PERFORMANCE AUDIT REPORT
ON
THE ACCOUNTS OF
NATIONAL MATERNAL, NEWBORN AND CHILD HEALTH (MNCH) PROGRAM
DISTRICT GOVERNMENT
TOBA TEK SINGH

Audit Year 2012-13

15th May, 2013

AUDITOR GENERAL OF PAKISTAN

PREFACE

The Auditor General conducts audit subject to Articles169 and 170 of the Constitution of the Islamic Republic of Pakistan 1973, read with Sections8 and 12 of the Auditor- General's (Functions, Powers and Terms and Conditions of Service) Ordinance 2001 of Pakistan and section 115 of the Punjab Local Government Ordinance 2001.The audit of National Maternal, Newborn and Child Health (MNCH) Program (Health Sector) District Government, Toba Tek Singh was carried out accordingly.

The Directorate General Audit District Governments Punjab (South), Multan, conducted audit of the National MNCH program District Toba Tek Singh during April and May, 2013 for the period January, 2007 to June, 2012 with a view to reporting significant findings to the stakeholders. Audit examined the economy, efficiency and effectiveness aspects of the National MNCH program. In addition, Audit also assessed, on test check basis, whether the management complied with applicable laws, rules and regulations in managing National MNCH program. The Audit Report indicates specific actions that, if taken, will help the management realize the objectives of the National MNCH program. Most of the observations included in this report have been finalized in the light of discussions in the DAC meeting.

The audit report is submitted to the Governor of the Punjab in pursuance of Article 171 of the Constitution of the Islamic Republic of Pakistan, 1973, read with Section 115 of the Punjab Local Government Ordinance, 2001 to cause it to be laid before the Provincial Assembly.

Islamabad (**Muhammad Akhtar Buland Rana)**
Dated: **Auditor General of Pakistan**

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Abbreviations and Acronyms

ANC	-	Ante Natal Care
BHU	-	Basic Health Unit
CBO	-	Community Based Organization
CMW	-	Community Midwife
CPR	-	Contraceptive Prevalence Rate
DCO	-	District Coordination Officer
DDHO	-	Deputy District Health Officer
DEC	-	District Evaluation Committee
DFID	-	Department for International Development
DHQ	-	District Headquarter Hospital
DO	-	District Officer
DPIU	-	District Program Implementation Unit
EDO	-	Executive District Officer
EDO (H)	-	Executive District Officer Health
EmONC	-	Emergency Obstetric and Newborn Care
ENC	-	Essential Newborn Care
IMNCI-		Integrated Management of Newborn &Childhood Illness
IMPAC -		Integrated Management of Pregnancy and Child Birth
IMR	-	Infant Mortality Rate
LHS	-	Lady Health Supervisor
LHV	-	Lady Health Visitor
LHW	-	Lady Health Worker

MCH	-	Mother & Child Health
MDG	-	Millennium Development Goal
MMR	-	Maternal Mortality Ratio
MNCH	-	Maternal, Newborn and Child Health
MNT	-	Maternal and Newborn Tetanus
MO	-	Medical Officer
MS	-	Medical Superintendent
MSDS	-	Minimum Service Delivery Standards
PC-1	-	Planning Commission – Performa 1
PHC	-	Primary Health Care
RHC	-	Rural Health Center
THQ	-	Tehsil Headquarter Hospital
SMPs	-	Standard Medical Protocols
T.T. Singh	-	Toba Tek Singh
UC	-	Union Council
WMO	–	Woman Medical Officer

EXECUTIVE SUMMARY

Directorate General of Audit, District Governments, Punjab (South), Multan conducted audit of National MNCH program District Government Toba Tek Singh in accordance with the INTOSAI Auditing Standards during April &May, 2013.

Government of Pakistan launched a program for improvement of Health Sector called, "National MNCH Program", in 2007 executed by the District Government Toba Tek Singh through Public Health Specialist, MNCH cell, under the supervision& administrative control (at district level) of Executive District Officer (Health) Toba Tek Singh. The main objective of this project was to improve EmONC services for achievement of health related MDGs 4&5 which are as under:

1. MDG 4:To reduce the Infant Mortality Rate (IMR)
2. MDG 5:To reduce the Maternal Mortality Ratio (MMR)

Through improved access, quality and equity in health services, the program has to achieve the above stated goals by:

i. Improving the availability and quality of primary and secondary health services;
ii. Better management of health services at community level;

The MNCH program was initiated to ensure progress towards achieving the Millennium Development Goals (MDGs) in maternal and child health.The program was to focus, mainly, on deployment of 157 Community Midwives (CMWs), refurbishing the labor wings in the DHQ and THQ hospitals, construction of new labor rooms and training of community midwives and Lady Health Supervisors (LHSs).

Keeping in view the targets of MNCH Program the main objectives of the audit were:

i. To ascertain that program was executed with due regard to economy, efficiency and effectiveness.
ii. To see that human and financial resources were utilized properly and goals / targets and objectives were achieved as given in PC-I.
iii. To review compliance with applicable rules, regulations and procedures.

iv. To ensure that internal controls were operative and functioning effectively.

The Government of Pakistan launched the MNCH Program for improving the availability and quality of primary and secondary health services in district Toba Tek Singh through Executive District Officer (Health). Funds of Rs35.307 million were released out of which expenditure of Rs26.919 million was incurred whereas Rs8.388 remained unspent.

Program activities fell short of the desired principles of economy, efficiency and effectiveness. Non-integration of different MNCH related activities under one management structure, deviation from program objectives ,non-launching of public awareness campaign on MNCH program, financial mismanagement due to spending the funds of the program for other purposes, cost overrun due to uneconomical procurement of vehicle, non-completion of works for provision of MNCH facilities, non-availability of data regarding achievement of targets and non-evaluation of the program by third party are some major audit findings observed during the audit.

Audit suggests that overall performance of the program may be improved by integration of all the MNCH related activities at district level under District MNCH Cell, deployment of CMWs in the remote/ underserved areas, strengthening of health facilities for provision of safe delivery services/ medicines to the patients, launching the public awareness campaign, effective & timely financial management, immediate completion of works, strengthening of district health information system (DHIS), conducting third party evaluation and gathering/ compiling data regarding achievement of program targets.

1 INTRODUCTION

Toba Tek Singh district is located in the north east of Pakistan in the Punjab province and situated at about 260 kilometers from Lahore. According to Demographic Survey information, the total population of District Toba Tek Singh in the year 2010 was 1.860 million and, population of urban area in Toba Tek Singh was 0.351 million.

District Toba Tek Singh comprises 3 Tehsils namely “Gojra”, “Kamalia” and “Toba Tek Singh”. District Government Toba Tek Singh is responsible to provide the health facilities to the general public of the district. Total health facilities under District Government Toba Tek Singh health department are 1 DHQ Hospital, 2 Tehsil Headquarter Hospitals (THQs), 6 Rural Health Centers (RHCs), 66 Basic Health Units (BHUs) and 23 Rural Health Dispensaries (RHDs). The total maternal, newborn and child health (MNCH) related human resource hired/ deployed by the MNCH Program Toba Tek Singh, is one Woman Medical Officer (WMO), 6 Lady Health Visitors (LHVs) and 114Community Midwives (CMWs). The existing system of health facilities is not only inadequate but also insufficient to provide contemporary health facilities to the general public.

The MNCH program was initiated to ensure progress towards achieving the Millennium Development Goals (MDGs) in maternal and child health. Specific objectives were:

1. To reduce the Under Five Mortality Rate to less than 65 per 1000 live births by the year 2011 (Target 2015: 45/1000)
2. To reduce the Newborn Mortality Rate to less than 40 per 1000 live births by the year 2011 (Target 2015: 25/1000)
3. To reduce the Infant Mortality Rate to less than 55 per 1000 live births by the year 2011 (Target 2015: 40/1000)
4. To reduce Maternal Mortality ratio to 200 per 100,000 live births by the year 2011 (Target 2015: 140/100,000)
5. To increase the proportion of deliveries attended by skilled birth attendants at home or in health facilities to 90%. (Target 2015: >90%)

Table 1: Key Health Indicators for Pakistan and Punjab in Comparison with Selected Countries

Country	Infant Mortality Rate[a]	Under-Five Mortality Rate[c]	Maternal Mortality Ratio
Bhutan	65	75	420
Bangladesh	54	57	380
India	56	74	540
Nepal	56	74	740
Sri Lanka	12	14	92
Pakistan	**80**	**99**	**500**
Punjab[c]	**77**	**112**	**300**

A United Nations Population Fund. 2007. *State of the World's Population*. New York.
B United Nations Children's Fund. 2006. *State of the World's Children*. New York.
C Government of the Punjab. 2004. *District-Based Multiple Indicators Cluster Survey 2003–2004.* Lahore.

The Health Department's targets and the associated health service indicators for the
IMR and MMR are in Table 2.

Table 2: Key Health MDGs and Associated Indicators for Punjab

Targeting Indicators	FY2004[a]	FY2007[b]	2015 Targets
Infant Mortality Rate per 1,000 Live Births	77	71	40
Under-Five Mortality Rate per 1,000 Live Births	112	102	47
Maternal Mortality Ratio per 100,000 Live Births	300	300	140
Percentage of Births Attended by Skilled Birth Attendants	32	38	100
Percentage of Fully Immunized Children (12–23 months old)	5079.7	Above 80	

A Government of the Punjab. 2004. *District-Based Multiple Indicators Cluster Survey 2003–04.* Lahore.
B Health Department, Government of the Punjab data

The program was divided in to two Phases.

