80.85**

(**Source**: Information furnished by the State Health Society, NRHM)

The above table shows that most of the unspent balances were lying against RCH-Flexi Pool, Additionalities under NRHM and NVBDCP which reflects that there was a shortfall in implementation of these components.

(B) District level

During test check of three districts, it was noticed that at the end of each financial year huge balances were lying with the DHSs, as detailed below:

[9] Interest was calculated taking interest on savings account at 4 *per cent* per annum.

Table No. 1.3.4: Details of balances lying with three test checked districts

(₹in crore)

Name of the district	2011-12	2012-13	2013-14	2014-15	2015-16
West Tripura	5.69	3.68	4.41	3.99	2.03
Dhalai	3.83	1.79	1.00	1.27	0.21
North Tripura	NA	0.81	1.28	1.57	2.22

(**Source**: Annual accounts of DHAPs and information furnished by the District Health Society, NRHM)

Moreover, unspent balances showed an increasing trend in North Tripura District over the period. Reasons for keeping huge unspent balances were lack of recruitment of human resources, shortfall in organising training for ASHAs, Auxiliary Nursing Midwives (ANMs), Lady Health Visitors (LHVs), Skilled Birth Attendant (SBA) services and shortfall in organising health camps.

The Mission Director, NRHM accepted (August 2016) the audit findings.

1.3.7.6 Outstanding advances

In Unakoti District, ₹ 1.62 crore was lying outstanding against 10 officials. Further, ₹ 1.18 crore was advanced by seven Chief Medical Officers during 2006-14 to the health facilities under its jurisdiction for implementation of various national health programmes approved under NRHM but no records were maintained as against whom the advances had been made. Details are in **Appendix-1.3.3 (A)** & **1.3.3 (B).** The Mission Director, NRHM lodged an FIR against these 17 officials with Kailashahar Police Station in April 2015. Present status of the case was not on record.

Similarly, it was noticed that ₹ 1.51 crore (**Appendix- 1.3.4**) was advanced to 116 officials for different purposes during June 2009 to November 2015 by the SHS and was lying outstanding till May 2016. It was neither on record nor stated to audit whether programmes for which advances given were actually implemented by the persons concerned.

Advances outstanding for such long periods is fraught with the risk of not utilising of funds for the purpose for which it was given and may lead to misappropriation of Government money.

The Department stated (October 2016) that out of advances of ₹ 1.51 crore, ₹ 1.03 crore had since been adjusted through submission of vouchers.

1.3.7.7 Outstanding loan

During test check of records, it was noticed that ₹ 7.25 crore transferred by the SHS to seven departments/societies as loan during September 2013 to June 2015 for running different project work/programmes were lying outstanding till August 2016. Authority under which loan was given and initiatives taken to adjust the outstanding loan was not found on record.

Scrutiny also revealed that loan amounting to ₹ 50.00 lakh was given to Revised National Tuberculosis Control Programme (RNTCP) in April 2014 which was

outstanding as of March 2016. However, as per information furnished by the Mission, only ₹ 33.96 lakh was shown as loan against RNTCP. Reason for such discrepancy was not found on record.

On being pointed out in audit, Mission Director, NRHM stated (August 2016) that as per approval of the authority loan was given to take up the activities on emergency basis and ₹ 1.81 crore had since been refunded.

The fact remained that the records of refund of ₹ 1.81 crore were not produced to audit and the reply does not mention about the remaining outstanding amount of ₹ 5.44 crore. The discrepancy of ₹ 16.04 lakh in RNTCP was also not explained by the Department.

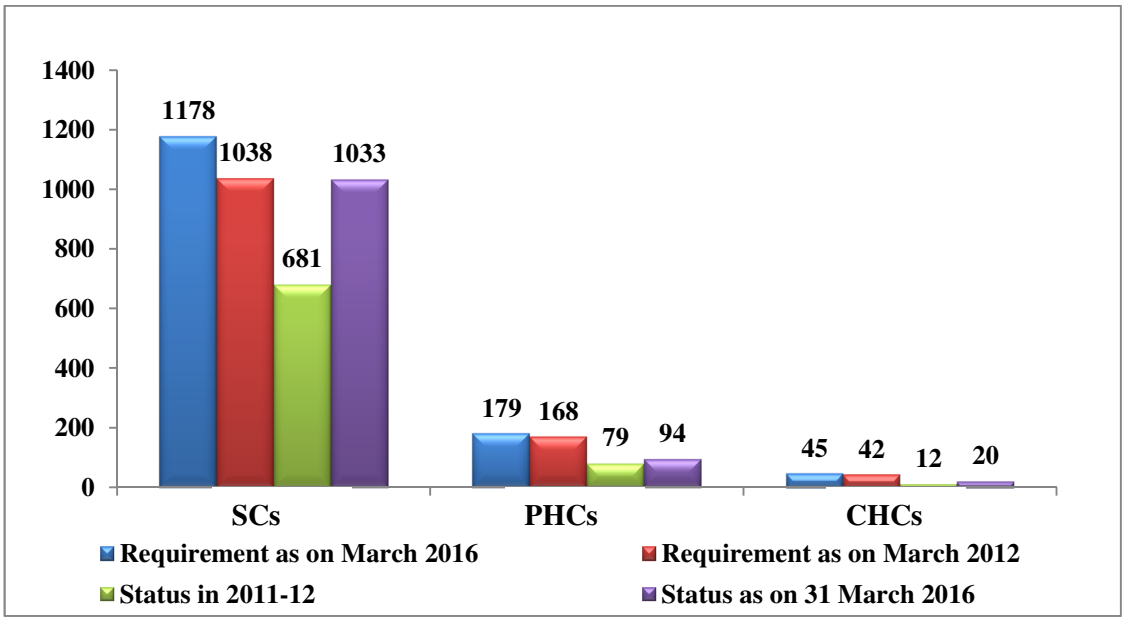
Capacity building and physical infrastructure

1.3.7.8 Failure to achieve targets

The health care infrastructure in rural areas has been developed as a three tier system *viz*., SC, PHC and CHC. As per decision of the State Government, every GP/ADC village should be covered by a SC. PHCs and CHCs were constructed following IPHS norms: one PHC per 30,000 population in general areas and one PHC per 20,000 population in difficult/tribal and hilly areas; one CHC per 1,20,000 population in general areas and one CHC per 80,000 population in difficult/tribal and hilly areas.

Status of health facilities as on 31 March 2016 are shown in **Chart No. 1.3.3**. It is seen that the number of SC, PHC and CHC in the State had increased from 681, 79 and 12 in 2011-12 to 1,033, 94 and 20 respectively in 2015-16. Yet, the existing number of SCs, PHCs and CHCs were short of their targets by 145, 85 and 25 (12, 47 and 56 *per cent)* respectively. Thus, despite improvement in the last few years, there existed a big gap between the requirement and the available health care infrastructure, particularly at the PHC and CHC level.

Chart No. 1.3.3: Status of SCs, PHCs and CHCs as of 2011-12 and 2015-16 against requirement



Source: Census 2011, Economic Review of Tripura and Departmental records.

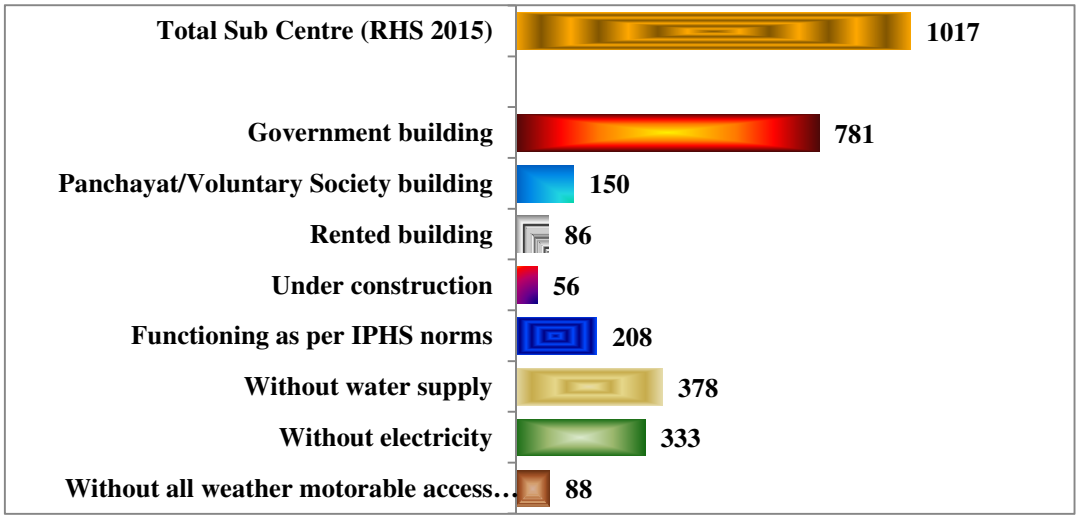
Test check of three districts revealed that there was a shortage of SCs, PHCs and CHCs by 11, 42 and 53 *per cent* respectively. North Tripura District was having 27 *per cent* shortages of SCs and Dhalai District 61 *per cent* shortages of CHCs.

The Department stated (October 2016) that phase wise implementation was going on to fill up the gap in infrastructure.

