PERFORMANCE AUDIT REPORT ON PROVISION OF BASIC HEALTH AMENITIES IN ISLAMABAD BY DIRECTORATE OF HEALTH SERVICES (DHS), CAPITAL DEVELOPMENT AUTHORITY

AUDIT YEAR 2022-23

AUDITOR-GENERAL OF PAKISTAN

PREFACE

The Auditor-General of Pakistan conducts audit under Articles 169 and 170 of the Constitution of the Islamic Republic of Pakistan 1973, read with Sections 8 and 12 of the Auditor-General's (Functions, Powers and Terms and Conditions of Service) Ordinance, 2001. The Performance Audit of the "Directorate of Health Services, Capital Development Authority/Metropolitan Corporation, Islamabad" was carried out accordingly.

Directorate General of Audit Works (Federal), Islamabad conducted performance audit of "Directorate of Health Services" during March - April 2023 covering the period from 2017-18 to 2021-22 with a view to reporting significant findings to stakeholders. Audit examined the economy, efficiency and effectiveness aspects of the Directorate. In addition, Audit also assessed, on test check basis, whether the management complied with applicable laws, rules and regulations in providing basic health facilities to residents of Islamabad.

The Audit Report indicates specific actions that, if taken, will help the management to realize the objectives of the Directorate. The observations included in this report have been finalized in the light of written management response, however, DAC was not convened by the PAO despite requests made by Audit.

The Audit Report has been prepared for submission to the President of Pakistan in pursuance of Article 171 of the Constitution of Islamic Republic of Pakistan, 1973 for causing it to be laid before the Parliament.

Sd/-

Islamabad
Dated: 20th December, 2023

(Muhammad Ajmal Gondal)
Auditor-General of Pakistan

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BCG	Bacillus Calmette-Guerin
BHU	Basic Healthcare Unit
CDA	Capital Development Authority
CDC	Center for Disease Control and Prevention
DAGP	Department of Auditor General of Pakistan
DHS	Directorate of Health Services
DTP	Diphtheria, Tetanus, Pertussis
EPI	Expanded Programme on Immunization
ERE	Employee Related Expenses
FP2030	Family Planning 2030
GFR	General Financial Rules
HAIs	Healthcare Associated Infections
HEM	Health Equity Model
HepB	Hepatitis B
Hib	Haemophilus Influenzae type-B
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
IA2030	Immunization Agenda 2030
IHRA	Islamabad Healthcare Regulatory Authority
IMR	Infant Mortality Rate
INTOSAI Institutions	International Organization of Supreme Audit
LHV	Lady Health Visitor
MC	Medical Centre
MCI	Metropolitan Corporation of Islamabad
MCV1	Measles Containing Vaccine 1st dose
MNCH	Mother and Newborn Child Health
M/o NHSRC	Ministry of National Health Services Regulations and Coordination

NIH	National Institute of Health
PFM	Public Finance Management
PCSIR	Pakistan Council of Scientific and Industrial Research
PCV	Pneumococcal Conjugate Vaccine
PFO	Pure Food Ordinance
PHC	Primary Healthcare
PPRs	Public Procurement Rules
PSQCA	Pakistan Standards and Quality Control Authority
PSR	Preliminary Survey Report
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

EXECUTIVE SUMMARY

The Performance Audit of Directorate of Health Services (DHS), under Capital Development Authority (CDA)/Metropolitan Corporation Islamabad (MCI) was carried out by Directorate General of Audit Works (Federal), Islamabad for the Financial Years 2017-2022 during March-April 2023. The Performance Audit was conducted as a part of the Directorate General Audit's approved Annual Audit Plan 2022-23. The main objectives of the audit were to evaluate the quality and efficacy of basic health facilities being provided by the Directorate and to assess the achievement of targets against National/International healthcare Standards and healthcare Policy frameworks. The audit also focused on achievement of economy, efficiency and effectiveness in expenditure, so as to optimally produce desired health results for the population of Islamabad. Audit was conducted in accordance with the International Organization of Supreme Audit Institutions (INTOSAI) Auditing Standards to examine whether the funds were utilized in conformity with applicable laws, rules and accounting policies/procedures.

The main objectives of the audit were to identify and highlight areas requiring immediate improvement and propose solutions in line with the economy, efficiency and effectiveness (3E's) for the provision of healthcare facilities.

Key Audit Findings

The following are the key audit findings identified during the Performance audit of the DHS:

i) Majority of the Medical Centres (MCs) under the Directorate lacked sufficient and appropriately trained medical staff

ii) The medical centres operating under the Directorate did not have adequate supply of basic and essential drugs to meet the healthcare needs of the local population

iii) The Directorate did not have an effective mechanism in place to conduct regular supervisory inspections of the medical centres to ensure the provision of quality healthcare services

iv) Despite having ambulances, the Directorate was not providing any ambulatory services to the local population

v) The Immunization Policy coverage was not optimal and the desired outcomes were not fully realized

vi) DHS failed to adequately implement the Pure Food Ordinance (PFO), 1960 neglecting its responsibility to control the disease spread to ensure the presence of hygienic eateries in Federal capital

vii) DHS and its medical centres were inadequately implementing cleaning and infection control protocols, thereby increasing the risk of healthcare-associated infections (HAIs) spreading

viii. There was dubious expenditure on medicines, awareness programmes and dengue/malaria prevention activities and expenditure was incurred without a competitive bidding process

ix. Unauthorized expenditure was incurred on 'sharing of revenue' with health personnel/employees without any approved policy for DHS

Recommendations

Based on the above audit findings, Audit recommends that:

i. DHS should take robust measures to address the shortage of appropriately trained and qualified healthcare professionals, particularly doctors, across its medical centers.

ii. DHS should ensure availability of all essential medicines/ drugs at its medical centres, maintaining adequate stock throughout the year.

iii. DHS should establish effective mechanisms for periodic supervision, monitoring & evaluation of medical centers

iv. Medical centres should establish ambulatory services and ensure efficient utilization of available ambulances for medical emergencies.

v. To align with the National Immunization Policy and achieve targets, DHS should take concrete measures to actively pursue the targets outlined in the immunization policy and ensure its successful implementation.

vi. DHS should promptly address the gaps in implementing the PFO, 1960 and strengthen its efforts to fulfill its responsibility of controlling the spread of diseases and ensure the presence of hygienic eateries in the federal capital.

vii. DHS should take immediate and comprehensive measures to enhance the implementation of cleaning and infection control protocols across all its medical centres.

viii. DHS should ensure transparency, accountability and compliance with regulations in the expenditure of funds on medicines, awareness programmes, and dengue/ malaria prevention activities.

ix. DHS should establish proper governance and financial discipline while dealing with revenue-related matters and should ensure compliance with policies and regulations in making payments to the employees as 'revenue share'.

1. INTRODUCTION

The city of Islamabad, has a population of 2.0 million as recorded in the National Population and Housing Census of 2017. Islamabad, being a central hub, is witnessing a significant shift of population from all over the country and this is supported by its annual growth rate of 4.91%, which is the highest recorded at the national level.[1] Urban proportion of population is 50.37%, while the rural makes up the remaining 49.63%. This notable growth rate surpassing that of other cities, brings forth substantial challenges in terms of socio-economic development. One of the key strategies is to prioritize the strengthening of healthcare services, which serve as a cornerstone in the public sector.

Healthcare services in the public sector follow a tiered referral system, where a network of healthcare facilities is organized based on increasing complexity and coverage. This system ranges from primary healthcare facilities to secondary and tertiary health facilities. Primary Healthcare (PHC) facilities encompass a range of essential units, including Basic Healthcare Units (BHUs), Rural Health Centers (RHC), and Mother and Child Health (MCH) Centers and address the primary healthcare needs of communities.

PHC plays a crucial role in achieving Universal Health Coverage (UHC) by ensuring accessible, affordable, and comprehensive healthcare services for all individuals. In 2018, Pakistan became a signatory to the UHC 2030 global compact, demonstrating its commitment to promote universal health coverage as part of its efforts to achieve the health-related Sustainable Development Goals (SDGs).[2] SDG-3 calls to "ensure healthy lives and promote well-being for all at all ages". By 2030, Pakistan has been assigned specific targets under SDG-3, which include reducing maternal mortality and neo-natal mortality, availability of skilled health personnel, combating communicable diseases, eliminating preventable diseases entirely,

[1] https://www.pbs.gov.pk/sites/default/files/population/2017/results/13501.pdf, https://www.finance.gov.pk/survey/chapters_18/12-Population.pdf
[2] https://www.who.int/news-room/feature-stories/detail/uniting-partners-accelerate-pakistan-progress-health-sustainable-development-goals

achieve universal health coverage (access to quality healthcare services, essential medicines and vaccines), management/reduction of health risk and promoting mental health and well-being.[3]

The Directorate of Health Services, established in 1984 and operating under the administrative control of the MCI, has evolved into a network of 13 medical centers and 2 mobile units and delivers primary healthcare services to the residents of Islamabad within its municipal boundaries. However, financial arrangements are under CDA. As per Schedule-II [Rule 3(3)] of Rules of Business, 1973 (amended up to 01.12.2021) CDA and MCI are under the administrative control of the Ministry of Interior (Interior Division).

The DHS being entrusted with the crucial responsibility of delivering basic healthcare amenities to the people of Islamabad, evaluating its operations and healthcare delivery system's efficiency was of the utmost importance. Hence, the Performance Audit was done in accordance with the Directorate General Audit's approved Annual Audit Plan 2022-23.

1.1 Directorate of Health Services

The DHS was established to provide primary healthcare services to Islamabad residents and CDA employees through the establishment of fixed medical facilities in urban sectors and mobile units in rural sectors located within Islamabad's municipal limits. The key responsibilities of DHS included the execution of initiatives like the Expanded Programme on Immunization (EPI), the eradication of Polio, and the enhancement of reproductive health programs. Additionally, undertaking measures to control vector borne diseases such as dengue, malaria etc. through larvicidal, spraying and fogging activities in Islamabad also covered in the purview of DHS. The DHS is also tasked with improving the hygiene standards at all edible centres of Islamabad's municipal boundaries in order to prevent the spread of diseases.

[3] https://www.sdgpakistan.pk/web/goals/goal3 & https://sustainabledevelopment.un.org/content/documents/11803Official-List-of-Proposed-SDG-Indicators.pdf

The MCs operating under the administrative jurisdiction of the DHS, are as follows:

S. No.	Name of Medical Centre & Location	Rural/ Urban	No. of Patients Visited (Jan to Dec 2022)
1.	MC F-11/4	Urban	2,244
2.	MC G-9 Markaz (Morning)	Urban	9,759
3.	MC G-9 Markaz (Evening)	Urban	1,290
4.	MC I-10/1, Shaheen Market (Morning)	Urban	4,666
5.	MC I-10/1, Shaheen Market (Evening)	Urban	570
6.	MC G-7, Gulshan Market	Urban	2,394
7.	MC G-5, Diplomatic Enclave	Urban	1,615
8.	MC B-Block, Pak Sectt.	Urban	-
9.	MC Simly Dam Colony	Rural	4,310
10.	MC Rawal Town	Urban	6,720
11.	MC Bara Kahu, Simly Dam Road	Rural	1,360
12.	MC I-8, CDA Block	Urban	5,344
13.	MC G-10 Markaz	Urban	2,315

In addition to the aforementioned medical centers, the DHS also oversees the operations of a Laboratory and an EPI Vaccination Center at DHS HQ, F-11, Islamabad.

Human Resource (major position) of DHS is as under:

Name of Post	Sanctioned Strength	In position/ available strength	Shortage
DG Health Services (B-20)	01	01	0
Director Health Services (B-19)	01	0	01
Addl Dir. Health (B-18)	01	0	01
Health Officer (B-19)	01	0	01
Entamologist (B-17)	01	01	0
Medical Officer (B-17/19)	14	06	08

Name of Post	Sanctioned Strength	In position/ available strength	Shortage
Divisional Accounts Officer	01	01	0
Admn Officer	01	0	01
Coord Officer	01	0	01
Food Inspector (B-16)	04	04	0
Anti Maleria (B-16)	01	01	0
Medical Assistant/Jr Technician (B-9)	03	0	03
Lab Technician (B-9)	01	0	01
Leady Health Visitor (B-12)	01	01	0
Dispenser/Chief Tech/Sr Tech (B-16/14)	18	17	01
Vaccinators/Sr. Tech/Jr Tech (B-16/9)	15	10	05
Midwife/Jr Tech (B-9)	05	02	03
Inspector Collector (B-7)	02	02	0
Sub-Total	72	46	26
Others (LDCs/Jr Assistants, Naib Qasid, Security guards, Helpers, Labour, Sweepers)	88	77	11
Grand Total	**160**	**123**	**37**

There is shortage of key posts like Medical Officers, Vaccinators and midwives. This factor is one of the causes towards inability of DHS to provide quality healthcare services as per PHC facilities standards. Out of six available Medical Officers, three are posted at MCs, leaving most of the MCs without a Medical Officer. Further, there are only six sanctioned posts of LHVs/Midwives which are insufficient to cater for the requirements of 13 MCs. Against six posts, only three LHVs/midwives were available. Human Resource (HR) related issues have been highlighted under Para 4.1.1 of the report.