PHASE - I: Launching and Initiation of phase-I from January 2007 to June 2012.The first phase of the program has further two sub segments. The activities to be performed in sub-programs are tabulated below:

First Segment (Phase I)	Second Segment (Phase I)
The first segment was the preparation to launch this program. It would consist of formation of a federal Program Implementation Unit (PIU) and strengthening of the MNCH Cells/directorates at the provincial and district level through initiating the process for filling of approved posts by appointments/transfer/deputation. The planning processin the district for the different components was to be completed during this period. This segment was to be continued until June, 2007.	The second segment was to be started from July, 2007 and included the civil works for refurbishing the labor wings in the DHQ and THQ hospitals and construction of new labor rooms. This included refresher trainings of midwifery tutors, training of community midwives and lady health supervisors (LHS). This phase would also focus on providing comprehensive EmONC services at DHQ and THQ hospitals. The situation analysis for ambulance services was also to be completed in this phase through application and testing of different models. It was proposed to conduct a third party evaluation of the program at the end of Phase I.

PHASE - II: Expansion and Consolidation from June, 2009 to June, 2012, to expand the activities of the Program including expansion of the services.
Funds amounting to Rs.35.307 million were provided to the National MNCH Program Toba Tek Singh during the period from July, 2007 to June, 2012. The stipulated completion period of program was June, 2012. The objectives of phase-II were as under:

One CMW for every 10,000 population in her catchment area supported by an active transportation/ referral service and comprehensive EmONC facilities was to be deployed by the end of this phase (157 CMWs for District Toba Tek Singh). A third party evaluation was to be conducted at the start of year, 2012 to assess the achievements and cost effectiveness of the program.	At the end of Phase I, based on the strategic plan, the findings from the implementation of the program and the pilot initiatives, a comprehensive plan for the MNCH activities of the program was to be prepared in consultation with major stakeholders and the provincial/ district governments. If required a revision of current or a new PC-1 would be prepared.

PLANNING

As per the Development policy, 1st and 2nd Phases of the program were required to be completed in June, 2012 whereas only a few activities of program were performed by MNCH cell district Toba Tek Singh within the stipulated time period.

To achieve the health related MDGs 4&5 and program objectives, work plans to be performed in phase I and Phase II of the program were targeted and necessary funds were approved/ released by the Provincial Program Coordinator, Punjab Lahore along with provision of equipment to be supplied to deployed CMWs in their catchment areas.

The planning was not carried out realistically and a fixed (at constant rate) remuneration was provided/ allocated in the PC-I for WMOs without keeping in view the annual incremental costs or inflation due to which there is extreme shortage of WMOs (one WMO working against a sanctioned strength of six WMOs). This segment of planning resulted in poor health services due to shortage of health service providers.

Management Responses and Further Audit Comments:

- Matter regarding non availability of data of program objectives was reported to EDO (Health), who replied that all possible efforts were made to achieve the program objectives.
  - The reply is not based on facts because no such document regarding achievement of program objectives was available with EDO (Health)/ district MNCH cell.
- Matter regarding weak monitoring and submission of fake monthly reports by CMWs was reported to EDO (Health) who replied that deployed CMWs were being monitored regularly by the MNCH cell along with holding regular monthly meetings of CMWs.
  - The reply is not based on facts as physical inspection of daily registers and monthly reports showed that the information provided by CMWs was fake and misleading.
- Matter regarding financial mismanagement due to incurrence of expenditure by unauthorized re-appropriation of funds amounting Rs.1.495 million was reported to EDO (Health), who replied that the budget allocation was under tied grant which was re-authorized for the next year by the competent authority i.e. Finance Department Toba Tek Singh and bifurcation under various heads of accounts was made according to genuine requirements of MNCH cell.
  - Reply is not tenable as the budget reauthorization/ re-appropriation was done without seeking administrative approval from the competent authority i.e. Provincial Program Coordinator.
- Matter regarding non-completion of works for provision of MNCH facilities was reported to EDO (Health), who replied that the amount was deposited with Works Department for execution of work as deposit work.
  - Reply is not tenable as no serious steps for completion of work within the stipulated period of time were taken by the management.
- Matter regarding unauthorized use of CMW van resulting in poor monitoring & supervision was reported to EDO (Health) who replied that the van had been used for Program activities i.e. for transportation of CMWs for examination at Allied Hospital

Faisalabad and for monitoring and supervision of CMWs at different health facilities by EDO Health being incharge of the program.

- The reply is not based on facts because not a single visit for monitoring and supervision of CMWs was made on the vehicle provided for this purpose.

EXECUTION

The execution of the Program started during April, 2007, with a delay of 3 months. The delay is due to non-approval of work plan within due time for program phase-I and late release of funds by the provincial govt.

Audit would recommend that the spheres of DCO and EDO (Health) may be defined clearly for effective co-ordination and monitoring. Further, audit recommends following points:

i. Improvement in internal control system and timely completion of program activities may be ensured.
ii. District Health Information System (DHIS) should be strengthened and monitored to evaluate the program outcomes.
iii. Objectives of the project should be made specific and quantifiable for fair monitoring and evaluation by all concerned.

Time Line

As per PC-I the Program was required to be completed up to June, 2012. The tasks of the entire program activities were not fully scheduled and time line was not followed in letter and spirit due to which the program is still incomplete after the expiry of due date i.e. June, 2012.

Program Activities

EDO (Health) utilized funds on payment of staff salaries, stipend to student CMWs and retention fee to deployed CMWs. Most of the program activities were affected due to:

- Non-utilization of MNCH vehicles on Program activities.
- Non-provision of full support to health facilities with reference to human resource.
- Non-provision of MNCH related services by various CMWs in their catchment areas.
- Non-launching of Public awareness campaign on MNCH program in spite of availability of funds.
- Non completion of CMW school and hostel facility for CMW students.
- Non-availability of essential and MNCH related medicines at health facilities.
- Lack of harmony in program activities.
- Medical equipment and accessories were not timely supplied to deployed CMWs for their better services.

Auditor Comments:

- Coordination mechanism between district MNCH cell and vertical programs was not developed by the district management.
- Activities to get the civil works completed well in time were not well planned by the Provincial as well as District authorities.
- The mechanism, to evaluate the program activities and results thereof, at different stages of the program, was not developed.
- Monitoring of deployed CMWs was not conducted properly due to which fake reporting and weak performance occurred.
- Hostel facility was not provided to the CMW students resulting in below standard practical trainings.
- Services of the MNCH staff were not utilized for program activities.
- Program vehicles were not used for the Program activities.
- Basic data of actual needs and requirements of each health facility regarding availability of trained staff, medicines and medical equipment was not collected from health facilities.

2 AUDIT OBJECTIVES

The major objectives of the audit were to:

i. Ascertain that program was executed with due regard to economy, efficiency and effectiveness.

ii. See that human and financial resources were utilized properly and goals / targets and objectives were achieved as given in PC-I.

iii. Review compliance with applicable rules, regulations and procedures.

iv. See that internal controls were operative and functioning effectively.

3 AUDIT SCOPE AND METHODOLOGY

SCOPE

The scope of audit is to examine the performance of the executive during planning, execution and implementation of National MNCH program and to comment on activities performed to attain the program objectives in District Toba Tek Singh. Audit of the National MNCH program District Toba Tek Singh was conducted for the period of 5 years i.e. from July 2007 to June 2012.

METHODOLOGY

The performance audit was conducted in accordance with the ISSAI standards keeping in view the rules and regulations framed by the Provincial Government from time to time. The following audit methodology was adopted during performance audit.

1. Study of PC-I and other documents.
2. Collection and scrutiny of relevant data, files, documents, reports, newspapers etc.
3. Interviews with concerned officers/ staff of District Health Department.
4. A field survey of health facilities on sample basis which included, DHQ, THQs, RHCs, BHUs and clinics of deployed CMWs.

4 AUDIT FINDINGS AND RECOMMENDATIONS

4.1 Organization and Management

- **Non-Integration of different MNCH related activities under one management structure**

  According to PC-I: Project Objectives and its relationship with Sectoral Objectives, "The overarching program goal is to improve accessibility of quality MNCH services through development and implementation of an integrated and sustainable MNCH program at all levels of the health care delivery system". Further, according to PC-I page 104, "MNCH Cell will be directly responsible for integration and implementation of all the MNCH related activities including National MNCH Program".

  All the MNCH related activities & vertical programs were not integrated at the district level, under the management of MNCH Cell, in contradiction of the requirement of the PC-I due to which quality services were not provided to the targeted population.

- **Deviation from Program objectives due to deployment of CMWs in the areas adjacent to health facilities**

  CMWs were to be selected from and deployed in the villages where there was no public health facility (RHC, BHU & MCH Centre, to provide 24/7 coverage to the underserved areas on priority.

  CMWs were required to be deployed to provide the MCH related services to the population for which it is not easy to reach a health provider/ skilled birth attendant.

  Field visits exposed that the CMWs of 2nd and 3rd batches were selected from and deployed in the areas adjacent to the health facilities (annexure-III) despite the fact that the program was initiated with the objective of major focus on the rural/ remote areas, where no health facility existed.

- **Poor services delivery at Basic EmoNC services health facility**

  During visit of RHC 316 GB it was noticed that the health facility had been running without electricity for last 9 months because transformer was damaged in August, 2012. The generator was also not

being utilized for want of POL budget. The laboratory of the hospital was non-functional due to non-availability of energy required for its operations. Deliveries were being conducted at the RHC without sterilization of the instruments required for the purpose. The facility was also out of stock of safe delivery kits and necessary medicines. Deliveries were being conducted in unsafe and infectious environment.

