

PART-I

Performance and Compliance Audits on Departments under Social Sector

CHAPTER - II

SOCIAL SECTOR

PART-I

2.1 Introduction

This chapter of the Audit Report for the year ended 31 March 2023 deals with the findings on audit of the State Government units under Social Sector.

During 2022-23, total budget allocation of the State Government in the Departments under Social Sector was ₹5,847.55 crore against which actual expenditure incurred was ₹4,587.10 crore (78 *per cent*). The Department-wise details of Budget Allocations and Expenditure incurred are shown in **Table 2.1.1**.

Table 2.1.1: Details of Department-wise Budget allocation and Expenditure

(₹ in crore)

Sl. No.	Name of the Department	Budget Allocation			Expenditure			Expenditure as percentage of Allocation
		Revenue	Capital	Total	Revenue	Capital	Total	
1.	Art & Culture	26.94	4.66	31.60	24.67	4.27	28.94	92
2.	Employment & Craftsmen Training	66.41	1.00	67.41	32.04	1.00	33.04	49
3.	Health & Family Welfare	894.13	461.06	1,355.19	794.58	446.56	1,241.14	92
4.	Higher Education	237.88	113.76	351.64	198.33	33.04	231.37	66
5.	Information & Public Relations	41.24	1.84	43.08	40.48	1.84	42.32	98
6.	Labour	12.48	0	12.48	11.75	0	11.75	94
7.	Municipal Affairs	105.76	511.33	617.09	32.99	157.87	190.86	31
8.	School Education	1,856.95	117.85	1,974.80	1,798.73	119.64	1,918.37	97
9.	Social Welfare	411.26	6.44	417.70	274.00	5.73	279.73	67
10.	State Council for Education, Research & Training (SCERT)	47.21	28.04	75.25	43.50	28.05	71.55	95
11.	Technical Education	47.25	30.26	77.51	44.97	29.76	74.73	96
12.	Urban Development	52.31	130.01	182.32	51.64	140.89	192.53	106
13.	Water Supply & Sanitation	121.44	416.39	537.83	106.85	80.95	187.80	35
14.	Women Welfare	12.60	0	12.60	12.50	0	12.50	99
15.	Youth Resources & Sports	50.56	40.49	91.05	49.52	20.95	70.47	77
Total		3,984.42	1,863.13	5,847.55	3,516.55	1,070.55	4,587.10	78

Source: Appropriation Accounts, 2022-23

It can be seen from the table above that:

- The expenditure incurred by the Government under different departments of Social Sector ranged between 31 and 106 *per cent*.

- The Urban Development Department had utilised ₹10.21 crore over the budgeted allocation.
- Out of 15 departments, in Social Sector, nine departments incurred more than 90 per cent of total budget allocation viz. Urban Development (106 per cent), Women Welfare (99 per cent), Information & Public Relations (98 per cent), School Education (97 per cent), Technical Education (96 per cent), SCERT (95 per cent), Labour (94 per cent), Art & Culture (92 per cent) and Health & Family Welfare (92 per cent) Departments during the year 2022-23.
- Revenue expenditure in the sector was ₹3,516.55 crore (77 per cent) of the total expenditure.
- Capital expenditure in the sector was ₹1,070.55 crore (23 per cent) of the total expenditure.

2.1.1 Planning and Conduct of Audit

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

Audit was conducted in 153 units of nine Departments involving an expenditure of ₹7,671.42 crore (including expenditure of previous years audited during the year) during 2022-23 under the Social Sector.

After completion of audit of each unit, Inspection Reports containing audit findings were issued to the Heads of Departments for taking appropriate remedial measures on the audit findings. The Departments were requested to furnish replies to the audit findings within one month of the receipt of Inspection Reports. Wherever replies were received, audit findings were reviewed and either settled or further action for compliance was advised. Important audit observations arising out of the Inspection Reports were processed for inclusion in the C&AG's Audit Report, which is submitted to the Governor of the State under Article 151 of the Constitution of India, for laying before the State Legislature.

This Chapter contains audit observations on one Performance Audit viz. "Welfare of Building and Other Construction Workers in Nagaland", one Subject Specific Compliance Audit viz. "Public Health Infrastructure and Management of Health Services in Nagaland" and two compliance audit paragraphs.

Performance Audit

LABOUR DEPARTMENT

2.2 Welfare of Building and Other Construction Workers in Nagaland

Building and Other Construction (BOC) Workers are one of the most vulnerable segments of unorganised labour in the country. Their work is of temporary nature and

working hours are uncertain. While risk to life and limb is inherent, basic amenities and welfare facilities are mostly non-existent or inadequate where provided.

A Performance Audit on 'Welfare of Building and Other Construction workers in Nagaland' was carried out covering the period from 2017-18 to 2022-23 with special emphasis on receipt of cess fund and utilisation of it on various welfare schemes for registered construction workers. The significant findings of audit are highlighted below:

Highlights

- *There was no effective mechanism to register all building and other construction workers with the Welfare Board.*

(Paragraph 2.2.10.1 (I))

- *No Establishment has yet been registered and consequently no fees has been collected on registration. There was no established mechanism to ensure that buildings or construction works get registered as an establishment.*

(Paragraph 2.2.10.2 (I))

- *Independent assessment of Cess by Inspectors through inspection of work sites/establishments was not undertaken by the Department. As a result, the Department is not able to identify employers of construction workers who are liable to pay Cess or to assess the Cess payable.*

(Paragraph 2.2.11 (I))

- *There were instances where the safety and health measures of construction workers were compromised as the precautions and facilities guaranteed under the Act were not provided.*

(Paragraph 2.2.12)

- *No meeting of the State Advisory Committee was held during February 2018 to February 2021. Consequently, the State Government and the Welfare Board were deprived of the benefit of advice and guidance on matters arising out of the administration of the Act.*

(Paragraph 2.2.14.2)

- *Though construction workers were predominantly migrant workers, no special benefits or facilities such as facilitation centres, transit accommodation, labour shed and mobile toilets were provided. This resulted in the needs of migrant works not being addressed.*

(Paragraph 2.2.14.3 (I))

- *NBOCW WB had expended an amount of ₹1.50 crore on purchase of nine vehicles which was in contravention of extant orders.*

(Paragraph 2.2.14.3 (V))

2.2.1 Introduction

With a view to providing welfare facilities to the construction workers of the country, Government of India (GoI) enacted two legislations viz. The Building and Other Construction Workers (Regulation of Employment and Conditions of Service) {BOCW (RECS)} Act, 1996¹ and the Building and Other Construction Workers Welfare Cess Act, 1996. The corresponding Central Rules of the two Acts were notified on 19 November 1998 and 26 March 1998 respectively².

In line with the Central Rules, the Government of Nagaland (GoN) constituted the Nagaland Building and Other Construction Workers' Welfare Board (NBOCW WB) under Section 18 of the BOCW (RECS) Act, 1996. Further, in exercise of the powers conferred under Section 62 and Section 40 of the BOCW (RECS) Act 1996, the GoN framed the Nagaland BOCW (RECS) Rules, 2010. In terms of these rules, the Welfare Board registers building and other construction workers through the Assistant Labour Commissioners (ALCs) of the respective district offices. Registered construction workers and their families are then provided social security through different welfare schemes specially designed for the purpose.

As per Section 3 (1) and 5 (1) of BOCW Welfare Cess Act, 1996 there shall be levied and collected a Cess for the purpose of the Act, at such rate not exceeding two *per cent* but not less than one *per cent* of the cost of construction incurred by an employer, as the Government may from time to time specify. Further, as per Rule 265 of NBOCW (RECS) Rules, 2010 registered construction workers are to pay fees of ₹25 for registration and ₹300 for renewal of registration per year. The amount collected as labour Cess and fees are remitted to a Cess Fund. On receipt of claims under various welfare schemes by registered and active beneficiaries and after establishing authenticity of claims, the approved amount is released out of the Cess fund to the beneficiaries account through Direct Benefit Transfer (DBT) mode. Cess fund is also utilised on administrative matters and on Training and Skilling of construction workers.

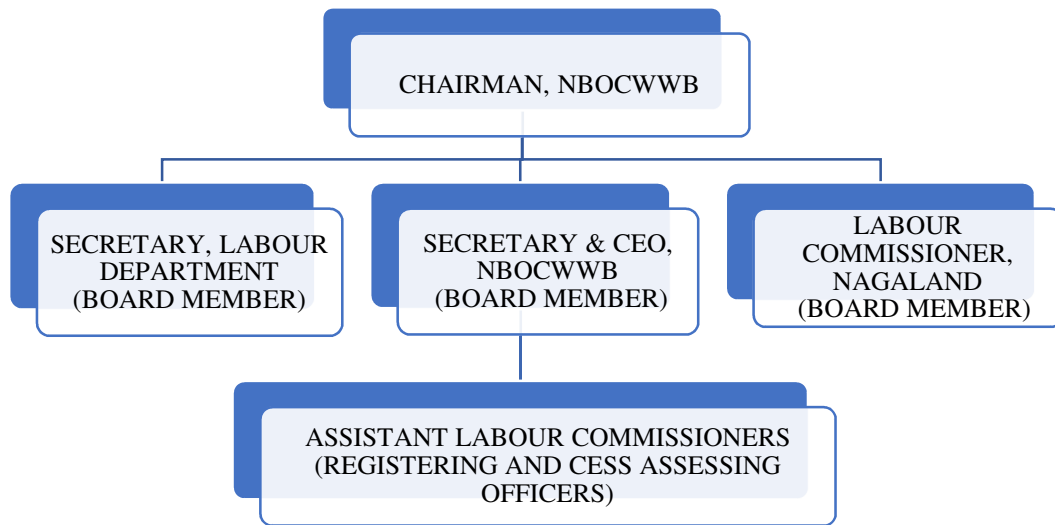
2.2.2 Organisational set up

Structural and functional organisation with regard to Cess fund administration showing interrelation of the Labour Department and NBOCW WB is shown in **Chart 2.2.1**.

¹ With the enactment of the Occupational Safety, Health and Working Conditions Code, 2020, this Act was subsumed under the OSH Code, 2020 *w.e.f.* September 2020. This Code is yet to be enforced in the State of Nagaland.

² The Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Central Rules, 1998 and the Building and Other Construction Workers Welfare Cess Rules, 1998.

Chart 2.2.1



Source: Departmental records

CHAIRMAN: The Chairman is the overall head of the Welfare Board and is responsible for convening meetings of the Welfare Board. All matters relating to implementation of decisions arrived at the Welfare Board meetings are executed only with the approval of the Chairman.

SECRETARY: Secretary of the Labour Department is a member of the Welfare Board. All communications with the Central Government as well as the State Government in relation to the working of the Welfare Board are made through the Secretary of the Department.

LABOUR COMMISSIONER: Labour Commissioner, Nagaland is a member of the Welfare Board and is the link between the Welfare Board and the State Government in matters of working of the Welfare Board. All communications with the administrative head of Labour Department and the subordinate Labour Department offices in the respective districts are made through the Labour Commissioner.

SECRETARY & CEO: Secretary & CEO is responsible for maintaining records of all Board meetings and daily administration of the Board office. He assists the Chairman in all matters of the Board.

ASSISTANT LABOUR COMMISSIONERS: ALCs are notified as registering officer and cess assessing officer and are responsible for all matters relating to registration/renewal of beneficiaries and implementation of various approved schemes in their respective districts. There are 10 ALCs in Nagaland. The manpower distribution and jurisdiction is given in *Appendix 2.2.1*.

2.2.3 Welfare schemes implemented by NBOCWWB

NBOCWWB implements the following schemes for the welfare of construction workers in the State:

- **Tools Grant:** On successful registration of a worker, ₹1,000 as a grant for purchase of tools is credited into the beneficiary's account annually, subject to renewal of registration. Implementation of this scheme commenced in 2011-12. The Tools grant was enhanced to ₹2,000 from 2022-23.
- **Insurance Cover:** Insurance cover is provided to active beneficiaries as follows:

Table 2.2.1: Insurance cover of beneficiaries

Cause	Coverage
Natural Death	₹2,00,000
Accidental Death	₹4,00,000
Total permanent disability	₹2,00,000

Source: Departmental figures

The scheme was initially formulated in line with Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY) and Pradhan Mantri Suraksha Bima Yojana (PMSBY) and was implemented in collaboration with Life Insurance Corporation of India (LICI). However, since 2019-20, NBOCWVB has fully adopted the two schemes and expenditure on the same is borne out of the Cess fund.

- **Medical Assistance:** Financial assistance of ₹1,000 per day for the first five days and ₹500 per day for the next 10 days on continuous hospitalisation is provided to registered beneficiaries, spouse and children as medical assistance. Implementation of this scheme commenced in 2014-15.
- **Children Education Allowance:** Children Education Assistance of ₹500 is provided per month to children of active beneficiaries studying between Nursery to Class X. The assistance is provided to a maximum of two children per beneficiary. Implementation of this scheme commenced in 2015-16.
- **Maternity Benefit for Women Beneficiaries:** Maternity benefit of ₹6,000 is provided to wives of active beneficiaries and registered active women beneficiaries subject to a maximum of two times per beneficiary. Implementation of this scheme commenced in 2015-16.
- **Skill Training for Building and Other Construction Workers:** The Welfare Board conducts trainings through Training Partners (TPs) as per approval of the Welfare Board. Training on Soft and Hard skills are provided to the selected trainees.

2.2.4 Audit objectives

The Performance Audit (PA) was conducted to ascertain whether:

- there was effective system for registration of establishments and beneficiaries;
- cess assessment, cess collection and transfer of collected cess to the fund was efficient;

- the Government prescribed appropriate health and safety norms and could ensure an environment of compliance to those norms by the employer;
- the Government implemented transparent and effective system of inspections to check evasion of Labour Cess and compliance to health and safety norms by Employers; and
- administration and utilisation of fund on implementation of welfare scheme by the Board was efficient and effective and as per Act and rules framed for the purpose.

2.2.5 Audit Criteria

The Audit findings have been benchmarked against the following criteria:

- BOCW (RECS) Act, 1996 and BOCW (RECS) Central Rules, 1998;
- Building and Other Construction Workers Welfare Cess Act, 1996 and Building and Other Construction Workers Welfare Cess Rules, 1998;
- Nagaland Building and Other Construction Workers (RECS) Rules, 2010;
- General Financial Rules, 2017;
- Receipt & Payment Rules, 1983;
- Provisions of Model Welfare Scheme and Modified Model Welfare Scheme issued by Ministry of Labour & Employment, Government of India (GoI); and
- Orders, Notifications and instructions of GoI and State Government.

2.2.6 Audit Methodology

The Performance Audit commenced with an Entry Conference (19 October 2022) with the Chairman, NBOCWWB, Nagaland wherein audit objectives, scope and criteria were discussed. The audit methodology included requisition of records, issue of questionnaires, examination of records and conduct of survey of construction workers at selected worksites, survey of registered beneficiaries (including Telephonic survey) who are registered through offices of the ALC, Kohima and Dimapur. Audit also conducted Joint Physical Verification (JPV) of two training centres³. The Report was prepared after incorporating replies submitted by the Department. The findings of audit were discussed in the Exit Conference (22 June 2023) with the Commissioner & Secretary to the Government of Nagaland, Labour & Employment. The replies received from the State Government are duly incorporated in this report in appropriate places.

³ Global Peers Skilling and Development Initiatives Pvt. Ltd. Dimapur and Zynorique Initiatives Society, Kohima

2.2.7 Audit Scope

The Performance Audit was conducted for the period from 2017-18 to 2022-23 with special emphasis on receipt of Cess fund and utilisation of it on various welfare schemes for registered construction workers.

Audit commenced with checking of records at the Office of Labour Commissioner, Nagaland, Kohima⁴ and the Office of NBOCW⁵. Two⁶ out of 12 districts (17 per cent) in Nagaland were selected for detailed audit, based on judgemental sampling, wherein the records of the Offices of ALC, Kohima and ALC, Dimapur were test checked. Survey of 169 registered beneficiaries⁷ and 69 workers in four work sites were conducted in these two selected districts. Three works divisions⁸ were selected for Audit, based on the volume of expenditure to assess the level of compliance with regard to the existing Rules and Instructions on labour cess and collection thereof in the State. To assess the compliance on registration matters and deduction and deposit of labour cess, information was collected from the offices of Directorate of Urban Development, Kohima Smart City Development Limited and Directorate of Municipal Affairs.

2.2.8 Receipt and expenditure of labour cess fund and beneficiaries

Table 2.2.2: Receipt and expenditure of labour cess fund

(₹ in lakh)

Year	Opening Balance	Receipt	Interest Generated	Total	Utilisation			Closing Balance
					Cess expenditure	Administrative expenditure	Total	
(1)	(2)	(3)	(4)	(5 = 2+3+4)	(6)	(7)	(8 = 6+7)	(9 = 5-8)
2017-18	2,539.44	1,216.48	83.53	3,839.45	756.47	25.31	781.78	3,057.67
2018-19	3,057.67	1,622.73	0.00	4,680.39	945.77	37.82	983.59	3,696.81
2019-20	3,696.81	2,346.44	0.00	6,043.25	1,151.10	47.29	1,198.39	4,844.86
2020-21	4,844.86	3,139.42	355.43	8,339.71	1,854.02	57.56	1,911.58	6,428.13
2021-22	6,428.13	3,831.70	0.00	10,259.83	2,387.19	94.92	2,482.11	7,777.72
2022-23	7,777.72	4,312.42	299.53	12,389.67	9,269.20	118.14	9,387.34	3,002.33

Source: Department figures

Table 2.2.3: Receipt and Expenditure of Beneficiary Account

(₹ in lakh)

Year	Opening Balance	Receipt	Interest Generated	Total	Utilisation	Closing Balance
(1)	(2)	(3)	(4)	(5 = 2+3+4)	(6)	(7 = 5-6)
2017-18	32.62	12.77	0.00	45.39	0.00	45.39
2018-19	45.39	36.74	0.00	82.13	8.51	73.62
2019-20	73.62	32.58	0.00	106.20	9.06	97.14
2020-21	97.14	24.94	0.00	122.08	8.39	113.69
2021-22	113.69	53.74	0.00	167.43	7.43	160.00
2022-23	160.00	56.52	0.00	216.52	166.66	49.86

Source: Departmental figures

⁴ For the period of accounts April 2021 to March 2023

⁵ For the period of accounts April 2017 to March 2023

⁶ Kohima and Dimapur

⁷ Kohima District: 90 out of 9,751 beneficiaries and Dimapur District: 79 out of 5,133 beneficiaries

⁸ Executive Engineer, CAWD Kohima, Executive Engineer, PWD (R&B) Dimapur Division and Executive Engineer, Police Engineering Project, Chümoukedima

Table 2.2.4: Utilisation of fund on various welfare schemes

(₹ in lakh)

Year	Tools Grant	Educational Scholarship	Medical Assistance	Maternity Benefit	Insurance (Claim on Death & Injury)	Year Total
2017-18	29.32	224.53	16.06	16.37	0.00	286.28
2018-19	71.55	636.05	9.52	11.60	0.00	728.72
2019-20	46.40	676.50	7.42	3.11	0.00	733.43
2020-21	22.33	1,081.02	3.12	2.47	0.00	1,108.94
2021-22	0.00	1,132.32	7.12	6.90	100.00	1,246.34
2022-23	353.34	1,343.10	5.16	7.38	98.00	1,806.98
Total	522.94	5,093.52	48.40	47.83	198.00	5,910.69

Source: Departmental figures

Table 2.2.5: Number of beneficiaries who had availed various welfare schemes

(In numbers)

Year	Tool Grant	Educational Scholarship	Medical Assistance	Maternity Benefit	Insurance (Claim on Death & Injury)	Year Total
2017-18	2,932	6,183	282	237	0	9,634
2018-19	7,385	7,126	162	156	0	14,829
2019-20	4,640	6,915	113	41	0	11,709
2020-21	2,233	11,807	31	31	0	14,102
2021-22	0	5,956	109	115	50	6,230
2022-23	17,681	13,539	90	123	49	31,482
Total	34,871	51,526	787	703	99	87,986

Source: Departmental figures

2.2.9 Acknowledgement

Audit acknowledges the assistance and cooperation extended by the Office of Nagaland Building & Other Construction Workers Welfare Board and Labour Department during the course of this audit.

Audit Findings

The findings of audit are discussed in the succeeding paragraphs:

2.2.10 System for registration of Beneficiaries and Establishments

In Nagaland, the local construction workers do not work under any defined employer but are driven by daily availability of work in their own locality or village. The dynamic nature of their employment makes it difficult for their identification by the Welfare Board. Town and village authorities were therefore authorised for identification and certification of beneficiaries to facilitate their registration. However, as this arrangement did not stand the test of reliability, it was aborted and an online registration system was incorporated in the existing portal. This system enabled the Welfare Board to conduct live registration from the identified worksites. Details of District wise registered beneficiaries and labour force are shown in **Tables 2.2.6 and 2.2.7.**

Table 2.2.6: District-wise number of registered beneficiaries as of March 2023

Sl. No.	Name of District	No. of Registered Beneficiaries
1.	Dimapur	5,133
2.	Kiphire	913
3.	Kohima	9,751
4.	Longleng	790
5.	Mokokchung	4,344
6.	Mon	4,632
7.	Noklak	0
8.	Peren	829
9.	Phek	2,987
10.	Tuensang	3,058
11.	Wokha	1,367
12.	Zunheboto	1,276
Total		35,080

Source: Departmental records

Table 2.2.7: Information on Labour Force in Nagaland for the year 2022-23

Sl. No.	Particular	Workers (in numbers)
1.	Number of Building and Other Construction Workers in Nagaland	35,080
2.	Number of Migrant Workers in Nagaland	15,527

Source: Department of Economics & Statistics, Government of Nagaland

Audit observations relating to the registration of Establishments and Beneficiaries are discussed in the succeeding paragraphs.

2.2.10.1 Registration of Beneficiaries

(I) Non-availability of effective mechanism for registration of workers

As per Section 12 (1) of BOCW (RECS) Act, 1996, every building worker who has completed 18 years of age, but has not completed 60 years of age shall be eligible for registration as a beneficiary under the Act. Further, the Model Welfare Scheme for Building and Other Construction Workers stressed on the importance of giving special attention in facilitating the migrant workers to register under the Act. Audit observed that till March 2023, 35,080 workers were registered with the Welfare Board. However, in the absence of a mechanism to ensure that all workers are registered, Audit cannot ascertain the status of registration. Audit also observed that there was no effective mechanism to facilitate or make aware, the migrant labourers to register with the Welfare Board. Audit further observed that there were 9,751 and 5,133 registered workers under Kohima and Dimapur districts respectively. However, a sample survey of 69 construction workers, of which 66 (96 per cent) are migrant workers, conducted at their worksite in Kohima and Dimapur revealed that none of them were registered as beneficiary under NBOCWFB.

In reply (July 2023), the Department stated that awareness programmes at identified locations were organised from time to time targeted at the migrant construction workers but in most cases, the workers do not possess required documents and are not keen to get registered due to the temporary nature of residence in the State. The Department further stated that absence of appropriate manpower in the Department was the major reason for not being able to establish an effective mechanism to ensure registration of workers. It was also stated that the outsourced registration process was

suspended since many non-workers were found to be registered through the outsourced process. The reply of the Department is indicative of the fact that there is no effective mechanism to register all the building and other construction workers with the Welfare Board.

(II) Registration and Renewal without proof of status

As per Rule 265 (1) and (2) of NBOCW (RECS) Rule 2010, an application for registration or renewal as a beneficiary shall be accompanied by proof of status as a building worker from the employer or contractor for whom the applicant has been working and proof of the beneficiary having been engaged in any building or other construction work for not less than ninety days during the preceding twelve months. Audit observed that registration of beneficiaries and renewal of registration were accorded without the requisite certification of the applicant being under the employment of a registered establishment or the beneficiary having been engaged in any building or other construction work for not less than ninety days during the preceding twelve months. The Department in reply (July 2023) stated that the beneficiaries were mostly self-employed local indigenous workers whose employment in construction sector are seasonal in nature and are mostly unorganised daily wage construction workers who do not work under a defined employer. The reply of the Department is not acceptable since the workers would need to be registered only after obtaining requisite documents as per NBOCW Rule, 2010.

(III) Non-renewal of membership

As per Rule 267 (3) of NBOCW (RECS) Rule 2010, if a beneficiary commits default in payment of contribution for a period of one year, he shall cease to be a beneficiary. Audit observed cases of default in timely renewal of membership by beneficiaries. As at the end of 2022-23, 2,892 beneficiaries remained inactive on account of non-renewal of membership.

Audit observed that the non-renewal of membership may be attributed to ineffective initiative by the Department in enforcing the provisions for registration of beneficiaries through the system of inspection. Consequently, genuine and eligible construction workers could not enjoy the benefits of registering with the Welfare Board. The Department accepted (July 2023) the observation and stated that the renewal process was affected due to limited access for renewal of membership in the designated registration counter at ALC Offices in respective districts. The Department further stated that it has now introduced an online renewal platform to enable the workers in accessing renewal of membership facility from the comfort of their workplace.

Recommendation: The Department may ensure that procedures relating to registration and renewal of registration of construction workers are adhered to.