1.2 Objectives of DHS

The main objectives of the Directorate of Health Services are as follows:

1.2.1 Establishing fixed medical centers in urban areas and providing mobile units to rural areas within Islamabad's municipal boundaries

1.2.2 Providing the following healthcare services to the residents of Islamabad and CDA employees:

- Consultation services
- Essential Drugs for common diseases
- Prevention of Vaccine Preventable Diseases (VPDs) through EPI/Vaccination programmes in Islamabad's urban areas, as well as outreach campaigns in rural villages
- Family planning assistance (Provision of contraceptives)
- Health Education
- Treatment of individuals with sun/ heat strokes
- Prevention of vector-borne diseases like dengue and malaria through larvicidal, spraying, and fogging activities To provide education, awareness and treatment to individuals affected by pollen allergy through establishing Pollen allergy camps To eradicate polio and reduce tuberculosis through effective implementation of comprehensive programs within targeted communities
- Provision of essential medicines and drugs to meet the healthcare needs of the individuals and communities

1.2.3 Implementation of PFO, 1960 and Municipal By-laws with the goal of reducing disease transmission and

enhancing hygienic conditions at all edible centers of Islamabad's municipal territories

1.3 Financial Outlay of the Directorate of Health Services

The budgetary allocations and expenditures for the Financial Years 2017-18 to 2021-22 were as follows:

(Rs in million)

Financial Year	Description	Budget	Expenditure	*Savings/ (deficit)
2017-18	ERE	90.239	62.817	27.422
	Other than-ERE	29.897	14.913	14.984
	Total	120.136	77.73	42.406
2018-19	ERE	71.051	73.214	(2.163)
	Other than-ERE	22.581	19.745	2.836
	Total	93.633	92.959	0.674
2019-20	ERE	26.141	87.687	(61.546)
	Other than-ERE	17.065	15.920	1.1447
	Total	43.207	103.608	(60.401)
2020-21	ERE	8.450	76.562	(68.112)
	Other than-ERE	30.536	27.850	2.686
	Total	57.568	106.908	(49.339)
2021-22	ERE	13.753	96.273	(82.520)
	Other than-ERE	61.474	50.946	10.528
	Total	75.227	147.219	(71.991)
Total	ERE	209.634	300.28	(186.919)
	Other than-ERE	180.135	131.87	32.179
	Total	389.769	432.15	(154.74)

ERE=Employee related expenditure – Actual expenditure exceeds the budget as originally CDA makes provision of 50% to MCI formations as loan as an interim arrangement after bifurcation of CDA and MCI since 2016-17.

*The last column of the table indicates the savings from the allocated budget for operating expense which indicates the underutilization of funds by the entity during last five years.

2. AUDIT OBJECTIVES

The performance audit had the following key objectives:

i. To evaluate whether PHC facilities are being offered at all Medical Centers of DHS in accordance with the set National/ International Standards

ii. To determine whether PFO 1960 and Municipal By-laws are effectively implemented by DHS to ensure hygienic conditions and food quality at all food centres in municipal areas of Islamabad

iii. To determine whether DHS is effectively carrying out all larvicidal, spraying, and fogging operations to prevent the spread of vector-borne diseases (malaria, dengue, etc.) following international standards

iv. To assess whether the DHS is effectively carrying out all EPI/ Vaccination programmes in accordance with the National policies and International Standards

v. To determine whether the Directorate adequately provides health education and awareness programmes to the general public in accordance with the desired outcomes

vi. To assess whether Safety Standards for Immunization services under National Immunization Policy-2022 are being followed

vii. To assess whether active and passive surveillance/ monitoring and periodic reporting of all notifiable VPDs are being carried out under National Health Vision 2016-2025

viii. To determine whether the DHS has developed and implemented an effective communication strategy to pursue immunization programmes to outreach zero dose and dropouts under National Immunization Policy-2022

ix. To assess whether the capacity building of all primary healthcare workers/ professionals is carried out through regular trainings

x. To determine on the basis of Human Resource Data/sanctioned and available strength whether all MCs have sufficient and qualified healthcare staff and whether PHC services are delivered as per approved plans and schedules

xi. To assess whether the DHS is ensuring immunization accessibility and availability for the marginalized community under National Immunization Policy-2022

xii. To determine whether the DHS has devised any strategy to ensure the timely availability of required quantities of Medicines, Vaccines, Syringes and allied equipment at its MCs

xiii. To evaluate whether the DHS is following WHO standards for managing waste generated by its healthcare centres/ units

xiv. To determine whether the Directorate has devised any regulatory mechanism to ensure the quality of vaccines and qualified HR at all its healthcare centers/ EPI centers as per National Health Vision-2016-2025

xv. To evaluate the total turnout ratio of patients at all MCs/ healthcare units of the Directorate

xvi. To assess whether all MCs/ healthcare units of Directorate have devised any guidelines based on international standards to disinfect and sterilize the healthcare equipment/ devices

xvii. To determine whether the DHS's resources are being used effectively to deliver desired results

xviii. To assess whether the procurements of medicines, vaccines, medical equipment, etc. are made in conformity with the set procurement rules and as per required standards

xix. To check whether the reconciliation of revenue and expenditure was made with CDA treasury

xx. To assess the physical verification methods of stores, equipment and medicines.

3. AUDIT SCOPE AND METHODOLOGY

3.1 Scope

The scope of the performance audit of the Directorate of Health Services includes the following:

- Thorough examination of the accounts records maintained by the Directorate for the period spanning from 2017-18 to 2021-22 in order to assess financial management and accountability practices followed by the Directorate
- Physical inspections and visits to MCs operating under the Directorate to assess the infrastructure, resources and quality of healthcare services delivered by these Centres
- Assessment of performance against Health Standards to evaluate Directorate's adherence to the protocols and standards (National/ International healthcare Standards and healthcare Policy frameworks) set by the WHO and other relevant health authorities. The assessment was to cover areas such as patient care, disease prevention, health promotion, emergency response, etc.
- Review of compliance with applicable rules including but not limited to the delegation of financial powers, procurement rules, System of Financial Control and Budgeting, General Financial Rules and other applicable regulations in order to identify any deviations or non-compliance that may impact the effectiveness and efficiency of the Directorate's operations

3.2 Methodology

The Performance audit of the DHS was conducted in accordance with audit guidelines of Department of Auditor General of Pakistan's (DAGP) Performance Audit Manual and International Standards for Supreme Audit Institutions (ISSAI) 3000-3100 as recommended by INTOSAI for Performance Auditing. The Audit commenced with the planning process for audit assignment in which a

Preliminary Survey Report (PSR) was developed, which served as a work plan for audit and outlined the objectives, scope and approach to be followed throughout the audit process.

The data collection phase involved the systematic gathering of both qualitative and quantitative information. Various methods were employed, including a thorough review of relevant documentation related to the Directorate and its MCs. Additionally, oral testimony was collected through discussions and meetings with staff/ workers at the Directorate and Centres.

Audit team conducted field visits and direct observations at the medical centres to perform a comprehensive evaluation of the entity's operations. Data was also acquired through checklists to evaluate the quality of healthcare service provision at different healthcare units/ MCs of DHS. During this process, visual data, such as photographs and diagrams, were also collected to support the audit findings.

Finally, the collected data was carefully analyzed and evaluated against the predetermined audit objectives and criteria which were devised in line with the National/ International healthcare standards and healthcare policy frameworks for PHC services. The audit team utilized appropriate analytical tools and techniques to assess the performance of the Directorate, identifying gaps or areas requiring improvement.

3.3 Limitation

The absence of standardized benchmarks or performance standards for primary healthcare units operating in the Federal capital posed a considerable challenge in effectively measuring and comparing the performance of the DHS. Without established benchmarks or performance criteria tailored to the unique context of the PHC sector in the Federal capital, it became difficult to precisely assess the efficiency and effectiveness of the medical healthcare units operating under the DHS's jurisdiction. In addition, the DHS had not developed a comprehensive operational framework containing clearly defined organizational objectives and performance indicators. This lack of a structured framework by the entity also posed challenges for audit in

precisely assessing the DHS's performance in relation to its established benchmarks. These limitations hindered the ability to conduct a comprehensive evaluation and make meaningful comparisons with the best practices on the subject matter. Consequently, it became challenging to ascertain the extent to which the DHS was meeting its objectives and fulfilling its responsibilities in the specific context of primary healthcare in the Federal capital.

4. AUDIT FINDINGS AND RECOMMENDATIONS

The detailed audit findings are given in the following sections:

4.1 Organization and Management

This section provides a comprehensive overview of the efficiency and effectiveness of the organization's management practices and evaluates the performance of the management team in terms of their ability to set strategic goals, make informed decisions, and allocate resources effectively. It focuses on various key areas such as coordinating mechanisms, IT infrastructure and data management systems, appointment, capability and training of management and staff. This section aims to evaluate the organization's ability to achieve its objectives, allocate resources effectively, and implement appropriate controls. Audit observed following key issues:

4.1.1 Inability to provide quality healthcare services as per Primary healthcare facilities standards

Every healthcare facility must adhere to the following standards in order to provide quality healthcare services:

a. Primary healthcare workforce, adequate quantity, competency levels and distribution of a committed multidisciplinary primary healthcare workforce that includes facility- outreach- and community-based health workers supported through effective management supervision and appropriate compensation (WHO's Operational Framework for PHC)

b. Medicines and other health products. Availability and affordability of appropriate, safe, effective, high-quality

medicines and other health products through transparent processes to improve health (WHO's Operational Framework for PHC)

c. All notifiable VPDs will be reported from all public and private health facilities on weekly basis using standard formats (Section 2.1.2 of Pakistan's National Immunization Policy, 2022-)

   Further, 'the 'Zero report' is completed and submitted weekly (for polio) (Para 4.3 of Islamabad Healthcare Regulatory Authority (IHRA) Standards for PHC Facilities -Draft)

d. The medical testing laboratory is managed by a suitably qualified and registered pathologist, experienced medical technologist or other suitably qualified and registered laboratory scientist' (Minimum Service Delivery Standards Regulations, 2021 (Draft), M/o NHSR&C)

e. Digital technologies should be used for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency and promote accountability' and 'Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors (WHO's Operational Framework for PHC)

f. The achievement of universal access to safe and quality reproductive healthcare and family planning services with increased and widely accessible method choices (The Objective-2 of FP2030 National Commitments, M/o NHSR&C)

g. Adopt best practices for addressing equity for access and availability of vaccines in preventing the VPDs, especially for marginalized and hard to reach communities (Section-6 of National Immunization Policy, 2022)

h. The staffs work to written operating procedures for managing Primary Care Services, written guidelines for the management of clients/ patients-

i) Where National and Provincial treatment guidelines are not available, they are developed and used by the primary Care Services

ii) Standard Operating Procedure (SOPs) are used for managing the facility, finances, equipment, cleaning procedures and stocks, e.g. equipment maintenance

(Rule-9, IHRA Standards (Draft) for PHC facility)

During performance audit of the Directorate of Health Services, MCI/CDA, Audit observed that the DHS was unable to provide quality PHC services according to the aforementioned standards as elucidated in the subsequent details below and the statement as annexed **(Annexure-A)**:

i. Audit observed that 13 MCs were being run by DHS where only three Medical Officers were posted/ available at centers G-9, G-7 and I-10 out of 13 medical centers which showed shortage of 10 Doctors/Medical Officers. The remaining 10 centers were functioning without any doctors/ medical officers. The inadequate number of MOs across 13 MCs often leads to incomplete task fulfillment, especially considering that one among them also holds the position of Director at the DHS, HQs F-9. The monthly salary for a MO employed at MC amounts to approx. Rs 316,000, equating to an annual expenditure of Rs 3,792,000 per MO and 11,376,000 for 3 MOs. This expenditure becomes questionable given their inability to diligently perform medical related duties at the MCs. Similarly, the number of Midwives/ Leady Health Visitors (LHVs) is 03 (01 LHV & 02 Midwives), which meant that 10 centres have no Midwife/LHV to provide quality antenatal care services to the patients. (Para 01).

Department replied that several proposals and requests for recruitment of Medical and Para-Medical and other vacant

posts were forwarded to higher-ups to cover the gap on urgent basis but the process was in pipeline since long.