- **Non-Launching of Public Awareness Campaign on MNCH program**

  According to letter No. 5082/MNCH &2269-2303/budget-2009-10/MNCH, 2466/MNCH dated 17.03.2009, 07.09.2009, 14.10.2010 respectively budget for awareness campaign in district, amongst the beneficiaries and healthcare providers was provided to district MNCH cell.

  District management of the National MNCH Program failed to develop any mechanism for launching public awareness campaign amongst the potential beneficiaries of health services and the funds provided for the purpose remained unutilized.

- **Hiring of staff without need/ requirement**

  As per PC-I of the National MNCH Program, Community Midwifery School and Hostel were to be constructed in the district during the year 2007-08 and staff for these components was to be hired in the year 2008-09.

  The contract for construction of Community Midwifery (CMW) School and Hostel was awarded on 31.05.10 but the work was incomplete till 15.05.2013. However, it was astonishing that the staff pertaining to revenue expenditure of the school& hostel (annexure-II) was hired in August 2008 i.e. 2 years before the award of work for the capital expenditure.

Recommendations

- All the MNCH related activities and vertical programs may be integrated at district level and managed by the District MNCH Cell for proper coordination of the services pertaining to maternal, newborn and child health so that it may help achievement of program goals.
- In future recruitment and deployment of CMWs should be in the underserved areas.
- Health facilities may be strengthened for provision of safe delivery services and medicines to the patients. Immediate measures should also be taken to get the transformer operational. Appropriate budget for running the generator should also be provided to the facility so that quality services may be provided to the mother, new born child and other patients.
- A mechanism for launching public awareness campaign may be developed and funds provided for the purpose may be utilized to boost up the campaign in the rural and remote areas for the information and knowledge of the deserving patients.
- Responsibility may be fixed for hiring the staff without requirement, even long before the commencement of construction of the capital component.

4.2 Financial Management

- **Financial mismanagement due to spending the funds of MNCH Program for other purposes by the District Government**

Funds for construction of community midwifery school, renovation at DHQ / THQ Hospitals and payment of stipend were being regularly released by the Provincial Program Coordinator, National MNCH Program Punjab, Lahore as tied grant to the District Government T.T. Singh.

Program activities were badly affected as the funds, provided to MNCH Program District Toba Tek Singh through A/C-IV, were not timely being paid by the District Accounts Office. These funds were being utilized by the District Government Toba Tek Singh for other purposes which resulted in non-completion of civil works and delayed payment of stipend etc.

- **Cost overrun due to uneconomical procurement of vehicle**

According to PC-I of the Program, funds amounting to Rs.3.550 million for purchase of three vehicles for the district (two for CMW School and one for District MNCH Cell) were allocated.

Two vehicles at the cost of Rs.4.270 million were procured instead of three vehicles.

Delay in procurement of vehicles resulted in extra burden on the National MNCH Program. Further, unspecified luxurious vehicles also resulted in cost overrun (annexure-IV).

- **Unauthorized re-appropriation of funds – Rs.1.495 million**

According to letter No.5118-5215/Budget-2000-10/MNCH dated 17.03.2010 issued by the Provincial Program Coordinator National MNCH Program, Punjab Lahore, "If any re-appropriation within the bifurcated funds is required, the case with full justification and recommendation must be referred to the undersigned for administrative approval".

Unauthorized re-appropriation of budget amounting to Rs.1.495 million (annexure-V) was made by the District MNCH Cell at the time of revalidation of the unspent funds of the previous years without seeking administrative approval from the Provincial Program Coordinator.

- **Non-Utilization of budget amounting to Rs.8.388 million**

According to PC-I, "A major constraint in improving availability and quality of health services is inadequate financial space available for provision of these services. The proposed program will increase cost-effectiveness and efficiency of health services by increasing their quality and access and through synergistic action with the ongoing initiatives".

Budget amounting to Rs.35.307 million was released to EDO (Health) Toba Tek Singh in the financial years 2007-12 out of which Rs.8.388 million could not be utilized (annexure-VI) to improve cost effectiveness and efficiency of health services by increasing their quality and access and through synergistic action with the ongoing initiatives.

- **Blockage of Resources**

Equipment was provided to National MNCH Program Toba Tek Singh for onward distribution to CMWs deployed in their catchment areas for better provision of services. The equipment costing 0.463 million (annexure-VII) was not distributed to deployed CMWs and the same was lying idle in store.

Recommendations

- Effective & timely financial management may be observed in future and the funds may be used only for the purpose for which they were provided. In special circumstances, if any re-appropriation within the bifurcated funds is required, the case with full justification and recommendation may be referred to the competent authority for administrative approval.
- Financial management is an area which involves high risks all over the world. The situation in underdeveloped countries is quite alarming regarding financial indiscipline. Specifically in this program, although a major portion remained unutilized, the instances of financial indiscipline has been observed. This could have been avoided if the management would have taken serious measures.

4.3 Procurement and Contract Management

- **Non completion of works for provision of MNCH facilities**

According to PC-I of the Program a CMW school along with hostel was to be completed by the end of year 2 i.e. 2008, however, funds for the same were released in August 2009by the Provincial Program Coordinator National MNCH program Lahore . According to work order the stipulated date of start of work was 31.05.2010 which was to be completed till 28.02.2011 but the same was not completed till May 2013 after a delay of 27 months (annexure-VIII).

Recommendations

- District management should take appropriate measures to get the works completed earlier so that the program goals may be achieved accordingly.
- The authority should also fix responsibility for non-completion of works within stipulated time period resulting in delayed program activities.

4.4 Asset Management

- **Misuse of CMW Van**

According to PC-I, the CMW component was to be provided with two vehicles each for supervision and monitoring purposes. The midwifery tutors would use these vehicles for field visits to CMWs, deployed in the field. The resources for the schools were to be provided to the MS/principal of the concerned hospital/ school irrespective of the condition that where the CMWs were recruited.

As per letter No.3289-3398/3-2007/MNCH dated 19.10.11 issued by the Provincial Program Coordinator National MNCH Program Punjab, Lahore, major gaps identified in poor performing districts are lack of robust monitoring and supervision of program activities due to use of MNCH vehicle by un-authorized person resulting not only in wastage of program resources but also affecting program activities badly.

The vehicle provided for CMWs visits to practical training sites and monitoring/ supervisory visits by the CMW tutors to CMW clinics was used for other/ personal purposes. Vehicle was not actually utilized for the program activities. The summary, given in annexure-IX, shows that only 4.68% use of the CMW van was for the activities related to actual purpose.

Recommendations

- It is recommended that the CMW van may be handed over to the management of the CMW School (Nursing School) with the instructions to use the vehicle only for the purpose of monitoring, supervision and transportation of CMWs to practical training sites.

4.5 Monitoring and Evaluation

- **Non-availability of data regarding achievement of targets**

In the PC-I of the National MNCH Program certain targets were set for provision of better health services and to decrease the IMR, MMR, Under 5 Mortality Rate etc. for achieving the Millennium Development Goals in maternal and child health.

Actual performance of the management regarding achievement of Program objectives/ targets could not be measured due to non-availability of data regarding achieved Program objectives at District MNCH cell. The management of the Program did not know its footing as far as the achievement of targets is concerned.

- **Third party evaluation not carried out**

As per the requirement of the PC-I of the Program a third party evaluation was to be conducted in June, 2012 which was not conducted due to which overall evaluation of the Program management could not be ascertained.

- **Non constitution of certification committee under MNCH program**

A committee, to certify that whether a health facility was providing "comprehensive EmONC", "basic EmONC" or "preventive services" (as per requirement of the PC-I) and to record observations in meeting register, was not constituted by the district management.

- **Weak monitoring and submission of fake monthly reports by CMWs**

As per the provisions of PC-I and guidelines issued by the Provincial Program Coordinator the CMWs were required to keep the record of activities performed by them in the field and submit the same in monthly reports.

Scrutiny of record i.e. monthly reports, daily registers of CMWs, correspondence files depicted that CMWs submitted their monthly reports supported by fake information (annexure-X) about deliveries conducted and patients attended just to show their good performance.

Recommendations

- The management should take appropriate measures to strengthen the district health information system to get the reliable data in connection with the Program objectives.
- CMW van should be handed over to the management of the CMW School (Nursing School) with the instructions to use the vehicle only for the purpose of monitoring, supervision and transportation of CMWs to practical training sites.
- Third party evaluation may be conducted for learning the lessons for future improvement of monitoring and evaluation.
- Responsibility should be fixed for providing fake information in monthly reports.
- Steps should be taken to avoid fake reporting as wrong data may affect attainment of the program objectives and determination of future targets.
- The authority should remove the bottlenecks involved in completion of the Program.

4.6 Environment

The program had a minimal environmental impact as most of the inputs of the program were focused on human resources. Although the increased utilization of health services lead to increase in hospital wastes, they in fact mitigated the waste being produced at household level during deliveries with improper disposal and created opportunities to properly dispose of that waste. As the hospital waste increased, so incinerators were needed at health facilities for its proper disposal. There was no proper mechanism developed for disposal of waste resulted from home based deliveries conducted by the CMWs.

Recommendations

- Incinerators may be provided at health facilities to cater the problem of improper disposal of waste for keeping the environment neat and clean.
- A proper mechanism may be developed for disposal of waste by the CMWs and guidelines in this regard may be issued.

4.7 Sustainability

Overall it is a good initiative of the Government of Pakistan for delivery of MNCH services through District Government to poor masses in remote areas of Toba Tek Singh District. The activities include batches of trained CMWs to replace TBAs (Traditional Birth Attendants). Utilization of Safe Delivery Kits will provide safer delivery services to the pregnant women of remote areas. However, the program must be made sustainable by ensuring consistency in program activities, availability of medicines and better delivery of health services to patients.