1.3.7.9 Quality of infrastructure

According to Rural Health Statistics (RHS) 2015, State-wise status of infrastructure in SCs is shown in **Chart No. 1.3.4.**

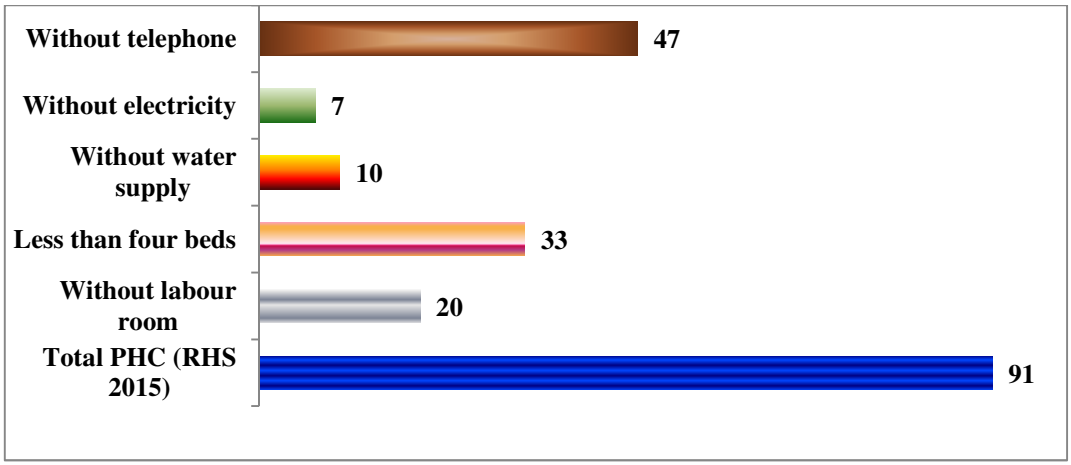
Chart No. 1.3.4: State statistics of SCs



(**Source**: Rural Health Statistics, 2015)

During physical verification of 23 SCs, it was noticed that 16 SCs (69.57 *per cent*) were running without water supply, 16 (69.57 *per cent*) without electricity , eight (34.78 *per cent*) without toilet, 22 (95.65 *per cent*) without telephone, and 19 (82.61 *per cent*) without ANM quarters. It was further noticed that though there were quarters for ANM in four SCs, they were unoccupied due to non-availability of water supply and dilapidated condition of the quarters. Details are shown in **Appendix-1.3.5**.

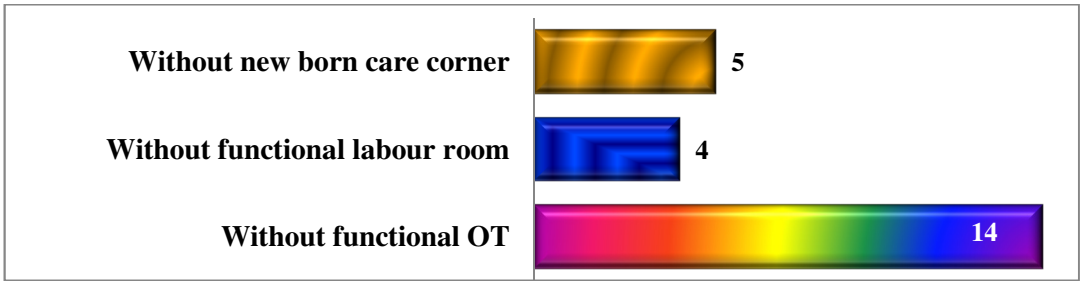
Chart No. 1.3.5: State statistics of PHCs



(**Source**: Rural Health Statistics, 2015)

Similarly, during physical verification of nine PHCs, it was noticed that two PHCs were functioning without electricity and eight PHCs without telephone. It was also noticed that labour room in three PHCs were not made operational due to non-availability of staff and lack of equipment *viz*., Radiant Warmer, Suction Machine, Steriliser, Normal Delivery Kit, etc. Details are shown in **Appendix-1.3.6**.

Chart No. 1.3.6: State statistics of CHCs



(**Source**: Rural Health Statistics, 2015)

Further, during physical verification of six SDHs/CHCs it was noticed that five CHCs/SDHs did not have Telephone, five CHCs/SDHs were not having Operation Theatre (OT), three CHCs/SDHs were without New Born Care Stabilisation Unit and four CHCs were without Blood storage facility. Though one SDH had Blood storage facility, it was not operational due to lack of manpower. Details are shown in **Appendix- 1.3.7**.

Thus, the existing infrastructure is devoid of even the basic amenities, and there had been under-utilisation of the resources.

It is evident that promotion of institutional deliveries was lacking as 22 *per cent* PHCs were running without labour room, 20 *per cent* CHCs without functional labour room and 70 *per cent* CHCs without functional OT in the State.

1.3.7.10 Development of infrastructure

NRHM aimed to bridge gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revamp of existing physical infrastructure and fresh construction or renovation wherever required. In Tripura, NRHM framework allowed expenditure upto 33 *per cent* of the total outlay on construction to remove deficiencies in public health infrastructure.

During 2011-16, out of the total available amount of ₹ 700.03 crore, ₹ 232.06 crore was spent on civil works. However, during the entire Mission period, Mission Director executed 430 new works (406 SCs, 24 PHCs) by investing ₹ 141.52 crore. It upgraded 97 facilities (50 SCs, 19 PHCs, 18 CHCs, eight SDHs/First Referral Units & two DHs) to IPHS benchmarks by investing ₹ 72.78 crore, 76 renovation works at a cost of ₹ 6.49 crore and other 21 works at a cost of ₹ 11.27 crore were taken up through four executing agencies.[10]

During the course of audit the following was noticed:

(A) Delay in completion of works

₹ 35.79 lakh was placed with the Rural Development Department (RDD) during 2007-08 to 2011-12 for construction of three SCs[11] but the works had not been completed due to reasons such as site dispute and delay in taking up construction works.

(B) Blockage of funds amounting to ₹ 2.93 crore

During 2009-10 to 2013-14, SHS placed ₹ 2.93 crore[12] with the RDD for construction of 13 SCs, one Neonatal Intensive Care Unit (NICU) in Belonia SDH and renovation of Madhupur PHC. It was observed that the construction work of none of the SCs had commenced as of July 2016 due to not handing over of site to the implementing agency. Though the funds were placed with the RDD for renovation of Madhupur PHC, Mission could not take decision whether the work was to be carried out through RDD or Public Works Department. It was noticed that provision of NICU had already been made in the newly constructed building for SDH, Belonia. So separate building was not required for NICU. Neither NRHM asked RDD to refund the fund already placed for construction of NICU in Belonia SDH nor RDD refunded the said amount.

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[10] Rural Development Department, Public Works Department, Tripura Housing and Construction Board and Engineering Cell of the NHM.

[11] New Health Sub Centre in Fultali GP, Noorpur GP and Monacherra GP.

[12] 2009-10: ₹ 10.35 lakh; 2010-11: ₹ 4.00 lakh; 2011-12: ₹ 13.39 lakh; 2012-13: ₹ 100 lakh; 2013-14: ₹ 165 lakh.

Consequently, an amount of ₹ 2.93 crore had been blocked over the years due to poor coordination, absence of proper assessment and lack of holistic planning at the level of the SHS.

(C) Inadequate utilisation of constructed buildings

SHS did not maintain status of utilisation of existing and newly created health facilities. During course of audit it was noticed that construction of one CHC, one PHC along with staff quarters and one SC were completed at a total cost of ₹ 6.64 crore and taken over by the concerned medical officers but were not utilised.

- Director of Family Welfare and Preventive Medicine, Government of Tripura, decided in October 2005 for upgradation of Mohanpur CHC under NRHM and placed ₹ 0.98 crore with Block Development Officer, Mohanpur in six installments during December 2005 to September 2011. The work was completed and handed over to the Medical Officer (in charge), CHC, Mohanpur in November 2014.
- The building had not been made operational till July 2016 due to a number of problems such as construction defects, absence of water supply and power connection, lack of provision for dressing room, nurse changing room, rest room with toilets for Doctors and Nurse, etc. despite the fact that the building was meant to be a health centre. As a result, there had been an idle expenditure of ₹ 0.98 crore. While admitting the facts, Director of Family Welfare and Preventive Medicine stated (July 2016) that an estimate was being prepared for rectifying the defects and other requirements.
- The work "Construction of Bhandarima PHC along with Staff Quarters" in North Tripura District was completed by the Public Works Department (Roads & Building), Kanchanpur Division at a cost of ₹ 5.40 crore and handed over to the Sub Divisional Medical Officer, Kanchanpur in March 2015. It was noticed (June 2016) that one Out Patient Department (OPD) Clinic was being run in one room of the PHC building and another room was used by Bhandarima (West) SC for Maternal and Child Health Clinic. Other 15 rooms of the building and 10 staff quarters were lying vacant and were not utilised.
- It was noticed that the building constructed for Bhandarima (West) SC in North Tripura District at a total cost of ₹ 0.13 crore were illegally used by "anti-social elements." A complaint was lodged in December 2015 with Anandabazar Police Station by the Medical Officer, however, further action in this regard is pending.
- One building constructed in July 2011 at a total cost of ₹ 0.13 crore for Kachimcharra SC in Dhalai District was not operational. On being pointed out in audit, Director of Family Welfare and Preventive Medicine stated (July 2016) that the new SC building could not be operationailised due to dispute with the private land owner.

Thus, lack of planning and monitoring led to delays and non-utilisation of facilities despite incurring expenditure of ₹ 6.64 crore.

1.3.7.11 Mobile Medical Units

With a view to provide health care at the door step of residents of inaccessible areas, GoI sanctioned (July 2008) four Mobile Medical Units (MMUs) equipped with specialised facilities. Audit noticed that three of the MMUs were not functioning for want of major repairs and maintenance. In 2015-16, GoI suggested (May 2015) that non-functional MMUs be condemned and proposal for new MMUs be submitted. However, these MMUs were neither declared as condemned nor were any fresh proposal submitted to GoI till July 2016.

Thus, due to non-availability of MMU services, rural people were deprived of getting specialised services at their door step.

1.3.7.12 Emergency Response Service

To provide 24x7 health emergency services throughout the State and pre-hospitalisation care to patients enroute to hospitals, SHS proposed ₹ 6.69 crore for procurement of Global Positioning System (GPS) enabled ambulances, establishment of Call Centre, etc. in 2012-13. Based on the proposal, GoI sanctioned ₹ 6.69 crore for procurement of 62 Basic Life Support (BLS) Ambulances, three Advance Life Support (ALS) Ambulances and their operational cost, etc. under Emergency Response Service (ERS).

