SPECIAL STUDY

ON

NATIONAL MATERNAL, NEWBORN AND CHILD HEALTH (MNCH) PROGRAM

DISTRICT GOVERNMENT

DERA GHAZI KHAN

AUDIT YEAR 2015-16

27th November 2015

AUDITOR GENERAL OF PAKISTAN

PREFACE

The Auditor-General conducts audit subject to 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 and Section 115 of the Punjab Local Government Ordinance 2001.The special study of National Maternal, Newborn and Child Health (MNCH) Program (Health Sector) District Government, Dera Ghazi Khan was carried out accordingly.

The Directorate General Audit District Governments Punjab (South), Multan, conducted special study of the National MNCH program District Dera Ghazi Khan during November, 2015 for the period January, 2007 to June, 2015 with a view to reporting significant findings to the stakeholders. The study was carried out on test check basis with a view to reporting significant findings to the District Health Authorities and stakeholders, in order to bring about improvement in the delivery of Emergency Obstetric and Newborn Care (EmONC) services. The study aimed at suggesting the improvement in the service delivery of health related facilities at community level.

The observations included in this report have been finalized in the light of written responses of the management concerned.

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

Islamabad (**Rana Assad Amin)**
Dated: **Auditor General of Pakistan**

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Acronyms and Abbreviations

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

MNCH	-	Maternal, Newborn and Child Health
MNT	-	Maternal and Newborn Tetanus
MO	-	Medical Officer
MS	-	Medical Superintendent
MSDS	-	Minimum Service Delivery Standards
PC-1	-	Planning Commission – Proforma 1
PHC	-	Primary Health Care
RHC	-	Rural Health Center
THQ	-	Tehsil Headquarter
SMPs	-	Standard Medical Protocols
D.G. Khan	-	Dera Ghazi Khan
UC	-	Union Council
UNICEF	-	United Nation's Child Fund
WMO	-	Woman Medical Officer

EXECUTIVE SUMMARY

Directorate General of Audit, District Governments, Punjab (South), Multan conducted special study on National MNCH Program District Government Dera Ghazi Khan in accordance with the INTOSAI Auditing Standards during November, 2015.

Government of Pakistan launched a program for improvement of Health Sector called, "National MNCH Program", in 2007 executed by the District Government Dera Ghazi Khan through Public Health Specialist and MNCH Cell under the supervision & administrative control (at district level) of Executive District Officer (Health) Dera Ghazi Khan. Funds of Rs 120.787 million were released out of which expenditure of Rs 69.844 million was incurred whereas Rs 50.943 remained unspent. The main objective of this project was to improve Emergency Obstetric and Newborn Care (EmONC) services for achievement of health related Millennium Development Goals (MDGs) 4&5 which are as under:

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

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

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

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

The main objectives of the special study were:

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

ii. To ensure that internal controls were operative, functioning effectively and to review compliance with applicable rules, regulations and procedures.

iii. To ascertain that program was executed with due regard to economy, efficiency and effectiveness.

The significant findings of the Special Study on National MNCH Program are given below:

a. Selection of CMWs was not according to the laid down criteria.
b. Different MNCH related activities were not integrated under one management structure and there were deviations from program objectives.
c. The availability of the medicines and equipment at health facilities was not ensured.
d. Public awareness campaign on National MNCH Program was not launched through preferred electronic media (which is more in use these days) as a tool of creating awareness amongst the local population.
e. Civil works for provision of MNCH facilities were not completed.
f. The achievement of Millennium Development Goals to reduce the Infant Mortality Rate and Maternal Mortality Ratio was not ensured.
g. Program activities fell short of the desired principles of economy, efficiency and effectiveness as regard to time and cost overrun.

The recommendations on the significant findings are given below:

i. Deployment of CMWs in the remote/ underserved areas may be ensured.
ii. All the MNCH related activities at district level should be integrated under District MNCH Cell.
iii. The system for provision of medicines and safe delivery services to the patients should be strengthened.
iv. Public awareness campaigns should be launched.
v. The civil works may be completed on priority.
vi. Strenuous efforts should be made at all levels to achieve the MDGs.
vii. System of internal controls should be strengthened.

INTRODUCTION

District Dera Ghazi Khan is located in the south west of the Punjab Province. According to Health Department Information, the total population of District D. G. Khan is 2.250 million.