2.2.10.2 Registration of establishments

(I) Non registration of Establishments

Section 7 of BOCW (RECS) Act, 1996 read with Rule 23 to 27 of NBOCW (RECS) Rule, 2010 states that every employer in relation to an establishment shall, within a period of sixty days from such commencement, make an application to the registering officer for the registration of such establishment and every application shall be accompanied by a demand draft showing payment of the fees for the registration of the establishment. Audit observed that no establishment was registered and consequently no fees were collected on registration. Audit also observed that there was no established mechanism to ensure that buildings or construction works get registered as an establishment. While accepting (July 2023) the observation, the Department stated that a few establishments were registered during the initial period of enforcement of the Act but that the process was discontinued due to the non-cooperation and stiff resistance from the employers of such establishments. The Department also stated that it will propose to the State Government for exploring the possibility of notifying the compulsory requirement for inclusion of registration number and certificate provided by the Labour Department in all contracts/tender applications.

(II) Non submission of Monthly Returns

Rule 268 and 269 of NBOCW (RECS) Rule 2010 states that every employer in relation to an establishment shall, within thirty days from such commencement, send to the Secretary, Welfare Board, containing particulars of building workers employed in the establishment and also submit a monthly return showing details of building workers employed by him and of the contribution deducted from their wages and remitted to the Board. A register containing such information is also to be maintained in Form XXXV of NBOCW (RECS) Rules 2010. As no establishment has been registered, the information on number of workers employed by an establishment and submission of monthly returns was not available.

(III) Non-intimation of required information to the registering officer

As per Rule 24 (3) and 26 (2) of NBOCW (RECS) Rule 2010, the employer shall intimate the registering officer in the event of any change in ownership of management or in the number of workmen or conditions of work. Audit observed that there was no record regarding intimation to the registering officer of change in ownership or management of the establishments. Audit further observed that mechanism for maintaining these records was not established.

Audit observed that the reason for the above deficiency is that the compliance to the statutory requirements were left solely to the owners of establishments and construction works without any proactive initiative by the Department to enforce the same through inspection. As a result, extant Acts and Rules, including non-collection of registration fee of establishments and of penalties in cases of non-compliance, were not observed affecting the welfare of the construction workers.

Recommendations:

The Department may-

- (i) *establish a mechanism to ensure that the Welfare Board strictly observes applicable Acts and Rules relating to the registration of establishments.*
- (ii) *ensure that registration as an establishment with the Board be made a prerequisite for Contractors and agencies for award of Work Orders.*

2.2.11 Cess assessment and collection

Audit observations relating to the assessment and collection of Cess are as follows:

(I) Assessment of Cess not made

As per Section 3 (1) and 5 (1) of BOCW Welfare Act, 1996 there shall be levied and collected a Cess for the purpose of the Act, at such rate not exceeding two *per cent* but not less than one *per cent* of the cost of construction incurred by an employer, as the Government may by from time to time specify. The Government of Nagaland notified⁹ levy and collection of cess at one *per cent* of the cost of construction incurred by an employer. The officer or authority to whom such return has been furnished under Section 4 shall, after making or causing to be made such inquiry as he thinks fit and after satisfying himself that the particulars stated in the return are correct, by order, assess the amount of Cess payable by the employer. Audit, however, observed that independent assessment of Cess by Inspectors through inspection of work sites/establishments was not undertaken by the Department. As a result, the Department was not able to independently identify employers of construction workers who are liable to pay Cess or to assess the Cess payable. Thus, assessment was not made by the Board for the actual cess payable.

(II) Delay in remittance of Cess

As per Section 4 (1) of BOCW Welfare Cess Rules, 1998, the Cess levied and collected shall be transferred to the Board within thirty days of collection. Audit observed that during December 2018 to September 2022, the office of the Kohima Smart City Development Ltd, deducted Cess amounting to ₹64.07 lakh from contractor's bill but delayed remitting the amount to the account of NBOCW, by 01 to 45 months. Similarly, the Engineering Wing of Urban Development Department, Kohima, delayed the remittance of Cess amounting to ₹73.23 lakh collected during 2019-2020 to 2021-2022 into the designated account for a period ranging from 01 to 12 months. Audit test check of Accounts of three¹⁰ Divisional offices also revealed that Cess amounting to ₹55.09 lakh for the year 2020-21 and ₹75.54 lakh for the year 2021-22 remained unremitted at the end of the respective years.

⁹ *Vide.* Notification No. LAB/ACT-6/1996 (Pt) Dated: 06 August 2011.

¹⁰ PWD (R&B) Dimapur Division, PWD (R&B) Pfuetero Division and Medical Engineering Division, Kohima.

(III) Filing of return on Cess and Monitoring of Compliance

As per Section 4 (2) and 8 of BOCW Welfare Cess Act, 1996, if any person liable to pay Cess, fails to file any return, the officer or the authority shall give a notice requiring such person to furnish such return before such date as may be specified in the notice. If any employer fails to pay any amount of Cess payable under Section 3, such employer shall be liable to pay interest on the amount to be paid at the rate of two *per cent* for every month. Audit observed that since no exercise was undertaken by the Department to identify buildings under construction or other construction works, the Department was not able to identify the employer of construction workers and thus to issue notice for filing of return and to impose a penalty for failure to pay Cess.

Audit observed that the reason for the above anomalies is the lack of an effective mechanism in the Department to enforce the provisions of the Act relating to assessment, collection and remittances of Cess. While accepting the observation, the Department stated (July 2023) that one of the major reasons for the shortcomings is the absence of appropriate manpower in the respective districts but assured that necessary corrective measures will be initiated to minimise such shortcomings.

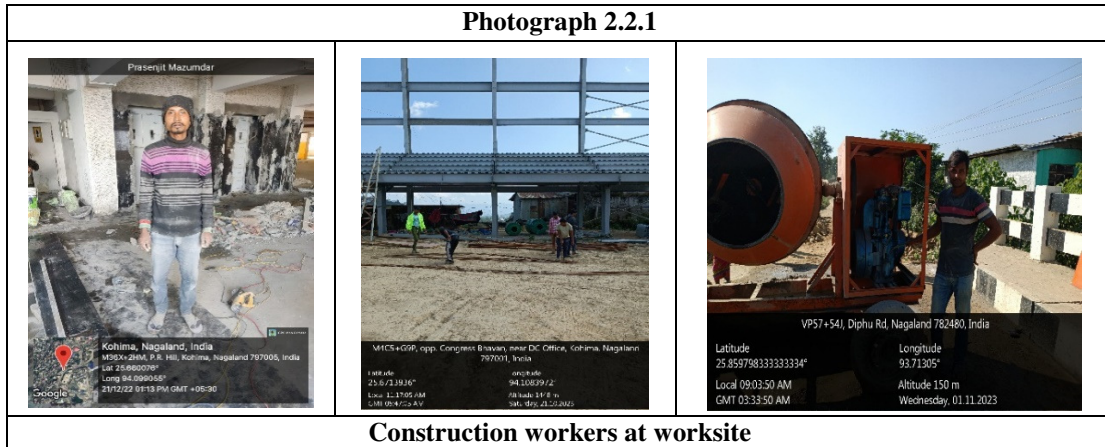
Recommendations:

The Department may-

- (i) ensure that inspection of work sites/establishments is conducted by notified officials to assess Cess payable and to ensure that Cess collected is remitted within the prescribed timeframe.***
- (ii) initiate measures to take suitable action against DDOs defaulting in transferring the collected Cess amount in time.***

2.2.12 Safety and Health Measures

Section 39 and 40 of the BOCW (RECS) Act, 1996 and Chapter VI to XXIV of BOCW (RECS) Central Rules, 1998 lay down provisions on safety and health norms to be maintained and provided to BOC workers. In line with this, the Government of Nagaland, Department of Labour also incorporated provisions on Safety and Health Measures under Chapter VI to Chapter XXIV in the NBOCW (RECS) Rules, 2010. The safety provisions under these Rules include precaution to be taken while demolishing a building; handling of explosives; suitable lighting of workplace; safe handling of tools and equipment; precaution to be taken in case of fire; safe transport of workers; keeping of safety nets; formulation of safety policy by employers and contractors and provision of medical facilities. Audit observed instances where the safety and health of BOC workers were compromised as the precautions and facilities guaranteed under the Act were not provided.



Audit further observed that the Department did not undertake regular assessment of conditions of worksites through inspections to ensure that statutory safeguards were in place with respect to the BOC workers. The Department accepted (July 2023) the observation and stated that it will re-evaluate its activities to minimise such shortcomings.

Recommendation: The Department may ensure that health and safety provisions as provided for in the Acts and Rules are strictly enforced.

2.2.13 System of Inspections

Audit observations on the system of inspection to check evasion of Labour Cess and compliance to health and safety norms by employers are as follows:

2.2.13.1 Function of Chief Inspector and Inspectors

Section 42 of BOCW (RECS) Act, 1996 provide for appointment of Chief Inspector and Inspectors for effectively carrying out the provisions of this Act and assigning to them such local limits as it may think fit. Further, Sections 43, 47 to 50 of BOCW (RECS) Act, 1996, Rule 251 of BOCW (RECS) Central Rules, 1998 lay down provisions regarding Powers of Inspectors and Penalties and Procedure for offences. The functions and powers of Assessing officers and Labour Inspectors include assessment of Cess returns and independent assessment of Cess payable, collection of Cess, inspection of buildings, construction sites and construction workers, search and seizure of registers, documents and requiring furnishing of information by any person applicable under this Act, registration of beneficiaries and establishments, imposing of penalty for contravention of provisions regarding safety measures under Section 40 of BOCW (RECS) Act, 1996 and imposing of penalty for non-payment of cess and for obstructing an inspector in the discharge of its duties.

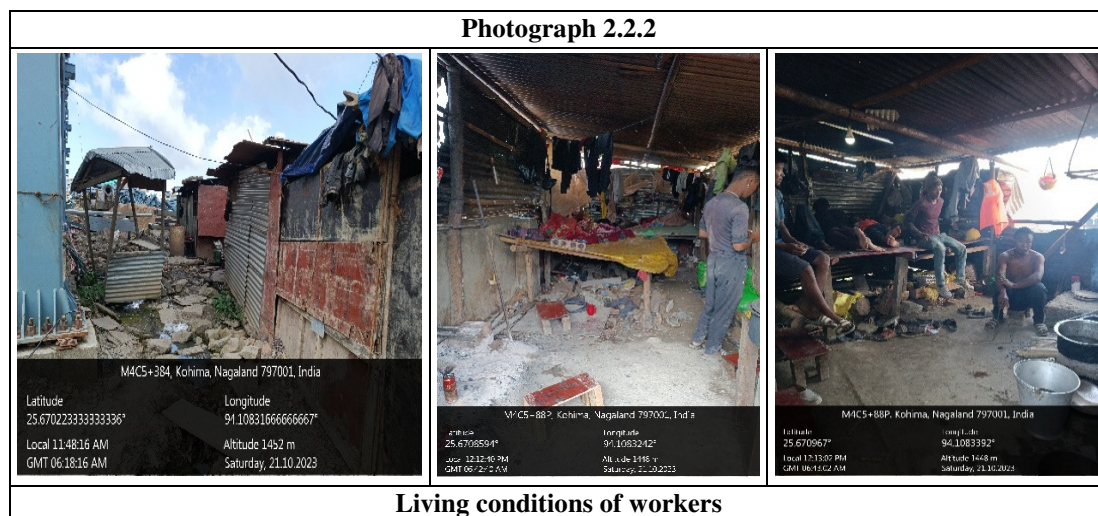
Audit observed that the GoN appointed Joint Labour Commissioner, Department of Labour as Chief Inspector of Inspection of Building and other construction works. Assistant Labour Commissioners and Labour Inspectors were also notified as Inspectors for the purpose of this Act and jurisdictional area defined. Audit, however, observed that inspections of building or other construction works were not carried out which resulted in absence of registration of establishments, non-registration of

trainees at training centres and construction workers at worksites surveyed and complete absence of filing of cess returns and assessment of cess as discussed in **Paragraphs 2.2.10.1 and 2.2.10.2** and in assessment and collection of Cess as discussed in **Paragraph 2.2.11**. The Department accepted (July 2023) the observation and stated that it will re-evaluate its activities to minimise such shortcomings.

Recommendation: *The Department may ensure that offices of the Chief Inspector and Inspectors are sufficient and utilised to the optimum so as to ensure that the system of inspections provided under the BOCW Act are carried out effectively and efficiently.*

2.2.13.2 Inspection of conditions of service

Section 28 to 37 of BOCW (RECS) Act, 1996 lay down conditions relating to working hours, welfare measures and other conditions of service of building workers such as drinking water, latrines, urinals, accommodation and canteen. Further, Section 45 and 46 of BOCW (RECS) Act, 1996 read with Rule 248 and 249 of BOCW (RECS) Central Rules, 1998 provide for responsibility of employers for compliance with the provisions relating to payment of wages and compensation and notice of commencement of building or other construction works. Audit observed that there was no system in place or inspections conducted to determine whether basic facilities such as drinking water, latrines, urinals, accommodation and canteen were provided to the BOC workers.



Similarly, there was no system in place or inspection carried out to ensure that employers provide basic conditions of work relating to working hours, wages and compensation to the BOC workers. As a result, the possibility that BOC workers were denied certain minimum standard of working conditions and facilities cannot be ruled out. The Department accepted (July 2023) the observation and stated that it will re-evaluate its activities to minimise such shortcomings.

Recommendation: *The Department may ensure an effective system of inspections to ensure that provisions relating to working hours, payment of wages, compensation and welfare measures are adhered to.*

2.2.13.3 Non-imposition of penalties

Section 47 to 50 of BOCW (RECS) Act, 1996 provides for imposition of penalties on account of contravention of provisions on safety and health measures, failure to give notice of commencement of building or other construction work, for obstructions caused to an Inspector in the discharge of his duties and violation of other provisions under this Act. As mentioned in **Paragraphs 2.2.13.1** and **2.2.13.2**, inspection was not conducted. As a result, the Department could not detect cases of non-compliance to safety and health measures, failure to give notice of commencement of building or other construction work and for violation of the other provisions of the Act. Audit also observed that provisions on safety and health measures were compromised. Even as inspections were not conducted, no penalties were imposed. The Department accepted (July 2023) the observation and stated that it will re-evaluate its activities to minimise such shortcomings.



2.2.14 Administration and implementation of welfare scheme

Audit observations on administration and utilisation of funds on implementation of welfare scheme are as follows:

2.2.14.1 Functioning of the Welfare Board

(I) Budget

Section 25 of BOCW (RECS) Act, 1996 provides that the Board shall prepare in such form and at such time, its budget for the next financial year, showing the estimated receipts and expenditure of the Board and forward the same to the State Government. Audit observed that during the period of audit (2017-18 to 2022-23), the budget was not prepared and forwarded to the State Government. The Department in reply (July 2023) stated that as the budgetary requirement is directly linked with the claims settlement of beneficiaries under various welfare schemes, a definite budget was never prepared by the Welfare Board in the past. The Department, however, assured that the Welfare Board will prepare an annual budget from the current year.

(II) Annual Report

Section 26 of BOCW (RECS) Act, 1996 mandates preparation in such form and at such time each financial year, its annual report, giving a full account of its activities during the previous financial year and submit a copy thereof to the State Government. Audit observed that the Annual Report was not prepared and submitted to the State Government. The Department accepted (July 2023) the observation and stated that the Welfare Board will prepare its cumulative annual report including the financial year 2023-24 and submit to the State Government henceforth.

(III) Annual Account

As per Section 27 of BOCW (RECS) Act 1996, the Board shall maintain proper accounts and other relevant records and prepare an annual statement of accounts in such form as may be prescribed. The Board shall furnish to the State Government before such date as may be prescribed, its audited copy of accounts together with the auditor's report. This shall then be laid before the State Legislature. Audit observed that during the period of audit (2017-18 to 2022-23), Annual statement of accounts was not prepared and furnished to the State Government for laying before the State Legislature. The Department accepted (July 2023) the observation and stated that the Welfare Board will prepare its cumulative annual statement of accounts including the financial year 2023-24 and submit to the State Government for laying before the State Legislature.

(IV) Human Resource Management

Section 19 of BOCW (RECS) Act, 1996 *inter alia* states that the Welfare Board shall appoint such officers and employees as it considers necessary for the efficient discharge of its functions and the terms and conditions of appointment of such officers and employees shall be such as may be prescribed. Audit, however, observed that the assessment of staff requirement for efficient functioning of the Welfare Board has not been made and that Service Rules have not been formulated. The Department accepted (July 2023) the observation and stated that drafting of Service Rules is almost nearing completion which will be forwarded to the Government for approval.

Recommendation: The Department may ensure that budget, annual reports and accounts are prepared and that a viable Human Resource Management policy is adopted.

2.2.14.2 State Advisory Committee

In accordance with Section 4 of BOCW (RECS) Act, 1996 and Rule 10 of NBOCW (RECS) Rule 2010, a State Advisory Committee (SAC) is to be constituted with members consisting of a Chairperson, two members of State Legislature, a member to be nominated by the Central Government, the Chief Inspector of Inspection, nominees of State Government representing the employers, building workers, associations of architects, engineers and insurance institutions. The main function of the Committee is to advise the State Government on such matters arising out of the administration of the Act and other interests. Audit observed that while the SAC was constituted for the period February 2018 to February 2021, no meeting of the SAC was held during this

period. Further, though the term of SAC had expired, a new SAC was yet to be reconstituted. As a result, the State Government and the Welfare Board were deprived of the benefit of advice and guidance on matters arising out of the administration of the Act. Reasons for not holding a meeting and for not constituting a new SAC were neither stated nor available on record. The Department accepted (July 2023) the observation and stated that the proposal has been submitted for re-constitution of SAC and efforts have been made by the Department for convening the SAC meeting.

Recommendation: *The State Government may constitute a functional State Advisory Committee at the earliest as envisaged in the Act.*

2.2.14.3 Compliance to the Model Welfare Scheme

In compliance to a Supreme Court order, the Ministry of Labour & Employment formulated the Modified Model Welfare Scheme for the welfare of construction workers. As per the Modified Model Welfare Scheme:

- i) The State Welfare Board may cover BOC workers under PMJJBY (Pradhan Mantri Jeevan Jyoti Bima Yojana) and PMSBY (Pradhan Mantri Suraksha Bima Yojana) by contributing 50 *per cent* of the total annual premium of ₹342 *i.e.*, ₹171 per worker per annum as the remaining 50 *per cent* will be borne by the Central Government under the converged PMJJBY/PMSBY Schemes. These schemes provide coverage of ₹two lakh in case of natural death and ₹four lakh in case of accidental deaths.
- ii) Paid maternity leave to registered construction workers ranging from 90 days to 26 weeks for up to two deliveries.
- iii) In order to mitigate the hardship that a BOC worker faces, the States are advised to take proactive steps to facilitate transit accommodation/labour shed cum night shelter, mobile toilets and mobile crèches to BOC workers in the areas of their concentration prior to their finding work.
- iv) Skill development trainings may be provided to the registered workers and their dependents.

Further, the Ministry of Labour & Employment Order (June 2016) issued under Section 60 of BOCW Act, 1996 directed not to spend the cess fund for any purpose other than for welfare of BOC workers and their family exclusively.

Audit observation relating to compliance to the Modified Model Welfare Scheme and Ministry's order are as follows:

(I) Amenities not provided

Paragraph 4 (A) & (B) of Model Welfare Scheme *inter alia* lays down provision for providing amenities such as transit shelters, labour sheds and toilets in areas of concentration of migrant workers. Audit observed that though the construction workers were predominantly migrant workers, no special benefits or facilities such as facilitation centres, transit accommodation, labour sheds, and mobile toilets were provided. This resulted in the needs of migrant workers who often face challenges

such as temporary housing, sanitation and access to information and services, not being addressed. In reply, the Department stated (July 2023) that the migrant construction workers do not concentrate in large number in a particular area thereby requiring such facilities. It was also stated that the facilities will be provided if such requirement exists in the future. The reply of the Department is not acceptable since it did not take proactive measures to identify locations where amenities were needed for migrant workers. Further, as the facilities are of a temporary/mobile nature, they should have been provided.

(II) Unmonitored provision of Paid Maternity leave

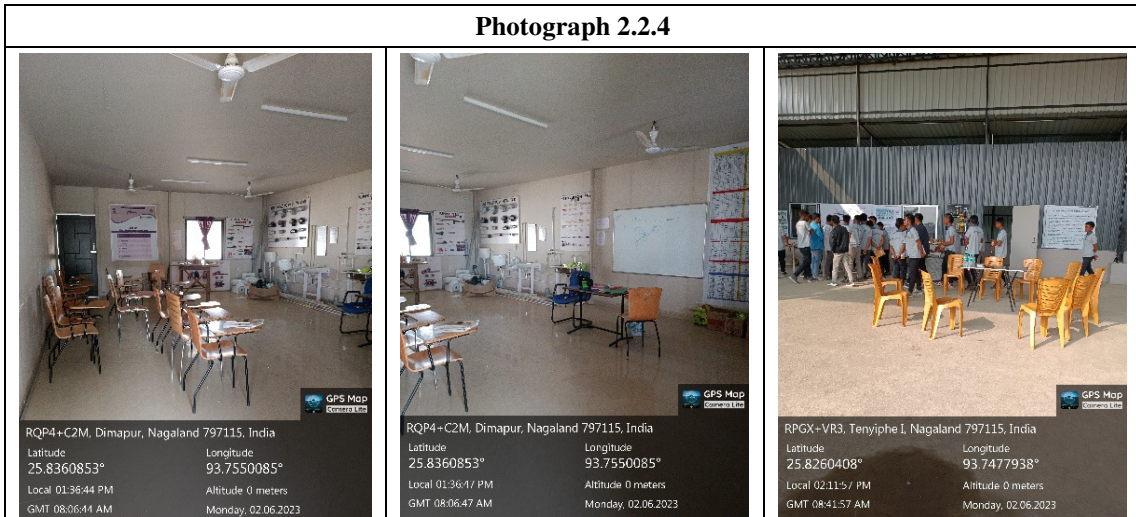
Paragraph 2.2 (ii) of the Model Welfare Scheme provides for paid maternity leave to registered construction workers ranging from 90 days to 26 weeks for up-to two deliveries. Audit, however, observed that no monitoring mechanism was in place to ensure that benefit of paid maternity leave was provided to eligible BOC workers by the employers. Out of 141 construction workers¹¹ surveyed, none of them were aware of the provisions of paid maternity leave. The Department accepted (July 2023) that monitoring of paid maternity leave of 90 days to 26 weeks was not done.

(III) Training on Skill Development not imparted to beneficiaries

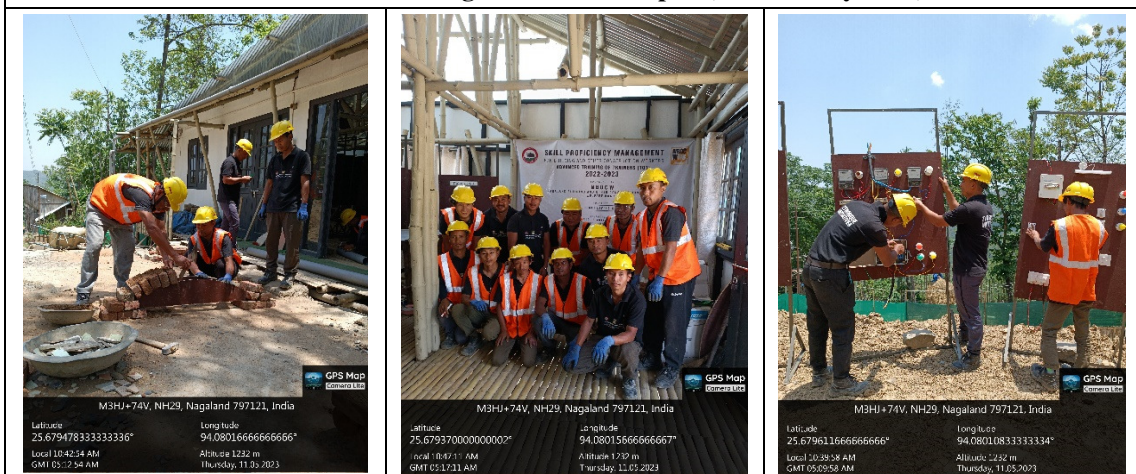
Paragraph 5 of the Modified Model Welfare Scheme provides for imparting of training on skill development to the BOC workers and their dependents so as to help them upgrade their skills or diversify by acquiring new set of skills. Audit observed that Skill Development Training was imparted by Training Partners (TPs) engaged and funded by the Board. Audit, however, also observed that the selection of trainees was done by the TPs, however there were instances of trainees not being from among the registered construction workers. Sample survey of trainees revealed that the trainees were un-registered. Further, sample survey of registered beneficiaries selected from the offices of ALC Kohima and ALC Dimapur and of construction workers (69 workers) at worksite revealed that none were imparted any training on Skill Development. While accepting (July 2023) the observation, the Department stated that unregistered workers were also trained and registered on completion of training. The Department also assured to train more registered beneficiaries.