Time and Cost overrun

There is a time overrun in the program. Targeted time for completion of Program was June 2012 which has lapsed. The program could not be successfully completed within due course of time. It is also pertinent to mention that no report regarding reasons of delay in completion of the program has been generated by District MNCH cell.
There is a cost overrun due to the following reasons:

- Budget was released in the financial year 2007-08 against the allocation for the year 2006-07. This release was only for the object of stipend which means that the aspect of provision of funds for all other activities of the program was completely ignored.
- Inflation cost for late procurement of vehicles as they were to be procured in the year 2006-07 and 2007-08 but procured on 30.06.2009.
- Funds amounting toRs.8.388 million were not utilized for program activities.
- Unauthorized re-appropriation of budget by the District MNCH Cell at the time of revalidation of the unspent funds of the previous years without seeking administrative approval from the provincial program coordinator.
- Supply of Safe Delivery Kits to health facilities & CMWs was not proportionate to the utilization and most of kits were returned near the date of expiry.

4.8 OVERALL ASSESSMENT

It was a good initiative, by the Federal, Provincial and District Governments, being beneficial to masses especially population of remote areas for provision of health facilities at grass root level by the deployed CMWs and health facilities.

- **Relevance**

  Better health facilities were provided, by deployed CMWs and health facilities, to the people, who could not travel long distance to the Hospital. However, the presence of various vertical programs , resulted in inefficient use of resources. With the help of focused approach and efforts, the program could have been a tremendous success in achieving the MDGs.

- **Efficacy**

  MNCH related services were found to be inadequate at health facilities and CMW clinics in district Toba Tek Singh. However, many pregnant women were helped by trained CMWs in their catchment areas through provision of pre-natal, natal and post natal facilities and referral of complicated cases to nearby health facilities.

- **Economy**

  Vehicles were procured on higher cost. Civil works could not be completed within the stipulated time period. Staff was hired for the CMW School even long before the start of its construction.

- **Efficiency**

  Efficiency is basically an input-output relationship of a program. In this context a major portion of program activities like, construction of school & hostel for CMW students, New Born Care Unit, repair of Labor room, handing over of equipment & delivery tables to CMWs, utilization of vehicles &human resource for program activities, MNCH awareness campaigns etc. remained incomplete due to which the efficiency of the program was effected.

- **Effectiveness**

  As far as the effectiveness of the program is concerned it can be safely stated that the program could not achieve its stated goals. The poor, confused statistics of program did not support the ascertainment regarding achievement of ultimate goals up to 2011-Reduce the rate of Under-Five Mortality Rate up to 65 per 1,000 Live Births, Reduce the IMR by <55 per 1000 live births, Increase the proportion of deliveries attended by Skilled Birth Attendants to 90% and Reduce the Maternal Mortality Ratio per 100,000 Live Births up to 200.

- **Ethics**

  The program aimed to reduce out of pocket expenditure of the poor but due to inconsistency in program activities i.e. non-availability of medicine, non-awareness about CMWs and poor environment of 24/7 health facilities, public prefer to get medication from private hospitals or practitioners. Poor monitoring of deployed CMWs, provision of fake data in monthly reports, lack of coordination between MNCH cell & deployed CMWs affected the program objectives. Late payment of stipend and retention fee also caused poor performance of CMWs. Lack of cooperation by hospital staff during training also affected the objectives.

- **Environment**

  The program had a minimal environmental impact as most of the inputs of the program were focused on human resources. Although the increased utilization of health services led to increase in hospital wastes, they in fact mitigated the waste being produced at household level during deliveries with improper disposal and created opportunities to properly dispose of this waste.

- **Performance Rating of the Program**

  Moderately satisfactory

- **Risk Rating of the Program**

  Medium

4.8.1 Procurement Procedure

No procurement of medicine and equipment etc. was made at district level.

4.8.2 Physical Inspection

During physical inspection of the health facilities and CMW clinics following shortcomings were noticed: -

- Health facility was running without electricity/ power supply for a long time.
- Medical equipment costing Rs.0.469 million was not issued to the deployed CMWs under MNCH and remained unutilized.
- The record of antenatal care, post natal care and delivery registers maintained by CMWs did not match the data/ record provided to DHIS.
- Equipment i.e. B.P apparatuses and weighing machines, were found out of order.
- Most of the deployed CMWs did not know the use of digital weighing machines, sterilizers.
- Sterilized Safe Delivery Kits were supplied without printed date of expiry which may result in infectious deliveries if used after expiry.

Auditor Comments:

- Time line to complete each phase of the program was not observed.
- There is no harmony/sequence in carrying out the program activities as the medical equipment was procured without trained staff to make it functional.
- After expiry of stipulated period of time major, portion of the program activities is incomplete that lagged the department to achieve program objectives.
- Basic medicines were neither procured nor provided to the deployed CMWs which resulted in inconsistency of availability of medicines in clinics of CMWs.
- Supply of Safe Delivery Kits was not properly managed.
- There is no follow-up mechanism for the program activities.

- Fake data was reported to DHIS. The monthly reports showed that number of patients was hypothetically increased just to show efficiency by CMWs.

4.8.3 Implementation

Economy

The supply of Safe Delivery Kits was not managed properly. Total 14,400 kits were provided in 2009-10 without working the actual requirements/ demand due to which 5200kits could not be utilized in the MNCH Program district Toba Tek Singh. The management had to return/ transfer these kits to other districts when they were going to be expired. However, most of the expenditure was incurred on activities other than MNCH program objectives.

Efficiency

Efficiency is basically an input-output relationship of a program. In this context a major portion of program activities remained incomplete i.e. functioning of CMW School, repair of labor rooms, advocacy and demand creation, development of proper referral system, MSDS trained staff and public awareness campaigns on MSDS etc. due to which the efficiency of the program could not be ascertained. Available resources whether HR or physical assets could not be fully utilized in absence of optimal trainings of the staff.

Effectiveness

As far as the effectiveness of the program is concerned it can be safely stated that the program could not achieve its stated goals. The poor, confused statistics of program did not support the ascertainment regarding achievement of ultimate goals - Reduce the rate of Under-Five Mortality Rate up to 65 per 1,000 Live Births, Reduce the IMR by <55 per 1000 live births, bring the rate of Percentage of Births Attended by Skilled Birth Attendants to 90 % and reduce the Maternal Mortality Ratio per 100,000 Live Births up to 200, up to year 2011.

4.8.4 Financial Aspect

Funds were released to MNCH Program district Toba Tek Singh by the PPIU as detailed below and some comparative analysis of budget and expenditure and utilization of budget under each head of accounts were given

which depicted that major portion of the budget was laying in savings i.e. 23.76% of amount released.

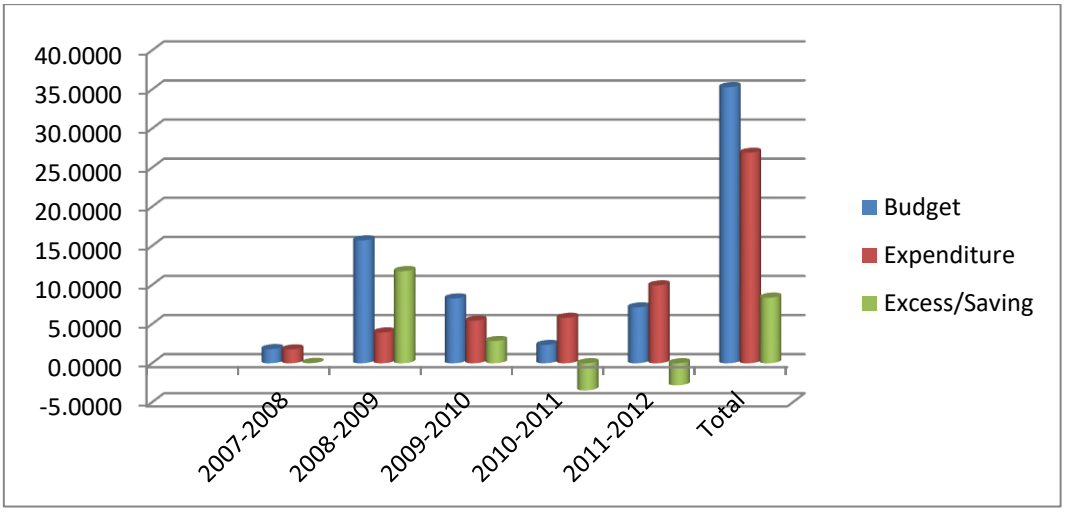
Year Wise Financial Releases and Expenditure:

Following is the five years comparative analysis of Budget & Expenditure for 2007-12 under National MNCH Program District Toba Tek Singh:

(Rupees in Million)

Financial Year	Budget	Expenditure	Excess/Saving
2007-2008	1.811	1.768	0.0430
2008-2009	15.722	3.938	11.7840
2009-2010	8.285	5.441	2.8440
2010-2011	2.340	5.81	-3.4700
2011-2012	7.149	9.962	-2.8130
Total	**35.307**	**26.919**	**8.3880**

GRAPHICAL PRESENTATION



IMPACT ANALYSIS

The cornerstone of this program is the availability of residential CMWs in the rural areas which depended on the proper selection by the selection committee. In order to obtain maximum benefits from the resources available within the district, it is proposed that the district leadership be fully involved in the program. Three batches of trained CMWs have been deployed in their catchment areas to deliver the services as Skilled Birth Attendants (SBAs) in replacement of Traditional Birth Attendants (TBAs), but no CMW has been provided with MNCH related medicines during the entire life of the program. During six months practical training in health facilities they could not complete their tasks to conduct independent deliveries. Total 114 CMWs were deployed in the community out of which only 28 CMWs were provided with delivery tables. Safe Delivery Kits were also not utilized properly. As far as the program vehicle is concerned the same was not used for program activities.