The reply was not tenable because it was the responsibility of DHS to prioritize the allocation of resources to fulfill the staffing requirements. Further, it is crucial to emphasize that growth and expansion should not come at the expense of compromising healthcare quality. Temporary stopgap arrangements may not adequately address the shortage of qualified medical professionals as the acute shortage is directly affecting the quality of medical care. Hence, the Audit maintains its position and re-emphasizes that DHS failed to fully equip its MCs with the required medical personnel, thereby neglecting the importance of qualified medical professionals in PHC. (Para 01)

ii. Audit noted that the essential medicines that a PHC facility must keep in stock, were not available at DHS medical centers. Out of 33 essential medicines/ drugs that DHS supplies to the centres, 17 were completely out of stock, and many others had low balances in the financial year 2021-22. (Para 02).

Department replied that CDA/MCI was time and again requested for enhancing budget, but on account of financial constraints, budget remained low.

The reply was not tenable because it was the responsibility of DHS to effectively take up the matter of funds with CDA/MCI administration. Budgetary constraints neither justify the failure to maintain an adequate stock of essential medicines and the absence of necessary medical tools nor do these constraints negate the need to take necessary actions to rectify the highlighted deficiencies in the provision of quality medical care. Moreover, the Financial records of the DHS from 2017-2022 showed consistent unspent balances at the end of each financial year, indicating underutilization of the allocated funds. This contradicts the department's explanation of budget constraints as there were available funds that could have been utilized to address the deficiencies. (Para 02)

iii. The Directorate was not reporting on all notifiable diseases and was not preparing the Weekly zero reports for polio in violation of the aforesaid standards. (Para 11)

Department replied that disease reporting system was very vigilant in Directorate of Health Services.

The reply was not agreed to because no system was found on record. The DHS was not reporting on notifiable diseases and was also not preparing the Weekly zero reports for polio in violation of the aforementioned standard. (Para 11)

iv. The laboratory lacked the qualified staff to carry out the tasks efficiently. For all lab-related duties, a dispenser had been deployed. (Para 12)

Department replied that Directorate of Health Services requested time and again to CDA for recruitment, but still no fruitful results were achieved.

The reply was not plausible because relying on a dispenser who received training from a lab technician did not meet the requirement of a qualified, registered pathologist/ lab scientist. Besides, the explanation of the management stating that since 2016 there had not been any lab technician appointed reflects badly on the performance of DHS. Besides, auditee's reply did not provide a justification for fulfilling the requirement for adequate laboratory equipment. (Para 12)

v. Health Management Information System (HMIS) was not implemented in DHS to generate information on the status of ongoing health-related activities in order to facilitate evidence-based decision-making and effective management of healthcare systems at all levels. (Para 19)

Department replied that DHS is working with meager resources and staff. Moreover, HMIS software training was not conducted for Doctors and paramedics of DHS, nor they were provided technology to upload the data accordingly. In future HMIS software would be initiated by DHS, if government fills the gaps of DHS, CDA/MCI. The reply cannot be accepted

because audit observation highlights the importance of HMIS and digital infrastructure for effective management of healthcare system, for which no satisfactory efforts were made by the management. (Para 19)

vi. Despite the significance of population planning to achieve sustainable population growth and importance of family planning services to enhance the health of mothers and children, the MCs of DHS were not providing the services in Islamabad increasing risk of enhanced rates of malnutrition, infant, neonatal and maternal mortality (Para 20).

Department replied that the Directorate had forwarded request to higher-ups to fill the vacant posts of DHS for smooth function. As the gap of DHS is filled by the competent authority, CDA, DHS would start the same services in its all centers. While the department acknowledged the resource constraints for providing family planning services, it did not provide a satisfactory explanation for lack of these services in its MCs and also did not provide a clear plan or any interim solutions to ensure the availability of these critical services. (Para 20)

vii. The DHS has no mechanism to ensure immunization accessibility & availability to the marginalized population in accordance with the Health Equity Model (HEM)/Framework[4], the concept envisions the provision of health services to all especially the vulnerable with the core concept of social justice in health. It aims to provide uniform health amenities to different segments of the residents across the federal capital The DHS did not adopt the Health Equity Model, despite the fact that its Annual Progress Report-2022 indicated that the

[4] Health financing is one of the thematic pillars under National Health Vision 2016-2025 to pave a way for ensuring access, coverage, quality and safety, which are essential requisites for achieving the ultimate goals of health system i.e. improved health, responsiveness, social protection, and efficiency. Many population sub-groups lack financial protection, and face risk of catastrophic health expenditure. A Health Equity Model/Framework aims at provision of pro-poor social protection initiatives facilitating access to essential primary, secondary health services and priority diseases for the marginalized and hard-to reach communities.

plan for introduction of Health Equity Model in the city has been principally approved. (Para 21)

Department replied that Director General (Health) had proposed HEM to be implemented in the City, but the proposal was not approved by CDA Board.

Contrary to the explanation provided regarding the non-approval of the HEM proposal by the CDA Board, the Annual Report of the DHS states that the HEM plan was principally approved. (Para 21)

viii. DHS did not have any operational framework with SOPs or guidelines for managing primary care services and delegated responsibilities to its work staff. In addition, there were no written roles and responsibilities of the working staff available. Further, healthcare services in the public sector follow a tiered referral system, where a network of healthcare facilities is organized based on increasing complexity and coverage. However, no formal Referral System exits in MCs. The patients are normally advised verbally to visit other designated facility on the basis of their condition. (Para 24).

Department replied that after formation of Islamabad Food Authority, Food activities were taken up by ICT in 2022. Rest of the activities are being done actively by DHS, CDA using SOPs. Moreover, in future DHS will strongly focus on SOPs to run its activities.

The department's reply fails to address the core issue raised in the audit para regarding the absence of an Operational Framework containing adequate SOPs for managing PHC services. While the reply mentions the existence of SOPs, it does not provide any evidence/ details in support as no manual of instructions or SOPs was available with the DHS describing its full functions/procedures. (Para 24)

Audit is of the view that all aforementioned inadequacies can cause a multitude of implications including compromised patient care, increased risk of preventable diseases, inadequate emergency response, limited access to necessary PHC services, compromised diagnostic

capabilities, limited reproductive health services, reduced efficiency and inequitable healthcare delivery.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends effective implementation of reforms to address the shortage of qualified medical professionals, essential medicines, infrastructure, resource allocation, disease reporting, laboratory capacity, family planning services, HEM implementation, and establish an operational framework for effective healthcare management. Additionally, PAO should look into the matter to fix responsibility against the persons who failed to adequately oversee the functioning of the department's healthcare delivery system.

(Paras 01, 02, 11, 12, 19, 20, 21 & 24)

4.1.2 Non-Achievement of Immunization Policy Targets for Infant Mortality Rate (IMR)

The Immunization Policy of 2022 envisages Pakistan's National Health Vision 2016-2025 by addressing its key goal - to reduce infant mortality rate from 74 to less than 40 (per 1000 births) and reduce maternal mortality rate from 276 to less than 140 (per 1000 births) and continue reducing the infant mortality rate through immunization targets and activities in order to achieve SDG 3 for the country.

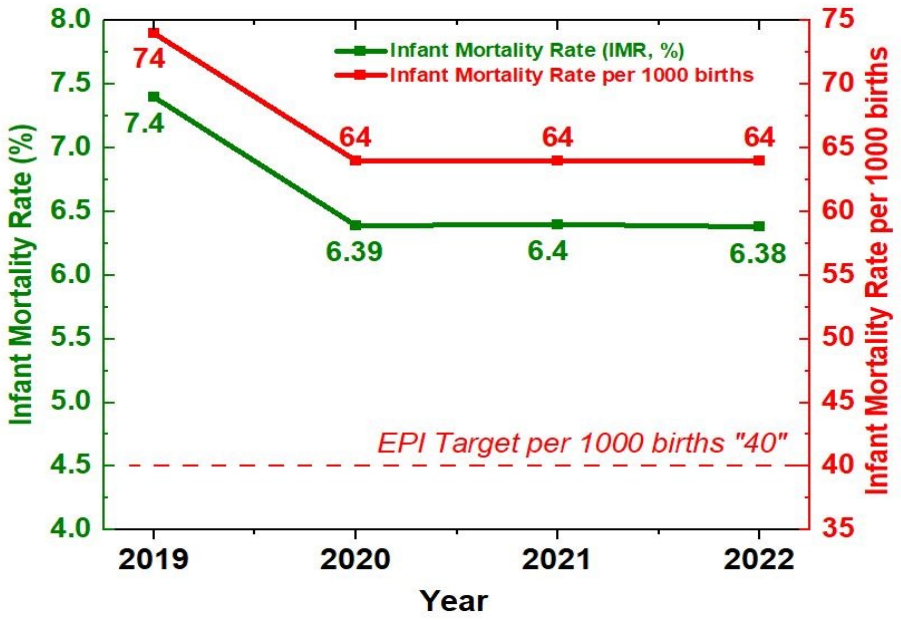
Further, as per National Immunization Policy 2022, Expanded Programme on Immunization envisions "to achieve the universal immunization coverage leaving no one behind to die from a Vaccine Preventable Disease (VPD)" (mortality from VPD should be less than 1% of the total child mortality).

During the Performance Audit of DHS, Audit evaluated the data pertaining to EPI coverage reports for the years 2019-2022 and found that Infant Mortality Rate (IMR), which was required to be reduced from 74 to less than 40 (per 1000 births) in order to meet the target as envisioned under the National Immunization Policy as

referred to above, was higher than the desired rate. The detail is given below:

Year	Annual Live Births	Surviving Infants	Infant Mortality	Infant Mortality Rate (IMR) (%age)	Infant Mortality Rate per 1000 births
2019	38033	35215	2818	7.4	74
2020	31188	29192	1996	6.39	64
2021	32718	30622	2096	6.40	64
2022	34349	32158	2191	6.38	64

The following graph shows the infant mortality rate per 1,000 births during 2019 to 2022 in relation to the required target of 40/1000 births:



Audit holds that the higher IMR than the desired target rate indicated that the immunization programme was not effectively serving in lowering the rate to less than 40 per 1000 live births.

Further, Audit requisitioned the data relating to vaccine coverage of infants against the target population to evaluate how effectively the DHS is attaining the immunization targets. In response, department could only provide the data relating to Penta-III vaccine

(Pentavalent vaccine protecting against 5 major diseases: diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenza type-b) coverage against the surviving infant population during the years 2019-2022. The detail is as under:

Year	Newborn	Surviving Infants	*Coverage on basis of Penta-III	% coverage
2019	38033	35215	517345	82
2020	31188	29192	443023	81
2021	32718	30622	439792	79
2022	34349	32158	497687	82

* Every child receives the multiple P-III doses vaccine (PI, PII, and PIII), which are reckoned and counted separately, thus the numbers under the PIII coverage column are higher than the numbers in the preceding column i.e. infants.

Audit made the following observations:

a. DHS did not maintain adequate data regarding the immunization targets of children and the vaccine coverage against their targets for a specific timeframe. The immunization coverage of children should include the percentage of children who have received all vaccines recommended for their age whereas DHS provided the immunization coverage based on Penta-III vaccine coverage only. Audit is of the opinion that without clearly established immunization targets and coverage goals, children may miss out on necessary vaccinations, leading to an increased incidence of VPDs and can result in increased morbidity and mortality rates.

b. DHS did not maintain the data relating to child mortality caused by Vaccine preventable diseases. In the absence of this data, it is difficult to identify the populations with the low vaccine coverage, which can lead to the continued spread of diseases and increased child mortality rates. Besides, without this data, it may be difficult to monitor and evaluate the effectiveness of interventions aimed at reducing child mortality rates.

Audit is of the view that due to lack of internal controls over data management and record-keeping practices, the DHS had not

maintained adequate data relating to immunization targets of children and child mortality caused by VPDs.

Audit pointed out the matter in April 2023. DHS replied that IMR is not the indicator of immunization coverage. It was working under the directions of Federal Directorate of Immunization and it was not responsible for conducting of health surveys. Therefore, DHS had no record of IMR. Moreover, DHS had never provided any number or percentage of IMR to any audit team. DHS further explained that there are multiple reasons of low vaccine coverage among children in Islamabad including lack of community awareness and misbeliefs that vaccines cause diseases etc.