¹¹ Dimapur: 34 construction workers and Kohima: 107 Construction workers

Photograph 2.2.4



Trainees at a Training Centre in Dimapur (06 February 2023)



Trainees at a Training Centre at Kohima (11 May 2023)

(IV) Insurance under PMJJBY and PMSBY

As per Paragraphs 1.1 and 1.2 of life and disability cover under Modified Model Welfare Scheme, the State Welfare Board may cover BOC workers under Health Insurance Policies such as PMJJBY and PMSBY, by making 50 per cent of the total contribution of premium as the remaining 50 per cent will be borne by the Central Government. Audit, however, observed that on account of absence of insurance cover with Life Insurance Corporation of India (LIC), the entire death claim (100 per cent Insurance Cover) amounting to ₹two crore was borne by the Board. The Department in reply (July 2023) stated that initially the insurance policy under PMJJBY and PMSBY for all registered beneficiaries was linked through LIC with a premium sharing of 50:50. However, due to functional problems caused by non-accessibility of LIC, Jorhat, Assam, the Welfare Board decided to implement its own life insurance scheme without linking with LIC. It was further stated that in this arrangement, no premium is paid to LIC, thus saving expenditure from the Cess fund of the Welfare Board. Reply of the Department should be seen in the light of the fact that the Welfare Board had paid for 100 death claims amounting to ₹two crore directly out of the welfare fund and not through the insurance claims.

(V) Inadmissible expenditure of Cess fund

In exercise of Section 60 of BOCW (RECS) Act 1996 and Section 123 of OSH Code, 2020, GoI issued Order not to spend the Cess fund on any purpose other than for the welfare of BOC workers and their family. Audit, however, observed that the NBOCWBB had expended an amount of ₹1.50 crore on purchase of nine vehicles which was in contravention to extant orders. The Department accepted (July 2023) the observation and stated that due to insufficient balance in the administrative account of the Board, ₹92.18 lakh was temporarily incurred from the Cess account and the amount was recouped in May 2023. However, there is no provision in the Act for expenditure towards procurement of vehicles from the administrative expenses.

Recommendations:

The State Government may-

- (i) ensure effective implementation of the provisions and instructions stipulated in the Modified Model Welfare Scheme.***
- (ii) fix responsibility on the officials concerned for using the Cess fund to procure vehicles in violation of the Government order mandating its exclusive use for the welfare of BOC workers and their families.***

2.2.15 Conclusion

The Performance Audit was conducted with a view to assessing the efficiency and effectiveness in the system for registration of beneficiaries and establishments, Cess assessment and collection, system of inspections to check evasion of Labour Cess and of compliance to health and safety norms by employers. Audit observed shortcomings in registration and renewal of beneficiaries, as well as registration of establishments. System for assessment and collection of Cess was also absent. Inspection to ensure compliance to health and safety norms by employers and to the other statutory provisions was not conducted and no penalties were imposed. Budget, Annual Accounts and Annual Plans were not prepared. The State Advisory Council which was meant for advising the State Government on matters arising out of the administration of the Act did not hold meetings for a significant period. There was ineffective implementation of the Modified Model Welfare Scheme. There were also no special benefits or facilities for the predominantly migrant construction workers. As a result of these shortcomings, a vulnerable section of society was not extended the legitimate facilities and benefits putting at risk their wellbeing.

2.2.16 Recommendations

The State Government may-

- (i) ensure that userfriendly procedures relating to registration and renewal of registration of construction workers are adhered to.***
- (ii) ensure that registration as an establishment with the Board be made a prerequisite for contractors and agencies for initiation of work and award of work orders.***

- (iii) *ensure that inspection of work sites/establishments is conducted by notified officials to assess Cess payable and to ensure that Cess collected is remitted within prescribed timeframe.*
- (iv) *initiate measures to take suitable action against DDO's defaulting in transferring the collected Cess amount in time.*
- (v) *ensure that health and safety provisions as provided in the Acts and Rules are strictly enforced.*
- (vi) *ensure that budget, annual reports and accounts are prepared and that a viable Human Resource Management policy is adopted.*
- (vii) *constitute a functional State Advisory Committee at the earliest as envisaged in the Act.*
- (viii) *ensure effective implementation of the provisions and instructions stipulated in the Modified Model Welfare Scheme.*
- (ix) *fix responsibility on the officials concerned for using the Cess fund to procure vehicles in violation of the Government order mandating its exclusive use for the welfare of BOC workers and their families.*

Subject Specific Compliance Audits

HEALTH AND FAMILY WELFARE DEPARTMENT

2.3 Public Health Infrastructure and Management of Primary Health Services

2.3.1 Introduction

Health in its widest definition means the total well-being of a person-physical, mental, social and spiritual. It is a basic human right that every individual of all societies deserves. National Health Policy 2017 aims to improve overall population health through a focus on health promotion and disease prevention. It emphasises restructuring and strengthening the public healthcare institutions with the goal of attaining the highest possible level of health and well-being for all at all ages. There is renewed commitment in India to accelerate the pace of achievement of Sustainable Development Goals (SDGs) including Goal 3 (Good Health and Well-being) relating to ensuring healthy lives and promoting well-being for all at all ages.

The Health and Family Welfare Department is responsible for providing comprehensive healthcare system in the State. The services offered by the healthcare system Department are preventive and promotive healthcare services, routine curative and rehabilitation services. The vast network of Health Sub-Centres (HSCs¹²), Primary Health Centres (PHCs¹³) and Urban Primary Health Centres (UPHCs) form the primary tier of public healthcare delivery system for rural and urban population

¹² HSCs are peripheral healthcare centres which serve a population of 5,000 in plain areas and 3,000 in hilly areas.

¹³ PHCs form the cornerstone of healthcare in rural areas which serve a population of 30,000 in plain areas and 20,000 in hilly areas.

respectively. Community Health Centres (CHCs¹⁴) and District Hospitals (DHs¹⁵) serve as the secondary tier for rural and urban population while Tertiary¹⁶ healthcare involves providing advanced and super-speciality services to be provided by medical institutions in urban areas.

A Performance Audit (PA) was conducted to cover the areas of basic health infrastructure facilities in the State focused on selected District Hospitals including CHC, Viswema which mainly caters to secondary health care services. The findings were reported in the C&AG's Performance Audit Report on "Select District Hospitals in Nagaland" for the year ended 31 March 2019.

The present Subject Specific Compliance Audit (SSCA) covers the primary health care services which provide health facilities at village and block levels. The SSCA also provides a holistic view of improvement of necessary infrastructure, created for meeting emergencies related issues and service delivery by the sampled health institutions for the period 2017-18 to 2022-23.

2.3.2 Overview of Public Healthcare facilities in Nagaland

Nagaland, the fifth smallest State in India, has a population of approximately 19.78 lakh as per Census 2011. To cater to the healthcare services of its citizens at different levels, the State has 12 District Hospitals¹⁷, two TB&CD¹⁸ Hospitals, one State Mental Health Institute, 23 CHCs, 136 UPHCs/PHCs and 452 HSCs. In addition, there are five Ayurvedic/Homoeopathic Dispensaries and 44 co-located AYUSH¹⁹ facilities, 44 AYUSH Health and Wellness Sub-Centres and three Integrated Ayush Hospitals (IAH) for providing AYUSH facilities to the people of the State. The structure of public healthcare facilities in the State is shown in **Chart 2.3.1**.

¹⁴ CHCs are referral centres and serve a population of 1,20,000 in plain areas and 80,000 in hilly areas.

¹⁵ DHs are equipped with advanced equipment and diagnostic services and intensive care facilities.

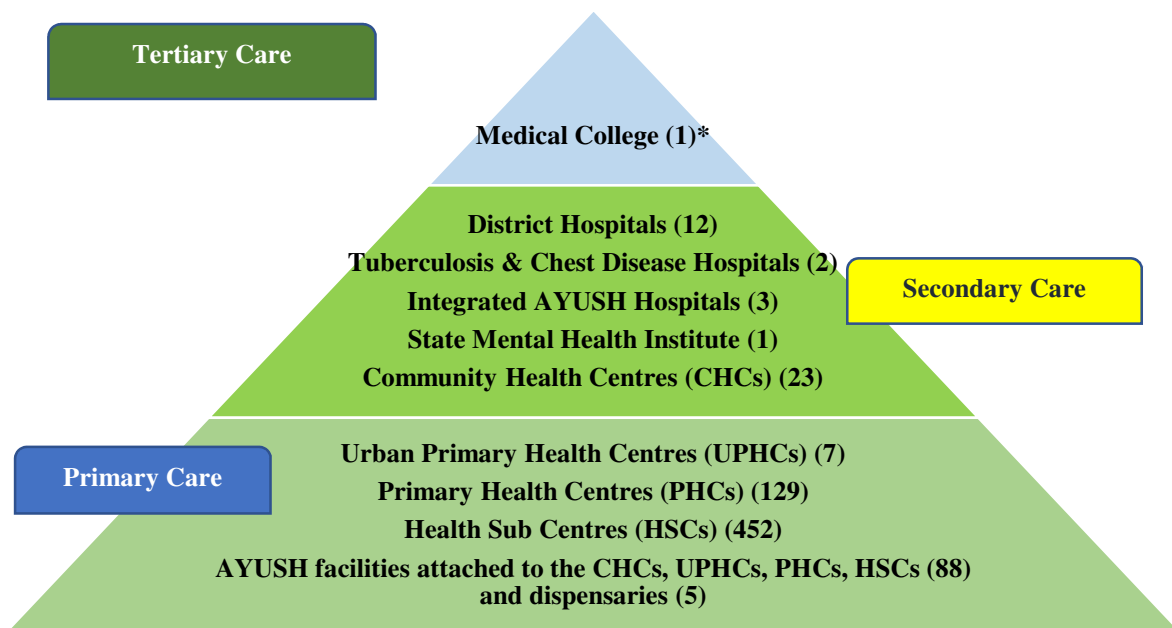
¹⁶ Tertiary healthcare is provided by medical colleges and advanced medical research institutes.

¹⁷ Including CHC Noklak which was upgraded (25 June 2021) to District Hospital (DH). DH, Noklak being upgraded recently has been excluded in audit analysis as it has been done for only 11 DHs in 11 Districts in the State.

¹⁸ Tuberculosis & Chest Diseases Hospital (Kohima and Mokokchung).

¹⁹ AYUSH is an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy and are the Indian systems of medical treatment.

Chart 2.3.1: Details of Health Facilities in the State



Source: Health and Family Welfare Department, Government of Nagaland

* (i) Nagaland Institute of Medical Sciences and Research, Kohima was inaugurated on 14 October 2023 and the session has started from 01 September 2023 for 2023-24 and (ii) GoN has signed a Memorandum of Understanding with MoHFW, GoI for establishment of a new Medical College at Mon on 15 September 2020.

The health facilities are under the administrative control of the Health and Family Welfare Department (H&FWD), Government of Nagaland (GoN).

The Principal Secretary, H&FWD is the Administrative Head of the Department who is assisted by the Principal Director and four Directors²⁰ at the Directorate level. The State Hospital²¹ (SH) and the District Hospitals (DHs) function directly under the Directorate of Health Services. The CHCs, the PHCs and the HSCs function under the Directorate of Family Welfare under the control of the Chief Medical Officers (CMOs) who are responsible for supervision of medical services provided by these health facilities in the twelve districts of the State. Besides these institutions, the State Health Society (SHS) and the District Health Society work under the National Health Mission Directorate to promote health services in the State.

2.3.2.1 Public Health Care facilities at the District and Primary level

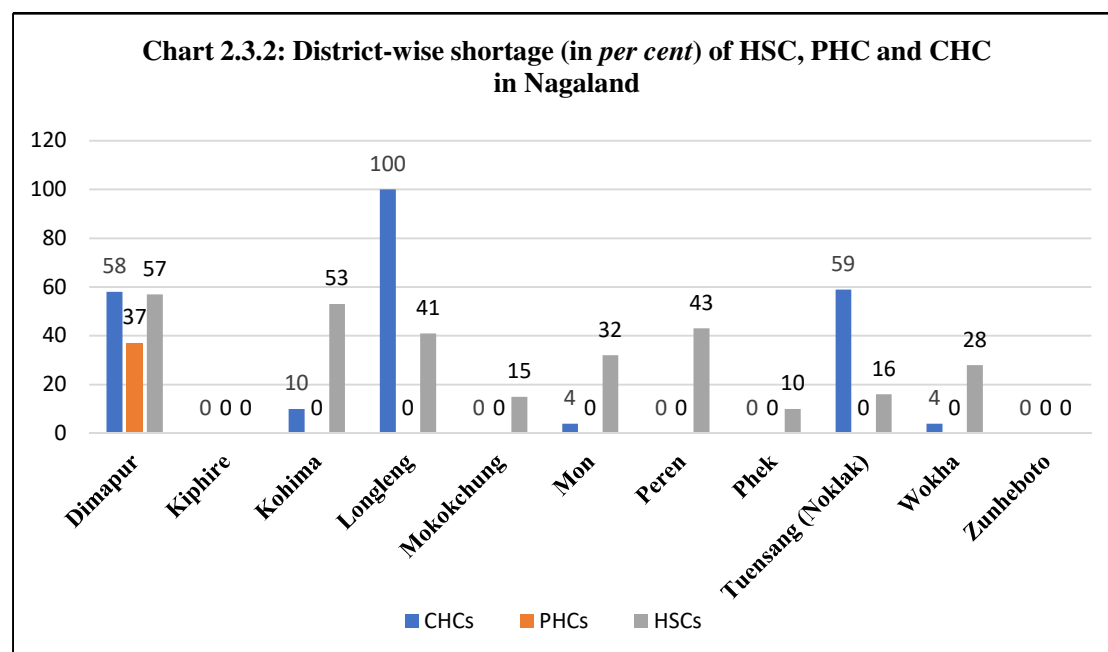
The State has twelve districts with DHs²². As regards availability of CHCs, PHCs and the HSCs in the districts, significant shortages of CHCs were noticed in Longleng (100 per cent), Tuensang (59 per cent) and Dimapur (58 per cent). Further, shortage

²⁰ Director, Health; Director, Family Welfare; Director, Medical Education & Radiation Safety and Director, Dental.

²¹ State Mental Health Institute, Kohima

²² MoHFW approved to upgrade CHC, Noklak to 50 bedded District Hospital (25 June 2021). DH, Noklak being upgraded recently has been excluded in audit analysis as it has been done for only 11 DHs in 11 Districts in the State.

of PHCs was noticed in Dimapur district (37 per cent) and shortage of HSCs was noticed in all districts except Kiphire and Zunheboto. Detailed position of CHC, PHC and HSC is given in *Appendix 2.3.1* and the status of overall district wise shortage is depicted in **Chart 2.3.2**.



Source: Information furnished by Department

2.3.2.2 Service availability in the DH, CHCs and the PHCs in the State

As per the Indian Public Health Standards (IPHS) norms, service availability in the DHs, CHCs and PHCs was grouped into essential services and desirable services. All the DHs in the State lacked essential services like (i) Anaesthesia in one DH, (ii) Otorhinolaryngology (ENT) and Psychiatry in five DHs, (iii) Ophthalmology and Orthopaedics in four DHs, (iv) Obstetrics and Gynaecology in three DHs, (v) Paediatrics and General Surgery in two DHs and (vi) General Medicine in one DH. The only available essential service in all DHs was Dental care. Further, desirable services²³ were not available in six DHs in the State.

Speciality services in General Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Ophthalmology and Emergency Services were essential services for CHCs as per the IPHS norms. However, no CHCs²⁴ in the State had all the above speciality services in the hospital as per the norms (refer **Paragraph 2.3.2.3**).

The PHCs in the State were not providing services as per the IPHS norms due to non-availability of doctors, nurses and paramedics (refer **Paragraph 2.3.2.3**).

While accepting the audit observation, the Department stated (October 2023) that though the Department desired to follow IPHS norms, the gap is more due to existing Human Resource (HR). It was further stated that as per IPHS norms, there is a

²³ Dermatology and Venereology.

²⁴ Information furnished/available for 17 CHCs out of 23 CHCs.

shortfall of 205 doctors, 321 MOs, 25 Dental Surgeons, 108 AYUSH MOs, 1,955 Nurses, 1,352 allied Health Providers and 100 Health Assistants and that the Department is utilising the existing HR with many constraints and as a result, DHs and CHCs do not have adequate specialist doctors. It was also stated that provision is available under NHM for Gap Filling of HR, however, many eligible doctors are not interested because of better perks in the private sector.

2.3.2.3 Availability of Doctors, Nurses and Paramedics in the DHs, CHCs and PHCs in the State

The IPHS provides the manpower requirement for the DHs, CHCs and PHCs as per the prescribed service delivery norms for each health facilities.

In case of DHs, major shortages existed in the cadre of specialist doctors which ranged from 08 to 56 *per cent*, General Duty Medical Officers which ranged from 43 to 100 *per cent*, Staff Nurses which ranged from 04 to 60 *per cent* and paramedical staff which ranged from 13 to 88 *per cent*. However, excess manpower in the cadre of specialist doctors was noticed in two DHs (33 to 61 *per cent*). Further, there was disparity in availability of adequate number of specialist doctors in the DHs as per IPHS norms. In case of General Medicine, there was shortage of doctors in six DHs *viz.*, Kiphire, Peren, Longleng, Phek, Zunheboto and Mokokchung, however, there was excess of doctors in case of two DHs *viz.*, Kohima and Dimapur. Further, there was shortage of Paediatricians in six DHs *viz.*, Peren, Mon, Phek, Tuensang, Zunheboto and Mokokchung and excess of Paediatricians in DH Kohima. Similar disparity was noticed in remaining nine mandatory Departments *viz.*, ENT, Orthopaedics, General Surgery, Ophthalmology, Dental, Obstetrics & Gynaecology, Anaesthesia, Radiology and Pathology. This implied that the State Government has not adopted a policy of systematic distribution of doctors among the available DHs. Detailed manpower position is given in *Appendix 2.3.2*.

As regards availability of specialist doctors, only three departments had specialist doctors available (10 out of 11 DHs) as per the norms. The overall status of specialist doctors is given in **Table 2.3.1**.

Table 2.3.1: Availability of Specialist Doctors in the respective Departments in DHs as per norms

Name of mandatory Departments	Dimapur	Kiphire	Kohima	Longleng	Mokokchung	Mon	Peren	Phek	Tuensang	Wokha	Zunheboto
General Medicine	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
General Surgery	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes
Obstetrics & Gynaecology	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Paediatrics	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No
Anaesthesia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Orthopaedics	Yes	No	Yes	Yes	Yes	No	No	Yes	No	Yes	No
Ophthalmology	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes

Name of mandatory Departments	Dimapur	Kiphire	Kohima	Longleng	Mokokchung	Mon	Peren	Phek	Tuensang	Wokha	Zunheboto
Radiology	No	Yes	Yes	No	Yes	Yes	No	No	No	No	No
Pathology	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
ENT	Yes	No	Yes	No	No	No	Yes	No	No	Yes	Yes
Dental	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

Source: Information furnished by Department

It can be seen from **Table 2.3.1** that out of 11 mandatory Departments, adequate number of specialist doctors were available only in DH, Kohima. It was also observed that in all the DHs, adequate number of specialist doctors were available in General Medicine except in DH, Longleng.

Recommendation: *The State Government may ensure equitable distribution of doctors among the health facilities.*

As per IPHS, the service of Specialist Doctors falls under the category of essential services in respect of CHCs. In CHCs, the shortage of specialist doctors ranged between 67 to 95 per cent as shown in **Appendix 2.3.3**. Out of 23 CHCs in the State, the specialist service in Obstetrics & Gynaecology was available only in five CHCs viz., Noklak, Pungro, Jalukie, Meluri and Tobu.

Similar shortages existed in the cadre of General Duty Medical Officers (GDMOs), Nurses and Paramedics which were 29 per cent, 62 per cent and 12 per cent respectively. Audit also observed an excess of manpower at CHCs in the following services- Obstetrics & Gynaecology (01²⁵), MBBS-MO/SMO (10²⁶), Staff nurse/ANM (04²⁷), Lab Technician (11²⁸) and Pharmacist (05²⁹), which resulted in skewed posting of manpower at CHCs. The overall status of shortages of medical staff in CHCs is depicted in **Chart 2.3.3**.

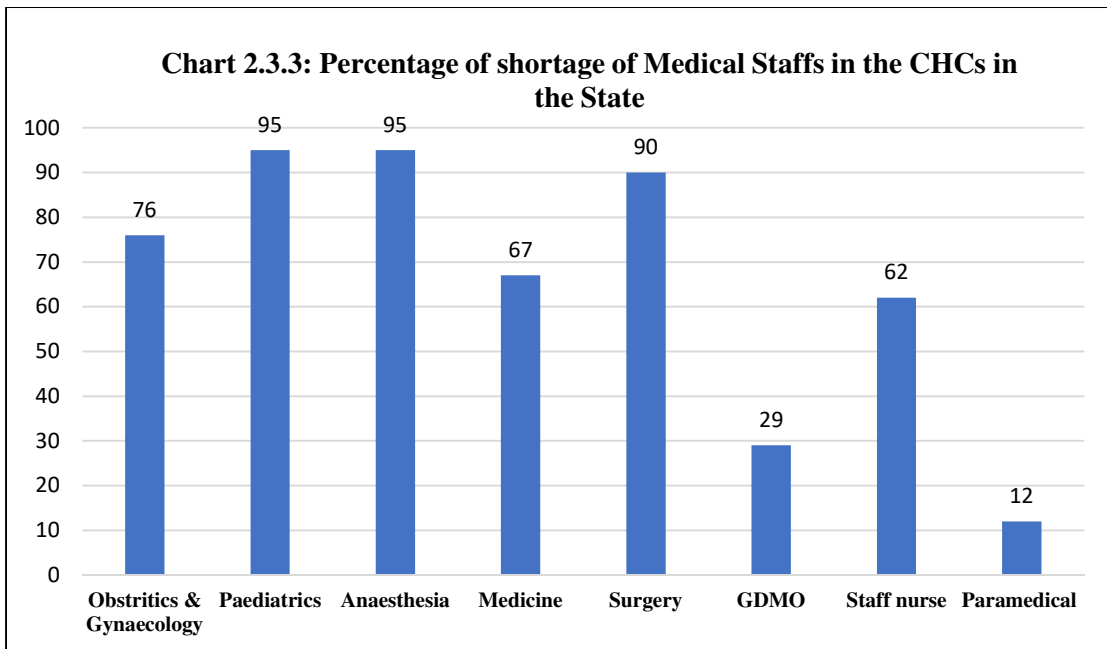
²⁵ CHC Pungro

²⁶ CHCs (Noklak, Medziphema, Bhandari, Jalukie, Pungro, Tuli, Dhansiripar, Meluri, Longkhim, Tobu)

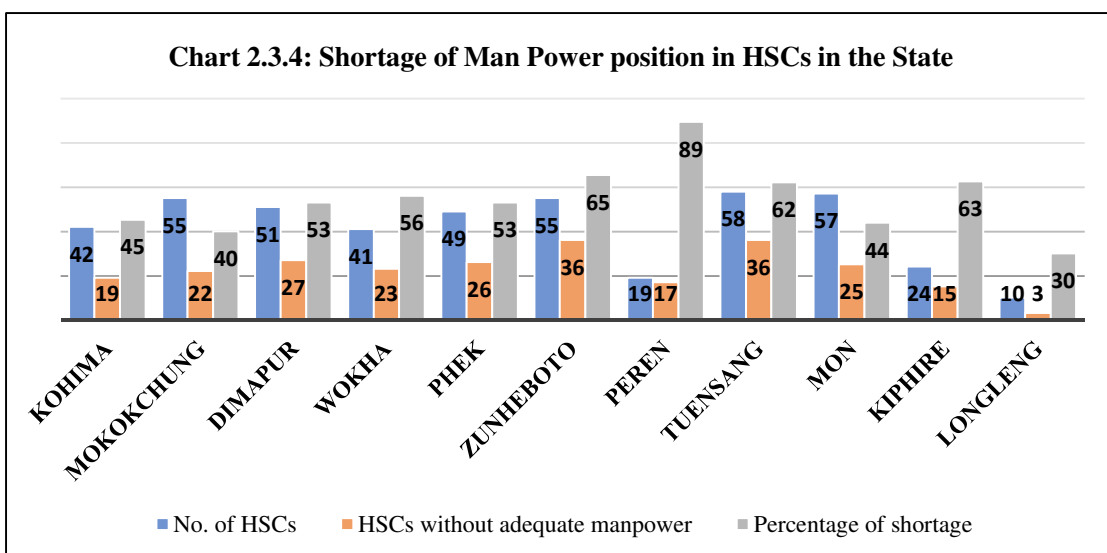
²⁷ CHCs (Noklak, Jalukie, Changtongya, Meluri)

²⁸ CHCs (Medziphema, Bhandari, Jalukie, Pungro, Tseminyu, Changtongya, Tuli, Dhansiripar, Sanis, Pfutero, Pughoboto)

²⁹ CHCs (Noklak, Tseminyu, Viswema, Changtongya, Pfutero)



PHCs in the State had shortfall in manpower and functioned with inadequate manpower, with respect to IPHS. The shortfall in manpower in PHCs was in GDMO (11 per cent), ANM (86 per cent), lab technician (64 per cent) and Pharmacist (33 per cent). Similarly, 52 per cent of HSCs in the State had shortage of manpower. District-wise position is given in **Appendix 2.3.4**. Availability of HSCs in the District and the number of the HSCs which had shortages of manpower *vis-à-vis* the norms ranged from 30 to 89 per cent. The highest shortage was noticed in respect of Peren District where 17 out of 19 HSCs witnessed shortage of manpower. The overall status of HSCs is provided in **Chart 2.3.4**.