CONCLUSION

Political, economic, management slackness, whatever may be the reasons the program is incomplete. There are certain deficiencies in supply and disbursement of medicine, equipment & machinery. Delayed and inadequate supply of equipment to the deployed CMWs, non-utilization of budget for construction of training center and public awareness campaigns, deployment of CMWs in the areas adjacent to health facilities instead of underserved areas are some of reasons due to which the program activities suffered. Major portion of civil work and repair & maintenance has also not been completed in spite of availability of funds. Non-constitution of certification committees for proper monitoring and evaluation of services provided by health facilities also contributed in non-achievement of objectives set in the PC-I. Non-availability of data regarding achievement of Program objectives is also a major impediment to evaluate the effectiveness of the Program. Third party evaluation of the Program was also a must which was not carried out. Although, the program could not achieve all of its objectives, yet its management has learnt a lot of lessons. It has generated a thought process among the MNCH program management. The lessons learnt would improve the results of upcoming programs.

4.1.1. Key Issues for the Future:

With tremendous and un-controlled explosion of population growth, the need for better health care facilities for a clean and healthy environment will increase with the passage of time. Following key issues may be deemed important for the future.

i. Timely Release and proper utilization of funds.
ii. Proper monitoring & supervision in the field.
iii. Transparent administrative and financial discipline.
iv. Mechanism for gathering and compilation of data regarding achievement of objectives.
v. Timely completion of program activities.
vi. Consistency in program activities.
vii. Completion &utilization of CMW School and Hostel.
viii. Supply of MNCH related medicines to health facilities & deployed CMWs.
ix. Intensive training programs for the MNCH related staff.

4.1.2. Lessons Identified:

- Clear understanding of the issues is extremely important for proper planning and implementation.
- Only integrated planning & comprehensive system produces desired & sustainable results.
- Merit-based selection and capacity building of staff is crucial for implementation of a plan.
- Commitment of the concerned authority is essential for implementation of program.
- Sustainability and smooth running of a program is not possible without training, proper supervision, strengthening of internal controls and awareness of the community.

6 ACKNOWLEDGEMENT

We wish to express our appreciation to the management and staff of National MNCH Program Toba Tek Singh for the assistance and cooperation extended to the auditors during this assignment.

ANNEXURE

Annexure-I

AUDIT FINDINGS AND RECOMMENDATIONS

Organization and Management

Non-Integration of different MNCH related activities under one management structure

"The program goal is to improve maternal, newborn and child health of the population, particularly among its poor, marginalized and disadvantaged segments. The overarching program goal is to improve accessibility of quality MNCH services through development and implementation of an ***integrated*** and sustainable MNCH program at all levels of the health care delivery system". (PC-I: Project Objectives and its relationship with Sectorial Objectives)

"It is proposed that an MNCH Cell will be established in each District Office of Health to work under the EDO (Health), and ***it will be directly responsible for integration and implementation of all the MNCH related activities including National MNCH Program***. EDO (H) can request the Federal/Provincial MNCH Cell to hire technical experts as consultants for the MNCH Cell in order to strengthen its technical capacity". (PC-I page 104: District MNCH Cell)

"This program envisages building management capacity and ***integrating different MNCH related activities under one management structure at the district leve***l. It also outlines strengthening management and organizational structures at the three levels of government". "***At the district level, the services provided through various MNCH related vertical programs*** (e.g., nutrition, malaria control in pregnancy, immunization, HIV, TB control, etc.) ***will be operationally integrated***, whereby a ***District MNCH Cell will coordinate or manage all such activities".*** (PC-I: Operational Arrangements – Management & Organizational Reforms)

All the MNCH related activities & vertical programs were not integrated at the district level, under the management of MNCH Cell, in contradiction with the requirement of the PC-I due to which quality services were not provided to the targeted population. Provincial Program Coordinator's letter No.3289-3398/3-2007/MNCH dated 19.10.11 states that "One of the reasons of Poor performance of MNCH program is negligible or very little coordination

between MNCH Program and LHWs Program at the district level and resultantly monitoring and supervision of deployed CMWs is not being done according to set protocols".

The implementation strategies cannot achieve their objectives until necessary reforms in the management and organizational systems are carried out. A majority of the maternal and early newborn deaths can be avoided by ensuring prenatal, postnatal and newborn care and availability of EmONC services within reasonable travelling distance. A fragmented and ad-hoc approach towards MNCH has mainly been responsible for the failure in achieving the desired results.

It is recommended that all the MNCH related activities and vertical programs may be integrated at district level and managed by the District MNCH Cell for proper coordination of the services pertaining to Maternal, newborn and child health so that it may help in achievement of program goals.

The matter was reported to EDO (Health) in May, 2013 who replied that there is coordination between MNCH cell and vertical program activities and training of deployed CMWs are conducted in this regard. Lady Health Workers have been instructed time to time to refer pregnant women to CMWs for antenatal, natal and post natal care. Furthermore, it is mentioned that all the vertical programs are under the administrative control of EDO Health. Coordination between these programs will be improved by close supervision and monitoring.

Hiring of staff without requirement Rs.1.549 million

As per PC-I of the National MNCH Program, Community Midwifery School was to be constructed in the district during the year 2007-08 and staff for the school was to be hired in the year 2008-09.

The contract for construction of Community Midwifery (CMW) School was awarded on 31.05.10 but the school was incomplete till 15.05.2013. However, it was astonishing that the staff pertaining to revenue expenditure of the school was hired in August 2008 i.e. 2 years before the award of work for the capital expenditure. Wasteful expenditure of Rs.1.549 million was made without justification. Detail of the staff hired without requirement is as under:

Name	Designation	Joining Date	Worked at
TanveerHussain	Computer Operator	27.08.2008	O/O EDO (H) T.T. Singh
Muhammad Shahzad	Security Guard	27.08.2008	O/O EDO (H), MNCH Cell T.T. Singh
Muhammad Sarfraz	Security Guard	27.08.2008	O/O EDO (H), MNCH Cell T.T. Singh
Muhammad Arif	Driver	05.07.2011	O/O EDO (H), MNCH Cell T.T. Singh

It is recommended that the responsibility may be fixed for hiring the staff without requirement even long before the commencement of construction of the capital component and loss sustained by the Program may be made good. It is also suggested that the staff may be adjusted against the vacant posts in the office of the EDO (Health)/ Health Department so that the wasteful expenditure borne by the National MNCH Program may be avoided and the funds may be utilized for the provision of MCH related services to the poor.

The matter was reported to EDO (Health) in May, 2013 who replied that said staff was hired against the sanctioned posts and the budget for the said posts was allocated by the Provincial Program Coordinator Punjab, Lahore.

Deviation from Program objective due to deployment of CMWs in the areas adjacent to health facilities

As per Provincial Program Coordinator National MNCH Program, Punjab, Lahore letter No.5460-97/3-2007/MNCH dated 18.03.2010, "it was decided in the beginning of the Program that the candidates for CMW class may be selected from the villages where there is no public health facility (RHC, BHU & MCH Centre). This decision was taken to provide 24/7 coverage to the underserved areas on priority. If these areas are now covered you may admit candidates from the villages where the public health facilities are also located".

It was observed during the field visits of the CMW clinics that the 2nd and 3rd batches (in April, 2008 &April, 2009) of CMWs were selected from and deployed in the areas adjacent to the health facilities despite the fact that the program was initiated with the objective of major focus on the rural/ remote areas

to provide the MCH related services to the population for which it is not easy to reach a health provider/ skilled birth attendants. This ban was lifted in the year 2010 with the condition that these remote areas are fully covered. Deviation from the program goals was made in the selection/ recruitment of CMWs as mentioned in annexure-III)

It is recommended that responsibility may be fixed on the selection committee for selecting the CMWs, from the areas where health facilities were already available, by ignoring the remote areas where such service was extensively required.

The matter was reported to EDO (Health) in May, 2013 who replied that the CMWs were recruited on the recommendations of the recruitment committee who observed all formalities in this regard.

The reply is not based on facts as the ban for selection of CMWs from urban slums was lifted in the year, 2010 with the condition that the remote areas were fully covered, whereas such irregular selections were made in the year, 2008-09.

Unsafe deliveries without sterilization of instruments

According to page48 of PC-I, "Maternal care would focus on strengthening ante-natal care, Tetanus toxoid vaccination, promoting birth preparedness by families, improving recognition of danger signs, adequate nutrition and rest during pregnancy, ***provision of clean delivery kits,*** and promotion of births by skilled birth attendants, postnatal care and optimal birth spacing". Further, "The required services at the basic EmONC level include management of neonatal infection", (Page 32 of PC-I).

It was observed, during the visit of RHC 316 GB, that there was no electricity in the health facility since last nine months due to which sterilization of the instruments, used in the deliveries, could not be carried out. The generator was also not being utilized for want of POL budget. The laboratory of the hospital was also not functional due to non-availability of electricity required for its operations. The health facility was also out of stock of safe delivery kits and necessary medicines. Deliveries were being conducted in unsafe and infectious environment.

The matter was reported to EDO (Health) in May, 2013 who replied that full efforts were being made for installation of new transformer. Sufficient budget has been provided to the health facility in the revised budget 2012-13 for functioning of Generator.