The Department's reply stating that IMR was not an indicator of immunization coverage was not acceptable because low vaccine coverage has a direct impact on IMR and it indicates the effectiveness of the immunization programme in reducing the rate. Furthermore, the auditee's assertion that DHS was not responsible for conducting health surveys and had no record of IMR was not justifiable as DHS has a crucial role in implementing immunization programmes and should have relevant data to monitor and evaluate their effectiveness. It is worth mentioning that the auditee in its reply had admitted that the vaccine coverage was low in Islamabad. As far as the factors explained by the auditee responsible for low vaccine coverage were concerned, it should be noted that creating awareness in the community was one of the salient functions of the DHS, and in this context, no specific data relating to community awareness programmes were produced to Audit. Therefore, the responsibility to provide community education to address misbeliefs in the population against immunization/vaccination rests with the DHS.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that DHS must implement its immunization programmes in a way that is consistent with the national immunization policy and its intended goals. Further, strong awareness programmes must be undertaken to educate communities to dispel their

misconceptions regarding vaccinations and explain benefits of vaccination for well-being. Lastly, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the functioning of the department's healthcare delivery system. (Para 03)

4.1.3 Failure to decrease Vaccine Dropouts and Zero-Dose Children as per National Immunization Policy-2022 and WHO targets

According to Para 1.4 of Section 1 of Pakistan's National Immunization Policy-2022 'A fully immunized child (FIC) is defined as a child who has received at least: Bacillus Calmette-Guerin (BCG) dose at birth, three doses of polio and two doses of IPV, three doses of Penta, three doses of Pneumococcal Conjugate Vaccine (PCV), two doses of Rota, and one dose of measles and rubella vaccines before 12 months of age'.

Further, WHO's Global Vaccine Action Plan's strategic objective-4 states that strong immunization systems are an integral part of a well-functioning health system. Hence, sustained coverage of diphtheria-tetanus-pertussis containing vaccines should be greater than 90% for three or more years.

Dropout rate was defined as the proportion of vaccination recipients who had begun their schedules but did not complete them. The WHO recommends that the coverage of both the Penta1 to Penta3 and Penta1 to Measles Containing Vaccine 1st dose (MCV1) dropout rates should be <10% so as to have better immunization coverage as well as reduced rates of morbidity and mortality in children <5 y of age.[5]

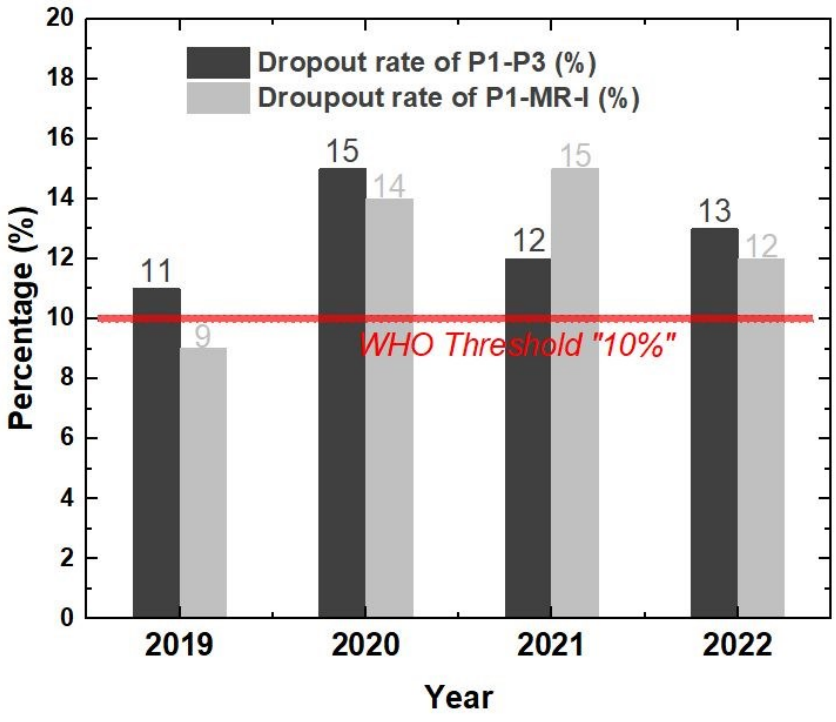
According to Pakistan's National Immunization Policy, 2022 'EPI Pakistan follows international definition set by WHO/ United Nation Children's Fund UNICEF (2020), a child will be considered a zero-dose who has not received Pentavalent-1 vaccine'.

[5] https://academic.oup.com/inthealth/article/

(A) During the Performance Audit of DHS, Audit evaluated the data pertaining to Annual EPI coverage reports relating to the Pentavalent vaccine, which is also known as Diphtheria, Tetanus, Pertussis (DTP) DTP- Hepatitis B (HepB)-Hib vaccine for the years 2019-2022. Audit observed that vaccine dropout rates of Penta1 to Penta3 was on the rise since 2019 while Penta1 to Measles1 was on the rise from 2019 to 2021 and then slightly reduced in 2022 but still its rate was greater than 10%. The year-wise detail is given in the following table:

Year	Penta-1 Coverage	Penta-3 Coverage	Measles-1 coverage	Dropout Penta-1 to Penta-3	Dropout Penta-1 to Measles-1
2019	32288	28739	29520	11%	9%
2020	27713	23652	23965	15%	14%
2021	27428	24179	23295	12%	15%
2022	15562	13616	12189	13%	12%

The following graph reflects a snapshot of vaccine dropout rates for Penta1-Penta3 and Penta1-Measles1 between 2019 and 2022 in comparison to the WHO's 10 percent threshold:



According to WHO's Global Immunization Coverage 2021, 18.2 million infants did not receive their first dose of the DTP vaccine in 2021, and an additional 6.8 million only received a portion of the recommended dose, demonstrating lack of access to immunization and other health services. More than 60% of the 25 million children were residing in ten nations including Pakistan.

Since administering all required doses of vaccine against Pentavalent was one of the key indicators of the performance of the immunization programme, rising dropouts against Penta1-Penta3 and Penta1-Measles1 showed that the Directorate was not effectively carrying out the immunization programmes to keep the vaccine dropout rates below 10%, which was the required threshold as per WHO vaccine dropout reference.

(B) During the Performance Audit of DHS, CDA/MCI, while evaluating the data pertaining to Annual Zero-Dose Coverage Reports for the years 2020-2022, Audit observed that the proportion of zero-dose children is growing rather than dropping in subsequent years. The detail is as under:

Year	Recorded zero dose	Covered zero dose	%age coverage	Zero-dose Children
2020	1388	1118	81	19.45%
2021	3724	2947	79	20.86%
2022	6032	4575	76	24%

Audit holds that the rising proportion of zero-dose children in each subsequent year is due to ineffective implementation of the National Immunization Policy and Immunization Agenda 2030 (IA2030).

Audit holds that under-vaccination of children was due to ineffective implementation of the Immunization programme as per set immunization policies and international standards.

Audit pointed out the matter in April 2023. The DHS replied that it covers 13 lac populations. As per SOPs one (01) vaccinator was required to cover 15,000 to 20,000 populations. To cover 13 lac populations, DHS needs 60 vaccinators, but on the ground DHS has

only 10 vaccinators. DHS requested Chairman CDA multiple times to recruit staff on urgent basis. DHS further explained that there are multiple reasons of low vaccine coverage among children in Islamabad including lack of community awareness and misbeliefs that vaccines cause diseases etc.

The management's reply was not justifiable. The increasing dropout rates indicated lack of effectiveness in ensuring children receive the complete recommended vaccine doses, leading to under-vaccination. Besides, the auditee's explanation regarding lack of community willingness did not absolve the Directorate of its responsibility to effectively implement the immunization programme as one of the prime responsibilities of the DHS is to improve community engagement through awareness campaigns to ensure vaccine uptake. Moreover, it was again the responsibility of the Directorate to proactively address staffing needs and work with the relevant authorities to overcome its administrative hurdles. Further, the auditee's explanation of the shortage of vaccinators also did not sufficiently justify the failure to reach zero-dose children as it was the responsibility of DHS to take proactive measures to address this issue on priority to ensure adequate coverage of the target population. The auditee's argument about the reporting criteria used by the polio programme was irrelevant to the issue at hand. The focus should be on reducing the proportion of zero-dose children by ensuring timely and complete vaccination coverage.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that the Directorate should effectively implement the immunization programmes in accordance with the relevant international standards in their entirety to keep vaccination dropout rates below 10% and to reach zero-dose children. Furthermore, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the department's operational activities to ensure improved healthcare delivery.

(Para 04 & 08)

4.1.4 Non-implementation of Pure-Food Ordinance 1960 to ensure food quality

As per Section 15 of PFO, 1960, it shall be the function of every local authority to carry into execution and enforce the provisions of this ordinance within its jurisdiction with a view that all articles of foods and drinks are sold in a pure and genuine state. Further, Section 17(2)(i) states that an Inspector (appointed by local authority) may enter into and inspect any market, godown, shop, stall or other places used for the sale of any food intended for human consumption or for preparation, manufacture or storage of any such food for the purpose of trade or sale. Further, Part-IV of PFO, 1960 provides penalties/fines for various offenses.

One of the salient functions of DHS is to implement PFO, 1960 and Municipal By-laws to control the disease spread and improve hygienic conditions of all edible centres within municipal areas of Islamabad.

During the Performance Audit of DHS, Audit observed that the Directorate had not been able to fully implement PFO, 1960 to ensure the quality of food within municipal areas of Islamabad. The Directorate only had four food/sanitary inspectors on its strength, which was far too few to conduct the necessary inspections to maintain food quality at all edible centres located within the municipal limits of Islamabad and impose fine for identified offenses.

In addition, the management was unable to produce the basic records pertaining to the total number of hotels, restaurants, salons, meat, dairy shops, and food eateries etc. that fall under the purview of the DHS's inspections. The management was also unable to produce the record detailing the edible centres that the food and sanitary inspectors had inspected within a specific time period, as well as the centres that were left unattended and those to whom notices, health cards, and certificates had been issued. The management's reluctance to provide the necessary records demonstrated that food and sanitary inspectors randomly conduct inspections without following a well-thought-out plan. Furthermore, no food samples were collected and tested from Pakistan Standards and Quality Control Authority

(PSQCA) or National Institute of Health (NIH) as no record was produced in this regard which clearly shows no quality tests were conducted. The average annual cost of salaries for four Food/ Sanitary Inspectors is Rs 7.223 million. However, this expenditure is considered as unjustified due to inadequate inspection-related services being provided. The absence of tangible inspection outcomes raises concerns about the value for money.

Hence, in absence of the requisite record, Audit couldn't validate the effectiveness of the inspection activities taken up by the inspectors under PFO, 1960 and Municipal By-laws to maintain food quality and to prevent disease spread.

Audit is of the view that ineffective implementation of PFO, 1960 was due to lack of internal controls to ensure adherence to laws, regulations and organizational policies.

Audit pointed out the matter in April 2023. The management replied that in order to implement PFO, 1960 in true letter and spirit, Islamabad must have 130 Food Inspectors. In the year 2000, a case was forwarded to CDA Board for hiring of at least 50 Food Inspectors, but the Authority had approved only four (04) food inspectors. Despite with meager resources and shortage of Food Inspectors, DHS was working to fulfill task of food quality control in Islamabad. Number of food premises in CDA area of control was 2218 according to survey conducted by DHS. Additionally, after the formation of Islamabad Food Authority, food quality control activities were taken up by it and DC, ICT on 13.04.2023 directed the DHS to stop its operations.

The reply was not acceptable because for decades the responsibility to ensure food safety standards in the capital remained a mandate of DHS but it neglected that responsibility, compromising the health of the residents. Besides, the auditee's mention of the number of food premises in the CDA's area of control did not address the Audit's concern regarding the lack of necessary records and inspections conducted by food and sanitary inspectors. The lack of proper documentation raised doubts about the effectiveness of food quality control activities. Moreover, the takeover of food quality control activities by Islamabad Food Authority in April 2023 did not excuse

the lack of implementation of PFO, 1960 prior to that period. The inability to produce records for quality testing of food items further supports the audit finding.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that PAO should look into the matter and fix responsibility against the persons who failed to regulate the operational activities of the department to ensure better service delivery.

(Para 05)

4.1.5 Inability to provide adequate access to Healthcare Services as per required PHC Facility Standards

As per WHO's Operational Framework for PHC, one of the standards that need to be followed for quality healthcare services includes secure and accessible health facilities to provide effective services, as well as transport systems that can connect patients to other care providers.

Further, IHRA Standards (Draft) provide that the facility and services provided are easily accessible to the catchment area population and the facility is located within 5 km of the patient.

Further, Ministry of NHSR&C's Minimum Service Delivery Standards Regulations, 2021 (Draft) provides that the healthcare facility is identifiable with a signboard and is easily accessible to the patients.