No separate manpower has been sanctioned for Line Services and Support Services for Paramedics and other staff in the health facilities in the State. The shortage of services manpower in the sampled health facilities is discussed in **Paragraph 2.3.7**.

2.3.2.4 OPD Services in the District Hospitals

According to the IPHS, the DHs are supposed to provide the Out Patient Department (OPD) services in General Medicine, General Surgery, Obstetrics & Gynaecology, Paediatrics, Ophthalmology, Otorhinolaryngology (ENT), Orthopedics, Psychiatry, and Dental Care.

All the DHs in the State were providing the OPD Services according to the availability of the Specialist Doctors with the Hospital. Detailed position for the year 2022-23 is given in **Table 2.3.2**.

Table 2.3.2: OPD Services in the DHs in the State during 2022-23

Sl. No.	Name of the Department	Number of patients visited who the Department during 2022-23										
		Dimapur	Kiphire	Kohima	Longleng	Mokokchung	Mon	Peren	Phek	Tuensang	Wokha	Zunheboto
1.	Dental	5,177	1,746	7,176	1,175	2,965	3,932	223	1,865	2,497	2,097	1,678
2.	Emergency	12,258	3,857	13,171	3,126	6,240	10,388	33	3,021	-	2,640	450
3.	ENT	4,440	270	7,109	118	577	1,829	52	656	675	997	400
4.	Eye	5,351	72	6,739	31	3,149	1,041	431	1,236	534	650	767
5.	Medicine	13,509	4,075	13,964	1,777	7,736	1,667	4,553	2,991	8,455	2,330	1,400
6.	Obstetrics & Gynaecology	6,187	1,464	12,652	704	5,082	711	287	815	2,645	1,864	900
7.	Orthopaedic	2,587	-	4,721	604	2,733	-	1	914	681	1,386	80
8.	Paediatrics	5,098	1,952	7,570	824	3,844	2,557	45	2,996	4,592	1,420	800
9.	Psychiatrics	205	-	2,102	-	139	-	4	1,841	1,655	42	150
10.	Surgery	4,712	2,240	9,716	374	2,048	1,261	2	926	1,025	662	900
11.	Dermatology & Venereology	4,419	333	5,365	122	756	-	168	-	-	886	-
12.	PMR	2,165	111	-	-	-	2,652	-	-	-	-	-

Source: Information furnished by the Department

As per the IPHS, OPD Services in Dermatology & Venereology is a desirable service in the DH level hospital. However, in four³⁰ out of 11 DHs, this service was not provided. The audit observations on OPD services in the sampled health facilities are discussed in **Paragraph 2.3.8**.

While accepting the audit observation, the Department stated (October 2023) that there are only six dermatologists under the Department and therefore, Dermatology services cannot be provided in all DHs.

2.3.2.5 Availability of beds in the District Hospitals in the State

According to the IPHS, the DHs are classified into five³¹ grades from Grade-I: to Grade -V according to the bed strength of the respective hospitals. In Nagaland there are 11 DHs³², where one DH has bed capacity of 300, two DHs have bed capacity of

³⁰ Mon, Phek, Tuensang and Zunheboto.

³¹ Grade -I DH with 100 beds, Grade-II with 200 beds, Grade-III with 300 beds, Grade-IV with 400 beds and Grade-V with 500 beds District Hospital.

³² DHs at Kohima, Dimapur, Phek, Longleng, Mokokchung, Kiphire, Longleng, Mon, Tuensang, Wokha and Zunheboto.

150 each, four DHs have bed capacity of 100 each and the rest four DHs have bed capacity of 50 beds each. Hospital beds were distributed among the different wards viz, Medicine Ward, Surgical Ward, Orthopaedic Ward, Paediatric Ward, Obstetrics and Gynaecology Ward and Ophthalmology Ward. The detailed position of beds is given in **Appendix 2.3.5**. Separate wards for Maternal care and Child care were available in all DHs except for DH Peren and DH Tuensang.

Despite specific guidelines in IPHS for bed allocation among the DHs having bed capacity of 100 beds and above, three DHs³³ fulfilling the above bed criteria, did not follow the IPHS norms for bed allocation. The Accident and Trauma Ward was not available in DHs Kohima and Dimapur. The Postpartum Ward was also not available in two DHs³⁴.

The Department replied (October 2023) that five Accident and Trauma Centres have been established in Kiphire, Tuensang, Mon, Kohima and Dimapur under National Programme for Prevention of Management of Trauma & Burn injuries. It was further stated that for all practical purpose any case of trauma is efficiently and adequately attended in the Emergency/Casualty Ward in every DH as well as in CHC/PHC. The reply of the Department is not tenable as specific beds were to be allocated for the Accident and Trauma Ward in each Hospital and the same had not been done.

2.3.2.6 IPD Services in the District Hospitals

According to the IPHS, District Hospitals are supposed to provide IPD Services in Medicine, Surgery, Maternity, Paediatrics, Nursery, Isolation related cases, Burn cases, Orthopaedics, Ophthalmology, Malaria and Infectious Disease related cases.

The DH at Kohima had a bed capacity of 300, the DHs at Dimapur and Mokokchung had bed capacity of 150 each, the DHs at Phek, Mon, Tuensang and Zunheboto had bed capacity of 100 each while the DHs at Kiphire, Longleng and Peren Districts had bed capacity of 50 each. All the DHs were providing IPD Services according to the availability of the Specialist Doctors with the Hospital. The overall position of IPD patients admitted in the DHs for the year 2022-23 is given in **Table 2.3.3**.

Table 2.3.3: IPD Services in the DHs in the State during 2022-23

Sl. No.	Name of the Department	Number of patients who visited the Department during 2022-23										
		Dimapur	Kiphire	Kohima	Longleng	Mokokchung	Mon	Peren	Phek	Tuensang	Wokha	Zunheboto
1.	Medicine	2,052	572	1,374	237	1,000	1,815	356	964	308	750	199
2.	Paediatrics	342	183	277	85	164	327	57	268	137	291	40
3.	Surgical	813	68	664	50	259	-	35	651	51	193	95
4.	Orthopaedic	84	-	155	-	272	-	-	180	12	260	-

³³ DHs at Kohima, Dimapur and Mokokchung.

³⁴ Dimapur and Mokokchung.

Sl. No.	Name of the Department	Number of patients who visited the Department during 2022-23										
		Dimapur	Kiphire	Kohima	Longleng	Mokokchung	Mon	Peren	Phek	Tuensang	Wokha	Zunheboto
5.	ENT	14	-	176	-	-	-	1	159	8	40	-
6.	Obstetrics & Gynaecology	2,814	292	2,046	200	945	1,045	75	364	22	247	479
7.	Eye	352	-	144	-	11	-	44	38	36	13	-
8.	SNCU	316	35	234	-	93	116	-	-	-	-	41
9.	ICU	77	-	443	-	-	-	-	-	-	-	-
10	Emergency	14,729	73	3,022	212	-	-	1,456	248	-	2,640	-

Source: Information furnished by the Department

Medicine and Paediatric Wards were available in all the DHs in the State. Intensive Care Unit (ICU) Service was available in all the DHs, however, data regarding patients admitted in ICU Ward was available only for DH, Kohima and Dimapur. Special Newborn Care Unit (SNCU) ward was not available in five DHs³⁵. The findings on IPD services in the sampled health facilities are discussed in **Paragraph 2.3.9**.

While accepting the audit observation, the Department stated (October 2023) that a ten bedded ICU ward has been established and was functioning in all the DHs and New Born Stabilisation Unit (NBSU) is available in all DHs. It was, however, stated that SNCU is available in only five DHs³⁶ as establishment of SNCU requires extensive resources and there are shortages of Pediatricians.

2.3.2.7 Availability of Diagnostic Service in the District Hospitals

According to the IPHS, the District Hospital laboratory and other diagnostic services shall serve the purpose of public health and be able to perform all tests required to diagnose epidemics or important diseases from a public health point of view. The recommended services which are supposed to be available in a District Hospital are (i) Clinical Pathology, (ii) Pathology, (iii) Microbiology, (iv) Serology, (v) Biochemistry, (vi) Cardiac investigation, (vii) Ophthalmology, (viii) ENT, (ix) Radiology, (x) Endoscopy and (xi) Respiratory function tests.

In all the DHs in the State, the recommended services, viz., (i) Clinical Pathology, (ii) Pathology, (iii) Microbiology, (iv) Serology and (v) Biochemistry tests were available. However, tests like Stress Test, Endoscopy, Bronchoscopy, Arthroscopy and Hysteroscopy and Pulmonary function tests under Respiratory investigation were not available in any of the DHs. Echocardiography under Cardiac Investigation was available only in DH, Kohima.

In respect of Radiology investigations, Hysterosalpingography or HSG which is an essential test for determining female fertility was available only in one DH³⁷. Further,

³⁵ DHs at Wokha, Phek, Peren, Tuensang and Longleng.

³⁶ DHs at Kohima, Dimapur, Mokokchung, Mon and Kiphire.

³⁷ DH, Kohima.

CT Scan Service was not available in any of the DHs in the State. The availability of diagnostic services in the sampled health facilities is discussed in **Paragraph 2.3.8.3**.

While accepting the audit observation, the Department stated (October 2023) that specialised/high end tests cannot be provided in all DHs in view of the shortage of specialist doctors.

2.3.2.8 Blood bank facilities in the District Hospitals in the State

According to the IPHS, every DH shall have a Blood Bank which shall be in close proximity to the Pathology Department and at an accessible distance to the Operation Theatre Department, Intensive Care units and Emergency and Accident Department. The Blood Bank should follow all existing guidelines and fulfil all requirements as per the various Acts pertaining to setting up of the Blood Bank. Further, as per Statuary Compliance paragraph in IPHS, hospital shall fulfil all statutory requirements and comply to all regulations (given in Annexure II of the guidelines) issued by local bodies, State and Union of India including License for Blood Bank or Authorisation for Blood Storage facility.

Out of 11 DHs, five DHs³⁸ in the State had Blood Banks as per the norms. However, in DH, Kiphire and Mokokchung, Blood Storage Units were found running without any power back-up.

While accepting the audit observation, the Department stated (October 2023) that there are three licensed Blood Banks functional in Kohima, Dimapur and Mokokchung, and six licensed Blood Storage Units (BSU) including DH, Wokha, Mon, Peren and Zunheboto out of which BSUs in Wokha and Peren are non-functional due to minor technical snag. It was further stated that in order to establish Blood Banks and Blood Storage Unit in all DHs in a phased manner, setting up of BB/BSU in the remaining districts had been approved under NESIDS, however, the fund is yet to be received.

2.3.2.9 Dietary Service in the District Hospitals in the State

According to the IPHS, the dietary service of a hospital is an important therapeutic tool. Apart from normal diet, diabetic, semi-solid diets and liquid diets shall also be available. Food shall be distributed in covered container. Quality and quantity of diet shall be checked by competent person on regular basis.

The Department had, however, not prescribed any diets for different categories of patients. Diet was not provided in covered container and records on checking quality of diet by competent person on regular basis to assure serving of quality diets to the patients, were not available to any of the DHs.

While accepting the audit observation, the Department stated (October 2023) that the Department had taken up necessary corrective measures for statutory compliances and to ensure serving of quality diet to the patients in all DHs.

³⁸ DHs at Dimapur, Mokokchung, Kohima, Kiphire and Zunheboto

2.3.2.10 Hospital Linen Service in the District Hospitals in the State

IPHS Guidelines for DHs prescribe the number of different types of linen³⁹ that are required for patient care services for DHs with different bed capacities in the category of 101 to 200, 201 to 300 and 301 to 500. It further stated that, DH should be provided with necessary facilities for dying, pressing and storage of soiled and cleaned linens and the same may be outsourced.

In the State, no prescribed norms were available with the hospitals for changing linen for the patients. The records for changing of soiled linens and providing of fresh linens were also not maintained by any of the DHs. Washing of soiled linens were not outsourced and was done in house. The fact was further confirmed by the findings at sampled health facilities as discussed in **Paragraph 2.3.14.2**.

While accepting the audit observation, the Department stated (October 2023) that the SOP for handling, washing and disinfecting of linen was circulated to the districts and health facilities for necessary action.

2.3.2.11 Management of Bio Medical Waste by District Hospitals in the State

Biomedical waste management is an integral part of infection control activity of a hospital. According to the Bio-Medical Waste Management Rules, 2016 (BMW Rules), hazardous, toxic and bio-medical waste has to be separated into 10 categories for the purpose of its safe transportation to specific site for specific treatment. Further, the BMW Rules stipulate the procedures for collection, handling, transportation, disposal and monitoring of the bio-medical waste with clear roles for waste generators.

All the DHs in the State were segregating the waste in different categories in separate-coloured bins, available at the point of generation of waste, particularly in the ward areas and OTs, as per the BMW rules. However, all the wastes were subsequently mixed at the time of disposal and hospital wastes were dumped in the Deep Burial pits. The BMW management in the sampled health facilities also revealed similar problems as discussed in **Paragraph 2.3.16**.

The Department replied (October 2023) that all DHs are authorised by the Pollution Control Board to manage BMW. The reply was, however, silent on the issue of dumping of wastes.

2.3.2.12 Mortuary Service in the District Hospitals

IPHS Guidelines for DHs provide that every DH should have the facilities for keeping of dead bodies and conducting autopsies. Out of 11 DHs, only seven DHs⁴⁰ had

³⁹ Abdominal sheets for OT, Bed sheets, Bedspreads, Blankets (Red and Blue), Doctor's overcoats, Draw sheets, Hospital worker OT coats, Leggings, Mackintosh sheets, Mats (Nylon), Mattresses (Foam) for adults, Mortuary sheets, over-shoe pairs, paediatric mattresses, Patient's coats (Female), Patient's pyjamas, Shirts (Male), Patna towels, Perennial sheets for OT, Pillows, Pillow cover and Table cloth.

⁴⁰ DHs at Phek, Wokha, Kiphire, Dimapur, Mon, NHAK and Zunheboto.

mortuary services. However, in these seven DHs which had mortuary services the facilities for keeping of dead bodies and conducting autopsy was not available.

While accepting the audit observation, the Department replied (October 2023) that due to resource constraints and lack of required specialised manpower, mortuary services were available in only seven DHs. No reply was furnished on the absence of mortuary service for keeping the dead bodies and conducting of autopsy in these hospitals.

2.3.2.13 Ambulance Service

According to the IPHS, the District Hospital shall have well equipped Basic Life support (BLS) and desirably one Advanced Life Support (ALS) ambulance. Serviceability and availability of equipment and drugs in ambulance shall be checked on daily basis.

Audit observed that the hospitals in the State were providing free ambulance service to emergent cases for referral transport to the higher health facility centre. Audit also observed that the Ambulances in the hospitals in the State lacked basic life support facility viz., Oxygen Cylinder, First Aid Box and trained paramedics, though required under the IPHS norms. The ambulances were basically being used merely as a transport vehicle. Audit further observed that while General ambulance services viz. '102 National Ambulance Service (NAS)' for catering to pregnant women, sick infants and sterilisation cases were available in the State, '108 Emergency Transport System' for all other medical emergencies were not available. The findings on ambulance services in the sampled health facilities are discussed in **Paragraph 2.3.17.**

While accepting the audit observation, the Department stated (October 2023) that the State was granted 102 NAS which is operational to cover all other medical emergencies in the State. It was further stated that the Department currently has 93 functional BLS ambulances and in view of resource constraints and lack of required specialised manpower, the Department is unable to provide ALS ambulances.

2.3.2.14 Status of implementation of AB-PMJAY in the State of Nagaland

Ayushman Bharat is a flagship health scheme of the Government of India, launched (23 September 2018) to achieve Universal Health Coverage (UHC) as recommended in the National Health Policy, 2017. PMJAY aims to provide health insurance cover of ₹Five lakh per family per year for secondary and tertiary care hospitalisation. As per Capacity Building Guidelines, AB PM-JAY, the State Health Agency through State Empanelment Committee (SEC) will empanel or cause to empanel private and public health care service providers as per the guidelines. Further, the guidelines stipulate that District Unit Implementation Units (DIUs) must be formulated in each district for functional coordination of scheme activities at the district level.

SEC was yet to be formed; however, DIUs were set up (August 2021) in all districts. Further, all Deputy Commissioner (DC) offices in the State had been established as contact points at district level for registration of beneficiaries, with no other contact

points in sub-division or block level. All the empaneled hospitals also had beneficiary registration facilities. The scheme was finally rolled out in the State on 23 September 2018.

The State had empaneled 108 hospitals (68 public hospitals, 19 Government of India hospitals and 21 private hospitals) as of 31 March 2023. Out of 108 empanelled hospitals, only Christian Institute of Health Sciences & Research (CIHSR), Dimapur was accredited with NABH entry level at the time of empanelment. No other hospital having such accreditation was empanelled under the AB-PMJAY.

Registration of households and beneficiary data revealed that in Nagaland, 12.85 lakh members of 2.33 lakh distinct households were eligible for getting benefit under this scheme. However, as of 31 March 2023, only 5.94 lakh (57 per cent) members of 2.17 lakh (84 per cent) households had been registered.

The trends of beneficiary admissions in public hospitals and private hospitals and claims paid to hospitals during 2018-19 to 2022-23 are shown in **Tables 2.3.4** and **2.3.5**.

Table 2.3.4: Number of beneficiaries admitted in public and private hospitals under PMJAY during 2018-19 to 2022-23

(In numbers)

Portability/ Non- Portability	Private/ Public Hospital	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Grand Total
Portability	Public	0	128	75	158	324	685
	Private	0	94	173	310	383	960
Non- Portability	Public	155	5,017	1,784	1,702	4,733	13,391
	Private	97	4,651	5,262	3,460	6,956	20,426
Total		252	9,890	7,294	5,630	12,396	35,462

Source: Information furnished by the Department

Table 2.3.5: Amounts of claim paid to public and private hospitals under PMJAY during 2018-19 to 2022-23

(₹ in crore)

Nature of Hospital	Claims paid during					
	2018-19	2019-20	2020-21	2021-22	2022-23	Total
Public	0.17	13.11	2.01	2.70	8.33	18.81
Private	0.29	5.57	16.18	15.84	33.85	79.29
Total	0.46	18.68	18.19	18.54	42.18	98.10

Source: Information furnished by the Department

The Department, in its reply, stated (October 2023) that the State had launched Chief Minister Health Insurance Scheme (CMHIS) in convergence with PM-JAY insuring all Government employees/pensioners and those not covered by PM-JAY and are indigenous inhabitant or permanent residents. It was further stated that the PM-JAY beneficiary base of 2.33 lakh had been increased to 2.59 lakh effective from April 2022, out of which 2.19 lakh (85 per cent) households had been covered as on 05 October 2023. It was also stated that out of the estimated 14.24 lakh individuals, 5.05 lakh individuals (35 per cent) have been covered.

2.3.2.15 Operationalisation of Health and Wellness Centres (HWCs)

In February 2018, the Government of India announced the creation of 1,50,000 Health and Wellness Centres (HWCs) by transforming existing Sub Centres and Primary Health Centres as the base pillar of Ayushman Bharat. These centres would deliver Comprehensive Primary Health Care (CPHC) bringing healthcare closer to the homes of people covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

In the State, as on 31 March 2023, 75 PHCs, 07 UPHCs and 301 HSCs were transformed into Health and Wellness Centres (HWCs), out of the total target of 402 as envisaged by the GoI.

The number of Patients served by the HWCs in the State as of 31 March 2023 are given in **Table 2.3.6**.

Table 2.3.6: Patients served by the HWCs in the State

District	2020-21	2021-22	2022-23	Total
Dimapur	35,192	1,06,718	48,204	1,90,114
Kiphire	18,679	15,666	13,509	47,854
Kohima	29,215	65,456	40,690	1,35,361
Longleng	8,931	9,107	8,372	26,410
Mokokchung	20,622	21,730	26,547	68,899
Mon	21,752	16,205	23,752	61,709
Peren	10,488	21,343	15,727	47,558
Phek	22,982	22,377	18,167	63,526
Tuensang	17,151	20,388	22,979	60,518
Wokha	17,724	22,897	24,013	64,634
Zunheboto	9,004	11,817	15,713	36,534
Total	2,11,740	3,33,704	2,57,673	8,03,117

Source: Information furnished by the Department

The Department, in its reply, stated (October 2023) that a total of 385 HWCs were operationalised (as of October 2023) indicating two more Health Sub Centres were transformed during March 2023 to October 2023.

2.3.2.16 Medical College in the State

During 2017-18 to 2022-23, a new Medical College was in the process of being set up in the State. Results of examination of implementation of “Establishment of new medical colleges attached with existing district/referral hospital” in the State are highlighted in **Paragraphs 2.3.28 to 2.3.30**.

2.3.3 Budget allocation and expenditure

Budget allotment and expenditure of the State Government and the H&FWD during 2017-18 to 2022-23 is shown in **Table 2.3.7**.

Table 2.3.7: Budget allocation and expenditure during 2017-18 to 2022-23

(₹ in crore)

Year	State		Health Sector			GSDP	Health Sector Expenditure (percentage of GSDP)
	Budget allocation	Expenditure	Budget allocation (percentage of State budget)	Expenditure (percentage of State expenditure)	Savings (percentage of health Sector Budget allocation)		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2017-18	18,449.87	15,942.27	683.79 (3.71)	614.09 (3.85)	69.70 (10.19)	24,393	2.52
2018-19	20,469.96	15,158.2	797.48 (3.90)	631.42 (4.17)	166.06 (20.82)	26,527	2.38
2019-20	22,496.42	19,733.63	819.25 (3.64)	668.95 (3.39)	150.30 (18.35)	29,716	2.25
2020-21	26,895.65	22,645.02	864.77 (3.22)	723.22 (3.19)	141.55 (16.37)	31,221	2.32
2021-22	25,644.46	21,690.85	1,201.54 (4.69)	922.49 (4.25)	279.04 (23.22)	35,007	2.64
2022-23	26,092.48	21,532.82	1,355.19 (5.19)	1,241.14 (5.76)	114.05 (8.42)	39,201	3.17
Total	1,40,048.90	1,16,702.80	5,722.02 (4.09)	4,801.31 (4.11)	920.11 (16.09)	--	--

Source: Finance Accounts and Appropriation Accounts, GSDP-Economics & Statistics Department, GoN

The National Health Policy, 2017 (NHP, 2017) states that the State's health sector spending is to be more than eight *per cent* of the State budget by 2020. However, health sector budgetary commitment did not reach eight *per cent* of the total State budget during 2017-23. Further, as against the goal and objective of NHP, 2017 to increase State health sector expenditure to 2.50 *per cent* of the Gross State Domestic Product (GSDP) by 2025, the State's expenditure on health sector was 2.25 *per cent* in 2019-20 which increased to 2.32 *per cent* in 2020-21. However, it is more than 2.50 *per cent* of the GSDP since 2021-22 onwards.

Recommendation: The State Government may ensure that the State health sector spending is as per the target set in the National Health Policy, 2017.

2.3.4 Audit objectives

The compliance audit was conducted to:

- i. ascertain that primary healthcare infrastructure and services are available and properly managed,
- ii. ascertain that support services in the primary healthcare facilities are available and adequate,
- iii. ascertain that efficient utilisation of assets created for medical emergencies in the State,
- iv. ascertain that the health and wellbeing conditions of people has been improved as per SDG 3, and
- v. examine implementation of 'Establishment of new medical colleges attached with existing district/referral hospital'.

2.3.5 Audit scope and methodology

The scope of audit involved assessing functioning of the sampled PHCs and CHCs (*Appendix 2.3.6*) during 2017-23 and evaluating the outcomes of the selected indicators. Two blocks (30 *per cent* of the available blocks) in each of the four sampled districts were selected through Simple Random Sampling Without Replacement (SRSWOR). In the sampled blocks, all available Community Health Centres and 30 *per cent* of the Primary Health Centre/Urban Primary Health Centre were selected using Probability Proportion to Size Without Replacement (PPSWOR) with number of patients as the sampling criteria. Thus, out of ten CHCs and 63 PHCs in the four Districts⁴¹, two CHCs and nine PHCs were selected for detailed scrutiny. The districts selected were the same as those selected in the sample for the Performance Audit of Select District Hospitals in Nagaland (Report No. 2 of 2021) in order to ensure a holistic view.

The Subject Specific Compliance Audit commenced with an Entry Conference on January 2022 with the Department of Health and Family Welfare, Government of Nagaland wherein the audit objectives, scope and audit criteria were discussed. Audit methodology involved scrutiny and analysis of records/data as per the audit objectives, scope and criteria, evidence gathering by scanning of records, joint physical inspection of various facilities of the sampled health care facilities and by taking photographs, issuing questionnaires/audit observations and obtaining replies. The findings and recommendations of the Subject Specific Compliance Audit were discussed with the Commissioner & Secretary, Department of Health and Family Welfare in an Exit Conference on 06 September 2023 and the views and replies of the Government have been suitably included in the report.

Audit objective 1: Whether primary healthcare infrastructure and services are available and properly managed.