District Dera Ghazi Khan comprises three Tehsils namely 1. D. G. Khan, 2. Taunsa Sharif, 3. Tribal Area. The District Government D. G. Khan is responsible to provide the health facilities to the general public of District D.G Khan. Total health facilities under District Government D. G. Khan are 1. One District Head Quarter Hospital, 2. One Tehsil Headquarter Hospital (THQ), 3. Nine Rural Health Centers (RHCs), 4. Fifty three Basic Health Units (BHUs), 5. Twenty three Rural Health Dispensaries (RHDs). The total Maternal, Newborn and Child Health (MNCH) related human resource hired / deployed by the management of MNCH Program Dera Ghazi Khan, is 1. Nine Woman Medical Officers (WMOs), 2. Nine Lady Health Visitors (LHVs), 3. Two hundred and thirty one Community Midwives (CMWs).

Background and project description

According to PC-I (Page-5), the existing system of health facilities is not only inadequate but also insufficient to provide health services to the general public in Pakistan. Therefore, the National MNCH Program was initiated in 2007 to ensure progress towards achieving the Millennium Development Goals (MDGs). The specific targets of the program were:

Sr. No.	Description	Target 2011	Target 2015
1	To reduce the Under Five Mortality Rate	65 per 1000 live births	45 per 1000 live births
2	To reduce the Newborn Mortality Rate	40 per 1000 live births	25 per 1000 live births
3	To reduce the Infant Mortality Rate	55 per 1000 live births	40 per 1000 live births
4	To reduce Maternal Mortality ratio	200 per 100,000 live births	140 per 100,000 live births
5	To increase the proportion of deliveries attended by skilled birth attendants at home or in health facilities	90%	More than 90%

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

Country	IMR (a)	Under-Five MR (b)	MMR (c)
Bhutan	65	75	420
Bangladesh	54	57	380
India	56	74	540
Nepal	56	74	740
Sri Lanka	12	14	92
Pakistan	**80**	**99**	**500**
Punjab	**77**	**112**	**300**

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

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

Table 2: Key Health MDGs and Associated Indicators for Punjab

Targeting Indicators	2004a	2007b	Targets 2015
Infant Mortality Rate per 1,000 Live Births	77	71	40
Under-Five Mortality Rate per 1,000 Live Births	112	102	45
Maternal Mortality Ratio per 100,000 Live Births	300	300	140
Percentage of Births Attended by Skilled Birth Attendants	32	38	100
Percentage of Fully Immunized Children (12–23 months old)	5079.7 Above 80		

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

Program Objectives

The program objectives were to be achieved in two Phases as detailed below.

Phase - I: January 2007 to June 2009.

The first phase of the program had further two sub segments. The activities planned to be performed in sub-programs are tabulated below:

First Segment

The first segment was the preparation to launch this program. It consisted of formation of a Federal Program Implementation Unit (PIU) and strengthening of the MNCH Cells / Directorates at the Provincial and District levels. The planning process in the district for the different components was to be completed until June 2007.

Second Segment

The second segment was to start from July, 2007 and included refresher trainings of midwifery tutors, training of community midwives and Lady Health Supervisors (LHS) and the civil works in Government Hospitals.

Phase - II: June, 2009 to June, 2012

The objectives of Phase-II are as under:

1. One CMW for every 10,000 population in her catchment area supported by an active transportation/ referral service and comprehensive EmONC facilities was to be deployed by the end of this phase.
2. A third party evaluation was to be conducted at the end of each phase to assess the achievements and cost effectiveness of the program.

Projects Achievements and Outcomes

Table-3 Activity Achievements

Activity	Expected output	Achievements	Remarks
Civil work for refurbishing the labor wings in DHQ, THQ hospitals and construction of new labor rooms	To facilitate the functioning of comprehensive, basic and preventive EmONC Service in the hospitals	Only labor wings in DHQ, THQ hospital were renovated / refurbished during 2011-12.	New labor rooms were not constructed and existing were renovated with the delay of three years. Hence availability of quality of health services could not be insured due to which MDGs remained unachieved
Strengthening the DHQ, THQ, RHCs and BHUs (Human Resource, Equipment and Medicines)	To provide comprehensive, basic and preventive EmONC Service at all health facilities.	Only Nine RHCs were strengthened during the period 2009 to 2015 out of which Four RHCs were working without services of additional WMOs during 2012 to 2014	DHQ, THQ and BHUs could not be strengthened during this period due to which all Health facilities could not provide EmONC Services.
Construction of CMWs School and Hostel	To improve the quality of midwifery training in the country	School was completed during June 2014. All the CMWs were trained in existing Nursing School	Quality of midwifery training could not be ensured and delay of constructions also resulted in cost overrun.
Training of CMWs	To increase the production of skilled birth Attendant replacing Traditional Birth Attendant	231 CMWs were trained	Deployed CMWs replaced the Traditional Birth Attendant for provision of health facility at gross root level. However, still there were some remote areas where CMWs could not be deployed.
Deployment of one CMW for every 10,000 population in her catchment area supported by an active transportation/ referral service and comprehensive EmONC facilities	To reduce the IMR and MMR through early detection and timely referral of obstetric and newborn complications	From 2011 to 2015 No. of antenatal cases were 82,560 and No. of deliveries conducted were 15,214 (20.94% of total deliveries) while only 843 (1.16%) complicated deliveries were referred to nearest health facilities	This ratio can be increased by providing all necessary medicines and equipment to health facilities. Referral system must be developed to encourage the CMWs
Third party evaluation	To assess the achievements and cost effectiveness of the program.	Not conducted	Due to non evaluation of program in District D.G. Khan, it could not be proved either targets of IMR & MMR were achieved or not.