During performance audit of the DHS, audit inspected various MCs of DHS located in different sectors to evaluate the quality of healthcare provided in accordance with the above-mentioned established standards. Audit made the following observations:

i. MC at G-10 was hardly identifiable as there was no signboard displayed to make it easily accessible for the

visiting patients as per established standards. Besides, the centre is located at a place which is not even visible to the general public to know about its locality and existence.

ii. Only 2315 patients visited the medical centre at G-10 against the catchment population of 101,945 from Sectors G-10, G-11, G-13 and G-15 during the period January to December 2022, which equates to a maximum of 7 patients visiting on any given working day, proving that relatively few patients visit the centre due to lack of visibility. Thus, an average of 192 patients visiting each month is far too few for the 101,945 people who live in Sectors G-10, G-11, G-13 and G-15 as a whole.

iii. At MC G-7, only 2244 patients visited the facility against the catchment population of 81,982 from the sectors G-6 & G-7 during the year 2022, which equates to a maximum of 7 patients visiting on any given working day, proving that relatively few patients visit the centre due to lack of visibility. 187 patients visiting each month are far too low for the 81,982 people who live in Sectors G-6 and G-7 as a whole.

iv. At MC F-11, only 2394 patients visited the facility against the catchment population of 67,710 from the sectors E-11 & F-11 during the year, which equates to a maximum of 8 patients visiting on any given working day, proving that relatively few patients visit the centre due to lack of visibility. 199 patients visiting each month are far too few for the 67,710 people who live in Sectors F-11 and E-11 as a whole.

Audit is of the view that a low patient turnover ratio compared to the target population due to lack of easy accessibility to the healthcare facilities resulted in underutilization of the healthcare units/ MCs impacting the quality and effectiveness of healthcare services provided by the MCs.

The lack of effective internal controls relating to operational procedures containing guidelines on maintaining clear signage and

ensuring easy accessibility resulted in underutilization of the healthcare facilities operating under DHS.

Audit pointed out the matter in April 2023. The DHS replied that it had only 03 (three) customized building of its own i.e., i) G-9, I-10 and G-7. Rest of the buildings were either hired or had been attached to DHS on temporary basis. Building was selected not on i) Need basis ii) Population basis, rather it was given on availability basis. Department further explained that it strived hard to make the healthcare facilities accessible, but cannot influence consumer choice as they don't use the facility.

The reply was not tenable because auditee's argument that consumers choose not to use the facility did not absolve the Directorate from its responsibility to ensure accessibility. It is the duty of DHS to proactively address issues that affect accessibility, such as lack of signboards and poor visibility, absence of adequate qualified staff, essential drugs etc. to encourage the patients to utilize the services. Besides, from the auditee's reply, it was clear that its efforts had not been fruitful and it had only 3 customized buildings.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends effective implementation of PHC service standards to make medical facilities easily accessible for patients. Furthermore, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the department's operational activities in order ensure better healthcare service delivery.

(Para 09)

4.1.6 Failure to eradicate measles as per National Immunization Policy and WHO targets

According to National Immunization Policy, 2022, measles should be eliminated together with several other VPDs. The EPI will implement mass campaigns with strict monitoring and safety of the vaccines.

As per World Health Organization (WHO) IA2030 target, as measles is so contagious, very high vaccine coverage (95%) with two timely doses of measles containing vaccine is required to prevent its spread. Further, Measles coverage is an important indicator for attaining the SDG3 goals of preventing VPDs. In IA2030, measles vaccination coverage and incidence recorded by surveillance are tracers of the strength of immunization programmes, indicating communities and age groups that are un- or under-immunized and where more emphasis is required.

During the Performance Audit of DHS, Audit evaluated the data pertaining to Annual VPDs Surveillance reports for the years 2017-2022. Audit observed that contrary to the objectives specified by the aforementioned National Immunization Policy, 2022, the graph of measles cases reported/ confirmed since 2017 is rising rather than declining.

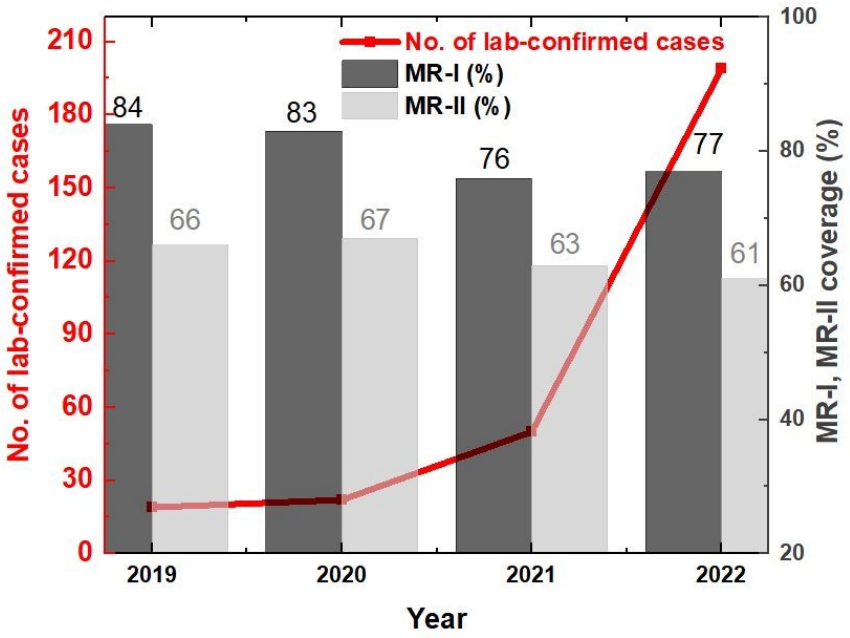
The detail is given in the following table:

VPD	**Years**	**No. of suspected cases reported**	**No. of lab-confirmed cases**
Measles	2017	197	35
	2018	168	3
	2019	52	19
	2020	51	22
	2021	180	50
	2022	327	199

Audit further observed that the vaccination coverage for measles during the last four years remained below the WHO's IA2030 target of 95%. The detail is as follows:

Years	**MR-I**		**MR-II**	
	Total Coverage	%age	Total Coverage	%age
2019	29520	84	23067	66
2020	23965	82	19676	67
2021	23390	76	19409	63
2022	24913	77	19579	61

The following graph shows the lower measles vaccination coverage, which fell short of the WHO's target of 95%, led to an increase in measles cases in subsequent years:



According to the audit, vaccine coverage lesser than the WHO's IA2030 and the rapid increase in measles cases over the course of the subsequent years is attributed to the inefficient implementation of the EPI/Immunization programme by the DHS in accordance with the set national immunization policy and international standards.

Audit pointed out the matter in April 2023. The management replied that there are multiple reasons behind low vaccination rates i.e. lack of community education/awareness, socioeconomic programmes, public health infrastructure and misbeliefs that vaccines cause diseases.

The reply was not plausible because evidence of rising measles cases over the years, indicated lack of effective implementation of immunization policies. The auditee's explanation regarding factors contributing to low vaccination rates did not justify its failure to achieve the desired coverage. It was the responsibility of DHS to address these challenges and implement effective strategies to overcome them.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that DHS needs to identify the gaps in its coverage for diseases like measles and effectively implement its immunization programme to reduce the increasing cases of measles as per set national and international targets. Additionally, PAO should look into the matter and fix responsibility against the persons for not effectively overseeing the department's operational activities to ensure enhanced healthcare services.

(Para 07)

4.1.7 Failure to Implement WHO and CDC guidelines on hygiene and Infection Control

According to WHO Guidelines on Waste Management of Healthcare activities, smaller healthcare facilities should have a smaller infection-control committee and the head of hospital should formally appoint the members of the waste-management team. and a waste management officer who will have overall responsibility for developing the health-care waste-management plan, and for the day-to-day operation and monitoring of the waste-disposal system.

As per CDC's (Centre for Disease Control and Prevention) guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008, healthcare facilities need to perform adequate cleaning, disinfection and sterilization of patient care devices and equipment.

IHRA Standards for PHC Facility (Draft) provide that:

- Separate male and female functioning, clean toilets/ latrines are available at healthcare facility: Standard-4.7
- Waiting area is clean and protected and has designated separate male/ female waiting areas: Standard-4.6

As per Ministry of National Health Services Regulations and Coordination (M/o NHSR&C), Minimum Service Delivery Standards Regulations, 2021(Draft);

- Waste is segregated in clearly labelled coded bins in accordance with the relevant national/international standards.

Audit observed the following:

i. Medical facilities operating under DHS neither have a Waste Management Plan nor any Waste Management Committee to manage the healthcare waste as per WHO guidelines. There were no separate colour-coded bins to collect and segregate the healthcare waste according to the set standards to prevent contaminations and infections from the hazardous/ infectious healthcare waste. Owing to the absence of a Waste Management Plan, MCs/ dispensaries lacked proper mechanism to gather and sort healthcare waste under various categories. This can result in improper handling during waste collection and transportation from multiple MCs/ dispensaries to the CDA hospital for disposal, potentially causing spread of infections due to improper segregation and mishandling of healthcare waste.

ii. The MCs/ Dispensaries working under DHS were not adhering to the guidelines set for the Sterilization and Disinfection of healthcare equipment. During the physical inspection of the Dispensary at F-11, Audit noted that the dispensary was cleaning the healthcare tools and medical instruments with a hand-cleaning sanitizer **(Annexure-B).** This practice can put the patients at serious risk of infection and can cause the spread of serious illnesses and diseases such as Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS), Hepatitis etc.

iii. During physical visits to the medical centres, it was found that there were no separate toilets/ latrines for male and female patients visiting the healthcare facility. Besides, the hygienic condition of the available latrines/ toilets was extremely poor **(Annexure-C).** The unhygienic conditions of the toilets can lead to the transmission of

various diseases such as Cholera, Dysentery, and Typhoid etc.

iv. MC at F-11 did not have a separate waiting area for male and female patients. Besides, the waiting area was unkempt and unclean with a dirty, filthy floor **(Annexure-D)**.

Audit maintains that DHS and its Medical Facilities were not adequately implementing the cleaning and infection control protocols which may lead to the spread of pathogens from person to person and can cause infections, including HAIs.

Audit pointed out the matter in April 2023. The DHS replied that it had a proper waste management plan and wastes of dispensaries were properly disposed of. Dustbin and syringe bins, etc were available. All equipment were sterilized with sanitizers. Buildings of medical centers were not customized; therefore separate bathrooms were not available.

The reply was not acceptable because, during physical visits, Audit found that the centres did not have colour-coded bins to segregate and dispose of medical waste according to the waste management guidelines. Auditee's claim of having a proper waste management plan was also not justified as highlighted in the audit observation, the Directorate and its MCs lack their own waste management plan to collect, segregate and dispose of the healthcare waste. Moreover, the use of hand-cleaning sanitizer for cleaning healthcare tools did not meet the guidelines for sterilization and disinfection of healthcare equipment. Lastly, the absence of separate toilets for male/female patients and the unhygienic condition of available toilets indicate a failure to meet the health standards for a healthcare facility.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends effective implementation of hygiene and infection control protocols to ensure a safe and hygienic healthcare environment. Furthermore, PAO should look into the matter and fix

responsibility against the persons who failed to efficiently regulate the department's operations in order to maintain better healthcare standards.

(Para 10)

4.2 Financial Management

This section includes an assessment of various aspects related to the management of funds and financial processes within the organization such as detailed analysis of any funds lapsed, reasons behind the lapses such as un-utilized budget allocations, instances of re-appropriations and surrender of funds, the reconciliation process between the organization and its accounting offices, detailed overview of the organization's bank accounts and adequacy of internal controls in managing these accounts, accuracy of payments in accordance with the established standards, rules and regulations, data archiving and record management for safe record custody. Audit observed following irregularities:

4.2.1 Unauthorized expenditure and discriminatory distribution of revenue share amounting to Rs 2.890 million besides non-reconciliation of receipts - Rs 29.484 million

As per Para 11 of Financial Management and Powers of Principal Accounting Officers Regulations, 2021, framed under Section 27 of Public Finance Management (PMF) Act 2019, Principal Accounting Officer shall ensure that public funds are used for public advantage and benefits. No payment order or sanction of expenditure shall be issued which may directly or indirectly benefits to its own advantage or any person or selected community unless the expenditure to be incurred by the order of a competent court of law or the expenditure is in pursuance of Government approved policy.

Rule 89(VIII) of General Financial Rules (GFR) Vol-I states that the head of the department and the Accountant-General, will be jointly responsible for the reconciliation of the figures given in the accounts maintained by the head of the department with those that appear in the Accountant-General's books. Unless in any case there are

special rules or orders to the contrary, such as those contained in paragraph 90, the reconciliation should be made monthly, the initial responsibility resting with the Accountant-General.

Audit noted that the DHS incurred an expenditure of Rs 2.890 million on account of 'share to employees' from the revenue of Rs 7.381 million collected by the DHS during 2021-22.