2.3.6 Physical infrastructure

2.3.6.1 Shortage of CHCs, PHCs and SCs

The required number of health facilities as per the Indian Public Health Standards (IPHS), their availability and shortfall thereof, against the three categories of healthcare infrastructure as of March 2022 are given in **Table 2.3.8**.

Table 2.3.8: Shortage of health facilities in the State

Health facility	Norms taken into consideration	Required as per norms*	Available	Percentage of Excess (+)/ Shortfall (-)
Health Sub-Centre (HSC)	One SC for every 3,000 people	739	452	(-) 39

⁴¹ Kohima District-three CHCs and 16 PHCs, Phek District- four CHCs and 22 PHCs, Wokha District - two CHCs and 14 PHCs and Tuensang District-one CHC and 11 PHCs.

Health facility	Norms taken into consideration	Required as per norms*	Available	Percentage of Excess (+)/ Shortfall (-)
Primary Health Centre (PHC)	One PHC for every 6 SCs or for every 20,000 people	111	136	(+) 23
Community Health Centre (CHC)	One CHC for every 4 PHCs or for every 80,000 people	28	23	(-)18

Source: Rural Health Statistics (RHS), 2022

*Calculated based on estimated mid-term Population of 22,18,000 as on 1 July 2022 (RHS, 2022)

It can be seen from **Table 2.3.8** that while PHC availability was higher than the norm, the shortage of HSCs and CHCs was 39 and 18 *per cent* respectively.

2.3.6.2 Non-availability of Operation Theatre and Blood Storage facilities

As per the IPHS, all CHCs should have a Blood Storage Unit which should be in close proximity to the Pathology Department and at an accessible distance to the OT and Emergency and Accident Departments.

Audit noticed that the two sampled CHCs *viz.*, Bhandari and Longkhim did not have the Blood Storage Unit as required under the IPHS.

2.3.7 Availability of services manpower in the sampled health facilities

Primary Health Centre: A PHC provides In-Patient Department (IPD), Out-Patient Department (OPD), Maternal and Child Health care, 24-hour emergency services. The status of availability of manpower in the sampled PHCs (10 bedded health facility) is provided in **Table 2.3.9**.

Table 2.3.9: Service delivery at the PHC level, 10 bedded health facility

Required service delivery	Manpower requirement as per norms	Availability of manpower in the sampled PHCs									
		Mangakhi	Thonoknyu	Zuketsa	Yimpang	Wozhuro	Seikhazou	Lozaphuhu	Kempfupfe	Kikruma	
OPD services, 24 hours emergency services, In-patient services, Maternal and Child Health Care, Immunisation	Essential										
	Medical Officer-MBBS	1	0	1	1	1	2	2	1	1	1
	Staff-Nurse	3	2	2	2	3	3	7	2	5	4
	Desirable										
Medical Officer-AYUSH	1	0	0	0	0	0	0	0	0	0	
Staff-Nurse	1	0	0	0	0	0	0	0	0	0	

Source: Information furnished by sampled PHCs

It can be seen from **Table 2.3.9** that for essential services, additional Medical Officers and Staff Nurses beyond the IPHS norms were provided in two sampled PHCs⁴². It can also be seen that Medical Officers in the AYUSH category were not available in

⁴² PHC Wazhuro and PHC Seikhazou.

all sampled PHCs. Further, there were no IPD services and dental services available in the sampled PHCs.

Community Health Centres: CHCs are to provide routine and emergency care which included specialist services in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics. Besides, Dental and AYUSH services were also to be delivered.

Audit noticed that none of the sampled CHCs provided the specialist medical officers to deliver required services at the CHC level. Non-availability of specialist doctors in the CHCs reduced them to being merely PHCs with additional beds and some additional diagnostic facilities.

The status of manpower availability in the sampled CHCs is provided in **Table 2.3.10**.

Table 2.3.10: Service Delivery at the Community Health Centre level, 30 bedded health facility

Required service delivery	Manpower requirement as per norms		Availability of manpower in the sampled CHCs	
	Essential		Bhandari	Longkhim
Routine and emergency care in Surgery, Medicine, Obstetrics & Gynaecology, Paediatrics, Dental and AYUSH in addition to all the National Health Programmes.	Medical Superintendent	1	1	1
	Public Health Specialist	1	0	0
	Public Health Nurse	1	0	0
	Specialist Doctors ⁴³	5	0	0
	Medical Officer- MBBS	2	3	1
	Medical Officer- Dental	1	1	1
	Medical Officer- AYUSH	1	1	1
	Staff-Nurse	10	10	6

Source: Information furnished by sampled CHCs

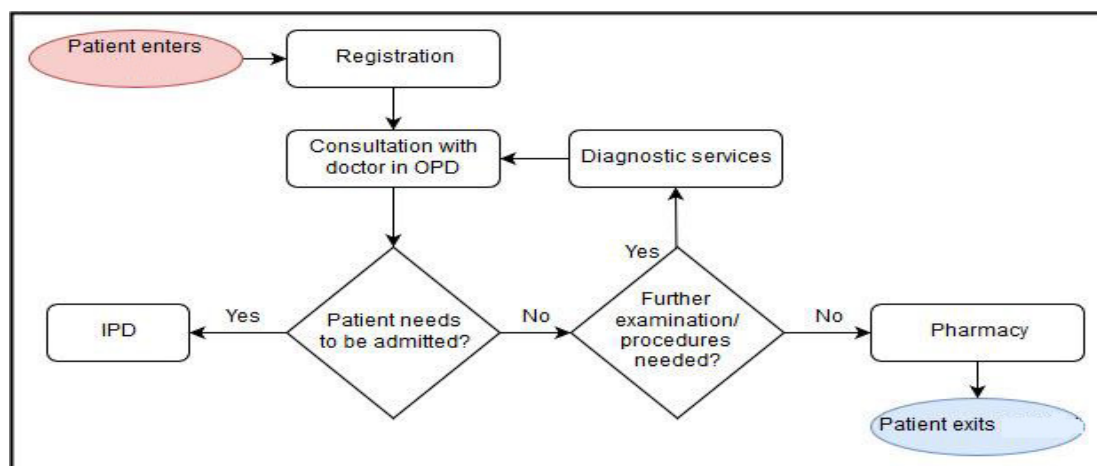
In absence of specialist doctors, the sampled CHCs referred the patients to the District Hospitals in Wokha and Tuensang.

2.3.8 Out-Patient Department Services in PHCs and CHCs

Out-Patient Department (OPD) normally remains integrated with the in-patient services and staffed by physicians and surgeons who also attend inpatients in the wards. Many patients are examined and given treatment as out-patients before being admitted to the hospital at a later date as in-patients. The treatment procedure followed in the Public Health facilities in the State is depicted in **Flow Chart 2.3.5**.

⁴³ Including General Surgeon, Physician, Obstetrician & Gynaecologist, Paediatrician and Anaesthetist.

Chart 2.3.5: Flow of OPD services in PHCs and CHCs



Audit findings pertaining to OPD services like registration, consultation, waiting time and other basic OPD facilities/services are discussed in the succeeding paragraphs.

2.3.8.1 Registration facility for OPD

Registration counter is the entry point of contact with the hospital for a patient and is an important component of the hospital for patients and their attendants. NHM Assessor guidebook (Vol-1) estimates that the average time required for registration can be 3-5 minutes per patient, which roughly works out to about 20 patients/hour per counter.

The average daily patient load on a registration counter in the sampled health facilities during 2022-23, is shown in **Table 2.3.11**.

Table 2.3.11: Patient Load in the Registration Counter during 2022-23

Name of the Health Facilities	Number of counters	Total Number of OPD Patients	Average number of patients per counter per month	Average number of patients per counter per hour
CHC, Bhandari	1	2,969	247	4
CHC, Longkhim	1	2,080	173	3
PHC Kemipfufpe	1	2,200	183	3
UPHC, Seikhazou	1	19,580	1,632	25
PHC, Lozaphuhu	1	940	78	1
PHC, Kikruma	1	2,361	197	3
PHC, Zuketsa	1	1,771	148	2
PHC, Wozhuro	1	1,350	113	2
PHC, Yimpang	1	498	41	1
PHC, Mangakhi	1	180	15	0
PHC, Thonoknyu	1	948	79	1

Source: Information furnished by sampled Hospitals

As per the IPHS, adequate seating arrangement, drinking water facility, provision of electrical fans and separate toilets for ladies and gents are basic facilities to be made available in the health facilities. All the sampled health facilities had moderate facilities as shown in **Appendix 2.3.7**. Further, all the sampled health facilities followed the manual system for registration of the OPD patients.

2.3.8.2 Patient load in OPD

The number of out-patients who attended the OPDs in the sampled CHCs and the PHCs during the period 2017-2023, is shown in **Table 2.3.12**.

Table 2.3.12: Number of out-patients in the sampled CHCs and PHCs

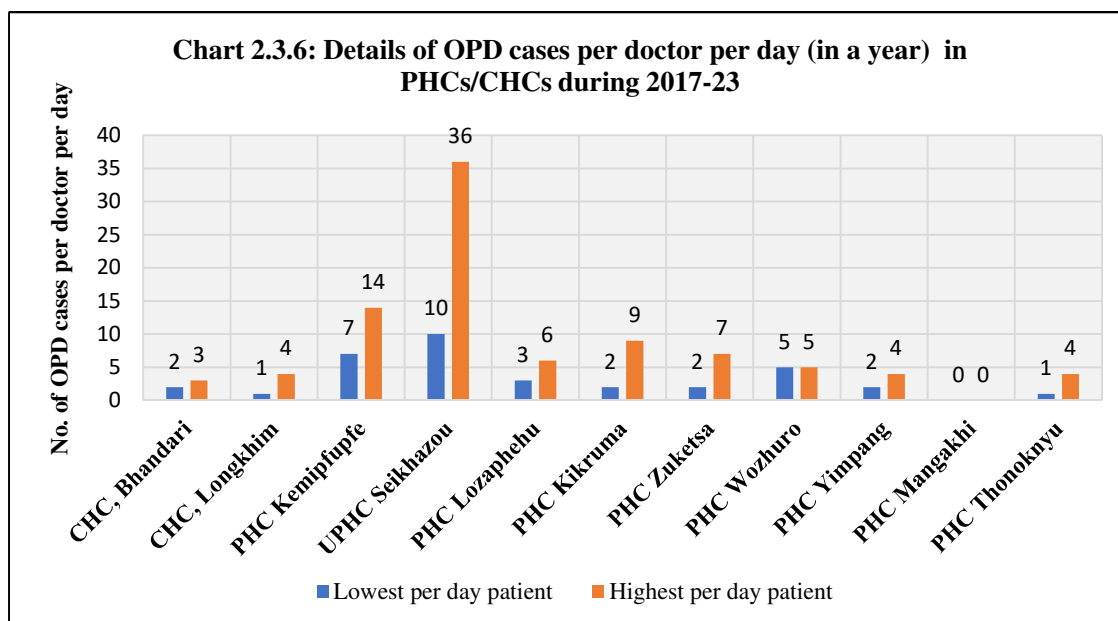
(in numbers)

Year	CHCs		PHCs								
	Bhandari	Longkhim	Kempifupfe	Seikhazou	Lozaphuhu	Kikruma	Zuketsa	Wozhuro	Yimpang	Mangakhi	Thonoknyu
	Number of Out-patients										
	Percentage increase (+)/ decrease (-)										
2017-18	3,448	4,379	1,949	10,380	1,632	582	526	1,464	530	1,112	1,050
2018-19	1,963	524	3,717	11,094	1,303	658	513	1,296	498	675	449
	(-)43	(-)88	(+)88	(+)7	(-)20	(+)13	(-)2	(-)11	(-)6	(-)39	(-)57
2019-20	2,378	356	1,894	11,731	1,193	903	661	1,334	566	284	492
	NA	(-)32	(-)49	(+)6	(-)8	(+)37	(+)29	(+)3	(+)14	(-)58	(+)10
2020-21	2,043	280	2,536	5,545	1,549	927	703	1,345	656	75	551
	(-)14	(-)21	(+)34	(-)53	(+)30	(+)3	(+)6	(+)1	(+)16	(-)74	(+)12
2021-22	3,071	2,072	2,136	19,577	937	896	1,771	1,348	948	178	343
	(+)50	(+)640	(-)16	(+)253	(-)40	(-)3	(+)152	0	(+)45	(+)137	(-)38
2022-23	2,969	2,080	2,200	19,580	940	2,361	1,771	1,350	498	180	948
	(-)3	0	(+)3	0	0	(+)164	0	0	(-)48	(+)1	(+)176

Source: Information collected from the test checked hospitals (NA-Information not available)

As seen from **Table 2.3.12**, the patient load showed an erratic trend during 2017-18 to 2019-20 and continued to show the same trend even during the Pandemic in 2020-21.

OPD cases per doctor is an indicator for measuring efficiency of OPD services in a hospital. Audit observed that there was an erratic trend in the OPD cases per doctor in the sampled CHCs and PHCs during 2017-23 as shown in **Appendix 2.3.8**. The overall status of OPD cases per doctor in the sampled CHCs and PHCs is shown in **Chart 2.3.6**.



Source: Departmental figures

Among the sampled PHCs, UPHC Seikhazou had patient load varying from 10 to 36 patients while Kempfupfe PHC had patient load varying from 07 to 14 patients per doctor during 2017-23.

2.3.8.3 Availability of diagnostic services

Diagnostic tests play a crucial role at every step of disease management. The diagnostic tests which are required to be done in the sampled health facilities and their availability are shown in **Table 2.3.13**.

Table 2.3.13: Availability of diagnostic tests in the sampled health facilities

Name of the health facility	X-Ray for chest, skull, spine, bones, abdomen and Dental X-Ray		No. of Clinical Pathology Services and other tests		ECG Tests		Ophthalmology Services	
	Required as per IPHS	Available	No. of tests as per IPHS	Tests available (per cent)	Required as per IPHS	Tests available	No. of tests as per IPHS	Tests available
CHC, Bhandari	Yes	No	29	6 (20.69)	Yes	No	3	0
CHC, Longkhim	Yes	No	29	18 (62.07)	Yes	Yes	3	0
PHC Kempfupfe	No	No	18	9 (38.89)	Desirable	No	0	0
UPHC Seikhazou	No	No	18	16 (88.89)	Desirable	No	0	0
PHC Lozaphuhu	No	No	18	2 (11.11)	Desirable	No	0	0
PHC Kikruma	No	No	18	5 (27.78)	Desirable	No	0	0
PHC Zuketsa	No	No	18	6 (33.33)	Desirable	No	0	0
PHC Wozhuro	No	No	18	10 (55.56)	Desirable	No	0	0
PHC Yimpang	No	No	18	0 (0.00)	Desirable	No	0	0
PHC Mangakhi	No	No	18	0 (0.00)	Desirable	No	0	0
PHC Thonoknyu	No	No	18	5 (27.78)	Desirable	No	0	0

Source: Information furnished by the health facilities

Audit noticed that Radiological investigation and Electrocardiogram (ECG) service were available in only one sampled CHC⁴⁴. Moreover, Pathology and Ophthalmology service was not available in any of the sampled CHCs though these were part of essential service delivery as per the IPHS guidelines. As regards the availability of Clinical Pathology services and other tests, audit observed that two PHCs did not have these services while in the remaining nine health facilities the availability ranged between 28 *per cent* and 89 *per cent*. Audit observed that the reason for inadequate availability was non-availability of equipment and qualified technicians.

It was further noticed that the XV FC approved ₹57.00 crore each under Health Sector Grant for 2021-22 and 2022-23. GoI had released ₹57.00 crore for 2021-22 out of which, Finance Department released ₹10.35 crore (March 2022) to the Department. During 2022-23, no grant was released by GoI.

While accepting the audit observation, the Department stated (October 2023) that with regard to free diagnostics in various health facilities, the HSCs and PHCs are being supplemented with the 15th Finance Commission (XV FC) Grants since 2021-22 till 2025-26. It was further stated that with reference to CHCs, Block level integrated public Health Lab is to be supplemented under the same XV FC grant and equipped through the Block Public Health Unit component and the same is to be implemented through the Rural Department, which is yet to be implemented. It was also stated that free diagnostic initiatives are yet to be supplemented due to delay and constraints of fund receipts. The Department also expressed hope to streamline the diagnostic services as per standards and guideline in the coming years.

2.3.8.4 Quality assurance of laboratory services

Quality testing of in-house pathological services through the Internal Quality Assessment scheme as well as through External Quality Assessment scheme is part of the quality assurance mechanism for laboratory services under the IPHS for the CHCs. The periodic validation of laboratory reports should be done with external agencies like District PHC/Medical College for quality assurance of laboratory services. Further, periodic calibration of laboratory equipment is also required.

Audit noticed that the Internal Quality Assessment scheme and the External Quality Assessment scheme were not designed for quality testing of in-house pathological services offered by the CHCs. No records regarding validation of laboratory reports by the District Health Authority for quality control of laboratory services, periodic calibration of laboratory equipment were made available to audit. Thus, there was lack of effective quality assurance mechanism for laboratory services provided in the sampled CHCs.

⁴⁴ CHC Longkhim

2.3.9 In-Patient Department Services in the PHCs and CHCs

Availability of doctors, nurses, essential drugs/equipment, dietary services and patient safety along with performance evaluation of IPD services as per the available norms *vis-à-vis* actuals are discussed in the succeeding **Paragraphs 2.3.9.1 to 2.3.9.6.**

2.3.9.1 Availability of in-patient services in the PHCs and CHCs

As per the IPHS guidelines, CHCs should provide Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics, Dental, AYUSH and emergency services while Eye Specialist services should be available at one in every five CHCs. Specialist in-patient service pertaining to General Medicine, General Surgery, Obstetrics & Gynaecology and Paediatrics should be available.

Audit observed that only General Medicine service was available in the sampled CHCs⁴⁵. No other specialist services were available in any of the sampled CHCs. Absence of specialist services for Surgery, Obstetrics & Gynaecology and Paediatrics in CHCs compels the patients seeking these services to travel long distance to the nearest DHs, which are available in all districts in the State.

2.3.9.2 Operation Theatre services

IPHS guidelines prescribe OTs for elective major surgery, emergency services, Obstetrics & Gynaecology and Orthopaedics for the CHCs.

Audit observed that the OT facility was not available in the two sampled CHCs. Thus, patients were denied the benefits of OT services.

2.3.9.3 Referrals of patients to higher facilities for better treatment

Audit noticed that out of 1,616 admitted patients in the sampled health facilities, 139 patients were referred to other Hospitals during 2017-18 to 2022-23. The detailed position is shown in **Table 2.3.14.**

Table 2.3.14: Admission of patients and referrals by the health facilities (2017-23)

Health facility(s)	Number of OPD patients (2017-23)	Number of patients admitted (IPD) (2017-23)	Number of patients referred out	Percentage of referral <i>vis-a-vis</i> admitted	Number of patients referred in maternal cases	Percentage of maternal cases referred to total referral
CHC, Bhandari	15,872	486	1	0.21	0	0
CHC, Longkhim	9,691	587	125	21.29	NA	NA
PHC Kemipfupfe	14,432	51	0	0	0	0
UPHC Seikhazou	77,907	43	2	4.65	0	0
PHC Lozaphuhu	7,554	17	0	0	0	0
PHC Kikuma	6,327	97	2	2.06	0	0

⁴⁵ CHC Bhandari and CHC Longkhim

Health facility(s)	Number of OPD patients (2017-23)	Number of patients admitted (IPD) (2017-23)	Number of patients referred out	Percentage of referral <i>vis-a-vis</i> admitted	Number of patients referred in maternal cases	Percentage of maternal cases referred to total referral
PHC Zuketsa	5,945	46	4	8.70	0	0
PHC Wozhuro	8,137	56	0	0	0	0
PHC Yimpang	3,696	0	0	0	0	0
PHC Mangakhi	2,504	0	0	0	0	0
PHC Thonoknyu	3,833	233	5	2.14	0	0
Total	155,898	1,616	139			

Source: Information furnished by sampled Hospitals (NA-Data not available)

It can be seen from **Table 2.3.14** that there were no referrals from PHC Kemipfupfe, PHC Lozaphuhu, PHC Wozhuro and PHC Mangakhi. The maximum number of referrals were from CHC, Longkhim which was 21.29 *per cent* of the total admissions during 2017-18 to 2022-23. This indicated that CHC, Longkhim was not capable of handling the cases and referred out the patients to the DHs resulting in additional expenses for patients due to absence of affordable services near home. This is a deviation from the objective of National Health Policy, 2017 which aims at reducing out of pocket expenditure due to health care cost. The referrals could have been avoided had CHC, Longkhim been provided with the specialist services as per the IPHS.

2.3.9.4 Documentation of OT procedures

NHM Assessor's Guidebook prescribes that the surgical safety checklist, pre-surgery evaluation records and post-operative evaluation records for OTs should be prepared for each case. As none of the sampled CHCs had OT facilities, they did not maintain the OT procedure and OT safety checklist. The absence of OT facilities in the sampled CHCs led to the omission of essential surgical safety protocols outlined in the NHM Assessor's Guidebook. As a result, surgical safety checklists and evaluation records were not maintained as prescribed, highlighting a critical gap in ensuring patient safety and quality of care at the CHCs.

2.3.9.5 Emergency service

According to the IPHS, a CHC should have the facility to attend emergency cases of surgery, medicine, emergency obstetric care, emergency care of sick children including facility based Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy and emergency oral health and cardio-vascular disease. A separate earmarked emergency area is to be located near the entrance of the hospital preferably having four rooms (one for doctor, one for minor OT, one for plaster/dressing and one for patient observation) with at least four beds. The PHC should be capable of providing appropriate management of injuries and accident, first aid, stitching of wounds, incision and drainage of abscess, stabilisation of the condition of the patient

before referral, dog bite/snake bite/scorpion bite cases, and other emergency conditions. The PHC should also have separate Minor OT/Dressing Room/Injection Room.

Availability of emergency services in the sampled health facilities is shown in **Table 2.3.15**.

Table 2.3.15: Status of availability of Emergency Services in the sampled Health facilities

Nature of the facility required to be available	Name of the Health facilities where the facilities are	
	Available	Not Available
Whether signage display for emergency on entrance available?	CHC Longkhim and, Seikhazou UPHC	CHC Bhandari and PHCs- Kemipfupfe, Thonoknyu, Wozhuro, Yimpang, Lozaphuhu, Zuketsa, Mangakhi and Kikruma.
Whether emergency ward has dedicated triage?	Nil	CHCs – Bhandari and Longkhim and PHCs- Kemipfupfe, Seikhazou, Lozaphuhu, Kikruma, Zuketsa, Mangakhi, Thonoknyu, Wozhuro and Yimpang.
Whether emergency ward has resuscitation and observation area?	UPHC Seikhazou	CHCs – Bhandari and Longkhim and PHCs- Kemipfupfe, Lozaphuhu, Kikruma, Zuketsa, Mangakhi, Thonoknyu, Wozhuro and Yimpang.
Whether emergency ward has separate provision for examination of rape/sexual assault victim?	UPHC Seikhazou	
Whether emergency ward has Separate emergency beds. Duty rooms for doctors/nurses/paramedical staff and medico legal cases?	Nil	CHCs – Bhandari and Longkhim and PHCs- Kemipfupfe, Seikhazou, Lozaphuhu, Kikruma, Zuketsa, Mangakhi, Thonoknyu, Wozhuro and Yimpang.
Whether emergency ward has Emergency block to have ECG, Pulse Oximeter, Cardiac Monitor with Defibrillator, Multi-parameter Monitor, Ventilator also?	Nil	
Whether emergency ward has procedure for Receiving and triage of patients?	UPHC Seikhazou	CHCs – Bhandari and Longkhim and PHCs- Kemipfupfe, Lozaphuhu, Kikruma, Zuketsa, Mangakhi, Thonoknyu, Wozhuro and Yimpang.
Whether emergency ward has emergency protocols are defined and implemented?	Nil	CHCs – Bhandari and Longkhim and PHCs- Kemipfupfe, Seikhazou, Lozaphuhu, Kikruma, Zuketsa, Mangakhi, Thonoknyu, Wozhuro and Yimpang.

Source: Joint Physical Verification data

It can be seen from **Table 2.3.15** that most of the emergency services were virtually absent in the sampled health facilities. Thus, due to non-availability of emergency services and other specialist services, emergency patients and patients with cardiovascular diseases, though CHCs were equipped to handle such cases, were referred to the DHs and other Hospitals for better treatment putting the patients at distress involving higher out of pocket expenses.

2.3.10 Maternal and Child Care

2.3.10.1 MMR and IMR

Maternal Mortality Rate (MMR) refers to the number of maternal deaths per 1,00,000 live births due to causes related to pregnancy or within 42 days of

termination of pregnancy, regardless of the site or duration of pregnancy. Infant Mortality Rate (IMR) indicates the number of deaths of infants (under one year) per 1,000 live births.

The All India MMR during 2014-16 stood at 130 per 100,000 live births which declined to 113 in 2016-18. The All India IMR which stood at 34 per 1000 live births in 2016 came down to 28 in 2020.

Trend of Maternal Deaths and IMR in Nagaland during 2017-23 is shown in **Table 2.3.16**.