Accordingly, the SHS invited tender in May 2013 *inter-alia* for procurement of above ambulances. These could not be procured by SHS because of poor response to the tender of May 2013. In 2013-14, GoI revalidated ₹ 3.58 crore for 37 BLS and three ALS but SHS did not procure the ambulances and no proposal was initiated by the SHS for revalidation.

In December 2015, the State Government decided that since ambulance facilities had already been extended to almost all CHCs and PHCs, present proposal for procuring BLS and ALS was not required.

During physical verification of test checked CHCs and PHCs it was noticed in audit that ambulances provided in the CHCs and PHCs were not equipped with the life saving equipment.

The fact remained that the GoI sanctioned fund for ERS to the State in 2012-13. This could not be availed by the State and these facilities were still not available.

1.3.7.13 Delay in procurement of Baby Care Pack

To incentivise 48 hours stay at health institutions after delivery, SHS proposed, in PIP 2011-12, for providing gift pack[13] to every mother for staying 48 hours in health institutions (PHCs, CHCs and SDHs) after delivery. Accordingly GoI sanctioned ₹ 1.40 crore for procurement of 20,000 Baby Care Packs in May 2011.

[13] Two nos towel, two meter funnel cloth, one duck-back sheet, baby bed net, baby blanket.

Supply orders for supply of 12,000 Baby Care Packs could be issued only in November 2015 and accordingly Baby Care Packs could be distributed to all the eight districts only in March 2016 after a delay of more than four years from the date of sanctioning of funds by GoI.

It was also noticed that during 2011-16, 2.23 lakh institutional deliveries were recorded against which 1.12 lakh mothers were discharged within 48 hours of delivery compromising the objective of providing safe delivery and safe natal care.

1.3.7.14 Medicines

State Government had drawn up a comprehensive drug list for different levels of health facilities. Medicines[14] were to be supplied to SCs, PHCs, CHCs, SDHs and DHs as per the essential drug list.

In course of audit it was noticed that only 17 to 63 *per cent* medicines in PHCs, 22 to 59 *per cent* medicines in SDHs and 8 to 18 *per cent* medicines in DHs were available against the norms. This indicated that all types of medicines were not available in the facilities.

On the other hand, it was noticed that out of the total amount of ₹ 40.91 crore sanctioned by the GoI for drugs and medicines, only ₹ 21.76 crore was spent for the same.

On being pointed out in audit Mission Director, NRHM stated (August 2016) that procurement of medicines was a time consuming process. Most of the funds were kept as committed expenditure for next year and hence year wise expenditure was not uniform. Funds for procurement of medicines had been placed with Director of Health Services and Director of Family Welfare and Preventive Medicine but Utilisation Certificate had not been received.

However, during physical verification it was noticed that test checked facilities were running with shortage of medicines and patients were directed to purchase medicines from the market.

1.3.7.15 Human resource

Efficiency and quality of health services largely depends on adequate number of qualified Doctors, Nurses and other Para-Medical Staff. There were no separate norms of State Government for posting of Medical Officers, Nurses and other Para-Medical Staff in the SCs, PHCs and CHCs. The availability of key health personnel *vis-a-vis* the overall sanctioned strength was as follows:

[14] SC-36; PHC-139; CHC/SDH- 249; DH-310.

Table No. 1.3.5: Availability of key health personnel *vis-a-vis* the sanctioned strength for the State as a whole

(***in number***)

Category	Sanctioned strength			Staff in position			Vacancies (percentage)
	State	NRHM	Total	State	NRHM	Total	
Medical Officer (Allo)	1480	7	1487	953	0	953	534(36)
Medical Officer (Ayur)	58	229	376	49	156	254	122(32)
Medical Officer (Homeo)	89			49			
Medical Officer (Dental)	105	71	176	35	48	83	93(53)
Specialist	NA	NA	NA	130	0	130	NA
Auxiliary Nursing Midwife	691	210	901	673	6	679	222(24)
Multi-Purpose Worker (Male)	704	86	790	689	0	689	15(02)
Staff Nurse	2092	3	2095	1891	3	1894	201(10)

(**Source**: Departmental records)

It would be seen from the above table that vacancies ranged between 2 and 53 *per cent* as compared to sanctioned strength in eight categories of health personnel. Sanctioned strength of specialists was not furnished though called for.

(A) Specialists

In course of audit, the following were noticed:

- In two test checked DHs[15], Radiologists, Pathologists and Dietician were not available. There was one Medicine specialist and one Obstetrician & Gynecologist against norms of two in each category.
- In four CHCs and two SDHs[16] specialists like Physician/Medicine specialist, General Surgeon/Surgery specialist, Obstetrician & Gynaecologist, Paediatrician and Anesthetist were not posted during 2011-16.

Shortage of specialists in DHs and non-availability of specialists in CHCs & SDHs in the test checked districts are symptomatic of a wider trend, where access to healthcare in rural areas remains limited to primary healthcare due to non-availability of specialists.

(B) Auxiliary Nursing Midwife

There were 1,033 SCs in the State as of March 2016. As per IPHS norms, 2,066 ANMs were required to be posted in 1,033 SCs. However, only 901 posts were sanctioned of which only 679 ANMs were in position and 222 posts (25 *per cent*) remained vacant as of July 2016. In 279 SCs (27 *per cent*) no ANM/Female Health Worker was posted.

Scrutiny of records in the three test checked districts[17] revealed that in 167 SCs (42 *per cent*) there was no ANM/Female Health Worker. Vacancy in North Tripura

[15] Kulai DH, Dhalai and Dharmanagar DHs.
[16] Mohanpur, Jirania, Anandabazar, Panisagar CHCs and Gandacharra, Kanchanpur SDHs.
[17] West Tripura, Dhalai and North Tripura District.

and Dhalai Districts were to the extent of 61 and 60 *per cent* respectively while in West Tripura District it was 18 *per cent*. Thus, there was disparity in posting of ANM/Female Health Workers amongst the districts.

During physical verification of 23 SCs it was further noticed that there was no ANM in 14 SCs and only one ANM each in eight SCs against requirement of two in each SC.

Acute shortage of ANMs in SC level showed that even though health centres had been established in most parts of the State, the quality of service provided remained questionable due to shortage of human resources (Medical Personnel).

(C) Other medical staff

Scrutiny of records revealed that out of three test checked districts, six PHCs in Dhalai District were running without Laboratory Technician and one PHC without Pharmacist.

It was further noticed that during 2011-16, GoI sanctioned ₹ 93.82 crore for the purpose of salary of human resources against which only ₹ 55.46 crore (59 *per cent*) was spent by the SHS. Scrutiny of PIP, Record of Proceedings (RoPs), Annual Accounts and Financial Management Report for the period 2011-16 revealed that the SHS did not recruit Anaesthetist, Obstetrician & Gynaecologist specialist, Dietician, RMNCH/FP Counsellors, Nutritionist, Health Economist, Technical Officer, Statistical Assistant, Epidemiologist, Microbiologists at District Laboratory, etc. although sanctions were obtained from the GoI.

Reason for non-recruitment against the vacant posts even after the sanction was granted by the GoI was neither found on record nor stated to audit.

(D) Accredited Social Health Activist

NRHM framework envisages providing one ASHA in every village with a population of 1,000. Audit observed that there were 7,332 ASHAs against the requirement of 3,892 as per the NRHM framework. While there were seven ASHAs per SC on an average, yet audit observed various problems relating to capacity building and infrastructure as stated below:

During 2011-16, SHS did not provide any drug kits to ASHAs. The ASHAs were made to work without even being provided with the most basic requirement *i.e.* the drug kits.

Further, when 69 ASHAs were interviewed by audit, the following were the responses:

- Pregnancy kit was not available with 35 ASHAs (51 *per cent*).
- Disposable delivery kit was not available with 62 ASHAs (90 *per cent*) and three ASHAs (4 *per cent*) had disposable delivery kit but they were not aware of its use.

- Blood pressure monitor was not available with 63 ASHAs (91 *per cent*) and six ASHAs (9 *per cent*) had blood pressure monitor but they were not aware of its use.

Thus, it could be concluded that Tripura faced a unique contradiction. On the one hand, the number of ASHAs was more than requirement as per NRHM norms. On the other hand, the ASHAs had neither been equipped with the required kits nor quality training given. Therefore, capacity building remained a major issue with consequences on the efficiency and effectiveness of the Mission.

The Department stated (October 2016) that due to shortage of specialists and other technical staff, sufficient human resource support could not be provided to all health facilities. Phase wise recruitment was going on to fill up the gap.

1.3.7.16 Training

NRHM framework stipulates that the implementation teams, particularly at the district level and State level, should develop specific skills. Analysis of the training schedule revealed that;

During 2011-16, out of a total of 3,492 trainings planned, only 1,165 were conducted leading to a shortfall of 2,327 trainings and the percentage of shortfall ranged between 34 and 100 *per cent* in various categories of training. The position of training in respect of some of the categories is detailed below:

- During 2011-16, training for medical officers on Laparoscopic Ligation (LL), Aneasthesia/Life Saving Anaesthesia Skills (LSAS), No Scalpel Vasectomy (NSV), Post Partum Intra Uterine Contraceptive Device (PPIUCD) and Rashtriya Bal Swasthyo Karyakram (RBSK) were not conducted although planned for.
- SHS planned to provide training to 84 health personnel on facility based Integrated Management of Neonatal and Childhood Illness during 2011-12 to 2014-15 against which only nine persons were trained in 2011-12. No training was planned in 2015-16.
- Training on Emergency Obstetric Care was planned to train 10 Medical Officers but only three persons were trained. Basic Emergency Obstetric Care training was provided to 168 Medical Officers only against target of 315.
- Immunisation training was provided to 102 Medical Officers against target of 192.
- Training on Reproductive Tract Infection/Sexually Transmitted Infection was provided to 170 Medical Officers against target of 500. No training was provided in 2015-16.
- 621 ASHAs had not been trained on each module against the prescribed seven modules for them.