Audit observed that the management paid an amount of Rs 2.890 million to the employees of DHS without any lawful authority as the expenditure was incurred without the approval of the competent authority/CDA Board. Furthermore, payment was made without any approved criteria/distribution policy approved by the competent authority. Given that there was no established distribution policy and the fund was allocated at the Director General's discretion, hence funds were not shared equally among the employees.

Furthermore, the DHS had remitted receipts amounting to Rs 29.484 million in CDA treasury during the period from July 2018 to June 2022 on account of revenue receipts of DHS, CDA. But the revenue receipts amounting to Rs 29.484 million were not reconciled with the CDA treasury.

In absence of reconciled accounts / reconciliation statements till June 2022 duly vetted from the Accounts Office/Treasury, the revenue expenditure incurred may be termed as unauthentic.

Audit is of the view that aforementioned instances can lead to financial irregularities, potential misuse of funds, and compromised financial accountability within the entity.

Audit pointed out the matter in April 2023. The DHS replied that it generated funds/income through laboratory tests and vaccinations and the share had been fixed by CDA Board between CDA and Medical staff as 50% each. Furthermore, Staff share would be distributed by the Director Health Services, CDA himself/herself. Reconciliation of revenue receipts was made.

The reply was not tenable because undue payment was made on account of employee share of revenue without any approval from CDA Board and distributed among the staff in an unequal / discriminated way. Further, revenue receipt was not reconciled with Treasury Division, CDA as no record was produced in support of the reply.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends implementation of strict financial controls to ensure proper authorization for expenditures and regular reconciliation of revenue receipts to ensure financial integrity and accountability within the entity in addition to fixing responsibility for non-reconciliation of revenue receipts. The matter of undue benefits availed by the employees without any specific approval needs to be probed and factual position may be intimated to Audit. Moreover, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the healthcare delivery system of the department.

(Para 18 & 22)

4.2.2 Non-utilization of funds received from the Ministry of National Health Services - Rs 22.868 million

Finance Division O.M No. F. No.1(269)-Dir(BC)/2020 dated 07.04.2020 states that the cut-off date for surrender of anticipated savings was set as 30.04.2020, however, in view of prevailing situation of the country due to covid-19, the above mentioned cut-off date for surrender of anticipated savings has been relaxed/extended up to 15.05.2020.

Further, as per Para 9 of Financial Management and Powers of Principal Accounting Officers Regulations, 2021, framed under Section 27 of PFM Act 2019, Principal accounting officer shall ensure that public funds are utilized for delivery and improvement of public services. Principal Accounting Officer shall put in place a system that ensures public service delivery while adhering to principles of value for money and reduction of waste. As per Para 14 (d) of Financial Management and Powers of Principal Accounting Officers

Regulations, 2021, autonomous organizations shall surrender to the Finance Division by thirty-first day of May each year, all anticipated savings in the grants or assignment accounts or grant in-aid controlled by them, provided that in an exceptional case of exigency, the Finance Division may extend the prescribed time limit before the close of the financial year. As per rule 12(2) of PFM Act 2019, after surrender of such amount, where requirement is justified, Finance Division shall provide for equivalent amount in the next financial year budget.

Audit noted that the DHS, CDA Islamabad received funds of Rs 30 million from the M/o NHSR&C under National Immunization Support Project on 14.05.2020 as DHS share for the purpose of programme management, surveillance, monitoring & evaluation, health education & communication, training & others etc.

Audit observed that the management had deposited funds worth Rs 30 million in the CDA treasury, however, the amount was not used for what it was intended for. The department was unable to use Rs 22.868 million as of yet. The unutilized amount was not surrendered to Government and retained in CDA account.

Audit is of the view that non-utilization of funds allocated to the DHS resulted in missed opportunities to improve healthcare services, hindering the entity's ability to meet its objectives and deliver quality healthcare services.

The inability to utilize the allocated funds by the DHS reflects poor financial management and accountability and is due to lack of effective monitoring, oversight, and accountability mechanism to ensure proper utilization of resources.

Audit pointed out the matter in April 2023. The management replied that Grant amounting Rs 30 million was transferred to the Head of Treasury as per rules of CDA. Out of the funds, EPI pre-fabricated unit was completed with the cost of Rs 7.132 million through Works Directorate of CDA. It is pertinent to mention that DHS would utilize the balance/remaining grant amounting to Rs 22.868 million for the remaining work of EPI as already planned by DHS, CDA/MCI.

The reply cannot be accepted because the funds were received on 14.05.2020 and only a sum of Rs 7.132 million was utilized till date leaving a balance amount of Rs 22.868 million which was not utilized after lapse of more than three years. It is also against the financial rules which do not permit carrying forward the funds to the next year in violation of authorization by the Parliament for a specific year under Article 80 of the Constitution of Islamic Republic of Pakistan.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends effective implementation of robust financial management controls to ensure efficient utilization of allocated funds. In addition, PAO should look into the matter and fix responsibility against the persons who failed to efficiently regulate the department's activities in order to maintain better financial management.

(Para 17)

4.3 Procurement & Contract Management

This section contains an assessment of the organization's practices and processes related to procurement and contract management. It evaluates aspects such as procurement procedures, contract awarding processes, compliance with procurement rules/ regulations, transparency and effectiveness of contract management. Audit observed following irregularity:

4.3.1 Irregular/doubtful expenditure on purchase of medicines, health awareness programmes, polio campaigns and anti-dengue activities - Rs 18.298 million

As per Rule 9 of Public Procurement Rules (PPRs), 2004, "save as otherwise provided and subject to the regulation made by the Authority, with the prior approval of the Federal Government, a procuring agency shall announce in an appropriate manner, all proposed procurements for each financial year and shall proceed accordingly without any splitting or regrouping of the procurements so planned. The annual requirements thus determined would be advertised

in advance on the Authority's website as well as on the website of the procuring agency in case the procuring agency has its own website".

According to Rule 20 of PPRs, 2004 save as otherwise provided hereinafter, the procuring agencies shall use open competitive bidding as the principal method of procurement for the procurement of goods, services and works.

(A) Audit noted that the Directorate of Health Services, CDA/MCI Islamabad incurred an expenditure of Rs 1.498 million on account of purchase of medicines and Rs 1.249 million on account of health awareness programmes during the financial year 2021-22.

Audit observed that medicines were purchased directly from selected suppliers on a piecemeal basis without engaging in a tendering process or obtaining bids. In contravention of PPRs, 2004, medicines were directly purchased from the supplier by the Directorate without constituting any Local Purchase Committee, undergoing a prequalification process or engaging in a competitive bidding process. It was also noticed that the identification marks were not affixed by the supplier/manufacturer on all the medicines available in the stores of DHS. Audit is of the view that the supplied medicine should be affixed identification marks as 'government supply' or 'not for sale' duly printed by the manufacturers.

In addition, during the financial year 2021-22, Rs 1.249 million was spent on health awareness programmes, but Audit was not provided with any information regarding the expenditures, including a complete list of the awareness campaigns that were carried out, tender documents, stocking information, etc. Since there was no purchase committee established, most of the purchases were made primarily from one supplier, M/s Nadeem Trading, without being reviewed or evaluated. This resulted in irregular expenditure of Rs 2.747 million on account of purchase of medicines and health awareness programmes. (Para 13)

(B) Audit further noted an expenditure of Rs 15.551 million was incurred on account of polio campaigns, and anti-dengue/malaria activities during the financial year 2021-22 as detailed in **Annexure-E**.

Audit observed the following irregularities:

i) Huge expenditure of Rs 15.551 million was incurred on purchases/supplies for polio campaigns and dengue/malaria activities during the financial year 2021-22 without any tendering/competitive bidding process in violation of Rule 9, of PPRs, 2004.

ii) Dengue Sprays worth Rs 4.682 million were purchased during the month of June 2022, however, dengue season starts from September to December. So the purchase of dengue sprays in off-season seems doubtful payment of Rs 4.682 million.

iii) Dengue/malaria spraying chemicals were purchased without any lab tests and without certification by technical authority.

iv) All purchases were made mostly from selected suppliers repeatedly and without scrutinizing/assessment by any Purchase Committee as no purchase committee was constituted.

v) In most of the cases, details of issuance/distribution / consumption of the items were not made available to Audit. (Para 14&15)

Audit maintains that mismanagement and absence of an effective oversight mechanism deprived public of the benefit of free and open competition which compromised the principles of transparency and fairness.

Audit pointed out the matter in April 2023. The DHS replied that initially it had utilized the Rate Running Contracts of the Capital Hospital, CDA for purchase of medicine till March 2022. The annual budget of DHS was very low i.e., Rs 1.5 million and no pharmaceutical firm/company would be attracted to smaller amount of Rs 1.5 million. Medicines were purchased through quotations with the approval of Director General as per Rule 42(b) of PPRs. Mandatory health awareness activities were performed in accordance with the basic

elements of PHC protocol and WHO health awareness strategies i.e. printing of fliers, distribution of brochures, installation of banners, health walks, community education speeches and community awareness through mega-phones on hired vehicles etc. Further, polio campaign items and anti-malaria/anti-dengue items were purchased through quotations with the approval of the Director General and taken on stock. After purchasing Anti-dengue and Anti-malaria spray/ chemicals, samples of spray and chemicals were tested from Pakistan Council of Scientific and Industrial Research (PCSIR) Laboratory, Peshawar/Lahore for quality verification.

The reply is not tenable because medicines were purchased without any tendering process and procurements were made through splitting of expenditure to avoid tender during the month of March and June. Likewise, medicines were procured without identification marks/stamps of "not for sale/Government property" and details of health awareness campaigns were not provided in support of the reply. The department has admitted that medicines, polio campaign items and anti-dengue/anti-malaria sprays/items, etc were procured on quotation basis without any tendering process/open bidding in violation of PPRs. Further, only one test report of PCSIR Peshawar dated 22.08.2022 was provided however, the DHS has purchased sprays/chemicals from different suppliers on different dates; the test was conducted in August 2022 but sprays were purchased in September/October 2021, and name of supplier firm was also not mentioned on the test report.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that procurement rules be implemented effectively and robust monitoring mechanism be put in place to ensure transparency, fairness, and compliance in the procurement process. Additionally, PAO should look into the matter and fix responsibility against the persons who failed to effectively oversee the department's activities in order to safeguard accountability for the use of funds.

(Para 13, 14 & 15)

4.4 Asset Management

This section contains an assessment of asset inventory and record, an analysis of the organization's practices for optimizing the use of assets, an examination of the organization's systems and controls in place to track and control assets and a review of the organization's processes for disposing of assets, and assessment of organization's compliance with applicable laws, regulations and internal policies regarding asset management, including any identified instances of non-compliance or deficiencies. Audit observed the following irregularities:

4.4.1 Irregular use of ambulances and inadequate maintenance resulting in unjustified expenditure on POL/repair - Rs 3.429 million

According to Ambulance Specification 2021-22 given by the M/o NHSR&C some of the medical provisions that an ambulance is supposed to have, are: oxygen cylinder, pulse oximeter, nebulizer, resuscitation kit, automatic external defibrillator, etc.

Audit noted that the DHS has five (5) ambulances. Inspection by Audit revealed that none of these medical features was present in DHS ambulances.

Further, access to high-quality emergency treatment is a fundamental medical need in every community, and ambulance emergency response is an essential medical function. But ambulances available with DHS were not even being used for emergencies, which may compromise the quality of healthcare needed in an emergency. The lack of ambulatory services due to their utilization for non-emergency purposes is a serious lapse on the part of DHS.

Audit further observed that these ambulances were being used unusually, for the pick-up and drop-off of employees of DHS and for the transportation of supplies. The use of ambulances for non-emergency activities demonstrates inefficient and inappropriate resource utilization, wasting public money, and amounts to the misuse of valuable assets. Moreover, an amount of Rs 2.125 million was spent

on POL and Rs 1.304 million spent on repair and maintenance of these ambulances during the Financial Year 2021-22, as detailed in Annexure-F.

Despite requests, no information or documentation was given detailing the medical applications of these ambulances or supporting their approved usage for transportation. Furthermore, neither there existed any vehicle tracking system nor the log books of the vehicles were being maintained as relevant record was not provided to Audit despite various verbal/written requests.

Audit is of the view that utilization of ambulances for non-emergency purposes can lead to delayed emergency response which compromises patient care besides being misuse of resources.

The lack of utilizing ambulances for emergency response and instead using them for non-emergency purposes indicates a deficiency in internal controls related to clear policies and procedures, resource allocation and management oversight.

Audit pointed out the matter in April 2023. The DHS replied that dealing with emergencies was not objective of DHS. Two ambulances are being used for outreach services, one for vaccine supply and two ambulances were donated by WHO for EPI services. Further, log books were also being maintained.