Table 2.3.16: Trend of Maternal Deaths and IMR of Nagaland during 2017-23

Year	Number(s) reported			IMR in India	IMR in Nagaland (of 1,000 live births)
	Live births	Maternal deaths	Infant deaths		
2017-18	19,697	28	216	33	11
2018-19	19,586	18	213	32	11
2019-20	20,423	22	170	30	8
2020-21	16,264	20	136	29	8
2021-22	16,090	11	151	28	9
2022-23	18,807	14	181	27	10

Source: Information furnished by the Department

The MMR for the State was not calculated as the live birth figure was below one lakh during 2017-18 to 2022-23. However, IMR⁴⁶ in the State was lower than all India figures. The IMR after decreasing in 2019-20 showed a continuous upward trend. During the period 2017-18 to 2022-23, the IMR was well below the All-India average figure, which is a positive sign.

2.3.10.2 Antenatal Care

According to the IPHS, HSCs are mainly responsible for providing Ante-Natal Care (ANC) service to pregnant woman which includes early registration of pregnant woman and providing a minimum of four ANC services, name-based tracking of all pregnant women for assured service delivery and identification of high-risk pregnancy cases. The role of the Auxiliary Nurse and Midwife (ANM) is to provide outreach services to the people under the respective Sub Centre.

The total number of Pregnant Women (PWs) in the State registered for ANC, registered within the first trimester (within 12 weeks), number of PW who received up to four ANC check-up, number of PW given TT2/Booster, during 2017-23 is shown in **Table 2.3.17**.

⁴⁶ Infant Mortality Rate

Table 2.3.17: Pregnant women registered and received ANC services

Year	Number of PW registered for ANC		No. of PWs received up to three to four ANC check-ups (per cent)	TT2 or Booster given to PWs (per cent)	IFA Tablets given to PWs (per cent)
	Total	Within first trimester (per cent)			
2017-18	37,217	11,165 (30)	7,071 (19)	14,887 (40)	3,350 (09)
2018-19	37,402	10,473 (28)	8,228 (22)	14,213 (38)	5,984 (16)
2019-20	39,235	10,593 (27)	9,024 (23)	16,086 (41)	9,024 (23)
2020-21	33,105	9,269 (28)	4,966 (15)	13,573 (41)	12,580 (38)
2021-22	33,759	9,790 (29)	6,414 (19)	15,192 (45)	14,516 (43)
2022-23	35,207	11,266 (32)	9,154 (26)	16,899 (48)	21,476 (61)
Total	2,15,925	62,618 (29)	49,663 (23)	86,370 (40)	64,778 (30)

Source: Information furnished by the Department

It can be seen from **Table 2.3.17** that during 2017-23, the registration of PW within the first trimester, showed gradual improvement. However, 71 per cent PW did not register within the first trimester during this period. Similarly, number of PW for three to four ANC check-ups, TT2 or Booster and IFA doses were 23, 40 and 30 per cent respectively.

Thus, the HSCs which were assigned to provide the ANC services to the PW did not perform in the key areas of activities though services are gradually improving.

While accepting the audit observation, the Department highlighted (October 2023) major challenges and issues like reluctance/unwillingness of pregnant women to come forward for ANC unless there are complications, the presence of geographical barriers and shortage of health units against the number of villages. Further, the Department highlighted the plan/strategy to address the issues through capacity building/sensitisation of health care workers, awareness for civil society & faith-based organisations and strengthening of outreach services.

The reply on reluctance/unwillingness of pregnant women to come forward was not tenable as it is the responsibility of the HSCs to reach out and to provide ANC services to pregnant woman.

2.3.10.3 Stillbirths

As per the National Family Health Survey-5⁴⁷ (NFHS-5), the rate of stillbirth in India is 0.90 per cent of live births. The trend of stillbirths in Nagaland is given in **Table 2.3.18**.

Table 2.3.18: Number and rate of stillbirths in the State

Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Total number of deliveries	19,943	19,690	20,619	16,474	16,215	18,981
Number of stillbirths	351	306	301	284	236	281
Percentage of stillbirth with reference to deliveries	1.76	1.55	1.46	1.72	1.46	1.48

Source: Information furnished by the Department

It can be seen from **Table 2.3.18** that the rate of stillbirths during 2017-23 in the State ranged between 1.48 and 1.76 per cent which was much higher than the national

⁴⁷ National Family Health Survey-5, 2019-21 data

average of 0.90 *per cent*. However, the stillbirth rate was zero *per cent* in the sampled PHCs and the CHCs during 2017-23 as shown in **Table 2.3.19**.

Table 2.3.19: Stillbirth rate in the sampled PHCs and CHCs

Hospital	Number of deliveries during 2017-18 to 2022-23	Number of still births	Percentage of still birth to deliveries
CHCs			
Bhandari	486	0	0
Longkhim	NA	NA	NA
PHCs			
Kempfupfe	48	0	0
Seikhazou	41	0	0
Lozaphuhu	17	0	0
Kikruma	97	0	0
Zuketsa	76	0	0
Wozhuro	57	0	0
Yimpang	NA	NA	NA
Mangakhi	NA	NA	NA
Thonoknyu	276	0	0

Source: Information furnished by sampled Hospitals

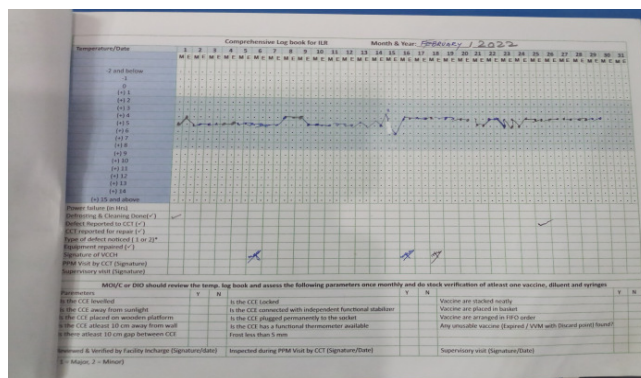
2.3.11 Management of drugs

2.3.11.1 Drug storage

As per the IPHS guidelines, sufficient number of racks shall be provided in CHCs/PHCs and drugs shall be stored properly and systematically. Further, as per IPHS guidelines, Medical Officers (in CHC/PHC) will ensure proper storage of vaccines and maintenance of cold chain equipment. Vaccine storage data sheet had provision for filling important information such as duration of power failure, use of independent stabilizer and vaccine found in frozen condition.

The audit findings relating to the storage of drugs and vaccines in the sampled health facilities are as under:

- Labelled shelves/racks were not available in Mangakhi PHC and Thonoknyu PHC.
- 24-hour temperature recording of the stored vaccines was not available in Mangakhi PHC and Yimpang PHC.
- Vaccine storage data sheet was not filled in and there was no monitoring by the person in-charge of the health facilities.
- Instructions for storage of vaccine were not available in Bhandari CHC, Mangakhi PHC, Yimpang PHC, Lozaphuhu PHC and Zuketsa PHC.



Photograph 2.3.1: Important information in the vaccine storage datasheet not filled (PHC Kempfupfe)

2.3.12 Conclusion

Though services of specialist doctors were to be made available in the CHCs as per the IPHS, no specialist services were available in the CHCs in the State except in CHC, Noklak, Pungro, Jalukie, Meluri and Tobu where Obstetrics & Gynaecology service were available. CHCs were functioning more like PHCs; the CHCs and PHCs are differentiated only in terms of the number of beds, with more beds in CHCs. Diagnostic services like Pathology and Ophthalmology which were required to be available in the CHCs as per the IPHS were missing. Quality assurance in the Laboratory Services as mandated under the IPHS was not done. Emergency and Trauma Care service was virtually absent in the sampled health facilities. Due to non-availability of emergency services and other specialist services, emergency patients and patients with cardiovascular diseases, were referred to the DHs and other Hospitals for better treatment putting the patients at distress involving higher out of pocket expenses. HSCs, responsible for providing ANC service to the pregnant woman including the outreach services to the people under them, could not provide the desired service as a result, more than 26 *per cent* of the registered PWs did not receive four ANC check-ups during 2022-23.

2.3.13 Recommendations

The State Government may-

- (i) ensure posting of specialist doctors and provide necessary emergency services as well as other specialist services in the deficient health facilities as per IPHS norms.*
- (ii) provide necessary diagnostic services in the CHCs to reduce the pressure at the District and State Level Hospitals and mitigate the problems of travelling longer distances and incurring out of pocket expenses by patients.*
- (iii) monitor the services rendered by the HSCs to ensure that the required service assigned to HSCs are delivered.*

Audit objective 2: Whether support services in the healthcare facilities are available and adequate

2.3.14 Other Support Services

The operational activities of a health facility comprise a wide variety of support services *viz.*, management of linens, dietary management, ambulance service, sweeping & cleaning service and hospital security service.

Management of support services in the sampled health facilities is discussed in the succeeding *Paragraphs 2.3.14.1 to 2.3.14.5.*

2.3.14.1 Dietary services

As per the IPHS guidelines, pregnant women are entitled to free diet in the health institutions. Further, the guidelines states that it is desirable to provide nutritious and well-balanced diet to all IPD patients keeping in mind their cultural preferences.

Audit observed that the Health and Family Welfare Department did not recommend types of diet depending upon the types of in-patients and that sampled PHCs and CHCs did not provide dietary services to the patients.

2.3.14.2 Hospital linen services

As per the IPHS guidelines, provision for clean linen shall be made for admitted patients. At least five sets of linen shall be made available. Laundry Services may be available in house or outsourced.

The Health and Family Welfare Department, GoN did not have any policy for providing clean and hygienic linen to patients and schedule of change of soiled bedsheets and blankets.

The schedule of changing the bedsheets could not be ascertained as no records were maintained by the sampled health facilities. Besides, records of collection of soiled linens from the wards and returning them back by the service provider were also not maintained. In absence of proper records, standards and procedure followed by the health facilities for sluicing of soiled, infected and fouled linen could not be ascertained in audit. Further, records relating to monitoring the type and quantity of the cleaning agent or the detergent used for cleaning the soiled linens were not available.

2.3.14.3 Infection control

As per the Hospital Infection Control Guidelines, hospitals should have Hospital Infection Control Committee (HICC) to formulate appropriate guidelines on hospital infection measures. It was observed that HICC was found to have been formed in five out of the 11 sampled health facilities. It was also noticed that infection control checklist was not prepared by eight sampled health facilities. Thus, HICC did not deliver any specific plan to control hospital infection.

Of the five sampled health facilities which had HICC, CHC Bhandari had the highest number of HICC meetings, which was five times since its formation in 2018. The HICC meetings in the other four health facilities which had HICC ranged from one to four.

2.3.14.4 Staff immunisation and medical check-up of health care workers

As per the IPHS guidelines (read with Infection Management and Environment Plan), immunisation of staff against Hepatitis B and Tetanus is a part of the hospital infection control programme and is to be followed by the CHCs/PHCs. Audit was informed that all the sampled health facilities provided Hepatitis B and Tetanus injections to all their health care workers except for PHC, Mangakhi which did not

immunise health workers with Hepatitis B. However, no records regarding staff immunisation could be produced by any of the sampled health facilities.

2.3.14.5 Disinfection and sterilisation

According to the NHM Assessor's Guidebook for Quality Assurance in the health facilities, the facility should have standard procedures for processing for disinfection and sterilisation of equipment and instruments.

Audit noticed that out of eleven sampled health facilities, two health facilities viz., CHC, Bhandari and PHC, Kemipfufpe adopted boiling, autoclaving and chemical sterilisation process for disinfection and sterilisation of hospital equipment and instruments. The other nine sampled health facilities were using only boiling or only chemical sterilisation for sterilisation of equipment and instruments.

2.3.15 Patient safety

2.3.15.1 Disaster management capability of hospitals

NHM Assessor's Guidebook envisages that a Disaster Management Plan (DMP) be prepared for each health facility and that disaster management training for hospital staff and periodic mock drills in the hospitals be conducted. Further, Standard Operating Procedures (SOPs) should be available, and a disaster management committee should be constituted.

Audit noticed that out of 11 sampled health facilities, only two health facilities viz., Kemipfufpe PHC and Seikhazou UPHC had a disaster management plan and a SOP on disaster management. However, no records regarding conduct of mock drill on disaster management were maintained by any of the sampled health facilities. It was also observed that a No Objection Certificate (NOC) was not obtained from the Nagaland Fire Services and Emergency Services under Home Department, GoN. Further, fire prevention plan was not found formulated in any of the sampled health facilities except in Seikhazou UPHC. Fire detection alarm was also not available in any of the sampled health facilities which was required as per norms. Thus, absence of fire control measures and DMP posed a major threat to the patients.

2.3.16 Bio-Medical Waste management

As per the Bio-Medical Waste Management (BMW) Rules, 2016, bio-medical waste shall be segregated into containers or bags labelled (as specified in Schedule IV) at the point of generation. Further, disposal by deep burial is permitted only in rural or remote areas where there is no access to common bio-medical waste treatment facility. Further, it shall be the duty of every health care facility to provide training to all its health care workers and others, involved in handling of bio medical waste at the time of induction and thereafter at least once every year and the details of training programmes conducted, number of personnel trained and number of personnel not undergone any training shall be provided in the Annual Report.

Audit observed that during 2018-23, all the sampled health facilities were segregating the waste into different categories in separate-coloured bins, available at the point of generation of waste, particularly in the ward areas.

It was further observed that all the sampled PHCs and CHCs were using deep burial pit for disposal of hospital wastes except for PHC Lozaphuhu where burning of waste was still in practice even though deep burial pit was available.



Photograph 2.3.2 Un-used burial pits/Burning pit

Photograph 2.3.2 shows the un-used burial pit and burning pit in PHC Lozaphuhu which poses a serious threat to the environment and the people who live in the surrounding areas. During audit, it was stated by all sampled PHCs and CHCs that training on BMW for the Staff was conducted as per norms, however, no records of training details are available in these sampled health centres.

2.3.17 Ambulance Service

According to the IPHS norms, each PHC/CHC should have ambulance facilities for transporting patients for timely and assured referral to higher units.

Audit observed that none of the sampled health facilities have ambulances except CHC, Longkhim and UPHC, Seikhazou. These two health facilities were providing ambulance service free of cost in emergency cases as a referral transport to the higher health facility.

2.3.18 Evaluation of In-patient Services through Outcome Indicators

This paragraph presents an assessment of overall Health Indicators of the State and the IPD services provided during 2017-23 in the sampled health facilities. The Outcome Indicators (OIs) prescribed in IPHS guidelines are Bed Occupancy Rate (BOR), Leave Against Medical Advice (LAMA) Rate, Absconding Rate and Referred Out Rate (ROR). **Table 2.3.20** gives the categorisation and methodology of evaluating these standards.

Table 2.3.20: Calculation of quality indicators

Type	Quality Indicator	Numerator	Denominator
Productivity of hospital	BOR (in per cent)	Total patient bed days X 100	Total No. of functional beds X No. of days in a month
Service quality of hospital	LAMA (Rate/1000)	Total No. of LAMA X 1000	Total No. of admissions
	Absconding (Rate/1000)	Total No. of Absconding cases X 1000	Total No. of admissions
Efficiency	ROR (in per cent)	Total No. of cases referred to higher facility X 100	Total No. of admissions

Source: IPHS Norms

Relative performance of the sampled health facilities on various OIs as worked out by audit is shown in **Table 2.3.21**.

Table 2.3.21: Outcomes vis-à-vis availability of resources in the sampled health facilities

Sl. No.	Name of the Health Facilities	Outcome Indicators			
		BOR (per cent)	ROR (per cent)	LAMA per 1,000	Abs. Rate per 1,000
CHCs					
1.	Bhandari	9.94	14.29	0	0
2.	Longkhim	11.21	21.32	0.82	0
PHCs					
3.	Kempifupfe	0.52	3.70	0	0
4.	Seikhazou	1.95	0.89	0	0
5.	Lozaphuhu	0.93	17.95	0	0
6.	Kikruma	1.41	0	0	0
7.	Zuketsa	2.17	2.00	0	0
8.	Wozhuro	0.44	3.51	0	0
9.	Yimpang	NA	0	0	0
10.	Mangakhi	NA	0	0	0
11.	Thonoknyu	4.48	0.74	0	0
Benchmark⁴⁸		80-100%	5.85	0.07	0.00

Source: Records of sampled health facilities, NA-No IPD services

From **Table 2.3.21** above, it can be seen that:

- CHC Bhandari has the lowest BOR of 9.94 which indicated that CHC Bhandari did not have the required IPD facility in terms of doctors and ancillary facilities.
- CHC Longkhim with ROR of 21 out of 1,000 patients was the highest amongst the sampled health facilities, indicating that health care facilities were not at par with other sampled health facilities.
- LAMA was nil in all sampled health facilities except in CHC Longkhim and Absconding rates were zero in all the sampled health facilities. However, this does not imply better service availability in the health facility as the BOR was low in all the sampled health facilities.
- PHC Lozaphuhu had low bed occupancy and a high referred out rate indicating that this PHC had struggled to provide quality services due to shortage of manpower, essential diagnostic services, absence of emergency and trauma care services. Similarly, PHCs, Kempifupfe and Wozhuro were also struggling to provide good services to the patients as reflected in the high Referral Out.

2.3.19 Patient rights and grievance redressal

According to the IPHS, grievance redressal mechanism is part of the Citizen Charter. The Government of Nagaland also instituted an on-line Public Grievance Redressal Mechanism System; however, the Health and Family Welfare Department is not part

⁴⁸ Benchmarks: BOR – as per IPHS, weighted average for rest of the outcome indicators.

of the system and none of the sampled health facilities mentioned the grievance redressal mechanism in the Citizen Charter displayed in the facility.

Of the sampled CHCs and PHCs, only PHC Yimpang and UPHC Seikhasou constituted Grievance Redressal Committee in 2021-22 and 2022-23 respectively. These health facilities did not receive any complaint till March 2023.

2.3.20 Conclusion

Hospital support services, viz., diet, laundry and linen service and infection control were operational in the sampled health facilities but without any standard operating guidelines. Health care facilities were running without any safety clearance from the Fire Department posing a major fire threat to the patients. Hospital Infection Control Committee (HICC) was found to have been formed in four out of the eleven sampled health facilities but did not deliver any specific plan to control hospital infection. Sampled Health facilities were found not adhering to the Bio Medical Waste Management Rules. PHC Lozaphuhu had low bed occupancy and a high referred out rate indicating that this hospital had struggled to provide quality services due to shortage of manpower, essential diagnostic services, absence of emergency and trauma care services. Similarly, PHCs, Kemipfupfe and Wozhuro were also struggling to provide good services to the patients as reflected by the high Referral Out. Grievance redressal mechanism was not available in nine out of 11 sampled health facilities.

2.3.21 Recommendations

The State Government may-

- (i) *ensure that standard operational guidelines be prepared for hospital support services like linen, laundry and diet service.*
- (ii) *ensure formation of HICC in each health facility and strengthen the effectiveness of HICC by providing specific training and resources to develop comprehensive infection control plans tailored to each facility's needs*
- (iii) *prioritise obtaining safety clearance from the concerned Department for all healthcare facilities to mitigate the risk of fire hazards and ensure patient safety.*
- (iv) *ensure strict adherence to Bio-Medical Waste Management Rules in all sampled health facilities to prevent environmental contamination and protect public health.*
- (v) *ensure to improve the quality of services and patient care at PHCs with low bed occupancy and high referral rates by conducting assessments, identifying root causes of service deficiencies, and implementing targeted interventions to address gaps in service delivery.*

Audit objective 3: Whether assets created for Emergency related services were utilised efficiently

2.3.22 Creation and Utilisation of assets

2.3.22.1 Funds and utilisation

Total pandemic affected cases in the State were 36,029 and there were 782 deaths (as on 13 July 2023). The status of receipts of funds and expenditure to deal with the pandemic situation in the State during 2020-22 are given in **Table 2.3.22**.

Table 2.3.22: Receipts and Expenditure of Covid Funds

(₹ in crore)

Financial Year	Name of the Component	Central Share	State Share	Total Funds	Expenditure	Balance
2019-20	ECRP ⁴⁹	3.71	0.00	3.71	3.71	0.00
	Sub-Total	3.71	0.00	3.71	3.71	0.00
2020-21	State Government Budget	0.00	72.95	72.95	70.55	2.40
	CM Fund	0.00	0.10	0.10	0.10	0.00
	NBCC	0.00	0.005	0.005	0.00	0.005
	NSDMA	0.00	0.44	0.44	0.44	0.00
	GoI Grants (NHM NEC)	3.00	0.00	3.00	3.00	0.00
	ECRP	0.41	0.00	0.41	0.41	0.00
	ER&HSPP ⁵⁰	10.27	0.00	10.27	9.94	0.33
	Vacc for HCW & FLW ⁵¹	1.10	0.00	1.10	1.07	0.03
	Sub-Total	14.78	73.495	88.275	85.51	2.765
2021-22	State Government Budget	0.00	34.88	34.88	32.83	2.05
	ER&HSPP	31.23	0.00	31.23	17.07	14.16
	Sub-Total	31.23	34.88	66.11	49.90	16.21
	Grand Total	49.72	108.375	158.095	139.12	18.975

Source: Departmental records, bills and vouchers

During 2019-22, ₹158.095 crore was available with the State for Covid management, out of which, ₹139.12 crore was utilised and ₹18.97 crore remained as balance (March 2022) with the Department.

The funds were mainly utilised for construction of PSA oxygen generation plants, platform/for ICU units, setting up of BSL laboratory, Bio waste incinerators, waste water treatment plants, various works under maintenance, diet for the patients, patients' transportation and for procurement of TrueNat machines, DG set, oxygen cylinders, ambulances, infrared thermometers, ventilators, consumables like medicines, mask, PPE kit, sanitizers, gloves, dietary charges, test kits, handwashes and sodium hypochloride. Detailed position is given in **Appendix 2.3.9**.

Of the balance amount of ₹18.97 crore, ₹14.16 crore was with NHM, Nagaland which was meant for Covid Essential Diagnostic and Drugs, ramping up Health Infrastructure with focus on Paediatric care units, IT Interventions, Capacity Building and Training. Further, it was noticed during audit of DHS that though there was no

⁴⁹ ECRP-Emergency Covid Response Funds.

⁵⁰ ER&HSPP – Emergency Response & Health Systems Preparedness Package.

⁵¹ Vaccination for Health Care Workers & Frontline Workers.

immediate requirement of funds for any Covid related activities, unutilised funds were not surrendered.

ECRP II funds, which constituted the major fund component during 2021-22 were mainly sanctioned for ramping up health infrastructure with the focus on Paediatric care units. Out of total sanctioned amount of ₹31.23 crore under ECRP-II, ₹14.16 crore remained unspent. Despite availability of funds, ramping up of health infrastructure was slow which resulted in slow pace of expenditure.

Apart from the above, the State received 24 PSA oxygen plants⁵² through three sources viz., PM cares, UNICEF and UNDP Programme as assistance in kind to deal with the Covid situation in the State.

The Department, in its reply stated (October 2023) that completion certificates of installation of prefab structure for all 108 units has been received and that the remaining balance amount of ₹1.46 crore would be released after the supply of furniture. The Department further stated that, the firm engaged for installation of 105 units has been directed to expedite the work for which an amount of ₹11.08 crore was yet to be released.

2.3.22.2 Verification of assets created

The issues related to post Covid utilisation/usage of the infrastructure created and the equipment/kits provisioned during the pandemic require thorough administrative planning, assessment of gaps in the hospital infrastructure and equipment and dedicated effort to bridge the gap with the additional infrastructure and equipment like ICU beds, ICU machines and Oxygen Concentrators created to deal with the situation in the State. Status of verification of major equipment and other hospital items in the five major hospitals in the State is shown in *Appendix 2.3.10*.

Audit noticed that assessment was not done to identify gaps in hospital infrastructure for utilisation of available additional infrastructure and equipment like ICU beds, ICU machines, Oxygen Concentrators. As a result, Oxygen Concentrator, Ventilator and ICU beds were found lying idle in the Directorate/hospital stores and were required to be re-distributed on need basis. The major items which were lying idle are as shown in **Table 2.3.23**.

Table 2.3.23: Idle lying of Covid equipment and assets

Sl. No.	Name of the Item	Total Quantity received	Quantity lying idle	Where lying idle
1.	ICU Beds	40	4	Directorate store
2.	Oxygen Concentrator	1,836	648	Directorate store
		352	10	CMOs-Dimapur, Kohima, Phek, Tuensang
		209	53	DHs-Dimapur, Phek, Tuensang, Wokha, Kohima
3.	Ventilator	414	38	Directorate store
		21	16	DHs-Phek, Wokha
4.	Covid Test Kits	6,98,133	3,24,886	Directorate store

Source: Departmental records

⁵² 15 nos. from PM cares, six nos. from UNICEF and three from UNDP.

2.3.22.3 Verification of Oxygen Plants and concentrators

The Government of Nagaland received 24 Pressure Swing Adsorption (PSA) plants from the PM-CARE Funds (15), UNDP (three) and UNICEF (six) during 2021-22. PSA plants were installed in all 11 DHs⁵³, eight CHCs⁵⁴ and in CIHSR, Dimapur. The status of Oxygen Plants in the respective health facilities is given in **Table 2.3.24**.