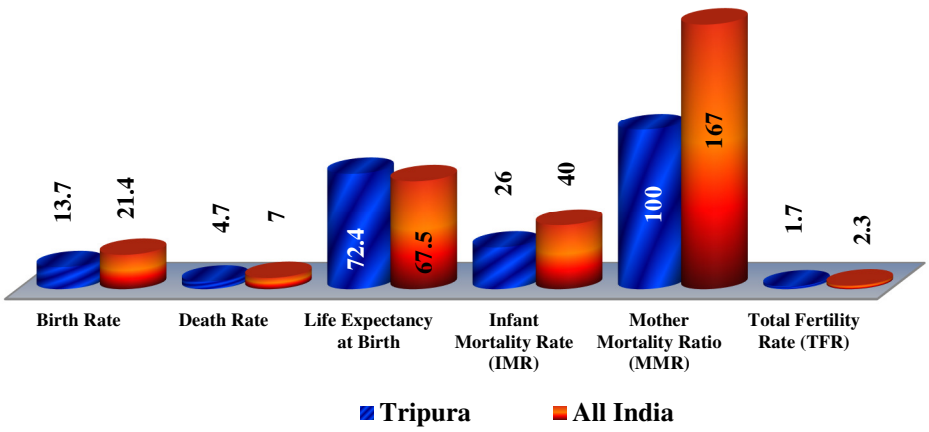
While no training programme was conducted in respect of LL, LSAS, NSV, PPIUCD and RBSK, the number of training programmes conducted in other modules as mentioned above fell short ranging from 34 to 89 *per cent*. Reasons for non-achievement of targets were neither found on record nor stated to audit. Thus, the State faces the twin problems of inadequate manpower and capacity building of the existing human resources.

Reproductive and Child Health Care, Immunisation and disease control programmes

1.3.7.17 Health indicators

Health indicators measure different aspects of health. When indicators are tracked over time, they allow us to see how the health of population is changing. A broad overview on Morbidity & Associated Mortality, Health Risks, Reproductive and Child Health in the State are shown in the chart below:

Chart No. 1.3.7: Status of health parameters of Tripura



(**Source**: Sample Registration System in India 2014; National Health Policy 2015; National Health and Family Welfare Statistics 2015; Programme Implementation Plan 2015-16)

From the above chart, it is seen that the Birth Rate in Tripura was 13.7 which was below the national average of 21.4. Similarly, the State performed better across various indicators such as Death Rate, IMR, MMR and TFR. Life Expectancy at Birth in Tripura was 72.4 while the national average was 67.5. Thus, health status indicators in Tripura under various parameters were better as compared to all India averages. However, a number of areas requiring improvements were noticed during audit.

1.3.7.18 Reproductive and Child Health programme

The RCH approach comprises critical components like informed choice of quality contraception, treatment of infertility, prenatal, natal and post-natal care for mother, etc. Some of the components of RCH and achievements there against are discussed below:

(A) Institutional deliveries

Maternal mortality and foetal losses could be reduced considerably if women undergo delivery under hygienic conditions under the supervision of trained health professionals.

Table No. 1.3.6: Details of home and institutional deliveries achieved during 2011-16

(in number)

Component	2011-12	2012-13	2013-14	2014-15	2015-16
No. of registered pregnant women	76,202	73,915	77,985	77,290	76,138
Total number of deliveries	51,277	52,191	52,424	51,514	50,847
Balance (untraced)	24,925 (33 %)	21,724 (29%)	25,561 (33%)	25,776 (33%)	25,291 (33%)
Institutional delivery	43,751	45,028	44,595	44,735	45,057
Home delivery	7,526	7,163	7,829	6,779	5,790
Percentage of institutional delivery	85	86	85	87	89
Percentage of home delivery	15	14	15	13	11

(Source: Departmental records)

Audit analysis revealed that:

- Institutional delivery showed an increasing trend, from 85 to 89 *per cent* during 2011-16 while home delivery decreased from 15 *per cent* in 2011-12 to 11 *per cent* in 2015-16.
- The Department could not track the fate of the balance registered pregnant women constituting about 29 to 33 *per cent* during the last five years for which no recorded reason was found. However, during test check of records at Anandanagar PHC three cases of duplication in registration of pregnant women was noticed.
- During 2013-16 only 2 *per cent* home deliveries were attended by Skilled Birth Attendants (SBAs). Thus, safe home deliveries were not ensured as number of home deliveries attended by SBAs was nominal. Reason stated for not attending home deliveries by the SBAs was shortage of trained SBAs since there were only 565 trained SBAs as of March 2016.
- During 2011-16, in the test checked districts institutional delivery ranged between 95 and 98 *per cent* in West Tripura District, between 84 and 87 *per cent* in Dhalai District while North Tripura District recorded the lowest institutional delivery ranging between 63 and 68 *per cent*.

In course of audit it was further noticed that-

- According to NRHM guidelines, Type-A SC may conduct normal delivery in case of need. But all 23 test checked SCs did not have the facility for institutional delivery.
- As per the guidelines, CHC should provide facilities for Obstetric Care and Emergency Obstetric Care including Surgical Interventions like Caesarean Sections. However, all four test checked CHCs did not have the facility of Caesarean Section delivery.

- The three selected districts showed a wide disparity in terms of percentage of institutional deliveries. At one extreme, North Tripura District registered low institutional deliveries ranging from 63 to 68 *per cent* due to less awareness among the beneficiaries, non-availability of transport facilities, etc. On the other extreme, in West Tripura District, institutional deliveries were in the range of 95 to 98 *per cent*.
- Out of 230 beneficiaries interviewed during Performance Audit, 194 were provided the facilities of institutional deliveries and 36 beneficiaries intimated that they preferred home delivery due to high institutional cost, non-availability of transportation, opinion of family members, etc. This indicated that the beneficiaries were not made aware of Janani Sishu Suraksha Karyakram (JSSK) under which pregnant women get free and cashless delivery and free transport.

Thus, while rate of institutional deliveries was high and increasing, yet the quality of the service provided was questionable due to lack of essential facilities and specialised medical persons. Further, there were pockets of the State where institutional deliveries were low thereby raising the question whether the programme had been effective across the State.

The Department stated (October 2016) that women prefer to be delivered by Medical Officer at PHC than delivery by ANM at SC. Due to lack of specialists, CHCs and SDHs were not strengthened.

(B) Ante Natal Care

As per norms, expecting mothers should receive two doses of Tetanus Toxoid (TT) vaccine, adequate amount of Iron and Folic Acid (IFA) tablets or syrup to prevent Anaemia. Pregnant women are expected to visit a health facility to have at least three Ante Natal check up for Blood and Urine Test and other procedures to detect pregnancy related complications.

Status of Ante Natal Care (ANC) coverage during 2011-16 was as under:

Table No. 1.3.7: Status of Ante Natal Care coverage during 2011-16

(in number)

Year	No. of pregnant women registered	No. of pregnant women who received three ANC check up	No. of pregnant women given 1st and 2nd TT immunisation	No. of pregnant women given100 IFA tablets
2011-12	76,202	42,646	50,730	60,245
2012-13	73,915	45,241	49,935	43,586
2013-14	77,985	48,026	50,716	29,850
2014-15	77,290	55,291	51,788	46,465
2015-16	76,138	51,776	50,899	49,069

(**Source**: Departmental records)

Scrutiny of the records revealed that:

- 36 *per cent* pregnant women did not receive three ANC check up during 2011-12 to 2015-16.

- 33 *per cent* pregnant women did not receive two doses of TT during 2011-12 to 2015-16.
- 40 *per cent* pregnant women did not receive 100 IFA tablets during 2011-12 to 2015-16. In course of audit it was noticed that there was a short supply of IFA tablets in the SCs which could be one of the reasons for short supply of IFA tablets to the pregnant women.

  The extent of ineffectiveness can be gauged from the fact that 54.4 *per cent* of pregnant women in Tripura suffer from Anaemia. Yet, 40 *per cent* of pregnant women did not receive the required 100 IFA tablets as per the norms.

In the test checked districts during 2011-16, shortfall in ANC check up was highest (44 *per cent*) in North Tripura District while shortfall in giving TT (60 *per cent*) and IFA tablets (56 *per cent*) was highest in West Tripura District.

From the findings mentioned above, it is evident that Information Education and Communications (IEC) activities *i.e.* awareness programmes were ineffective to a large extent. For instance, ASHAs could not motivate 36 *per cent* pregnant women to visit the facilities for taking preventive measures against risk of complications at the time of delivery.

The Department stated (October 2016) that micro plan for 100 *per cent* coverage had been taken up for remote villages and tea gardens. There was no short supply of IFA tablets but consumption by the mother was less due to its side effect *i.e.,* Gastric Irritation and Black Stool. However, extensive IEC was taken up.

The fact remains that inspite of extensive awareness programme, 36 *per cent* pregnant women did not receive three ANC check ups and 40 *per cent* pregnant women did not receive 100 IFA tablets during 2011-12 to 2015-16.

(C) Post Natal Care

The well-being of a mother and the newborn child depends not only on the care she receives during pregnancy and delivery, but also on the type of care the infant and the mother receives during the crucial first few weeks after delivery.

Scrutiny of records revealed that during 2011-16, against 2.23 lakh institutional deliveries 1.12 lakh women were discharged within 48 hours of delivery. It was observed that out of three tests checked districts, North Tripura District registered the highest percentage (72 *per cent*) of discharge within 48 hours of delivery during 2011-16, although reason for discharge was neither found on record nor stated to audit. However, test checked facilities reported that in case of normal deliveries women took discharge from the facilities at their own request.