The reply was not tenable because the primary purpose of ambulances is to provide emergency medical services, and their diversion for non-emergency activities indicates a misuse of resources. Besides, the auditee's claim that logbooks were properly maintained is not substantiated by facts, as no relevant records or logbooks were provided despite multiple requests. Moreover, the auditee's argument that dealing with emergencies was not the objective of DHS was not valid as in this case, the presence of five ambulances cannot be justified. Transport of staff and medicines can surely be done using any other economical vehicle.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that in addition to creating a system to assure vehicle tracking, the department needs to ensure logbook maintenance for ambulances. Furthermore, the department may reconsider its use of ambulances if responding to emergencies is not its objective keeping in view the functions of Cares Directorate of CDA. Finally, PAO must hold the management accountable for failing to sufficiently monitor the operations of the DHS as per required standards.

(Para 06)

4.4.2 Non-conducting of physical verification of stock & stores

According to rule 159 of GFR, Vol-1 "A physical verification of all stores should be conducted at least once in every year under rules prescribed by the competent authority" subject to the following conditions that verification is not entrusted to a person-

(i) who is the custodian, the ledger, keeper, or the accountant of the stores to be verified, or who is a nominee of, or is employed under the custodian, the ledger keeper or the accountant, or

(ii) who is not conversant with the classification, nomenclature and technique of the particular classes of stores to be verified", as required under Rule 159 of GFR, Vol.-I.

An examination of the record of the Directorate of Health Services, CDA Islamabad disclosed that various purchases were made during the year 2021-22 but physical verification of stores and stock was not conducted by the Directorate during the year. Store is being maintained through a Sub-Assistant as no designated storekeeper exists.

Non-conducting of physical verification of stock/stores can lead to inaccurate stock levels, disrupting supply chain management and can also increase the risk of stock loss or theft which can ultimately cause financial loss and compromised patient care.

Audit is of the view that failure to conduct physical verification of stock and stores is due to ineffective internal controls related to inventory management.

Audit pointed out the matter in April 2023. The management replied that when Stock/ Store is received, the Store In-charge of concerned section takes the stock on stock register. Meanwhile, two officers i) Indenter, ii) Divisional Audit Officer, DHS inspect the store physically. After physical verification of stock, bills of firms concerned are processed.

The reply was not tenable because no physical verification report was provided to Audit in support of the reply.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends the implementation of regular and systematic physical verification of stores and stock to ensure efficient inventory management and accountability. Further, need of post of designated store keeper may be assessed. Additionally, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the department's activities to safeguard accountability and ensuring an efficient inventory management.

(Para 23)

4.5 Monitoring & Evaluation

This section provides a brief assessment of the organization's monitoring and evaluation practices including the established processes, procedures and tools for monitoring and evaluating performance, evaluation of key indicators developed by the organization to track performance and progress towards objectives. This also includes an assessment of the organization's preparation of periodic monitoring reports and examination of the meetings held by the monitoring and steering committees responsible for overseeing performance. Audit observed the following irregularity:

4.5.1 Non-conducting of Internal / External Monitoring and Inspection of the Medical Centers

As per Rule 20 of IHRA Act, 2018, (Inspection Team), (1) The Authority may by order in writing appoint an inspection team to perform the functions and exercise the powers of the Authority for inspection under this Act, subject to such conditions and limitations as the Authority may specify in this behalf. (2) The inspection team may inspect a healthcare establishment, equipment and healthcare services provided by the healthcare establishment for grant, renewal, suspension or cancellation of registration or licensing. (3) The inspection team may inquire any case if there has been any instance or allegation of maladministration, malpractice or failure in the provision of healthcare services against a healthcare establishment. (4) The Authority may impose a fine which may extend to fifty thousand rupees upon a healthcare professional who a) refuses or fails, without reasonable cause, to furnish any information to the inspection team; or b) gives any false or misleading information to the inspection team.

Audit noted that there are 13 medical centers operating in Islamabad under the administrative control of the Directorate of Health Services, CDA. While no records, monitoring reports, or inspection notes were made available to Audit throughout the course of the audit, Audit concluded that the DHS did not undertake any internal or external monitoring and evaluation of the centres or document any inspections of the centres by the higher/ responsible authorities. Failure to conduct periodic monitoring and evaluation of healthcare units compromised the quality of healthcare services besides causing detrimental impacts on resource utilization, continuous improvement in service delivery and stakeholder confidence.

Audit is of the view that the inability of DHS to conduct periodic monitoring/ evaluation of healthcare services indicated the lack of internal controls related to policies and procedures, performance measurement and quality assurance.

Audit pointed out the matter in April 2023. The DHS replied that a monitoring committee exists that includes (i) Store supervisor (ii) Deputy Director, DHS, (ii) DDO, DHS, (iii) Director, DHS. The Committee visited centers and reports were being submitted to D.G (Health) on regular basis.

The reply cannot be accepted because no inspection/monitoring report was provided to Audit during audit and even no documentary evidences were provided in support of the reply.

DAC meeting was not convened despite requests by Audit on 19.05.2023 and 07.06.2023.

Audit recommends that a comprehensive monitoring and inspection system should be developed and implemented to ensure the quality of healthcare delivery system and record of constitution of monitoring committee and inspection notes thereof may be provided to Audit. Additionally, PAO should look into the matter and fix responsibility against the persons who failed to adequately oversee the department's activities to ensure better delivery of healthcare services.

(Para 16)

4.6 Environment

Due to the absence of an internal waste management system, the waste generated by the DHS and its medical centres/ units is transported to the CDA hospital for disposal. Without a dedicated waste disposal mechanism under the control of DHS there may be limited control and oversight over the waste management process during segregation and collection of healthcare waste from various MCs/ dispensaries of DHS. This lack of control can lead to improper handling, or insufficient monitoring of healthcare waste, increasing the potential for negative environmental impacts as well as the spread of HAIs.

4.7 Sustainability

Due to shortage of qualified and skilled medical practitioners, and healthcare staff, DHS faces challenges in maintaining its HR

sustainability. Staff position (Medical Officer, Dispensers, Vaccinators and midwives is reflected in Annexure-A). To ensure sustainability, the DHS should focus on attracting, retaining and training healthcare professionals, thereby ensuring a consistent and skilled workforce to meet the healthcare needs of the population.

EPI Pakistan also views sustainability as a crucial element in ensuring that there are enough resources to pay for the cost of vaccines. As a nation, Pakistan promotes and sanitizes regional resource mobilization so that everyone can contribute their own resources to cover the cost. It further emphasizes on community and private sector engagement, and strengthening of PHC to ensure sustainability[6].

DHS has financial sustainability concerns given that it hasn't been able to achieve financial self-sufficiency despite generating its own revenue from a variety of means, such as trade vaccinations, lab tests, and spraying and fogging activities. Instead of distributing revenue share among its employees, the entity should formulate an effective strategy to better utilize the funds for enhancing the healthcare delivery services. To conclude, the DHS has to put into effect cost-effective strategies to generate sufficient revenue to achieve financial self-sufficiency besides exploring ways to attain sustainability as envisioned by EPI Pakistan. It also needs to devise effective policies for the efficient utilization of funds in order to achieve long-term financial viability and improved service delivery.

4.8 Overall Assessment

DHS holds a crucial role in promoting the well-being and health of Islamabad's residents; however, it has not been able to fulfill this responsibility adequately. Quality primary healthcare services have not been provided to the residents of Islamabad due to a host of reasons. Some of the major reasons that hindered the performance of the DHS include the absence of a standardized framework to guide operational activities, inadequate maintenance of relevant data, scarcity

[6] https://epi.gov.pk/wp-content/uploads/2023/01/NationalImmunizationPolicy2022-compressed.pdf

of healthcare professionals and staff, insufficient infrastructure to cater to the needs of the capital city, and the ineffective monitoring and supervision practices. The cumulative effect of these factors resulted in the facility's inability to deliver efficient and effective healthcare services to the target population. Consequently, the performance of the DHS in proving quality healthcare services to the residents of Islamabad has been deemed "unsatisfactory".

4.8.1 Relevance

The primary healthcare functions of the DHS including EPI/ immunization programmes, family planning assistance, prevention of VPDs, provision of essential drugs, consultation services and ensuring availability of hygienic eateries in the federal capital, demonstrate its relevance by aligning with the government's sectoral policies such as National Health Vision 2016-2025, National Immunization Policy 2022, and the government's policy goals and objectives for safeguarding public health and well-being under SDG-3.

4.8.2 Economy

The entity's performance is marred by several irregularities as principles of economy were disregarded in a number of instances during procurements. These issues encompass lack of fair competition and transparency during the procurement of medicines, as well as the expenditure incurred on health campaigns. Moreover, a significant amount was spent on polio and anti-dengue/ malaria activities without a competitive bidding process. Other irregularities include off-season purchases of dengue sprays, procurement of chemicals without lab tests, repeated purchases from selected suppliers without assessment and lack of details regarding item issuance and distribution.

4.8.3 Efficiency

Firstly, the low patient turnout at the medical centers of the DHS suggests that the facilities are not efficiently attracting the intended beneficiaries, potentially resulting in the underutilization of resources and services. Additionally, the non-availability of family planning and Mother and Newborn Child Health (MNCH) related

services indicate a gap in service provision and inefficiency to meet the comprehensive healthcare requirements of the community. Furthermore, the lack of concerted efforts in developing an operational framework/ SOPs suggests the lack of clear guidelines and standardized practices, which can hinder the efficient functioning of the facility.

4.8.4 Effectiveness

The effectiveness of DHS was compromised by various factors. These include the non-availability of an adequate quantity of essential medicines at MCs, hindering timely treatment; the lack of ambulatory services despite having ambulances, delaying urgent care; inadequate reporting of notifiable diseases, hindering disease control; an unequipped laboratory with insufficient staff, compromising accurate diagnostics; the absence of family planning and mother and child healthcare services, increasing rates of malnutrition, infant, neonatal and maternal mortality; inadequate accessibility of immunization facilities to marginalized communities, reducing coverage rates; ineffective implementation of food safety regulations, risking public health and inability to achieve immunization targets, increasing vaccine dropouts, zero-dose cases and preventable diseases, and last but not the least, non-availability of doctors at MCs.

4.8.5 Equity

In modern societies, it is important for all government agencies to work for the amelioration of differences between socioeconomic classes. Many sectors of Islamabad have either a slum or a settlement of underprivileged segments of society. Therefore, it is imperative for the entity responsible for basic health services in the city to try to reach out to these communities to provide services and awareness about issues like communal hygiene, family planning and immunization programmes. However, DHS has not adopted Health Equity Model, and its performance on this front is gloomy.

4.8.6 Compliance with Rules

The DHS exhibits significant instances of non-compliance with rules and regulations. These include irregularities in medicine procurement without a proper tendering process, direct procurements from specific contractors/ firms without competitive bidding, absence of an operational framework, lack of monitoring and inspection of healthcare services extended by the medical centres, failure to implement healthcare regulations, unauthorized expenditures from the revenue, under-utilization of funds/ grants, irregular spending on health awareness programmes without proper expenditure records, non-reconciliation of revenue receipts, and the lack of physical verification of stock and stores.

4.8.7 Performance Rating of the Entity

Unsatisfactory

4.8.8 Risk Rating of the Entity

High

5. CONCLUSION

Performance assessment of the DHS reveals that it has not been able to effectively achieve its objectives due to significant shortcomings. These include poor planning, lack of standardized operational framework, inadequate oversight mechanism, non-compliance with health standards and regulations, under-utilization of resources, and a shortage of qualified healthcare workforce, medicines and equipment. DHS has not proactively coordinated with Federal Directorate of Immunization for assuming responsibilities with reference to infant mortality, etc. Consequently, the residents of Islamabad are deprived of an efficient basic healthcare system, leading to an unnecessary burden on secondary and tertiary care hospitals. To address these issues, it is essential to focus on training and hiring qualified medical staff, enhancing infrastructure, developing a comprehensive operational framework aligned with national and international health standards, maintaining accurate data through

HMIS, implementing strong internal controls for rules compliance and financial accountability, and exploring diverse options to attain financial sustainability.