Table 2.3.24: Status of verification of Oxygen Plants in the health facilities in the State

Sl. No.	Health Facility	Audit findings	Department's reply (October 2023)
1.	DH, Kohima	The PSA System remained non-functional from the date of installation (July 2021) to the date of verification (July 2022) due to usage of lower capacity stabilizer as 150 KVA capacity was supplied instead of 300 KVA capacity stabilizer.	The PSA has been utilised. Joint Physical Verification (January 2024) confirmed it.
2.	DH, Wokha	The PSA system was yet to be made functional till the date of verification (August 2022) due to non-connection of pipe to the manifold, oxygen plant leakage and non-installation of separate transformer.	The issue related to non-connection of pipe to manifold and leakage has been repaired. However, transformer is yet to be provided.
3.	DH, Tuensang	The PSA system was yet to be made functional till the date of verification (August 2022) due to non-installation of separate transformer.	Transformer is yet to be provided, though functional with Generator.
4.	DHs - Phek and CHC Bhandari	The PSA system (CHC, Bhandari) was yet to be made functional till the date of verification (August 2022) due to low voltage. The Oxygen plants were installed and remained functional.	Functional with dedicated transformer.

Source: Joint Physical verification data

In all the cases where the plants remained non-functional, the patients were provided Oxygen Cylinder bottles after refilling, implying that there was no reduction in the expenditure on oxygen cylinders despite the installation of PSA plants as these plants remained unutilised.

While accepting the audit observation on usage of Oxygen Cylinder in those hospitals where PSA plants remained non-functional, the Department stated (October 2023) that Oxygen cylinder is used since the transformer is yet to be provided by the Government.

2.3.23 Conclusion

Significant funds earmarked for dealing with the pandemic situation in the State remained un-utilised. Funds amounting to ₹18.97 crore were not surrendered despite no immediate requirement. Progress on ramping up of health infrastructure with the focus on Paediatric care units was slow despite availability of funds. There was no

⁵³ DH, Kohima (two), DH, Dimapur (one), DH, Kiphire (one), DH, Peren (one), DH, Phek (two), DH, Tuensang (two), DH, Mokokchung (two), DH, Zunheboto (one), DH, Mon (one), Dh, Wokha (one) and DH, Longleng (one).

⁵⁴ CHCs – Yachem, Jalukie, Noklak, Pungro, Tobu, Meluri, Bhandari and Aghunato (one each).

reduction in the expenditure on Oxygen Cylinders despite the installation of PSA plants, as these plants largely remained un-utilised. Assets created during the pandemic, were found idle and are to be re-distributed on need basis.

2.3.24 Recommendations

The State Government may-

- (i) *undertake assessment of utilisation of funds immediately and ensure that the Department surrenders the excess funds.*
- (ii) *regularly monitor progress of health infrastructure works for early completion and speedy utilisation of earmarked funds.*
- (iii) *assess the utilisation of the assets and equipment created and procured during pandemic and consider redistribution based on the requirement of the health facilities.*

Audit objective 4: Whether the State spending on health has improved the Health and Well-being conditions of people as per SDG 3

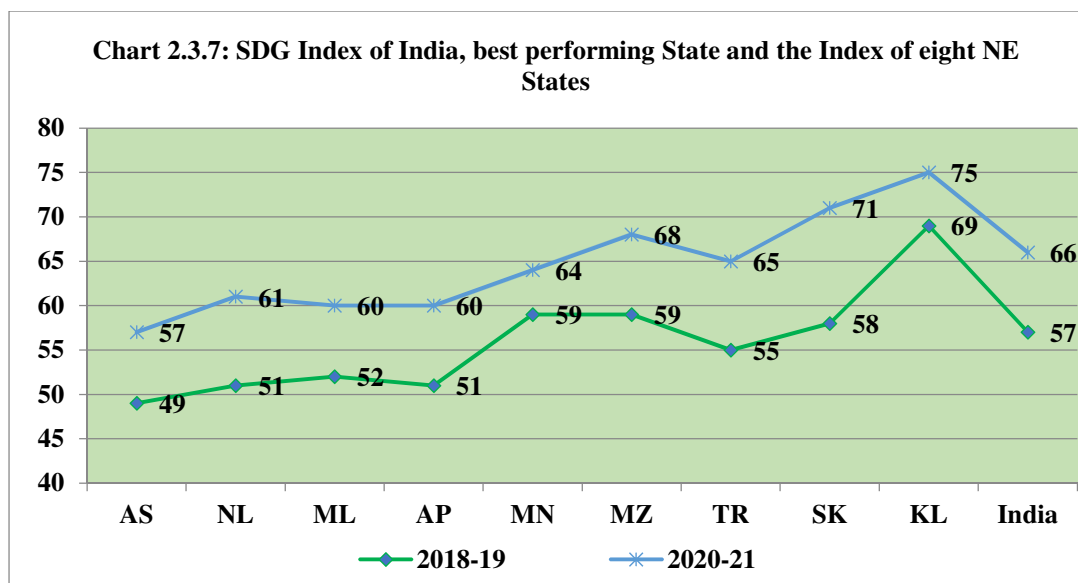
2.3.25 Introduction

The global indicator framework for Sustainable Development Goals (SDGs) was adopted by the General Assembly of the United Nations in July 2017 and is contained in the Resolution adopted by the General Assembly on Work of the Statistical Commission pertaining to the 2030 Agenda for Sustainable Development.

NITI Aayog leads the country's efforts to achieve the SDG, driving the 2030 Agenda through cooperation and competitive federalism. NITI Aayog, the nodal body mandated to oversee the progress, developed the framework of the SDG India Index and Dashboard back in 2018, to capture the progress made by our States and Union Territories to monitor the progress and achievements towards realising the 2030 Agenda. The task at hand for NITI Aayog is not just to periodically collect data on SDGs but also to proactively realise the goals and targets. The Ministry of Statistics and Programme Implementation (MoSPI) has collaborated with other Ministries to develop indicators for SDG goals. NITI Aayog, in consultation with MoSPI, drafted an initial mapping of these goals. This mapping extends to the Centrally Sponsored Schemes, including those implemented by the States and recent GoI initiatives. Moreover, Ministries and States are aligning Central and State schemes with SDGs.

2.3.25.1 Status of SDGs in the India and the North Eastern States

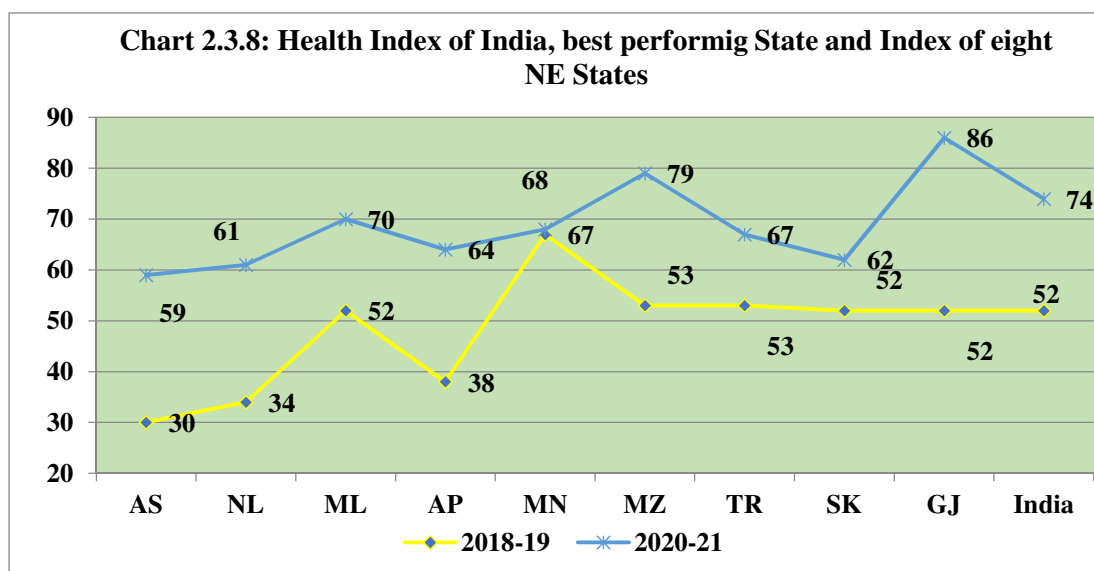
As per the NITI Aayog report on 'SDG Index India and Dashboard of 2021', the progress made by the States and the Country as a whole in achieving SDGs is depicted in **Chart 2.3.7**.



Description of Legends: AS-Assam, NL-Nagaland, ML-Meghalaya, AP- Arunachal Pradesh, MN- Manipur, MZ- Mizoram, TR-Tripura, SK-Sikkim, KL-Kerala

It can be seen from **Chart 2.3.7** that the Country as a whole and all the North-eastern States are gradually moving towards achieving the SDG Goals since the States have improved their Index positions during 2018 to 2021. Nagaland is in the fifth position with the score of 61 among the NE States and achieved the 20th rank at All India level.

The position with respect to SDG Goal 3 on the Health and Well Being conditions of people has been depicted in **Chart 2.3.8**.



Description of Legends: AS-Assam, NL-Nagaland, ML-Meghalaya, AP- Arunachal Pradesh, MN- Manipur, MZ- Mizoram, TR-Tripura, SK-Sikkim, GJ-Gujarat

All the States and the Country as a whole are gradually moving towards achieving the Goal of Health and Well Being of the people. Gujarat recorded best performance at Pan India level with score of 86. Nagaland is in seventh position among NER states with a score of 61 just above the NER state of Assam (score-59). Though Nagaland

has moved from 34 to 61 during 2018-19 to 2020-21, indicating a substantial improvement, it still has scope for further improvement.

2.3.25.2 Performance of the State on health specific Indicators

The indicators and the target under SDG-3 on the Health and Well-being conditions of the people and their achievement at the National level and by the State of Nagaland are shown in **Table 2.3.25**.

Table 2.3.25: Status of achievement of SDG-3 in the State vis-a-vis all India achievement

Sl. No.	SDG Indicator	Target	Achievement at:		Remarks, if any.
			All India	State	
1.	Maternal Mortality Ratio (per 1,00,000 live births)	70	113	NA	Maternal mortality is not calculated in the State since annual live birth figure is below 1,00,000.
2.	Under 5 mortality rate (per 1,000 live births)	25	36	37	Current data was not available, 37 pertains to SDG India Index 2.0 (2019-20).
3.	Percentage of children in the age group 9-11 months fully immunised.	100	91	54	-
4.	Total case notification rate of Tuberculosis per 1,00,000 population	242	177	233	The State is in much better condition compared to the Country as a whole.
5.	HIV incidence per 1,000 uninfected population	0	0.05	0.73	More than 14 times of All India average, very high and needs to be checked.
6.	Suicide rate (per 1,00,000 population)	3.5	10.4	1.90	The State is in much better condition compared to Country as a whole.
7.	Death rate due to road traffic accidents (per 1,00,000 population)	5.81	11.56	1.02	The State is in much better condition compared to Country as a whole.
8.	Percentage of institutional deliveries out of the total deliveries reported	100	94.40	83	Government needs to strengthen awareness activities to encourage institutional deliveries.
9.	Monthly per capita out-of-pocket expenditure on health as a share of Monthly Per capita Consumption Expenditure (MPCE)	7.83	13	7.90	This can be linked with the absence of specialists at CHC, which results into visiting District Hospitals.
10.	Total physicians, nurses and midwives per 10,000 population	45	37	1	Government needs to speed up recruitment process.

Source: SDG India Index 3 (2020-21) and SDG India Index 2 (2019-20)

It can be seen from **Table 2.3.25** that out of the 10 SDG-3 Health Indicators, the State is lagging behind the All-India average in seven indicators while maternal mortality is not calculated in the State since annual live birth figure in the State is below 1,00,000. The obvious reason being that the State spending on the health sector was low and ranged from a meagre 3.19 per cent to 4.25 per cent of the State budget during 2017-22 as against eight per cent of the total budget of the State envisaged in the National

Health Policy (NHP), 2017. Another contributing factor is that the primary and secondary health care facilities in the State were running with acute shortage of manpower in the cadre of doctors, nurses and paramedics.

The State formed (16 October 2019) a High-Level Steering Committee under the Chairmanship of the Chief Secretary of the State to monitor the progress of the implementation of SDG Goals and provide course corrections, however, only a single meeting of the Committee was held since its formation till March 2023. This had indicated a lack of planning and monitoring mechanism towards the achievement of SDG Goals in the State.

2.3.26 Conclusion

The State is lagging in achieving the SDG -3 indicators in seven out of the ten targeted areas in comparison to the national achievements. Spending on the health sector was lower than that envisaged in the National Health Policy, 2017. Though monitoring mechanism was designed and developed, regular monitoring was not in place.

2.3.27 Recommendation

The State Government may ensure adequate spending on health sector, prioritise the filling up of vacant medical and paramedical posts and implement effective monitoring mechanisms to achieve SDG targets.

Audit objective 5: Examine implementation of ‘Establishment of new medical colleges attached with existing district/referral hospitals’

2.3.28 Introduction

To meet the shortfall of human resources in health, the Ministry of Health and Family Welfare (MoHFW), Government of India (GoI) approved (February 2014) the Centrally Sponsored Scheme (CSS) for “**Establishment of new medical colleges attached with existing district/referral hospitals**” preferably in underserved districts of the Country. Under this scheme, fund sharing between the Central Government and State Government is in the ratio of 90:10 for North Eastern/Special category States and 75:25 for other States. The MoHFW, GoI identified (February 2014) Kohima district in Nagaland for implementation of the scheme. Accordingly, a Memorandum of Understanding (MoU) was signed (March 2014) between the GoI and GoN to establish a new Medical College as per the guidelines and instructions issued by the MoHFW. Nagaland University agreed (July 2014) in principle to affiliate the proposed **Nagaland Medical College at Kohima (NMCK)** subject to grant of permission by MoHFW, GoI. As per the Scheme Guidelines, the qualifying criteria are land measuring not less than 20 acres and an existing hospital of not less than 300 beds. GoN certified the availability of land measuring 12.70 acres at District Hospital, Kohima (Naga Hospital Authority Kohima (NHAK)) and 25 acres at Phreibagei, Kohima. Further, NHAK was proposed to be used as a teaching hospital initially. Under the Scheme, Medical College building, staff apartments/residence,

sports complex and boys and girls hostels were proposed to be constructed at Phreibagei, Kohima.

Though MoU was signed between the GoI and GoN for implementation of the scheme in 2014, GoN did not meet the qualifying criteria under section 3(2)(5) of Establishment of Medical College Regulations, 1999 and could not obtain Letter of Permission (LoP) from the National Medical Commission (NMC) (previously Medical Council of India) till 2022-23. LoP for commencement of academic session during 2023-24 was obtained only in April 2023 for 100 MBBS seats.

Targets *vis-à-vis* achievement towards the implementation of the scheme

The implementation of the scheme can be broadly classified into three main components *viz.*, land acquisition, execution of civil works and commencement of session. Component-wise targets *vis-à-vis* achievement are detailed below:

Land Acquisition: The acquisition of land which could have been completed by August 2015, was completed in March 2018 (Refer **Paragraph 2.3.28.1 (ii)**).

Execution of civil works: Under the scheme “Establishment of new medical colleges attached with existing district/referral hospitals”, seven components of civil works were to be executed. The work on these components commenced from December 2018 with stipulated dates of completion between March 2020 to March 2021. However, these works were completed by December 2023. The present status of the civil works executed under the scheme as on 31 December 2023 is detailed in **Table 2.3.26**.

Table 2.3.26: Physical status of the works under the scheme as on 31 December 2023

Sl. No.	Name of the components	Date of completion
1.	Construction of Medical College Building, Kohima	December 2023
2.	Construction of 200 sq m apartment at Nagaland Medical College, Kohima	October 2023
3.	Construction of 100 sq m apartment at Nagaland Medical College, Kohima	July 2023
4.	Construction of Sports Complex at Nagaland Medical College, Kohima	April 2022
5.	Construction of Boys and Girls Hostel at Nagaland Medical College, Kohima	December 2023
6.	Construction of Dean Residence at Nagaland Medical College, Kohima	April 2022
7.	Construction of MS Residence at Nagaland Medical College, Kohima	April 2022

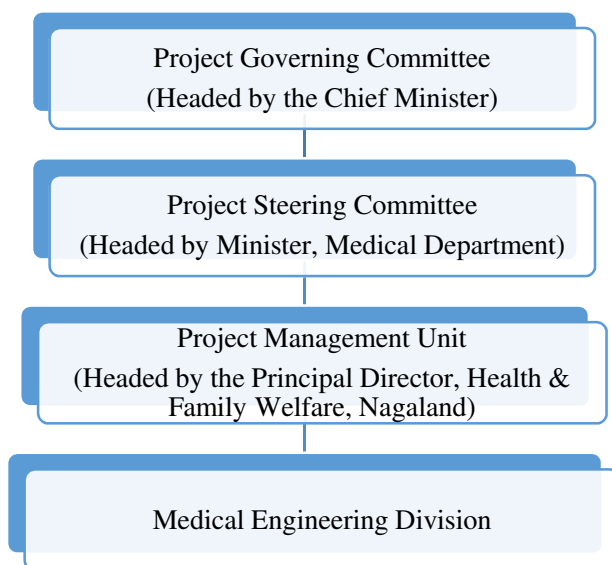
Source: Departmental figures

Commencement of session: As per the MoU, the session of the college was to commence from the 2015-16. However, the Nagaland Institute of Medical Sciences and Research, Kohima (NIMSR) was inaugurated on 14 October 2023. Accordingly, the academic session of the college commenced only from 2023-24.

2.3.28.1 Organisational Setup

The DoH&FW is the nodal department for implementation of the CSS “Establishment of new medical colleges attached with existing district/referral hospital” in the State. The organisational structure for implementation of the scheme for Nagaland Medical College Kohima (NMCK) is shown in **Chart 2.3.9**.

Chart – 2.3.9: Organisational Structure



Source: Departmental records

2.3.28.2 Planning

(i) Inordinate delay in acquisition of land for NMCK

Clause 9 of the guidelines envisaged that a suitable single plot of land measuring not less than 20 acres is owned and possessed by the person or is possessed by the applicant by way of 99 years lease for the construction of the college. GoN informed (August 2015) GoI about the possession of land measuring 37.70 acres for establishment of Medical College at Kohima as detailed in **Table 2.3.27**.

Table 2.3.27: Details of land settlement orders

Sl. No	Settlement order no. & date	Name of Department/ Organisation	Location and plot No.	Patta/ Permit No.	Area (in acres)
1.	No. REV/MS/5/90-91 dated 20/05/2014	NHAK	Hospital Colony/90	090	12.70
2.	No. REV/PATTA-2009 dated 20/01/2013	Principal Director, H&FW, Nagaland	Phriebagei/92	092	25.00
Total area					37.70

Source: Departmental records

Audit, however, observed that GoN paid (February 2016) an amount of ₹17.53 crore⁵⁵ for acquiring land measuring 40.25 acres and a final payment of ₹19.67 lakh⁵⁶ for the resurveyed area at Phriebagei, Kohima for establishment of Medical College and obtained land patta in March 2018. Thus, the information to GoI in August 2015 about the possession on land free from encumbrances was incorrect as corroborated by the fact that civil work could commence only in December 2018 after the possession of land in March 2018. The inordinate delay in acquisition of land resulted in a delay in commencing the civil works.

⁵⁵ @ ₹100 per square feet *vide* cheque no. 808734 dated 23 February 2016.

⁵⁶ *vide* cheque no. 098162 dated 26 October 2016.

The Department, in its reply stated (October 2023) that GoN had acquired an area of 10 acres at Phriebagei, Kohima village during 2006 for establishment of District Hospital Kohima now renamed as MCH Hospital of NIMSR Kohima. It was also stated that another 12.70 acres of land was available with NHAK. Therefore, the total land available initially was 22.70 acres, which is within the MCI requirement of 20 acres. It was further stated that despite approval by the Government to acquire another 35-40 acres of land for Medical College Kohima during the SLAA meeting on 21 December 2015, the land patta of newly acquired 40.251 acres could be obtained only in March 2018.

However, possession of land was only for 22.70 acres and not 37.70 acres as informed to GoI during August 2015.

2.3.28.3 Financial Management

(i) Fund receipt and expenditure

The details of funds released by GoI and State share released by GoN and expenditure thereof are shown in **Table 2.3.28**.

Table 2.3.28: Fund position during 2015-16 to 2022-23 (as of November 2022)

(₹ in lakh)						
Year	GoI release	State share to be released	Total	Release by Finance Department, GoN	Expenditure	Closing balance
2015-16	2,750.00	305.55	3,055.55	0.00	0.00	
2016-17	2,353.00	261.44	2,614.44	0.00	0.00	
2017-18	2,500.00	277.79	2,777.79	2,750.00	0.00	
2018-19	9,407.00	1,045.22	10,452.22	0.00	132.51	
2019-20	0.00	0.00	0.00	2,500.00	1,411.95	
2020-21	0.00	0.00	0.00	0.00	2,754.77	
2021-22	0.00	0.00	0.00	3,000.00	3,029.12	
2022-23	0.00	0.00	0.00	9,512.50	2,196.95	
Total	17,010.00	1,890.00	18,900.00	17,762.50	9,525.30	8,237.20

Source: Departmental records

(ii) Short-release of State share

The Administrative and Financial sanction stipulates that for every instalment released by GoI, the State was also required to release its corresponding share. Audit observed that GoI had released its share of ₹170.10 crore (November 2015 to March 2019), however, the State was yet to release its matching share of ₹11.38 crore (October 2023).

The Department, in its reply, stated (October 2023), the Department has already submitted proposal to the State Government for release of State share (May 2023).

(iii) Revision of cost

As per the Ministry's sanction order, grant-in-aid is subject to the conditions and principles laid down in Rule 206 to 215 of the General Financial Rules (GFR), 2005. Rule 215 (2) (ii) of the GFR, 2005 stipulates that Centrally Sponsored Schemes

should be designed in consultation with individuals States or Union Territories and the outlays should be demand driven. States should be delegated adequate powers to change the details of the schemes to suit local conditions, subject to reporting such changes to the concerned Ministry or Department. Further, as per the estimates for the civil works, there would be a four *per cent* increase in project cost annually.

Audit observed that during December 2018 to January 2020 the cost of civil works for execution of college main building, hostel, sports complex and residential building was revised from ₹102.87 crore (original cost) to ₹124.11 crore (2nd revision) which was more than ₹21.24 crore (20.65 *per cent*) by adding some additional items of works as detailed in **Appendix 2.3.11**.

The Department, in its reply (October 2023) stated that site excavation and retaining wall were not incorporated in the original work orders, hence supplementary work orders were issued for the said work amounting to ₹21.24 crore as per site conditions. However, excluding civil works like site excavation and retaining walls indicated shortfall in project planning, site assessment and DPR preparation, which should have been identified through technical/site surveys at the outset. The Department was, also, silent on reporting such changes to the concerned Ministry which was in contravention of the extant Rules.

(iv) Deduction by Finance Department

The Finance Department, GoN instructed (September 2000) all concerned to ensure that estimates of all Capital Works prepared include a levy of 13 *per cent* departmental charges. The same was re-circulated (May 2011) for information and strict compliance by all concerned.

Audit observed that the estimates of the Capital works under the scheme were prepared without including 13 *per cent* departmental charges. Audit, further observed that the Finance Department, GoN issued⁵⁷ a drawal authority of ₹10 crore during 2017-18 from which it irregularly deducted ₹1.15 crore as departmental charges. As departmental charges were not included in the estimate, the deduction of departmental charges is irregular and resulted in shortage of fund (₹1.15 crore) compared to the projected estimate and plan in the DPR.

While accepting the audit observation, the Department stated (October 2023) that the deduction of departmental charge at source by the Finance Department was done at the Government level.

(v) Diversion of fund

As per the terms and conditions of financial sanction of MoH&FW, GoI, the grantee institution was not authorised to divert the grants for another purpose. Audit, however, observed that the Department, in contravention of the administrative sanction order, diverted the scheme fund of ₹10.62 crore *inter-alia* for payment of

⁵⁷ Vide drawal Authority No. 69 under demand no. 35 dated 14 June 2017.

additional plot and land premiums, temporary loans to Medical College in Mon and the Nagaland Multi-Sectoral Project as shown in *Appendix 2.3.12*.

The Department while accepting (October 2023) the audit observation, stated that an amount of ₹10.00 crore was returned and the remaining ₹0.62 crore was covered under contingencies.

(vi) Loss of bank interest

Clause 6 of the Memorandum of Understanding (MoU)⁵⁸ stipulates that GoN should open a separate dedicated bank account in a public sector bank for implementing the scheme. Funds received from the Ministry will be maintained in that account. Audit observed that the implementing Department (DH&FW) opened (August 2014) a savings bank account⁵⁹ for receipt of the fund. However, Audit observed that GoN delayed the release of GoI share of ₹170.10 crore ranging from 19 months to 46 months during 2015-16 to November 2022. Had the amount been kept in the saving account, the Department might have earned bank interest of ₹18.88 crore (*Appendix 2.3.13*).

In its reply, the Department stated (October 2023) that it has no comment to offer.

(vii) Non-submission of submission of Utilisation Certificate in time

MoH&FW, GoI, in its sanction order, instructed that Utilisation Certificate (UC) should be furnished for every instalment. As per Clause 9 of the MoU, GoN was required to submit UC to the GoI, on or before 15th March and 15th September every year. Audit observed that the GoI had released its share in eighteen instalments from February 2015 to February 2019. Audit, however, observed that the Department was not regularly submitting UCs and that up to January 2020, only one UC amounting to ₹11.66 crore was submitted to GoI out of the total amount of ₹52.50 crore released by the GoN. Thus, UCs were not submitted in time, in contrast to the Ministry's directives.