The year wise status of post natal care coverage during 2011-16 is shown in **Chart No. 1.3.8.**

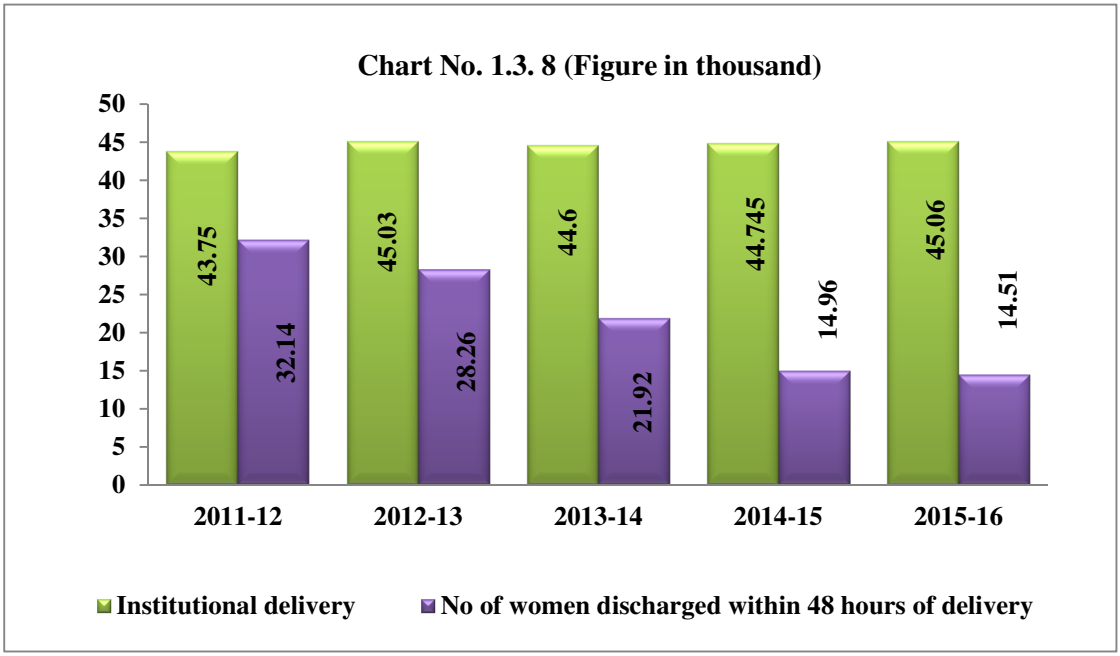


Table No. 1.3.8: Status of post natal care coverage during 2011-16

(in number)

Component	2011-12	2012-13	2013-14	2014-15	2015-16
Total number of deliveries	51,277	52,191	52,424	51,514	50,847
Women received post partum check up within 48 hours after delivery	NA	NA	43,672 (83%)	45,778 (89%)	44,110 (87%)

(**Source**: Departmental records)

During 2013-14 to 2015-16, 11 to 17 *per cent* women did not receive Post-Partum Check up within 48 hours of delivery. Thus, while all the programmes were being implemented across the State as per the guidelines, the coverage, the quality and effectiveness of the interventions cannot be assured.

1.3.7.19 Janani SurakshaYojana

The Janani Suraksha Yojana (JSY) was introduced in 2005-06 as a key intervention to enable and encourage women to access Institutional Delivery services and thereby effect reductions in MMR and IMR to 100/1,00,000 and 26/1,000 live births respectively by 2016. Status of MMR and IMR in Tripura was 100/1,00,000 and 26/1,000 live births and the target in the State of Tripura was achieved.

As an incentive to boost the goals stated, a financial package was provided through the JSY to all pregnant women. Below Poverty Line (BPL), Scheduled Castes and Scheduled Tribes pregnant women in rural areas of high focus States, who deliver in a health centres, were eligible for a cash incentive of ₹ 700 to meet both direct and indirect expenses incurred on delivery. The scheme also provides ₹ 500 to BPL women who prefer to deliver at home.

Targets and achievement during 2011-16 are shown below:

Table No.1.3.9: Target and achievement against JSY scheme during 2011-16

(in number)

Year	No. of pregnant women registered for ANC	No. of pregnant women registered under JSY	Target for payment	No. of beneficiaries received cash payment	Expendi-ture (₹ in crore)	No. of institutional deliveries	No. of home deliveries
2011-12	76,202	40,125	NA	39,088	3.51	43,751 (57%)	7,526
2012-13	73,915	40,785	NA	28,077	2.42	45,028 (61%)	7,163
2013-14	77,985	43,959	50,490	37,157	2.30	44,595 (57%)	7,829
2014-15	77,290	44,687	45,088	42,549	2.68	44,735 (58%)	6,779
2015-16	76,138	44,498	66,299	47,752	3.19	45,057(59%)	5,790

(**Source**: Target- RoP; Expenditure: Annual Accounts/Financial Management Rreport/Progress Report Registration: Health Management Information System data provided by Mission Director)

Scrutiny of records revealed that ₹ 14.10 crore was paid to the 1.95 lakh beneficiaries during 2011-16.

Under JSY, disbursement of cash incentive was to be made to the beneficiary immediately after delivery or at the time of discharge. However, during survey of beneficiaries, it was noticed that 46 *per cent* did not receive incentives and 44 *per cent* beneficiaries' intimated receipt of JSY incentives with a delay ranging from 8 days to 365 days.

Further, in two test checked facilities,[18] 1,722 beneficiaries did not receive incentives. Reason given for not disbursing the incentives was that the beneficiaries did not turn up to receive the incentives after discharging from the facilities or papers were not submitted by the beneficiaries.

While accepting audit observation, the Department stated (October 2016) that low coverage and delay in payment was due to Aadhaar based direct benefit transfer payment system.

1.3.7.20 Complete Immunisation not achieved

Immunisation of children against six preventable diseases, namely Diphtheria, Measles, Polio, Tetanus, Pertussis and Tuberculosis has been the cornerstone of routine immunisation under the universal immunisation programme.

The immunisation coverage during 2011-16 was as under:

Table No. 1.3.10: Target and coverage of children under routine immunisation during 2011-16

(in number)

Year	Target	Coverage of children up to one year (full immunisation)	Vitamin-A (1st dose) provided to the children
2011-12	55,686	44,119 (79)	22,906
2012-13	53,316	45,965 (86)	52,486
2013-14	52,586	47,315 (90)	44,174
2014-15	53,370	48,784 (91)	44,573
2015-16	53,379	47,013 (88)	39,162

Source: Departmental figures. (Figures in bracket indicate percentage)

[18] Kulai District Hospital, Dhalai; Ganganagar PHC.

The above table shows that during 2011-16, 79 to 91 *per cent* children upto one year were fully immunised. However, the 1st dose of Vitamin-A was also not provided to many of the children. It was further observed from records that birth dose of Oral Polio Vaccine (OPV) was administered only in 52 *per cent* cases, with Dhalai District recording the lowest (25 *per cent*).

Thus, complete immunisation was lacking and drop outs were substantial during the course of full vaccination period which was supposed to be completed by around nine months of child's age.

On being pointed out in audit Mission Director, NRHM stated (August 2016) that to prevent wastage of vaccine zero dose OPV was not administered in the facilities where number of deliveries per day varied from 0 to 10.

Thus, by not administering zero dose OPV, immunisation of the new born babies was compromised.

1.3.7.21 Janani Sishu Suraksha Karyakram

Janani Sishu Suraksha Karyakram (JSSK), introduced in 2011, is an initiative to eliminate out of pocket expenses for both pregnant women and sick neonates. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including in the case of a caesarean section.

According to National Family Health Survey (NFHS) number 4, average out of pocket expenditure per delivery in public health facility was ₹ 4,248 in rural areas in Tripura. Audit noticed that at the time of delivery, doctors directed pregnant women to purchase prescribed medicine and other consumables of their own from private medicine shop in violation of the JSSK scheme.

Thus, the objective of the scheme to provide free and cashless services to all pregnant women had not materialised.

While accepting audit observation, the Department stated (October 2016) that all the medicines may not be available at the facilities. In that cases patients had to buy from local shop which was reimbursed later on. Now all the required medicines are procured from State and supplied to facilities.

1.3.7.22 Family planning

The SHS procured 15 Laparoscopes at a cost of ₹ 1.04 crore in 2011 and distributed to different facilities.

Five Laparoscopes Machines (Kanchanpur SDH, Sabroom SDH, Dharmanagar DH and Kailasahar DH) valued ₹ 34.66 lakh were lying idle due to non-availability of trained Medical Officers and discontinuation of annual maintenance contract.

While accepting the audit observation, the Department stated (October 2016) that training of Medical Officers and continuation of annual maintenance contract would be taken up.

1.3.7.23 National Disease Control Programme

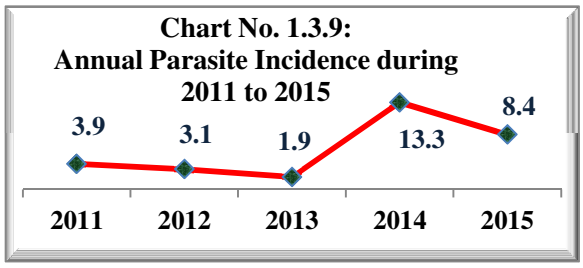
National Vector Borne Disease Control Programme (NVBDCP) for Malaria was one of the programmes under National Disease Control Programme (NDCP) which was test checked during the Performance Audit and the followings were observed.

National Vector Borne Disease Control Programme

NVBDCP endeavours to control vector borne diseases by reducing Mortality and Morbidity due to Malaria, Filaria, Kala-azar, Dengue, Chikengunya and Acute Encephalitis Syndrome/Japanese Encephalitis in endemic areas.

Malaria

NVBDCP targeted achieving Annual Parasite Incidence (API) of less than one per thousand of population nationwide by 2017. It was noticed that during 2011-16 in the State, API ranged from 1.9 to 13.3, as shown in **Chart No. 1.3.9**, with Dhalai District having the highest API (52.4) in 2014.