It is recommended that deliveries should be attended after proper sterilization of the instruments so that spread of infectious diseases may be avoided in mothers and newly born children.

Non constitution of certification committee under MNCH program

According to PC-I, the certification that the facility is providing "comprehensive EMOC", "basic EMOC" or "preventive services" shall be done by a committee.

The committee would visit the concerned health facility and record their observations in a meeting register, copies of which shall be kept at the district health office and the concerned facility, information will also be sent to the Provincial MNCH Cells/Directorates and Federal MNCH PIU. The certification would automatically expire at the end of one year and will have to be renewed by the committee in order to disburse the incentives. The certification could be revoked at any time upon non-performance up to the required standards.

The certification committee was not constituted for certification that the facility was providing "comprehensive EMOC", "basic EMOC" or "preventive services".

Audit required justification for non-constitution of certification committee in response to which the management replied that the matter was noted for future compliance.

Non-Launching of Public Awareness Campaign on MNCH program

According to letter No. 5082/MNCH &2269-2303/budget-2009-10/MNCH, 2466/MNCH dated 17.03.2009, 07.09.2009, 14.10.2010 respectively budget for awareness campaign, amongst the beneficiaries and healthcare providers, was provided to MNCH program district Toba Tek Singh.

It was observed that during the years2007-12 funds to the tune of Rs.210, 000 (as detailed below) were allocated for launching of public awareness campaign on MNCH.

Financial Year		Budget Allocation	Expenditure
2009-10	Seminars	60,000	-
2012-13	Seminars/ConfrenceA03903	150,000	-
Total		**210,000**	-

In-spite of availability of funds neither any campaign for public awareness about the MNCH services was launched, nor any material, relating to information of availability skilled birth attendants in the catchment areas, was displayed in the health facilities for the guidance of beneficiaries.

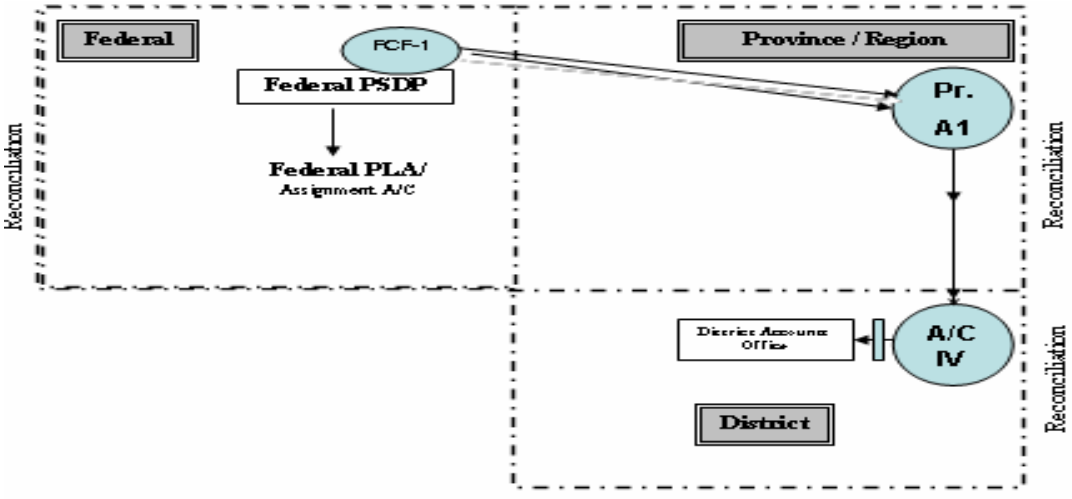
Audit recommends that proper awareness campaign may be launched for the knowledge and facility of the public.

The matter was reported to EDO (Health) in May, 2013 who replied that awareness material provided by Provincial Program Coordinator Punjab Lahore has been distributed to CMWs as well as displayed at office of the Executive District Officer Health Toba Tek Singh and training hall of District Health Development Centre Toba Tek Singh. However at District level funds could not be utilized due to financial crises.

Financial Management

Financial Miss-management due to spending the funds of MNCH Program for other purposes by the District Government

Funds for construction of community midwifery school, renovation at DHQ / THQ Hospitals and payment of stipend were being regularly released by the Provincial Program Coordinator National MNCH Program Punjab, Lahore as tied grant to the District Government T.T. Singh. The flow chart of funds is as under:



It was noticed that the program activities were badly affected due to the reason that the funds provided to MNCH Program district Toba Tek Singh through A/C-IV were not timely being paid by the District Accounts Office. These funds were being utilized by the District Government Toba Tek Singh for other purposes which resulted in non-completion of civil works and delayed payment of stipend etc.

It is recommended that separate SDA Account should be opened for National MNCH Program district Toba Tek Singh and funds should be directly released in that account instead of releasing them in A/C-IV as tied grant. This practice may prevent the utilization of the Program funds for any other purpose and resultantly funds flow management may be improved.

The matter was reported to EDO (Health) in May, 2013 who replied that the Provincial Program Coordinator will be requested to open separate SDA account for National MNCH Program Toba Tek Singh and to release funds directly in that account so that fund flow management may be improved.

Unauthorized re-appropriation of budget amounting to1.495 million

According to letter No.5118-5215/Budge-2000-10/MNCH dated 17.03.2010, "If any re-appropriation within the bifurcated funds is required, the case with full justification and recommendation must be referred to the undersigned for administrative approval".

It was observed that expenditure on the following object was incurred over and above the budgeted amount:

Object Code	Name of Object	Budget (Rs.)	Expenditure (Rs.)	Excess (Rs.)
A03407	Rates & Taxes	10,000	14,875	4,875
A03806	Transport of Goods	-	29,900	29,900
A03807	POL Charges	235,000	636,066	401,066
A03959	Stipend/Retention Fee	9,863,581	10,803,775	940,194
A06103	Incentive	314,200	412,897	98,697
A01270	Tutor Allowance	48,000	57,000	9,000
A013101	Repair of M & E	-	11,300	11,300
Operating Expenses Total		10,470,781	11,965,813	1,495,032

The budget was unauthorized re-appropriated by the District MNCH Cell at the time of revalidation of the unspent funds of the previous years without seeking administrative approval from the provincial program coordinator. It means that intentional deviation was made for spending the funds on the objects other than the objects for which the funds were available.

It is recommended that effective financial management may be observed in future and the funds should be used only for the purpose for which they were provided. In special circumstances, if any re-appropriation within the bifurcated funds is required, the case with full justification and recommendation may be referred to the competent authority for administrative approval.

The matter was reported to EDO (Health) in May, 2013 who replied that the budget allocation was under tied grant which was re-authorized for the next year by the competent authority i.e. Finance Department Toba Tek Singh and bifurcation under various head of accounts was made according to genuine requirements of MNCH Cell. All expenditure has been incurred after fulfilling all formalities and per-audit checks.

Reply is not tenable as the budget reauthorization/ re-appropriation was done without seeking administrative approval from the competent authority i.e. Provincial Program Coordinator.

Uneconomical procurement of vehicle – Cost Overrun amounting to Rs.4.020 million

In the PC-I of the Program funds amounting to Rs.3.550 million for purchase of three vehicles for the district (two for CMW School and one for District MNCH Cell) were allocated.

It was observed that only two vehicles, at the cost Rs.4.270 million, were procured. Detail is as under:

Component	**Procurement as per provision of table 3 of PC-I**					**Actual Procurement**				
	year of Purchase	Description of vehicle	Qty	Rate	Amount	Date of Purchase	Description of vehicle	Qty	Rate	Amount
District MNCH Cell	2006-07	1000 cc Van	1	0.750	0.750	30.06.09	Suzuki Jimny 1328 cc	1	1.620	1.620
CMW School	2007-8	12 seater van	2	1.400	2.800	30.06.09	Hiace Commuter Dual A/C 3.01	1	2.650	2.650
Total			**3**		**3.550**	**Total**		**2**		**4.270**

Details given in the above table show that despite procurement of two instead of three vehicles, an excess expenditure amounting to Rs.0.720 million, over and above the allocation for the district, was incurred. Cost overrun in this component is calculated as under:

Excess expenditure already incurred (4.270-3.550)	= Rs. 0.720 million
Expected expenditure for one CMW Van (Including approximately inflation)	= Rs. 3.300 million
Total Cost Overrun	= Rs. 4.020 million

Delayed procurement and excess engine capacity/ luxurious vehicles resulted in extra burden on the National MNCH Program as well as low standard monitoring and supervision activity. As per page 72 of the PC-I, "The CMW tutor shall observe the interaction of the CMW for antenatal care, postnatal care and child care and provide observations to improve her performance. If the CMW is involved with a delivery case the tutor shall provide technical assistance to the CMW and if referral is required the Supervisory vehicle of the tutor may be utilized for this purpose".

It is recommended that the vehicle may be procured as early as possible so that it may be used for monitoring and supervision of the CMWs and capacity building of the skilled birth attendants by increasing hands on practical training.

The matter was reported to EDO (Health) in May, 2013 who replied that the allocation of budget in PC-1 and procurement of Vehicles were made at Provincial level and vehicles were handed over to District MNCH Cell by the Provincial Program Coordinator. Moreover, the Provincial Program Coordinator National MNCH Program Lahore will be requested to procure the remaining vehicle and hand over to the concerned District MNCH Cell for better monitoring and supervision of CMWs and capacity building of the skilled birth attendants by increasing hands on practical trainings.

Non-Utilization of Budget under MNCH

PC-I (page XII) states, "A major constraint in improving availability and quality of health services is inadequate financial space available for provision of these services. The proposed program will increase cost-effectiveness and efficiency of health services by increasing their quality and access and through synergistic action with the ongoing initiatives".