2.3.28.4 Implementation of project

(i) Non recovery of secured advance

Section 32.4 (5) of CPWD Manual 2014 envisages that recoveries of secured advances so made should not be postponed from the bills for work done, as the materials are already used. Audit observed that 358.21 Metric Tonnes (MT) of Thermo Mechanically Treated (TMT) bar/round bar was brought to site by the contractor for construction of "main college building" during the 19 months period from March 2019 to September 2020. The contractor, as per the terms and condition of the contract agreement, claimed secured advance (90 per cent) of the total value of

⁵⁸ Executed on 10 March 2014.

⁵⁹ State Bank of India Savings, Kohima Bazar Branch, Bank Account No. XXXXXXXXX421.

materials brought to site. Accordingly, a total of ₹2.85 crore (90 per cent of the material cost) was paid in three installments⁶⁰.

Audit observed that though the whole quantity of TMT bar was utilised and payment made, only ₹0.54 crore⁶¹ was recovered from the 2nd, 3rd and 4th RA bills out of the ₹2.85 crore paid as secured advance to the contractor.

While accepting the audit observation, the Department stated (October 2023) that in the Contract agreement the limit for recovery of secured advance is not specified, however full recovery of secured advance shall be made prior to or at the last and final running account bill.

(ii) Excess payment for TMT bar

The terms and conditions executed between the Department and contractor for undertaking works of Main College Building were based on NPWD, Schedule of Rates 2016 (SOR). The revised cost estimate was also as per the 2016 SOR. 317.703 MT of TMT bar was utilised for construction of retaining wall of the main college building and payment of ₹277.70 lakh was made in the 2nd RA bill @ ₹87.41 per Kg as per NPWD SOR 2016. Audit, however, observed that in the 3rd and 4th RA bill, the contractor was allowed higher rate of ₹98.00 per Kg (2016 SOR) for 375.61 MT⁶² of TMT bar as detailed in **Table 2.3.29**.

Table 2.3.29: Details of excess payment

TMT bar (in Kg)	Rate allowed for retaining wall (₹/kg)	Rate allowed for main college building (₹/kg)	Difference (₹) (3-2)	Amount (₹ in lakh) (1x4)
1	2	3	4	5
3,75,629	87.41	98.00	10.59	39.78

Source: Departmental records

Thus, ₹39.78 lakh was paid in excess to the contractor by allowing higher rate for the same item of TMT bar.

The Department replied (October 2023) that due to mudslide, an RCC retaining Wall was required to be constructed before construction of the building. Hence, approval of the NPWD (H) was obtained for TMT bar @ ₹87.41 per Kg and the contractor was paid as per the work done based on the Technical/Administrative approval for the RCC Retaining wall. It was also stated that the contractor was paid @ ₹98 per Kg for 375.61kg MT of TMT based on the rate quoted by the successful bidder for construction of Medical College building.

However, higher rate was allowed to the contractor @ ₹98.00 instead of ₹87.41 for the same specification of TMT bar, resulting in avoidable payment to the contractor.

⁶⁰ ₹104.53 lakh (November 2019), ₹137.00 lakh (February 2020) and ₹43.92 lakh (October 2020).

⁶¹ ₹20.00 lakh (2nd Running Account Bill), ₹12.90 lakh (3rd Running Account Bill) and ₹20.60 lakh (4th Running Account Bill).

⁶² 93,072 Kg (3rd Running Account Bill) + 2,82,537 Kg (4th Running Account Bill) =375.61 MT.

(iii) Non-utilisation of required TMT bar

As per Clause 313 of NPWD Code, before a work is given out on contract, the Executive Engineer must prepare the necessary contract documents such as specification of the work to be done and of the materials to be used along with a schedule of quantities. Further, Clause 205 of NPWD Code stipulates that a detailed estimate must be prepared for the sanction of the competent authority. This technical sanction can only be accorded by the Officers of the Public Works Department in accordance with the powers delegated as follows:

Nature of powers	Authority	Extent of powers
technical sanction to original works and special repairs	Chief Engineer	Full Power
	Superintending Engineer	Upto ₹20.00 lakh
	Executive Engineer	Upto ₹5.00 lakh

Audit observed that the Chief Engineer (Housing), NPWD approved the Bill of Quantity (BOQ) for construction of RCC retaining wall against the main college building for five metre height and 205 metre length and reinforcement of RCC @ 2,441.84 Kg per metre length.

Examination of MB, approved estimate and payment vouchers and JPV revealed that 156 metre length of retaining wall had been executed for which 3,17,703 Kg of TMT bar was utilised. However, as per the approved BOQ, for execution of 156 metre length of retaining wall, 3,80,927.04 Kg⁶³ of TMT bar would be required. Thus, required 63,381 Kg of TMT bar was not utilised, as shown in **Table 2.3.30**.

Table 2.3.30: Actual execution vis-à-vis approved estimate

Approved TMT bar (in Kg/ metre)	Actual executed TMT bar (per metre)	Less executed (1-2)	Total length executed (in m)	Total less execution (in Kg) (3x4)	Rate (in ₹)	Amount (₹ in lakh) (5x6)
1	2	3	4	5	6	7
2,441.84	2,036.55	405.29	156	63,225.24	87.41	55.27

Source: Departmental figures and JPV

However, there was no revised technically sanctioned estimate based on which the execution was done. Thus, the shortfall of 63,381 kg of TMT bars against the approved BOQ, without a revised technically sanctioned estimate, indicates deviation from the approved design and non-adherence to technical specifications.

The Department replied (October 2023) that the construction of RCC retaining wall with a total length of 153 m was done as per the approved drawing and payment was made as per the work executed. It further stated that there is no variation in terms of the size of wall, however, reinforcement was reduced during execution and in consultation and assurance from the Consultant that it will not pose a threat to the safety of the structure which indirectly reduced the cost.

The reply on assurance from the Consultant is not acceptable as the Consultant is not a technically competent authority to give assurance on the safety of the structure due to lesser utilisation of TMT bar.

⁶³ 156m x 2,441.84 Kg = 3,80,927.04 Kg.

(iv) Avoidable payment of remuneration to Consultant Key Expert and technical support team

Clause 42 of the General Conditions of Contract (GCC) on Remuneration and Reimbursable Expenses stipulates that the Client⁶⁴ shall pay to the Consultant (i) remuneration that shall be determined on the basis of time actually spent by each expert in the performance of the services after the date of commencing of services or such other date as the parties shall agree in writing; and (ii) reimbursable expenses that are actually and reasonably incurred by the Consultant in the performance of the services. Audit observed that during execution, four key experts who did not perform any services during the initial period (2017-18 to 2019-20) were paid remunerations as detailed in **Table 2.3.31**.

Table 2.3.31: Details of remuneration paid to Key Experts

(₹ in lakh)

Sl. No.	Name of original staff	Name of replacing staff	Qualification	Position	Period	Amount per month	Input month	Total amount
1.	Shri Lalit Mawkin	Shri Rajesh Yadav	B.Tech Mechanical Engineering	Medical Equipment Specialist	1 st year 2017-18	5.00	3	15.00
2.	Shri Pradeep Sreekanthan	Shri Anurag Saxena	MBA System Marketing and BIS	Information Technology Specialist	1 st year 2017-18	5.00	3	15.00
3.	Shri Nilish Maheshwari		B.E and Master in Business Administration	Procurement and SOP expert	1 st year, 2 nd & 3 rd year 2018-2020	3.25	10	32.50
4.	Ms. Bela Mathur	Shri Mayank Goyal	B.E Electrical	MEP electronic & mechanical	1 st year, 2 nd & 3 rd year 2018-2020	3.00	9	27.00
Total								89.50

Source: Departmental records

During this period, the services provided by the Consultant were preparation of DPR, soil testing, drawing, architectural design, contract documents and management of infrastructure. Audit, however, observed that the Department while examining the remuneration bills submitted by the Consultant allowed payment of remuneration worth ₹89.50 lakh for experts not related to the services rendered during the period resulting in avoidable expenditure to that extent.

The Department, while furnishing their reply (October 2023) submitted details of the service provided by the experts, Log book and Attendance register. However, it was seen that only one key expert (at Sl. No. 4 above) rendered service. Thus, the Department paid an amount of ₹62.50 lakh to experts who did not render their services.

2.3.28.5 Monitoring

The Project Governing Committee (PGC) is the highest authority empowered to take measures for successful completion of NMCK. The Project Steering Committee

⁶⁴ Department of Health & Family Welfare (DoH&FW).

(PSC) gives directions and guidance as approved by the PGC and monitors the quality of work. The Project Management Unit (PMU) looks into the day-to-day management of the project besides preparing strategies, operational plans and budgetary requirements on infrastructure, manpower and other aspects of establishment of Medical College as well as institutional processes such as autonomy act, and service rules, for examination of the PSC.

Audit observed that during 2016-17 to 2020-21, the PGC, conducted only three meetings and the PSC conducted only two meetings. The Department also did not frame any guidelines for monitoring and evaluation of the project to ensure that the project was running according to plan. The absence of regular monitoring from the highest levels contributed to prolonged delay in completion of civil works, delay in commencement of session, diversion of fund, non-submission of UCs in time, non-recovery of secured advance, excess payment for TMT bar and avoidable payment of remuneration to consultant.

Recommendation: The State Government may ensure that the Project Governing Committee (PGC) and Project Steering Committee (PSC) conduct regular meetings to strengthen the monitoring mechanism.

2.3.29 Conclusion

There was an inordinate delay in acquisition of land for NMCK which delayed commencement of civil works resulting in delay in completion of civil works. LoP for commencement of academic session was obtained only in April 2023 as a result the academic session could commence only from 2023-2024. There was short release of State share, irregular diversion of fund and delay in submission of Utilisation Certificates. The secured advanced paid to contractors was not fully recovered and the monitoring mechanism was deficient.

2.3.30 Recommendations

The State Government may-

- (i) ensure that the matching State share is released in time for timely completion of the infrastructure works.***
- (ii) ensure that the Scheme guidelines are strictly followed. Any change in the details of the scheme, including revisions in cost or scope, should be expeditiously reported to the concerned Ministry or Department.***
- (iii) ensure that estimates for all Capital Works prepared include departmental charges.***
- (iv) strictly ensure that scheme funds are not diverted for other purposes.***
- (v) ensure the release of scheme fund to the implementing department in time.***
- (vi) ensure timely submission of UCs by the implementing department to GoI.***

- (vii) *direct the Implementing Department to strictly ensure recovery of mandatory deductions from the RA bills and ensure recovery of the excess amount paid to the contractor at the earliest.*
- (viii) *ensure that the execution of works is done as per technical sanction and revision of works, if any, may be done by obtaining proper technical sanction from the competent authority.*
- (ix) *ensure that the amount paid to the consultants who did not render their services be recovered at the earliest.*

Compliance Audit Paragraphs

URBAN DEVELOPMENT DEPARTMENT

2.4 Unfruitful expenditure

A pipeline project of ₹27.97 crore for providing water supply to Kohima town proved unfruitful due to inability of the State Government to augment bulk water supply.

In order to mitigate the acute water crisis through the existing water distribution network (bunched system⁶⁵), the State Investment Program Empowered Committee⁶⁶ (IPEC) recommended (April 2011) to the Ministry of Housing and Urban Affairs (MoHUA), Government of India (GoI), the project “Supplying and Laying of Distribution Network of 318 Km Length in Kohima Municipal Council Area” under Tranche-II of Asian Development Bank (ADB) funded North Eastern Region Urban Development Programme⁶⁷ (NERUDP) to meet the water requirement of a growing population in Kohima city. The MoHUA approved (September 2011) the project for ₹32.28 crore and a bipartite Loan Agreement (ADB Loan No. 2834-IND) was signed between GoI and ADB on 19 November 2012. The scope of work involved laying of pipeline of 318 Km⁶⁸ within the existing right of way (RoW) and road shoulders in 27 Hydraulic zones of Kohima City. The new distribution network (loop system) was designed to receive and distribute 31 million litres per day (MLD) of water upto 2043 and for drawing water (27.86 MLD) from the Dzukou/Tepuiki stream for Kohima city.

⁶⁵ Commissioned in November 1978.

⁶⁶ Constituted under the Chairmanship of Secretary, Urban Development Department, GoN. IPEC is responsible for according Administrative and Financial sanctions of the components under the project and approval of annual works plan.

⁶⁷ NERUDP/NERCCDIP was implemented by MoHUA, GoI over the period 2009-19 with financial assistance from ADB. GoI was providing 100 per cent funds to states; the money flows to the states from MoHUA budget as 90 per cent grant and 10 per cent loan. Based on expenditure by states, the ADB’s funding was claimed by MoHUA for GoI. The states submit statement of expenditure to MoHUA every month. MoHUA releases the funds excluding ineligible expenditure, if any, to the states. The states were required to make counterpart budget provision in their annual budget to meet project expenses without waiting for release by MoHUA to facilitate smooth implementation of the project.

⁶⁸ Ductile Iron (DI)=24 Km, Galvanised Iron (GI)=97 Km and High Density Polyethylene (HDPI)=197 Km, with diameters ranging from 32 mm to 300 mm.

For implementation, monitoring and supervision of the project, Government of Nagaland (GoN) created the State Investment Program Monitoring and Implementation Unit (SIPMIU) under Urban Development Department (UDD), GoN. Notice Inviting Tenders was floated in February 2012 and the work was awarded (February 2013) to M/s. Tantia Constructions Limited, Kolkata for ₹32.28 crore (Contract Package No. KHM-WA 2), stipulated to be completed within two years (February 2015). The terms and conditions of the loan agreement stated that both Central and State Governments shall ensure that all land and RoW required for the project are made available to the contractor in accordance with the schedule agreed under the related works contract. Clause 2.1 of General Conditions of Contract (GCC) stipulate that the Employer shall give the Contractor right of access to, and possession of the Site within the time stated in the Contract date to enable the Contractor to proceed without disruption in accordance with the programme. Clauses 8.2 and 10.3 of the GCC states that the Contractor shall complete the whole work within the Time for Completion including achieving the passing of the Tests on Completion and completing all work which is stated in the Contract as being required for the works to be considered to be completed for the purposes of Taking-Over. The Contractor shall carry out the Tests on Completion as soon as practicable, before the expiry date of the Defects Notification Period (*i.e.* 365 days).



Scrutiny of the project revealed that -

- The agreement did not provide any provision that the payment was to be made to the contractor only after the completion of specified tests and handing over the project to the Department. Hence, the Department did not safeguard the execution of the works and paid the full amount to the contractor before completion of the specified tests.
- Encumbrance free RoW was not made available to the contractor as stipulated under Clause 2.1 of GCC.
- The agreed commencement date of civil works was 01 August 2013, however, clearances for the pipe laying works were obtained (April-May 2016) from the authorities⁶⁹ concerned only after the expiry of the targeted date of completion (*i.e.*, February 2015) of the project. Further, permissions for pipeline laying works from colony/panchayat authorities⁷⁰ were obtained during the period from September 2016 to December 2017.

⁶⁹ Executive Engineer, Public Works Department (National Highway) Division No. 1 Kohima on 04 April 2016 and Deputy Commissioner, Kohima on 23 May 2016.

⁷⁰ Lower Chandmari colony (13 September 2016), Agri Forest Colony (23 January 2017), Bayavu Colony (23 January 2017), Officers' Hill Colony (14 July 2017) and D Block Colony (06 December 2017).

- Photographs of the pipeline laying works are appended below:

Photograph No. 2.4.1	Photograph No. 2.4.2
	
Earth excavation works (13 July 2023)	Pipeline laying works (13 July 2023)

- The project could not be completed by February 2015 and it was extended from time to time.
- In June 2019, funding from ADB was closed but in order to complete the project, the stipulated time for completion of the project was extended by the Ministry of Finance, GoI till June 2021.
- The project was further extended till March 2022 due to Covid-19 pandemic. In March 2022, GoN also approved revision of the scope of work from 318 Km to 212 Km length⁷¹ and the project cost was reduced to ₹27.97 crore.
- The reasons for delay in completion and subsequent reduction in scope of works were stated (February 2021) to be due to disputes on RoW from landowners/colony panchayats/construction activities/departmental permission, changes in landscape due to development/natural disaster, Covid-19 lockdown and limited time period to complete the balance work within the project closing date.
- The project was then reported to be completed on 31 March 2022 and the contractor was paid (July 2014 to March 2022) ₹27.97 crore in 32 Running Account (RA) bills (including 1st and 2nd escalation bills). Out of the total expenditure of ₹27.97 crore incurred by the State, an amount of ₹26.74 crore was reimbursed by MoHUA (March 2022).
- Audit also observed that even after a year of completion of the new distribution network project, the same had not been tested and commissioned for handing over by UDD to the Public Health Engineering Department (PHED⁷²), GoN in violation of Clauses 8.2 and 10.3 of the GCC. Thus, the project was not safeguarded by testing it even before expiry of defect liability period (*i.e.* up to March 2023) to ensure contractor's liability in case of defects in the system.

⁷¹ DI pipe (22.93 KM), HDPE pipe (159.61 KM) and GI pipe (29.46 KM).

⁷² Public Health Engineering Department (PHED), GoN is responsible for providing safe and potable drinking water supply in the State.

Audit further observed that the water supply capacity from current sources⁷³ (February 2023) to Kohima city is 3.36 MLD during the monsoon season and 1.23 MLD during the lean season against the demand of 18.71 MLD. Kohima city thus faces a significant water deficit ranging from 15.35 to 17.48 MLD (82.04 to 93.43 per cent) indicating a severe year-round shortage of water supply. The water demand is projected to increase to 31 MLD by 2043. The primary cause behind this shortage was non-taking up of the water source augmentation project for tapping Dzukou/Tepuiki stream (27.86 MLD) by the PHED due to land disputes between two land owner-villages.

The expenditure of ₹27.97 crore incurred on the new distribution network, therefore, proved unfruitful as the project objective of improving water supply to Kohima city remained unachieved.

In reply, the Government stated (May 2023) that the contractor had completed laying of the distribution network of 212 Km, however, testing and commissioning of the distribution network could not be taken up as RA bills 30 to 32 (₹3.97 crore) and Retention Money (RM) of ₹0.62 crore has not been paid to the contractor. It was also stated that the price escalation bills (3rd to 6th) amounting to ₹3.38 crore submitted by the contractor could not be paid as the Ministry had declined to consider the same even though there was an escalation clause in the Contract Agreement. It was further stated that MoHUA has been requested (November 2021 and June 2022) to reimburse the pending claims so that payment can be made to the contractor, and the contractor can complete the testing, rectification and commissioning of the already laid 212 Km water distribution network.

The reply of the Government is not acceptable as the RA bills (30 to 32) and RM were already paid (February-March 2022) to the contractor. The project was also certified completed without conducting/passing Tests⁷⁴ on completion. The current sources of water are unable to support the new water distribution network and even after incurring an expenditure of ₹27.97 crore, the new water distribution network remained idle. Consequently, the citizens of Kohima city are yet to be benefitted by this project.

⁷³

Sl. No.	Water source	Location	Water availability (MLD) at distribution system	
			Monsoon season (June to September)	Dry season (October to May)
1.	Dzüna	Jotsoma village	1.52	0.61
2.	Dzücharu	Phesama village	1.42	0.47
3.	Aradura stream	Phesama village	0.144	0.06
4.	Zarü	Mima village	0.05	0.05
5.	Old Ministers' Hill	Old Ministers' Hill	0.23	0.04
Total			3.364	1.23

Source: Executive Engineer, PHED, Urban Division, Kohima, Nagaland (as of February 2023)

⁷⁴ After laying and jointing, the pipeline must be pressure tested to ensure that pipes and joints are sound enough to withstand the maximum pressure likely to be developed under working conditions.

Recommendations:

The State Government may-

- (i) *ensure that all requisite clearances are obtained before preparation of DPR.*
- (ii) *take up augmentation of bulk water supply for Kohima city on priority and ensure that the new water distribution network is commissioned so that the project objective is fulfilled without further delay.*

SCHOOL EDUCATION DEPARTMENT

2.5 Excess payment

Printing of lesser number of pages of school textbooks resulted in excess payment of ₹0.94 crore.

Rule 144 of General Financial Rules (GFR), 2017 states that every authority, delegated with the financial powers of procuring goods in public interest, shall have the responsibility and accountability to bring efficiency, economy, and transparency in matters relating to public procurement and for fair and equitable treatment of suppliers and promotion of competition in public procurement. The specifications in terms of quality and type, as also quantity of goods to be procured, should be clearly spelt out keeping in view the specific needs of the procuring organisations. The specifications so worked out should meet the basic needs of the organisation without including superfluous and non-essential features, which may result in unwarranted expenditure. Rule 161 of GFR, 2017 states that advertised tender should be used for procurement of goods of estimated value of ₹25.00 lakh and above. Rule 208 of GFR, 2017 states that all materials shall be counted, measured or weighed and subjected to visual inspection at the time of receipt to ensure that the quantities are correct, that the quality is according to the required specifications and that there is no damage or deficiency in the materials. Further, Paragraph 1.7 of the Manual for Procurement of Goods (MPG), of the Department of Expenditure and updated in collaboration with the Central Vigilance Commission (CVC) states that transparency, fairness, equality, competition and appeal rights has to be ensured by the procuring authorities.

Scrutiny (August 2022) of records of the Principal Director (PD), School Education Department (SED), Nagaland, Kohima showed that the Government of Nagaland (GoN) sanctioned an amount of ₹2.85 crore⁷⁵ during 2019-22 towards printing cost of 3,10,700 textbooks for Class-I to VIII in 18 local Dialects/Modern Indian Languages (MIL) for free distribution in Government and Private schools of the State. Total 3,10,700 number of books⁷⁶ were printed as per work order and distributed to the

⁷⁵ ₹1.00 crore (No. EDS/9-118/87(Vol-II)226 dated 02 March 2020) + ₹0.85 crore (No. EDS/9-118/87(Vol-II)336 dated 27 March 2021) + ₹1.00 crore (No. EDS/9-118/87(Vol-I)306 dated 25 March 2022).

⁷⁶ 1,17,100 books in 2019-20, 1,01,060 books in 2020-21 and 92,540 books in 2021-22.

schools. Tribe-wise number of text books approved and printed during 2019-22 is provided in **Appendix 2.5.1**.

Examination of records further showed that the Department issued three work orders⁷⁷ for ₹2.85 crore to M/s Artworks, Kohima for printing Class-I to VIII text books (Local Dialect/ MIL) with a stipulation to complete the works within 50 days from the date of issue of work orders. The payments to the firm were to be on the basis of the number of pages printed in the text books @ ₹0.80/page⁷⁸ and the certification by the Text Book Verification Committee (TBVC), SED. The supply works were completed during February 2020 to February 2022 and the Department paid ₹2.85 crore⁷⁹ to the firm.

Audit observed that the selection of the firm, M/s. Artworks, Kohima, by the Department was in violation of Rule 161 of GFR, 2017 and Paragraph 1.7 of the MPG regarding competitive bidding, as the selection was based on the quotation submitted by the firm and not on the basis of open tendering. The selection process, therefore, lacked transparency, fairness and competition. Audit further observed that excess payment of ₹0.94 crore⁸⁰ was made to the firm since against the total number of 279.21 lakh pages approved for printing by GoN, only 161.19 lakh pages had been printed as detailed in **Appendix 2.5.2**. Over payment was because the TBVC, SED did not cross-verify the actual number of pages printed in the text books and accordingly did not notify the Department to make payment for actual pages printed.

Thus, besides violation of the provisions of GFR in selection of the firm, there was inability on the part of the TBVC, SED to cross-verify the actual number of pages printed in the text books resulting in excess payment of ₹0.94 crore.

In reply, the Department (July 2023) stated that the old rate fixed in 1994-95 for printing of local text book in black and white is being followed as the rates have not been revised till date, whereas the present printed textbooks are in colour. The Department further added that the supplier was nominated on the basis of past work experience and not on open tendering.

The Department's rationale for supplier selection based on past experience and adopting outdated rates could not ensure economy, efficiency, transparency and competitive procurement practices mandated under the GFR and MPG which led to excess payment.

⁷⁷ No. ED/TBP/04-A/2019-20 dated 13/11/2019, No. ED/TBP/LOCAL/2020-21 dated 21/12/2020 and No. ED/TBP/LOCAL/2021-22 dated 29/11/2021.

⁷⁸ ₹0.45 (Composing rate per page) plus ₹0.35 (Printing cost per page).

⁷⁹ ₹1.00 crore (Bill No. 2372 dated 14/3/2020) + ₹0.85 crore (Bill No.650 dated 30/3/2021) + ₹1.00 crore (Bill No.868 dated 26/3/2022).

⁸⁰ 1,18,02,060 pages X ₹0.80.

Recommendations:

The State Government may-

- (i) ensure that procurement is made strictly in accordance with principles of GFR and CVC guidelines and payment is based on actual pages printed.**
- (ii) initiate steps for recovery of the excess payment made to the firm.**
- (iii) ensure that the TBVC establishes robust verification procedures to prevent overpayments and also ensure accurate billing based on actual production quantities.**