During 2011-16, 1.17 lakh Malaria positive cases were recorded in the State of which Plasmodium falciparum[19] cases were 1.11 lakh and 143 death cases were registered.

Scrutiny of records of Dhalai District with respect to sudden spurt of Malaria after 2013 revealed that:

- To prevent malaria, the Department was to conduct 1st round of DDT spray during February to April and 2nd round between May to July each year and distribute Long Lasting Insecticidal Treated Mosquito Nets (LLINs).

  In 2014, 1st round DDT spray took place in Dhalai during 30 May 2014 to 19 July 2014 and 2nd round between 1 August 2014 and 8 September 2014 instead of the scheduled time *i.e.* 1st round- February to April and 2nd round-May to July. Reasons for delay in DDT spray was neither found on record nor intimated to audit. Further, during the years 2012-13 and 2013-14, no LLINs were supplied.

- The Multi Purpose Worker (MPW)/ANMs were not visiting the interior areas of Dhalai District. ASHAs of the remote villages were staying in the town areas and they did not visit field regularly. Malaria screening done by ASHAs was also inadequate. It was further noticed that 18 ASHAs and six MPWs were absent from their duties for a long time. They neither stayed in the respective villages nor provided any information about the occurrence of Malaria/Fever cases within the time which ultimately led to nine deaths at Girendrachandra

[19] Plasmodium falciparum is a protozoan parasite, causing the most dangerous form of Malaria in human.

Para and Joychandra Para under Gandacherra Sub Division in May-June 2014.

- No review meeting had been held during the period of audit *i.e*. 2011-16. Reason for not conducting review meetings was neither found on record nor stated to audit.
- During 2013-14 as per NVBDCP guidelines, Artemisinin- based Combination Therapy[20] (Artesunate + Sulfadoxine-Pyrimethamine) {ACT (SP)} was replaced by Artemisinin- based Combination Therapy- Artemether- Lumefantrine (ACT-AL). In that period Rapid Diagnostic kit (bivalent) and ACT-AL were not supplied to the district resulting in acute shortage of diagnostic kits and Anti-Malarial drugs in the district. Thus, due to shortage of ACT-AL, patients suffering from Malaria could not be treated.

Mortality rates from Malaria continue to be high in the State. The Mission had been ineffective in addressing this due to systemic failure where the entire machinery from ASHAs to SHS seems to have been ineffectual due to reasons cited above.

Quality assurance

1.3.7.24 Setting up of organisational framework for quality assurance

State Quality Assurance Committee (SQAC) at the State had been constituted (August 2014) which was headed by the Principal Secretary, Health and Family Welfare Department. District Quality Assurance Committees (DQACs) at the district level had been constituted (August 2014) headed by the District Magistrate and Collector of the respective districts. The broad responsibility of the SQAC was to oversee the quality assurance of activities across the State and also ensure regular and accurate reporting of the various key indicators. However, the SQAC had not met till June 2016.

In 2015-16, State Quality Assurance Unit (SQAU[21]) visited 21 field units but tour records were not made available to audit. As a result, gaps identified by the SQAU and action taken report, if any, could not be analysed.

Scrutiny of records further revealed the following:

- Operational guidelines on quality assurance requires that the DQAC meet at least once in a quarter. But in three test checked districts, DQAC did not organise any meeting to oversee the quality assurance activities in the districts.
- According to the operational guidelines on quality assurance, in-charge of health facility should form an Internal Quality Assurance Team (IQAT), which should have representation from all departments, Nursing Staff, Laboratory and Support Staff. The team should meet periodically (more frequently initially) to

[20] Artemisinin-based combination therapy (ACT) is recommended for the treatment of Plasmodium falciparum malaria. Fast acting artemisinin-based compounds are combined with a drug from a different class.

[21] Operational and implementation arm of SQAC.

discuss the status of quality initiative in their area of work. But in none of the test checked facilities IQAT were constituted.

Thus, assessment and reporting of quality of health care in health centres had not been given adequate importance over the years.

1.3.7.25 Quality in health care

(A) Internal assessment

In three test checked districts, internal assessment was not done in any of the test checked facilities. Thus, due to absence of internal assessment at the facility level, gaps in the services provided by the facility could not be identified.

(B) Patient satisfaction survey

According to the operational guidelines on quality assurance, a quarterly feedback {OPD – 30 patients, and for In Patient Department (IPD) – 30 patients in a month, separately} should be taken on a structured format by the hospital manager. This feedback would be analysed to see which are the lowest performing attributes and further action would be planned accordingly.

In the test checked facilities, patient satisfaction survey was not conducted during 2011-16. As a result, quality of service provided to those facilities could not be ascertained. During physical verification it was noticed that cleanliness of premises, OPD, Wards and Toilets in most of the facilities were not up to the mark. The position of some of the facilities is shown in the following photographs:

Poor cleanliness-SDH, Gandacherra

Poor cleanliness -SDH, Gandacherra

Poor waste management-DH, Dharmanagar

Poor waste management-SDH, Kanchanpur

Dumping of waste inside the hospital premises, beside the kitchen- SDH, Gandacherra

Medicines were kept in floor flooded with water-Brajendranagar PHC

1.3.7.26 Health Management Information System

An updated and reliable health database is the foundation of decision making across all health system building blocks.

During scrutiny of Health Management Information System (HMIS) data uploaded in the website along with records maintained in the test checked facilities few parameters were cross checked wherein it was noticed that data fed in the HMIS differed by 18 to 109 *per cent* in SCs, 2 to 48 *per cent* in PHCs, 45 to 97 *per cent* in CHCs, 7 to 210 *per cent* in SDHs and 4 to 75 *per cent* in DHs. Details are shown in **Appendix- 1.3.8**.

Thus, audit observed that HMIS lacks data integrity and its data cannot be relied upon for making decisions.

1.3.7.27 Reporting and monitoring

- According to notification (July 2005) issued by the Health and Family Welfare Department, GoI, the State Rural Health Mission should meet at least once in every six months to review progress in implementation of NRHM and to assess inter-sectoral co-ordination, etc. However, no such meetings took place during 2011-16.

- According to the rules and regulations of the SHS, meeting of the Governing Body shall be held at least once in every six months. At the annual meeting, Income and Expenditure Account and the Balance Sheet for the past year, Annual Report of the Society, Budget for next year, Annual Action Plan and research work for the next year, etc. shall be brought before the members and discussed. However, it was noticed that Annual Accounts of the Society and related aspects were never discussed and approved in the Governing Body meetings during 2011-16.

While accepting audit observation, the Department stated (October 2016) that it would be strengthened as Information Technology based systems were initiated.

1.3.8 Conclusion

A 'bottom-up' approach to planning, as was envisaged by the Mission, was not followed. Absence of perspective planning, non-conduct of household surveys and inadequate community involvement had resulted in failure to identify gaps in health facilities and areas of intervention.

Budget estimates were not realistic. Financial management and coordination was poor as percentage of utilisation of available funds was in the range of 51 to 69 *per cent*. There was short release of ₹ 273.46 crore by GoI due to non-utilisation of funds in the previous years and non-fulfilment of prescribed conditions for release of funds.

The desired level of capacity building and strengthening of physical infrastructure had not been achieved. Existing number of SCs, PHCs and CHCs were short of the targets by 12, 47 and 56 *per cent* respectively. Many of the existing SCs lacked basic amenities and construction activities were delayed on account of various reasons. Shortages of specialists in DHs and non-availability of specialists in CHCs and PHCs in the test checked districts were symptomatic of a wider trend, where access to health care in rural areas remained limited to primary health care due to non-availability of specialists. Adequate training was not being provided to the existing medical staff.

The effectiveness of the programmes under the Mission could not be fully vouched for as gaps had been found in their implementation. For instance, a third of pregnant women did not receive TT and 40 *per cent* did not receive the required IFA tablets. In the last five years the Department could not track the fate of about 29 to 33 *per cent* of registered pregnant women for which no reasons were found on record.

Assessment and reporting of quality of health care in health centres were not done in the three test checked districts. Monitoring at the State level had been inadequate.

1.3.9 Recommendations

- Horizontal and vertical linkages should be identified and included in plans for effective implementation of the Mission. The mechanism for coordination between district, block and village levels should be strengthened.

- The financial management should be improved and steps should be taken to avoid accumulation of unspent balances by timely spending on various aspects of the programme and increasing the pace of implementation of the programme.
- Steps should be taken for speedy completion and utilisation of all the construction works undertaken and facilities available.
- Appropriate steps should be taken by the SHS for increasing the proportion of institutional deliveries, especially in tribal and remote areas of the state.
- Availability of human resource at various levels may be ensured through regular and/or contractual recruitment. Training courses, as per training need analysis, should be undertaken to harness the full potential of available human resources.
- Discrepancy between the HMIS data and field data should be assessed and minimised.

REVENUE DEPARTMENT

1.4 Management of State Disaster Response Fund

Ministry of Home Affairs (MHA), Government of India (GoI) framed[22] (September 2010) the guidelines on constitution and administration of State Disaster Response Fund (SDRF) for providing immediate relief to the victims of natural calamities[23]. The guidelines became operative from 2010-11. As per guidelines the provision for disaster preparedness, restoration, reconstruction and mitigation should not be a part of SDRF and such expenditure should be built into the State Plan funds. These were further revised in July 2015 on the recommendations of the XIV Finance Commission.