During performance Audit of National MNCH Program Toba Tek Singh it was observed that budget of Rs35.307 million was released to EDO (Health) Toba Tek Singh in the financial years 2007-12. The said amount was bifurcated under different heads to perform different activities to achieve the MDG-4, reducing the infant mortality rate (IMR) and MDG-5, reducing the maternal

mortality ratio (MMR) but only an amount of Rs.26.919 million (up to June 2012) was utilized under this program.

Resultantly some major activities of the program were not performed for which the budget was allocated.

Audit is of the view that non-utilization of budget is weak financial control on the part of EDO (Health) and district management (MNCH cell).

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that almost all activities have been performed by District MNCH Cell. However due to financial crises at District level faced by District Government the budget could not be utilized.

Blockage of Resources

According to letter No.PMIU/PHSRP/M&E.1-09/10578 dated August 8, 2009, DG health circulated that all the BHUs, RHCs and MNCH related departments of the THQs and DHQs hospitals have to be fully staffed and equipped as per MSDS.

During performance Audit of National MNCH Program Toba Tek Singh it was observed that various equipment were supplied to MNCH cell during 2011-12 for further distribution to CMWs deployed in their catchment areas for better provision of services. The different items mentioned in table below were not distributed among the deployed CMWs and the same were lying in store for a long period of time.

The non-utilization of medical equipment in violation of instructions may result into non-working of medical equipment. Further it is also worth mentioning that in various health facilities the equipment was kept blocked.

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that all deployed CMWs have been provided equipment, the remaining equipment will be distributed to next deployed batch in future accordingly.

Procurement and Contract Management

Non completion of works for provision of MNCH facilities

According to PC-I of the National MNCH Program, "All the DHQ hospitals will be provided with funds for repair and maintenance. The amount has been estimated at an average cost of Rs. 1.2 million per DHQ Rs1.0 million per THQ providing Comprehensive EmONC services". According to Letter No.3255 dated 17.06.2009 by Provincial Coordinator MNCH program Lahore the following schemes were approved for MNCH Program district Toba Tek Singh.

It was revealed from scrutiny of record and visit of health facilities that contrary to the above program objectives targeted to achieve in the end of 2nd and 3rd year the same was not achieved in spite of availability of funds and huge operational expenditure.

Sr. No.	Name of health facility	AA cost/date	Nature of Work	Start	Completion	Updated cost	Status
1	M/R to labor room at DHQ (Contractor Name Abdul Rasheed)	1.200m/25.05.2010	Work revised for construction of New Born Babies	31.05.2010	28.02.2011	0.647 m	Contractor left the work incomplete with a cost of Rs0.647 m. The remaining work was completed on self-help basis. The unit was inaugurated in April,2013(completion 28.02.2011)
2	E.CG.H Gojra(Name of Contractor Sunder Construction Co)	0.888 m /06.03.2010	M/R to Eye Cum General Hospital	29.06.2010	28.08.2010	0.056 m	The work was to be completed by 28.08.2010 but same has not been completed.

Funds were released for the above works under Tied Grant. Further, the funds were transferred to DO (Buildings) as Deposit Work but execution agency did not complete the works within the time, due to which the program activities have not been achieved along with wastage of cost already incurred.

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that the amount was deposited with Works Department for execution of work as deposit work. Executing agency (DO Building) had been asked many times to execute the work. More efforts will be made in this regard.

Audit recommends that matter may be brought to appropriate level for fixing of responsibility.

Non completion of CMW School and hostel in spite of availability of funds

According to PC-I of National MNCH program, "As the institutional training will be residential in nature, the schools will be provided funds for constructions of hostels for 35 students. The cost is estimated at Rs 6.25 million per school, however keeping in view that a majority of these schools already have hostels available, these funds can be reallocated within the province by the provincial MNCH Cells to districts where the hostels are really needed"

Detail of schools to be established is as under:

CMW schools by province and year of program according to PC-I

Province	Year 1	Year 2	Year 3	Year 4
Punjab	61	0	0	0

Name of Work	Name of Contractor	Date of Start	Date of Completion	Cost	Up dated status
Construction of CMW school/hostel	Ehsan Brothers(MRS 4th Quarter 2009) vide W/ Order No.5193 dated 31.05.2010 with completion period 9 month	31.05.2010	28.02.2011	2.047m up to the end 2012(29%) and cost up to 2013 current status 5.151 m (66%)	The work is still incomplete. The contractor is not executing the work.

During Performance Audit of National MNCH Program (2006-12) it was noticed from scrutiny of record that school and hostel building for CMW students was administratively approved at a rough cost of Rs 5.972 million, funds were released on 26.08.2009 amounting to Rs5.700 million. The work was awarded by W&S department on 21.05.2010 and date of completion was 04.01.2011, the work was revised and approved by DDC at the cost of Rs7.761 million.

During visit of site in the Month of May, 2013 it was revealed that the building was still incomplete, so despite release of funds, it could not be used for the purpose for which it was to be constructed. CMW students were required to reside in hostel during their classes at school but due to non availability of hostel the same was not provided to the students.

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that the contractor started the work timely but due to stoppage of payment by District Accounts Office Toba Tek Singh the work is still incomplete by the contractor. Efforts are being made for completion of work.

Audit recommends that matter may be brought to appropriate level for fixing of responsibility.

Asset Management

Unauthorized use of CMW van resulting in poor monitoring & supervision

"There will be two 12 seater vans per CMW School. The Community midwives will be given practical training at the hospital as well as at designated THQ/RHCs. The CMW tutor will also be responsible for providing supervisory support in the field to the CMWs, therefore the program is designed to provide mobility to the CMW Schools to enable quality training". (Table 3 of PC-I: List of vehicles required)

"The schools will be provided with two vehicles each for supervision and monitoring purposes. The midwifery tutors shall use these vehicles for field visits to CMWs which have been deployed in the field, in addition the vehicles will also be used to transport the CMWs under training for hands on training during the one year institutional training and for transportation to the practical training sites during practical training if no accommodation exists at the site". (Component 2 (C.4) of PC-I: Training and deployment of community midwives)

"The resources for the schools will be provided to the MS/principal of the concerned hospital/ school irrespective of where the CMWs are recruited". (Table 11 of PC-I: Capital cost of midwifery school)

As per letter No.3289-3398/3-2007/MNCH dated 19.10.11 issued by the Provincial Program Coordinator National MNCH Program Punjab, Lahore "Major gaps identified in poor performing Districts are lack of robust monitoring and supervision of program activities due to use of MNCH vehicle by un-authorized person resulting in not only the wastage of program resources but also affecting badly program activities".

The vehicle provided for CMWs visits to practical training sites and monitoring/ supervisory visits by the CMW Tutors to CMW clinics was used for other purposes and mostly for private/ personal purposes. It is also depicted from the log book of the van that not a single supervisory visit was done by the CMW Tutor on CMW van due to which the most important function of monitoring and clinical supervision was entirely ignored. Constraints in the logistic system usually disrupt field operation particularly those related with supervision.

The matter was reported to EDO (Health) in May, 2013, who replied that the Van has been used for Program activities i.e. for transportation of CMWs for examination at Allied Hospital Faisalabad and for monitoring and supervision of CMWs at different health facilities by EDO Health being in charge of the Program. All expenditure of POL is incurred for Program activities. However Van has been handed over to the management of CMW School (Nursing School) with the instructions to use the Vehicle only for the purpose of monitoring, supervision and transportation of CMWs for hands on practical training to improve the service quality of health care providers.

It is recommended that the CMW van may be handed over to the management of the CMW School (Nursing School) with the instructions to use the vehicle only for the purpose of monitoring, supervision and transportation of CMWs for hands on practical training to increase the service quality of health providers

Deliveries by CMWs without utilization of Safe Delivery Kits

According to PC-I, "Once qualified and registered with the Nursing Examination Boards, midwives shall be facilitated to establish safe delivery practices in the community to provide antenatal and post natal checkups, birth preparedness counseling, Family Planning Advice, and **providing safe delivery"**.

During Performance Audit of National MNCH Program (2006-12) it was noticed from scrutiny of monthly reports of CMWs (selected) that CMWs did not utilize the Safe Delivery Kits during deliveries. Safe delivery kits were provided to all CMWs to avoid complications during delivery and providing safe delivery the same was not utilized in spite of stock provided to them for the said purpose. The detail of stock available and utilized is attached in the table.

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that all CMWs have been equipped with sterilizers and safe delivery kits for safer deliveries and their stock of SDK is replenished on monthly basis and they are also trained in this regard.

Audit recommends that matter may be investigated.

Monitoring and Evaluation

Non-availability of data regarding achieved Program objectives

According to PC-I of National MNCH Program, "The program will ensure progress toward achieving the Millennium Development Goals in maternal and child health. Specific program objectives are:

1. To reduce the Under Five Mortality Rate to less than 65 per 1000 live births by the year 2011 (Target 2015: 45/1000)

2. To reduce the Newborn Mortality Rate to less than 40 per 1000 live births by the year 2011 (Target 2015: 25/1000)

3. To reduce the Infant Mortality Rate to less than 55 per 1000 live births by the year 2011 (Target 2015: 40/1000)

4. To reduce Maternal Mortality ratio to 200 per 100,000 live births by the year 2011 (Target 2015: 140/100,000)

5. To increase the proportion of deliveries attended by skilled birth attendants at home or in health facilities to 90%. (Target 2015: >90%)

6. Increase in Contraceptive Prevalence Rate from 36 (2005) to 51 in 2010 and 55 in 2015".

During Performance Audit of National MNCH Program (2006-12) it was noticed from scrutiny of record that the program objective were not achieved as the indicators of the program showing current status is poor at provincial level. However no data for achieved program objective was available in the office of National MNCH cell Toba Tek Singh. No study /survey report for deriving the program objectives was conducted.