5.1 Key Issues for the Future

The key issues that have hindered the Directorate's ability to effectively achieve its objectives and need to be addressed for the future improvement of its performance are as follows:

i. Improved Planning

The DHS should focus on developing robust planning strategies that align with their objectives and prioritize the healthcare needs of the population they serve. This will help in better resource allocation and effective service delivery.

ii. Standardized Operational Framework

Implementing a standardized operational framework will ensure consistency and efficiency in the service delivery.

iii. Enhance Oversight Mechanism

Establishing a proper oversight mechanism is crucial to ensure the delivery of quality healthcare services. Regular monitoring and evaluation should be conducted to identify areas of improvement and to ensure the provision of quality healthcare services.

iv. Compliance with Health Standards and Regulations

Strict adherence to health standards and regulations is vital for maintaining quality healthcare services. The DHS should prioritize compliance and implement measures to continuously monitor and enforce these standards.

v. Optimal Resource Utilization

The DHS should strive to optimize the utilization of available resources, including the healthcare workforce, medicines, medical equipment etc. Addressing the shortage of qualified healthcare workforce and ensuring the availability of essential medical supplies will contribute to improving the quality of healthcare services.

vi. Enhance Diagnostic Services of Laboratory

To ensure the optimal functionality of the lab and enhance diagnostic services, it is crucial to invest in the procurement of the latest equipment besides the recruitment of qualified personnel capable of performing laboratory functions.

vii. Measures to attain Financial Sustainability

In order to achieve financial sustainability, the DHS should take measures to explore various avenues and options to generate its own financial resources. By doing so, the entity can reduce its dependence on external funding and establish a more sustainable financial framework for its operations, especially EPI/ Immunization activities.

5.2 Lessons Identified

i) To carry out healthcare activities successfully, it is crucial to ensure that healthcare plans align with the organization's objectives and the needs of the community.

ii) For improved delivery of healthcare services, it is necessary to devise and implement a well-structured and standardized operational framework. The provision of quality healthcare services is ensured by establishing efficient monitoring systems, such as periodic inspections and strict compliance to health standards. Appropriate tool of monitoring like Health Management Information System may be deployed. Awareness campaigns need to be enhanced through appropriate and forceful channels.

iii) The efficient utilization of available resources, including the healthcare workforce, medicines and medical equipment, is essential for improving healthcare accessibility and quality, which is not in the case of DHS.

iv) Financial sustainability is crucial for the long-term success and viability of the DHS and in continuing its healthcare services unhindered. For the purpose, DHS should employ cost-effective measures to significantly boost its revenue generation and to attain financial self-sufficiency. This will further enable investments in infrastructure, equipment, and staff recruitment, leading to improved healthcare quality and accessibility. Services being provided by DHS need to be projected and confidence-building measures be adopted to attract more users.

Acknowledgement

The staff and management of the Directorate of Health Services, CDA/MCI immensely helped the auditors during the execution of this performance audit, and we wish to extend our sincere appreciation for their support.

Annexures

Annexure-A

Ref to Para 4.1.1

Inability to provide quality healthcare services as per Primary Healthcare facilities standards

S. N	Name of Med. Centre	Catchment Population	No. of Patients Visited (Jan to Dec 2022)	Staff Position				Monitoring/ Inspection of MCs	Ambulance Service	HMIS System	Family Planning Services/ MNCHS	HEM/ Framework	Operational Framework/ SOPs	Reporting of notifiable diseases (Polio)
				Med-ical Officer	Dispen -sers	Vaccin- ators	LHV/ Midwife							
1	MC F-11/4	67,710	2,244	-	01	01	-	NIL	NIL	Not implemented	NIL	Not implemented	NIL	NIL
2	MC G-9 (Morning/ Evening)	70,227	11,049	01	02	01	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
3	MC I-10 (Morning/ Evening)	128,910	5,236	01	02	01	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
4	MC G-10	54,318	2,315	-	01	01	01	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
5	MC, G-7	81,982	2,394	01	01	-	01	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
6	MC, Diplomatic Enclave, G-5	23,582	1,615	-	01	-	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
7	MC, B.Block Pak Secretariat	0	0	-	01	-	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
8	MC, Simly Dam		4,320	-	01	-	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
9	MC, Rawal Town	42,745	6,720	-	01	01	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL

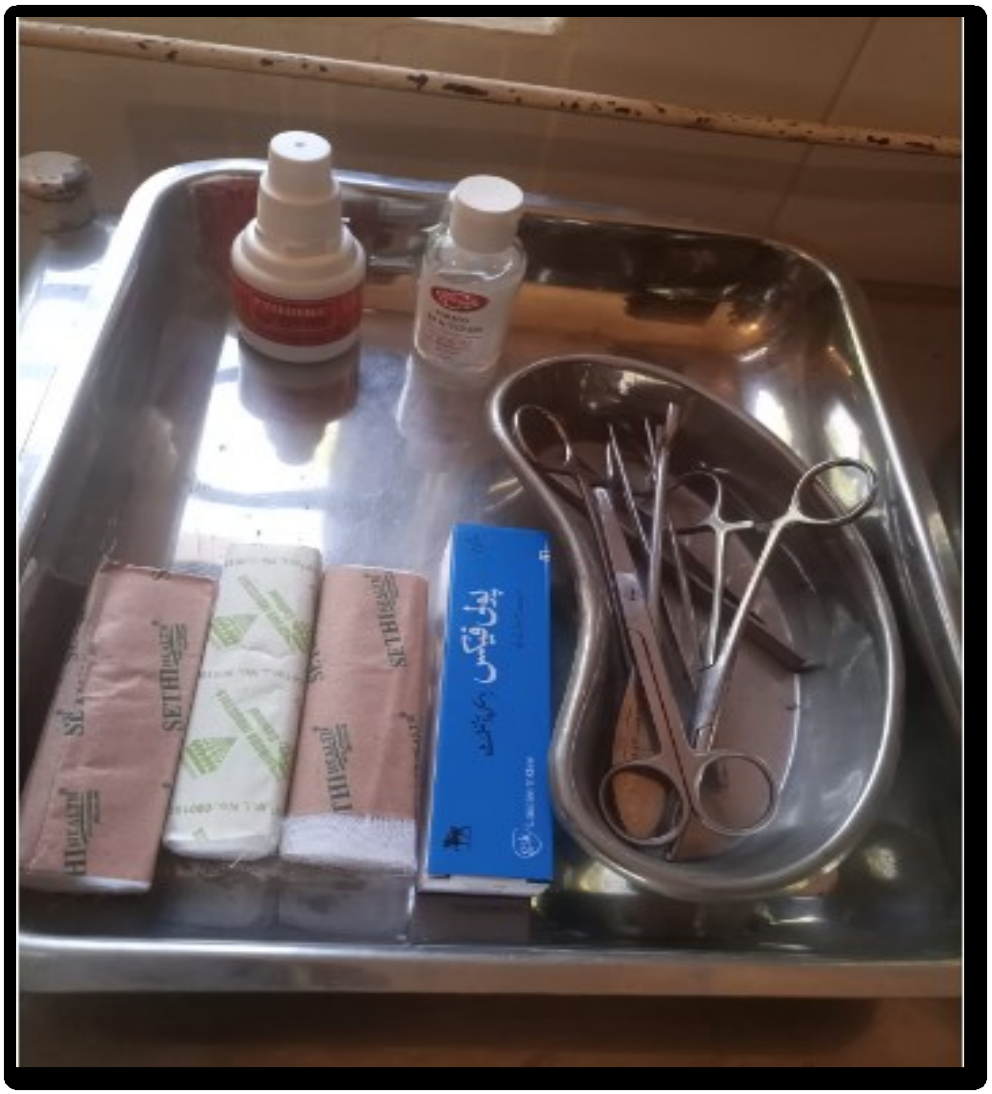
S. N	Name of Med. Centre	Catchment Population	No. of Patients Visited (Jan to Dec 2022)	Staff Position				Monitoring/ Inspection of MCs	Ambulance Service	HMIS System	Family Planning Services/ MNCHS	HEM/ Framework	Operational Framework/ SOPs	Reporting of notifiable diseases (Polio)
				Med-ical Officer	Dispen -sers	Vaccin- ators	LHV/ Midwife							
10	MC, Bhara Kahu		1,360	-	01	-	01	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL
11	MC, I-8	52,155	5,344	-	01	01	-	NIL	NIL	S/A	NIL	Not implemented	NIL	NIL

Annexure-B

Ref to Par 4.1.7

Failure to Implement WHO and CDC guidelines on hygiene and Infection Control

A photo captured at MC-F-11 depicts healthcare staff utilizing hand sanitizer to disinfect / clean instruments / tools



Annexure-C
Ref to Para 4.1.7

Failure to Implement WHO and CDC guidelines on hygiene and Infection Control

(A photograph captured at MC-G-10 showing unsanitary condition of toilets)

Annexure-D
Ref to Para 4.1.7

Failure to Implement WHO and CDC guidelines on hygiene and Infection Control

Photos captured at MC-F-11 showing an unclean, disorganized, and unkempt waiting area that lacks segregation for male and female patients

Annexure-E

Ref to Para 4.3.1

Irregular/doubtful expenditure on purchase of medicines, health awareness programmes/campaigns/activities without tendering /details of verifiable expenses - Rs 18.298 million

Details of expenditure on Anti-Malaria, Anti-Dengue Activities and Polio Campaigns

S. No.	Name of Vender	Head of Account	CV.No/ Month	Amount (Rs)
1	M/s Cultevo Crop	Anti-Malaria	24-Jun-22	492,772
2	M/s Saad Enterprises	Anti-Malaria	48/June 2022	941,581
3	M/s Cultevo Crop	Anti-Malaria	52/June 2022	472,725
		TOTAL		**1,907,078**
4	M/s Nadeem Traders	POLIO campaigns	8-Nov-21	858,315
5	M/s Saad Enterprises	POLIO campaigns	10-Nov-21	383,109
6	M/s Nadeem Traders	POLIO campaigns	13-Jun-22	884,437
7	M/s Saad Enterprises	POLIO campaigns	June 2022	610,898
8	M/s Saad Enterprises	POLIO campaigns	June 2022	564,831
		TOTAL		**3,301,590**
9	M/s Shah Trading	Anti-Dengue	36/June 2022	932,080
10	M/s Saad Enterprises	Anti-Dengue	12-Nov-21	744,506
11	M/s Saad Enterprises	Anti-Dengue	20-Nov-21	331,852
12	M/s Saad Enterprises	Anti-Dengue	21-Nov-21	897,232
13	M/s Shah Trading	Anti-Dengue	7-Dec-21	100,000
14	M/s Shah Trading	Anti-Dengue	12-Dec-21	950,320
15	M/s Saad Enterprises	Anti-Dengue	15-Dec-21	167,201

S. No.	Name of Vender	Head of Account	CV.No/ Month	Amount (Rs)
16	M/s Nadeem Traders	Anti-Dengue	16-Dec-21	179,807
17	M/s Shah Trading	Anti-Dengue	25-Dec-21	907,250
18	M/s Shah Trading	Anti-Dengue	26-Dec-21	450,760
19	M/s Shani Travels	Anti-Dengue	9-Jan-22	744,960
20	M/s Nadeem Traders	Anti-Dengue	23-Jun-22	455,534
21	M/s Nadeem Traders	Anti-Dengue	45/June 2022	1,122,640
22	M/s Nadeem Traders	Anti-Dengue	46/June 2022	850,515
23	M/s Nadeem Traders	Anti-Dengue	49/June 2022	93,074
24	M/s Shah Trading	Anti-Dengue	50/June 2022	469,860
25	M/s Cultevo Crop	Anti-Dengue	51/June 2022	945,450
		TOTAL		**10,343,041**
		GRAND TOTAL		**15,551,119**

Annexure-F
Ref to Para 4.4.1

Detail of POL and repair & maintenance related expenditure on ambulances (FY 2021-22)

S. No	Months	from 1st of Each Month to 15Th				from 16th of Each Month to 30th/31st				Total POL Cost	Repair & Maint. Cost
		No. of vehicles	POL in liters	Rate	Cost	No. of vehicles	POL in liters	Rate	Cost		
1	July	5	125	113.99	71,244	5	125	116.53	72,831	144,075	1,304,000
2	August	5	125	116.53	72,831	5	125	116.53	72,831	145,663	
3	September	5	125	115.03	71,894	5	125	120.04	75,025	146,919	
4	October	5	125	122.04	76,275	5	125	134.48	84,050	160,325	
5	November	5	125	134.48	84,050	5	125	142.62	89,138	173,188	
6	December	5	125	142.62	89,138	5	125	137.62	86,013	175,150	
7	January	5	125	141.62	88,513	5	125	144.62	90,388	178,900	
8	February	5	125	144.62	90,388	5	125	154.15	96,344	186,731	
9	March	5	125	144.15	90,094	5	125	144.15	90,094	180,188	
10	April	5	125	144.15	90,094	5	125	144.15	90,094	180,188	
11	May	5	125	144.15	90,094	5	125	144.15	90,094	180,188	
12	June	5	125	174.15	108,844	5	125	263.31	164,569	273,413	
	Total	**5**	**1500**		**1,023,456**	**5**	**1500**		**1,101,469**	**2,124,925**	**1,304,000**

Total POL Cost .. .. .. Rs 2.125 million
Total Repair & Maintenance Cost.. Rs 1.304 million
Total .. .. Rs 3.429 million