An audit was conducted during April-July 2016 through test check of records of the Disaster Management Cell[24] of the Revenue Department, two[25] districts out of eight districts of the State (including records of six Sub-Divisions [26] under their jurisdiction) and Relief, Rehabilitation and Disaster Management (RRDM) Directorate to ascertain whether the Department's management of the funds placed in SDRF was efficient. The following was observed:

1.4.1 Planning

Planning is an important element for the success of any activity. It is therefore, imperative that that the State should have their plans in place for management of SDRF. Analysis of planning showed that the State did not have a Disaster Management Plan till the year 2016 and therefore, also did not have concrete plans for management of SDRF which should have been built into the DM Plan as detailed below:

State and District Disaster Management Plan

The National Disaster Management Act (NDMA) had issued guidelines for preparation of the State Disaster Management Plan (SDMP) in July 2007 which would also include plans for management of SDRF. The State Disaster Management Authority (SDMA) however, brought out the SDMP only in May 2016 after a delay of about nine years from the date of issuing the guidelines by NDMA.

The Government replied (October 2016) that the SDMP was prepared through several consultations and process of fine-tuning the SDMP document took time.

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22 Based on Section 48 (1) of the Disaster Management Act, 2005 (DM Act) and recommendations of XIII Finance Commission.

23 Cyclone, drought, earthquake, fire, flood, tsunami, hailstorm, landslide, avalanche, cloud burst and pest attack (later on, frost and cold waves were also included w.e.f. 2015-16).

24 The Disaster Management Cell functioning under the Revenue Secretariat was set up mainly to coordinate various activities of different organs of the State Government towards disaster risk preparedness, mitigation and search, rescue and relief operations during and after disaster with particular reference to earthquake.

25 Two districts, Sepahijala and West Tripura; which received highest funding during 2011-16.

26 SDMs, Sadar, Jirania and Mahanpur under West Tripura District and SDMs, Jampuijala, Bishalgarh and Sonamura under Sepahijala District.

It was thus, evident that the financial arrangements for disaster management were outlined in the SDMP, which was brought out only in May 2016 and therefore, the management of the SDRF was being administered in an adhoc manner over the years without any annual plans.

The Revenue Department intimated (July 2016) that District Disaster Management Plan (DDMP) had been prepared by the districts and were being updated regularly as and when required. Despite the request made (June 2016) at the Secretary level, the copies of plans had not been furnished (October 2016).

Further, the DDMPs should be prepared by the DDMA, after consultation with the local authorities and having regard to the national plan and the State plan and should be approved by the SDMA. Therefore, questions arise over how the DDMPs were prepared when in fact the SDMP had not been prepared till May 2016.

In the exit conference, the Secretary, Revenue Department intimated (October 2016) that the DDMPs were finally approved by the SDMA in September 2016 and also assured that the approved DDMPs would be furnished to audit.

The Government replied (October 2016) that the DDMPs were prepared before issue of NDMA guidelines and were updated on annual basis. It further added that all the districts had updated and approved DDMPs for the year 2016-17.

1.4.2 Financial management

As per the guidelines of SDRF, the GoI would contribute 90 *per cent* of total annual allocation in the form of Non-plan grants in two instalments (June and December) each year and the balance 10 *per cent* would be contributed by the State Government.

The position of funds received, availability of funds, actual expenditure, closing balance and expenditure reported to GoI during 2010-11 to 2015-16 are given in the **Table No. 1.4.1** below:

Table No. 1.4.1

(₹ in lakh)

Year	Opening balance	Funds due to be released as per recommendation of the XIII FC (for 2010-15) and XIV FC (for 2015-20)		Funds released by		Total availability of funds during the year	Expenditure (*per cent*)	Closing balance	Expenditure reported to the GoI
		GoI	State	GoI	State				
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
2010-11	6,287.71*	1,738.00	193.00	869.00	Nil	7,156.71	Nil	7,156.71	843.05
2011-12	7,156.71	1,825.00	203.00	2,694.00	396.00	10,246.71	3,029.52 (29.57)	7,217.19	804.62
2012-13	7,217.19	1,916.00	213.00	958.00	106.44	8,281.63	1,067.82 (12.89)	7,213.81	1,654.54
2013-14	7,213.81	2,012.00	223.00	2,970.00	218.06	10,401.87	317.50 (3.05)	10,084.37	450.00
2014-15	10,084.37	2,112.00	235.00	2,112.00	229.00	12,425.37	622.50 (5.01)	11,802.87	450.00
2015-16	11,802.87	2,800.00	300.00	2,790.00	272.50	14,865.37	1,284.37 (8.64)	12,581.00	1,149.36

Source: Departmental records and Finance Accounts of the State.

*Closing balance as on 31.03.2010 lying in the Calamity Relief Fund transferred to SDRF as per SDRF guidelines.

Discrepancies in figures reported to GoI

Analysis of the data showed that there were discrepancies between the expenditure figures reported to the GoI and the expenditure reflected in Finance Accounts of the State every year since 2010-11. In 2010-11, no expenditure was reflected in the Finance Accounts but it was reported to GoI that the Department had incurred an expenditure of ₹ 8.43 crore. During 2013-14, the expenditure figure in the Finance Accounts was ₹ 3.17 crore while it was reported to GoI as ₹ 4.50 crore. It indicated that the Revenue Department responsible for administering SDRF was not properly monitoring the expenditure incurred out of SDRF.

After the discrepancies were pointed out in audit (June 2016), the Department replied (July 2016) that the Finance Department had been consulted and the matter was under examination.

Delay in submission of certificate with regard to creation of SDRF

Secondly, as per the guidelines, the 1st installment of Central contribution to SDRF for 2010-11 was to be released by GoI unconditionally and the 2nd installment was to be released on receipt of certificate with regard to creation of the SDRF by October 2010. The State Government submitted the certificate regarding creation of SDRF to GoI in July 2011. GoI released the 1st installment of ₹ 8.69 crore in June 2010 unconditionally. However, the 2nd installment of ₹ 8.69 crore for 2010-11 was delayed and was released by GoI during 2011-12. Scrutiny of records by audit revealed that the delay was due to delay in submission of requisite certificate by the State Government.

Delay in contribution by State Government

Further, there have been delays on the part of the State Government to contribute its share. As per recommendation of XIII Finance Commission, the GoI released its contribution of ₹ 96.03 crore to State Government during 2010-15. The State Government released its share of ₹ 9.50 crore against recommendation of ₹ 10.67 crore during 2010-15. Thus, there was short release of State share of ₹ 1.17 crore. Similarly, during 2015-16, the GoI released its contribution of ₹ 27.90 crore. On the other hand, the State Government released only ₹ 1.55 crore against State share of ₹ 3.10 crore during the year. Thus, there was short release of ₹ 1.55 crore.

1.4.2.1 Loss of interest of ₹ 38 crore

As per the guidelines of SDRF, on receipt of the amounts of contribution from the Government of India and/or State Government, the SEC should invest the funds in one or more of the following instruments:

a) Central Government dated security;

b) Auctioned treasury bills and

c) Interest earning deposits and certificates of deposits with scheduled commercial banks.

It was observed that during 2010-11, the Department did not incur any expenditure from the available funds of ₹ 71.56 crore. During 2011-12 to 2014-15, annual expenditure under SDRF was maximum in 2011-12 (29.57 *per cent*) and minimum in 2013-14 (3.05 *per cent*) of available funds. In 2014-15, the percentage of utilisation of funds was only 5.01 *per cent*.

As a result, the unspent balances over the years had increased substantially from ₹ 71.56 crore in 2010-11 to ₹ 118.03 crore in 2014-15. Despite availability of huge balances at the end of each year, these were not invested in any of the prescribed instruments. It was only in March 2016 that the Department invested ₹ 73 crore in fixed deposits for a period of one year.

The Department, by not investing the unspent balances in interest bearing term deposits according to the guidelines, lost an opportunity to earn an interest of about ₹ 38 crore upto March 2016 as shown in **Table No. 1.4.2** below:

Table No. 1.4.2

(₹in crore)

Year	Unspent balance of funds as on 31 March	Period of investment	Rate of interest applicable for term deposit of one year *(in percentage)*	Amount of interest
2010-11	7,156.71	01.04.2011 to 31.03.2012	8.25	5.90
2011-12	7,217.19	01.04.2012 to 31.03.2013	9.25	6.68
2012-13	7,213.81	01.04.2013 to 31.03.2014	8.75	6.31
2013-14	10,084.37	01.04.2014 to 31.03.2015	9	9.08
2014-15	11,802.87	01.04.2015 to 31.03.2016	8.5	10.03

Thus, improper financial management led to loss of ₹ 38 crore to the State exchequer.

In reply, the Government stated (October 2016) that in addition to ₹ 73 crore, a sum of ₹ 27 crore was also invested (May 2016) in fixed deposit. It further added that the matter had been taken note for future guidance so that such instances could be avoided in future.

1.4.2.2 Diversion of ₹ 34.90 lakh

Guidelines of SDRF issued in September 2010 and July 2015 provide that funds should be used for meeting the expenditure required for providing immediate relief to the victims of cyclone, drought, earthquake, fire, flood, tsunami, hailstorm, landslide, avalanche, cloud burst and pest attack (later on, frost and cold waves were also included w.e.f. 2015-16). As per guidelines (September 2010) the provision for disaster preparedness, restoration, reconstruction and mitigation should not be a part

of SDRF and such expenditure should be built into the State Plan funds. Revised guidelines of SDRF which became effective from July 2015, provide that 5 *per cent* of annual allocation of SDRF may be kept for capacity building activities related to disaster management. As per guidelines of SDRF (September 2010 and July 2015), the MHA, GoI would fix items and norms of expenditure from the SDRF from time to time.