Area	S	
	At the time of PC-I	Target
Under 5 mortality rate	105(2001)	65/1000 L/B
New born mortality rate	77/1000 L/B	40/1000 L/B
Infant Mortality Rate	81/1000(**RAF)	55/1000 L/B
Maternal Mortality Rate	300/100000 L/B	200/100000 L/B
Attendance at home by SBA	30%	90%

*TRF (Technical Resource Facility)

**RAF (Research & Advocacy Fund)

Matter was reported to EDO health Toba Tek Singh in May, 2013, who replied that all possible efforts were made to achieve the program objectives. The reply is not based on facts that no such document regarding achievement of program objectives was available with EDO (health).

Weak monitoring and submission of fake monthly reports by CMWs

The EDO (H) Toba Tek Singh vide his letter No. 2828-34/MNCH dated 20.01.2011 deployed CMWs in their catchment areas with the instructions to provide antenatal, natal, postnatal services, and keep record of all activities.

During Performance Audit of National MNCH Program (2006-12) it was noticed from scrutiny of record like, monthly reports, daily registers of CMWs, correspondence files etc. that various CMWs submitted their monthly reports supported by fake information about deliveries conducted, patients attended just to show their performance (annexure-X). The matter needs justification.

The matter was reported to EDO (Health) in May, 2013 who replied that monthly reports are submitted by CMWs by taking data input from their daily registers, clerical / written mistakes may happen but they are visited regularly.

Annexure-II

Detail of Staff hired without need/ requirement

Name	Designation	Joining Date	Worked at
TanveerHussain	Computer Operator	27.08.2008	O/O EDO (H) T.T. Singh
Muhammad Shahzad	Security Guard	27.08.2008	O/O EDO (H), MNCH Cell T.T. Singh
Muhammad Sarfraz	Security Guard	27.08.2008	O/O EDO (H), MNCH Cell T.T. Singh
Muhammad Arif	Driver	05.07.2011	O/O EDO (H), MNCH Cell T.T. Singh

Annexure-III

Recruitment of CMWs from areas where health facilities are situated

Name of CMW	Batch No.	Batch recruited in	Address of CMW	Name of Health Facility	Distance
KousarParveen	2nd	April 2008	KachiKothiPirMahal	RHC PirMahal	½ Km
ShaziaAkram	2nd	April 2008	345 GB	BHU 345 GB	½ Km
SobiaNaz	2nd	April 2008	Ayub Colony Gojra	THQ Gojra	1 Km
RozianKousar	2nd	April 2008	411 JB	BHU	½ Km
Yasmeen Iqbal	2nd	April 2008	330 GB	BHU 330 GB	1 Km
SadiaTahir	2nd	April 2008	Itfaq Town Rajana	RHC Rajana	½ Km
SadiaNaseem	3rd	April 2009	293 GB	DHQ TT Singh	1 Km
AzraIshtiaq	3rd	April 2009	295 GB	DHQ TT Singh	½ Km

Annexure-IV

Uneconomical procurement of vehicle

Rupees in million

Component	Procurement as per provision of table 3 of PC-I					Actual Procurement				
	year of Purchase	Description of vehicle	Qty	Rate	Amount	Date of Purchase	Description of vehicle	Qty	Rate	Amount
District MNCH Cell	2006-07	1000 cc Van	1	0.750	0.750	30.06.09	Suzuki Jimny 1328 cc	1	1.620	1.620
CMW School	2007-8	12 seater van	2	1.400	2.800	30.06.09	Hiace Commuter Dual A/C 3.01	1	2.650	2.650
Total			**3**		**3.550**	**Total**		**2**		**4.270**

Description	Amount
Excess expenditure already incurred (Rs.4.270-Rs.3.550, as calculated in annexure-IVabove)	0.720
Approximate cost of one CMW Van	3.300
Total Cost Overrun	4.020

Annexure-V

Unauthorized re-appropriation of funds

Object Code	Name of Object	Budget (Rs.)	Expenditure (Rs.)	Excess (Rs.)
A03407	Rates & Taxes	10,000	14,875	4,875
A03806	Transport of Goods	-	29,900	29,900
A03807	POL Charges	235,000	636,066	401,066
A03959	Stipend/Retention Fee	9,863,581	10,803,775	940,194
A06103	Incentive	314,200	412,897	98,697
A01270	Tutor Allowance	48,000	57,000	9,000
A013101	Repair of M & E	-	11,300	11,300
Operating Expenses Total		10,470,781	11,965,813	1,495,032

Annexure-VI

Non-Utilization of Funds

Financial Year	Budget	Expenditure	Excess/Saving
2007-2008	1.8110	1.768	0.0430
2008-2009	15.7220	3.938	11.7840
2009-2010	8.2850	5.441	2.8440
2010-2011	2.3400	5.81	-3.4700
2011-2012	7.1490	9.962	-2.8130
Total	**35.3070**	**26.919**	**8.3880**

Annexure-VII

Blockage of resources

Sr. No	Name of Item	Date of receipt	Quantity received	Disbursed	Laying in Store	Cost	Value
1	Kit Bag	2010-12	30	24	6	10,000	60,000
2	Adult Weighing Machine	2010-12	30	24	6	3,000	18,000
3	Baby Weighing Machine	2010-12	30	24	6	3,000	18,000
4	B.P. Apparatus	2010-12	30	24	6	4,000	24,000
5	Sterilizer	2010-12	30	24	6	5,000	30,000
6	Stethoscope	2010-12	30	24	6	500	3,000
7	Episiotomy Sessions	2010-12	30	24	6	200	1,200
8	Medium Artery Forceps	2010-12	30	24	6	500	3,000
9	Small Artery Forceps	2010-12	30	24	6	500	3,000
10	Kidney Tray	2010-12	30	24	6	300	1,800
11	Instrument Tray	2010-12	30	24	6	300	1,800
12	Bowel 10”	2010-12	30	24	6	300	1,800
13	Fetus Scope	2010-12	30	24	6	300	1,800
14	Allies Forceps	2010-12	30	24	6	300	1,800
15	Non toothed Forceps	2010-12	30	24	6	300	1,800
16	Toothed Forceps	2010-12	30	24	6	300	1,800
17	Bowel 6”	2010-12	30	24	6	300	1,800
18	Measuring Tape	2010-12	30	24	6	1,000	6,000
19	Disposable Mask	2010-12	30	24	6	100	600
20	Needle Holder	2010-12	30	24	6	300	1,800
21	Delivery Table	2010-11	56	28	28	10,000	280,000
Total							**463,000**

Annexure-VIII

Non-completion of CMW School

Name of Work	Name of Contractor	Date of Start	Date of Completion	Cost	Up dated status
Construction of CMW school/hostel	Ehsan Brothers(MRS 4th Quarter 2009) vide W/ Order No.5193 dated 31.05.2010 with completion period 9 month	31.05.2010	28.02.2011	2.047m up to the end 2012(29%) and cost up to 2013 current status 5.151 m (66%)	The work is still incomplete. The contractor is not executing the work.

Annexure-IX

Unauthorized use of CMW Van

Purpose/ Use of CMW Van	**Vehicle Running (KMs)**	**(% age)**
CMW Visits (requirement of the PC-I)	3,359	4.68%
Private/ Personal Use	23,311	32.50%
Other Purposes in EDO (H) Office	45,063	62.82%
Total	71,733	100.00%

Annexure-X

Fake Reporting by CMWs

Sr. No.	Name of CMW & address	Duplication Showed	Reported in month	Fake reporting in month of	Other Issue
1	Sobia Siddique 3rd Batch	Niala W/o Atif	Delivery in Month 10/2012	Delivery in Month 11/2012	The same showed in monthly report 10/2012 &11/2012
		Iqra W/o Jameel	Delivery in Month 08/2012	Delivery in Month 09/2012	The same showed in monthly report 08/2012 &09/2012
2	Hafeeza Majeed 3rd Batch	Shumaila W/o Ajmal	Delivery in Month 09/2012	Delivery in Month 11/2012	The same showed in monthly report 09/2012 &11/2012
3	Razia Dildar	No delivery in the Month 01/2013 but showed 2 deliveries in the monthly report			
4	Abida Aslam 3rd Batch	01 delivery in the Month 12/2012 but showed 06 deliveries in the monthly report			
5	Hafiza Ansa Parveen 3rd Batch	02 deliveries in the Month 12/2012 but showed 04 deliveries in the monthly report			
6	Nomia Parveen 3rd Batch	No delivery was conducted in the Month of November 2012 but showed 02 deliveries in monthly report by PHS			
7	Balqees Akhtar 3rd Batch	01 delivery was conducted in the Month of November 2012 but showed 02 deliveries in monthly report by PHS			
8	Noreen Akhtar 3rd Batch	Khalida W/o M. Zahid	Delivery in Month 07/2012	Delivery in Month 08/2012	The same showed in monthly report 07/2012 &08/2012
		Shaheen W/o Shahid	Delivery in Month 07/2012	Delivery in Month 08/2012	The same showed in monthly report 07/2012 & 08/2012
9	Rukhsana Nazir 3rd Batch	Humera W/o Asif	Delivery in Month 11/2012	Delivery in Month 12/2012	She also Reported 05 deliveries in the month Nov/2012 but daily register showed 02 deliveries