Test check of records of one District Magistrate and Collector (DM & C) and four Sub Divisional Magistrate (SDMs) offices revealed that during 2011-16 an expenditure of ₹ 34.90 lakh was spent on the items which were not admissible as per norms fixed by the MHA, GoI under SDRF, as shown in the **TableNo. 1.4.3** below:

Table No. 1.4.3

Name of the office	Inadmissible item of works	Period of procurement	Amount utilised *(₹in lakh)*
DM & C, Sepahijala	Purchase of generator set, payment of telephone bill, Misc. Expenses etc.	January 2013 & July 2014	8.78
SDM, Sadar	Repair of boat, financial assistance to the affected persons due to construction of drain by State Public Works Department, repair of shop, removal of illegal construction, etc.	April 2013 & September 2014	6.98
SDM, Mohanpur	Repair of Tehshil Kachari building, financial assistance to road accident victims, etc.	June 2012 and June 2015	2.13
SDM, Bishalgarh	Maintenance of security camp of State Police affected by cyclone, purchase of spun pipes to remove water logging, purchase of camera, construction of temporary drain etc.	May 2012 & October 2015	8.02
SDM, Sonamura	Construction of store room in SDM office, repair of boat, purchase of generator, etc.	October 2011 & February 2014	8.99
Total			**34.90**

Thus, it would be seen that the Department in violation of the guidelines/norm of assistance of SDRF diverted ₹ 34.90 lakh towards inadmissible items.

In reply, the Government stated (October 2016) that advertisement cost, awareness programme and procurement of search, rescue and evacuation equipment were admissible under SDRF. However, the fact remained that advertisement cost and awareness programme being a part of capacity building was admissible for financing under SDRF only from April 2015. Further, the expenditure incurred on capacity building, procurement of search, rescue and evacuation equipment from April 2015 onwards have not been included in the amount of □ 34.90 lakh objected upon.

1.4.2.3 Subsidiary accounts not maintained

As per the guidelines of SDRF, the accounts of the SDRF (approved calamity-wise) and the investment should be maintained by the Accountant General (AG) in charge

of accounts of the State in the normal course. The SEC would maintain subsidiary accounts (calamity-wise) in such manner and details as may be considered necessary by the State Government in consultation with the AG.

It was noticed that subsidiary accounts were not maintained by the State Executive Committee. Thus, due to not maintaining of subsidiary accounts, the calamity-wise allocation of funds and expenditure incurred could not be examined in audit and in turn, the AG in charge of accounts of the State could not compile the accounts of the SDRF (approved calamity-wise) and the investment as envisaged in the guidelines of SDRF.

In response to an audit query made in June 2016, the Government informed (July 2016) that the matter was under consideration of the Government.

1.4.2.4 Monthly reports to GoI not submitted

The MHA, GoI is the nodal Ministry for overseeing the operation of SDRF and shall monitor compliance with the prescribed processes for SDRF. Manual on Administration of SDRF and National Disaster Relief Fund stipulate that the State Government was required to send details relating to monthly expenditure on the various eligible natural calamities out of SDRF to MHA as per the items and norms of expenditure from SDRF and as per the prescribed format on monthly basis by 15th of the following month to which the report pertains.

It was noticed that the State Government did not furnish any monthly report to the MHA up to the year 2015-16. Hence, in absence of monthly reports item-wise and calamity-wise expenditure under SDRF could not be analysed. Reason for non-furnishing of monthly reports was neither found on record nor furnished to audit even though called for (June 2016).

In reply, the Government stated (October 2016) that the reports were not prepared due to non-availability of item-wise data and GoI also never asked for the reports.

The above indicated that the Revenue Department being responsible for administering SDRF, did not monitor the expenditure made out of SDRF and also did not prepare subsidiary accounts as discussed in preceding paragraph. Non adherence to such a monitoring mechanism at all levels is a serious issue that needs to be resolved at the earliest.

1.4.3 Internal control

Rule 292 of General Financial Rules (GFR) provide that the Head of the Office may sanction advances to a Government servant for purchase of goods or services or any other special purpose needed for the management of the office, subject to condition that the Head of the Office should be responsible for timely recovery or adjustment of the advance. The adjustment bill, along with balance if any, shall be submitted by the Government servant within 15 days of the drawal of advance, failing which the advance or balance shall be recovered from his salary.

Test check of records of SDMs revealed that:

Adjustment of advances not monitored

- Advance payments were made out of SDRF during the years 2011-16 by the five SDMs [27] to the Government officials of SDM offices for disbursement of financial assistance in cash to the disaster victims. As per GFRs, the officials should submit adjustment of such advances made to them after distribution of financial assistance to the disaster victims. But, the SDMs did not maintain register of advance to monitor submission of adjustments against the advances so made to the officials in violation of the extant rules. As a result, position of outstanding advances could not be examined in audit.

Absence of database of beneficiaries

- The SDMs were responsible for disbursement of relief assistance to the disaster victims. But, consolidated record/data base indicating name of the beneficiaries from SDRF with the required details such as their location, Aadhaar or any other identity proof of the beneficiaries, amount given with dates, nature of disasters occurred with dates, etc. were not maintained by the SDMs.

Thus, non-observance of provisions of GFRs for not maintaining of database by the SDMs indicated lack of internal control in the system. The possibilities of malpractices including misappropriation of cash and duplicate payments to the beneficiaries could not be ruled out. Prevalence of such irregularities and violations of guidelines put into question the economy and effectiveness of the funds being released for disaster related purposes.

In reply, the Government stated (October 2016) that the matter would be taken up with the district authorities.

1.4.4 Conclusion and recommendations

Lack of adequate planning, monitoring and assessment in management of SDRF was evident by the fact that the fund was being administered in an adhoc manner without a SDMP over the years. Consequently, the Department did not prepare annual plans for management of the fund. The Department did not monitor the expenditure made out of SDRF. As a result, incorrect figures to the GoI were reported. The Department did not invest the unspent balances of SDRF prudently. The funds earmarked for providing assistance to the beneficiaries were diverted by the SDMs for purposes not admissible under the scheme guidelines.

Adequate and effective disaster plans should be put in place in each district to ensure a holistic approach to management of the fund.

The unspent balance of SDRF should be invested prudently to earn optimum interest on such investments as envisaged.

[27] Except, SDM, Sonamura under the jurisdiction of Sepahijala District.

HEALTH AND FAMILY WELFARE DEPARTMENT

1.5 Misappropriation of Government revenue

Failure to enforce the extant provisions regarding handling of Government money received by Government officials coupled with deficient monitoring of the collection and deposit led to misappropriation of ₹ 3.72 lakh, apart from non-accounting of unascertained amount of Government revenue collected through 19 missing TR-5 Receipt books.

According to the system prevailing in the Agartala Government Medical College (AGMC) and G.B. Pant Hospital, Agartala, user fees against hospital service delivery like X-ray, CT Scan, Ultrasonography, ICU/Cabin charges, Blood bank, etc. were collected from the patients in the Central Laboratory and the respective units/wards of the Hospital. The collections were made using TR-5 Receipt books being issued to all the collecting windows from the Hospital store section. The amount of cash so collected was then deposited by the collecting officials of the respective collecting windows to the Cashier regularly for onward deposit to the bank account of the Rogi Kalyan Samiti of AGMC and G.B. Pant Hospital.

In this context, Rule 7(1) of the GFR, may be referred to which *inter alia* provided that all moneys received by or tendered to Government officers on account of the revenues of the Government shall, without undue delay be paid in full into a treasury. Monies received as aforesaid shall not otherwise be kept apart from the accounts of the Government.

Examination of records (July-August, 2015) of the Medical Superintendent of AGMC and G.B. Pant Hospital, Agartala for the period from April 2012 to June 2015 revealed that out of ₹ 39.16 lakh collected through 187 TR-5 Receipt books from the patients on account of fees for the aforementioned services during May 2012 to June 2015, ₹ 35.44 lakh only was deposited by the collectors to the Cashier leaving a balance of ₹ 3.72 lakh[28] as detailed in **Appendix – 1.5.1 (A)** to **(D).** Thus, the balance amount of ₹ 3.72 lakh remained out of Government account as of September, 2016 and was suspected to be misappropriated.

Further examination of records of stock and issue of TR-5 Receipt books maintained in the Hospital store section revealed that 20[29] more TR-5 Receipt books containing 2000 pages (100 pages in each book) were used for collection of fees against service delivery in the Central Laboratory of the Hospital during the period between December, 2013 and June, 2015. However, neither the counterfoils of these used TR-5 Receipt books were traceable nor any amount of revenue against collection of fee using these TR-5 Receipts books found deposited to the Cashier.

[28] (Central Lab- ₹ 3.57 lakh, X-ray unit- ₹ 0.01 lakh and Blood Bank- ₹ 0.14 lakh).

[29] Book Nos:-18779, 18780, 18781, 18782, 18788, 18789, 18790, 18791, 18792, 18793, 18794, 18795, 19672, 19675, 19678, 19679, 19680, 19681, 22667, 23473.

The Medical Superintendent while admitting the lapse stated (April 2016) that out of aforementioned 20 untraced TR-5 Receipt books one book (Book No. 22667) had been retrieved which disclosed a total collection of fees of ₹ 0.24 lakh during the period between 23 December 2014 and 25 December 2014 and was deposited (March, 2015) to the Cashier.

Scrutiny of the prevailing system of collection of fees through multiple collection windows and their subsequent deposits to the Cashier disclosed that the misappropriation of revenues occurred due to inadequacy in the internal control system where the collectors deposited cash to the Cashier without any verification by any superior authority. Even the Cashier, while receiving the cash deposit from the collecting officials, simply issued a receipt indicating the amount of actual deposit without exercising any check with the counterfoils of TR-5 Receipt books or the totaling of the Collection Registers maintained in the receiving windows.

Thus, non-enforcement of the extant provisions regarding handling of Government money received by Government officials coupled with non-existent scrutiny mechanism on the collection and deposit of the amount of revenue led to misappropriation of Government revenues of ₹ 3.72 lakh, apart from non-accounting of undisclosed amount of Government revenue collected through 19 missing TR-5 Receipt books.

Medical Superintendent, while admitting misappropriation of ₹ 3.72 lakh, stated (April 2016) that a Committee had been formed to inquire into the matter. The enquiry report as well as the position of recovery of the misappropriated Government revenue had not been furnished as of October 2016.

The matter was reported to the Government (June 2016); reply had not been received (October 2016).