Table-4 Multiple Indicator Cluster Survey (MICS) Punjab Key Findings December 2015 (By UNICEF)

Area	At the time of PC-I (F.Y. 2004)	Target 2015	As per MICS 2015
Under 5 mortality rate	105(2001)	65/1000 L/B	93/1000 L/B
New born mortality rate	77/1000 L/B	40/1000 L/B	Not Available
Infant Mortality Rate	81/1000(**RAF)	55/1000 L/B	75/1000 L/B
Maternal Mortality Rate	300/100000 L/B	200/100000 L/B	Not Available
To increase Contraceptive Prevalence Rate	36%	55%	39%
Attendance at home by SBA	30%	90%	61%

Planning

According to the PC-I, all Phases of the program were required to be completed in June, 2012, however, planned activities were not fully performed by MNCH Cell District Dera Ghazi Khan within the stipulated time period.

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

The planning was not carried out realistically and a fixed (at constant rate) remuneration was provided/ allocated in the PC-I for WMOs without keeping in view the annual incremental costs or inflation due to which there was extreme shortage of WMOs.

Execution

The execution of the Program started in April, 2007, with a delay of three months. The delay was due to non-approval of work plan within the due time for Program Phase-I and late release of funds by the Provincial Government. However, the Federal PIU, MNCH Cells at Provincial and District levels were established accordingly.

Time Line

According to the PC-I the Program was required to be completed up to June, 2012. The tasks of the entire program activities were not fully scheduled and

time line was not followed in letter and spirit due to which the program is still incomplete i.e. in 2015.

Financial Aspect

Funds were released to MNCH Program District Dera Ghazi Khan by the Provincial Government as detailed below and comparative analysis of budget and expenditure and utilization of budget under each head of accounts was made which depicted that major portion of the budget was lying unspent i.e. 42 % of amount released.

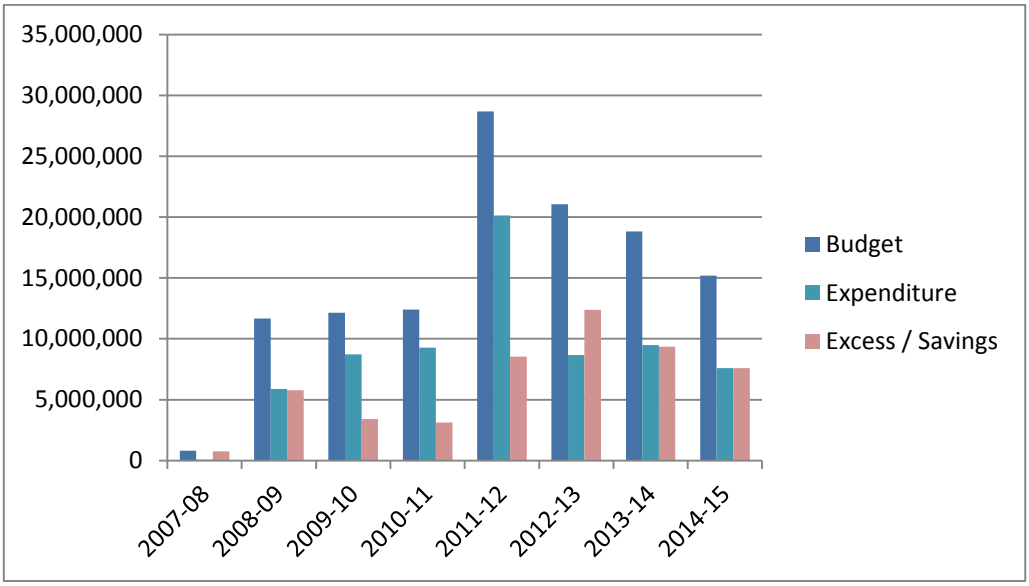
Year Wise Financial Releases and Expenditure:

Comparative analysis of Budget & Expenditure for 2007-15 under National MNCH Program District Dera Ghazi Khan is given below:

(Amount in Rupees)

Year	Budget			Transferred from previous year	Expenditure			Excess / Savings
	Salary	Non Salary	Total		Salary	Non Salary	Total	
2007-08	783,660	29,840	813,500	0	63,981	0	63,981	749,519
2008-09	8,105,000	3,571,000	11,676,000	749,519	2,446,921	3,443,716	5,890,637	5,785,363
2009-10	10,523,370	1,605,000	12,128,370	5,785,363	8,156,781	560,947	8,717,728	3,410,642
2010-11	11,951,000	456,000	12,407,000	3,410,642	8,969,096	312,000	9,281,096	3,125,904
2011-12	16,656,000	12,029,000	28,685,000	3,128,904	8,157,875	11,981,000	20,138,875	8,546,125
2012-13	20,490,701	572,000	21,062,701	8,546,125	7,952,884	725,000	8,677,884	12,384,817
2013-14	17,571,817	1,256,000	18,827,817	12,384,817	8,607,698	875,629	9,483,327	9,344,490
2014-15	6,616,012	8,571,256	15,187,268	9,344,490	3,237,614	4,353,279	7,590,893	7,596,375
Total	**92,697,560**	**28,090,096**	**120,787,656**	**43,349,860**	**47,592,850**	**22,251,571**	**69,844,421**	**50,943,235**

Graphical Presentation



Program Activities

EDO (Health) utilized funds on payment of staff salaries, stipend to student CMWs and retention fee to deployed CMWs. Program activities were not fully performed due to the:

- Non-provision of MNCH related services by various CMWs in their catchment areas and lack of harmony in program activities.
- Non-provision of full support to health facilities with reference to human resource.
- Non-availability of essential and MNCH related medicines & equipment at health facilities.
- Non completion of CMW school and hostel facility for CMW students.
- Non-launching of Public awareness campaign on MNCH program in spite of availability of funds.
- Non-utilization of MNCH vehicles on Program activities.

Special Study Objectives and Scope

Objectives

The major objectives of the study were:

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

ii. To ensure that internal controls were operative, functioning effectively and to review compliance with applicable rules, regulations and procedures.

iii. To ascertain that program was executed with due regard to economy, efficiency and effectiveness.

Scope

The scope of study is to examine the performance of the executive during planning, execution and implementation of National MNCH Program and to comment on service delivery and to attain the program objectives in District Dera Ghazi Khan. Special study of the National MNCH Program District Dera Ghazi Khan was conducted for the period of eight years i.e. from July 2007 to June 2015.

Methodology

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

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

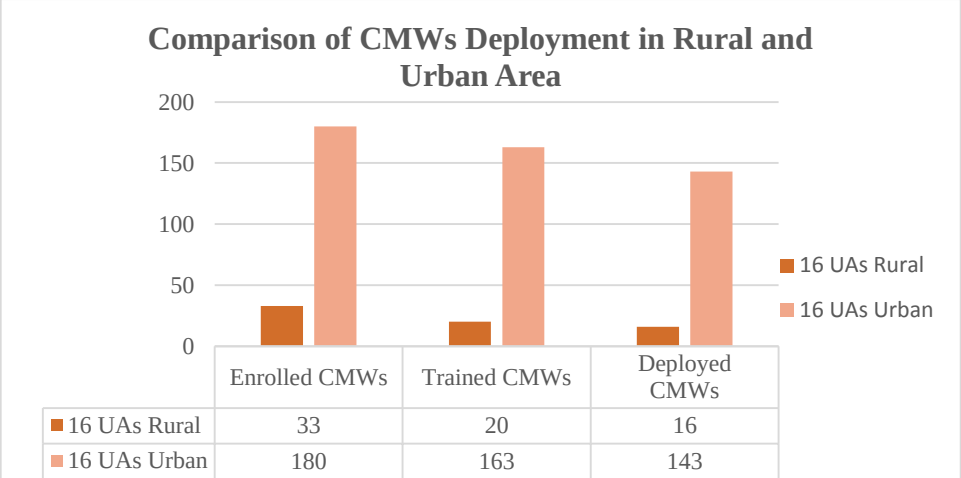
Study Findings

A-Organization and Management

During special study following issues were noticed:

1. According to PC-I (Page No.58): CMWs were to be selected from and deployed in the villages where there was no public health facility (RHC, BHU & MCH Centre), to provide 24/7 coverage to the underserved areas on priority. CMWs were required to be deployed to provide the MCH related services to the population for which it is not easy to reach a health provider/ skilled birth attendant.

   It was observed from the office record (selection of CMWs) as well as monthly reports of CMWs that these were selected from and deployed in the areas adjacent to the health facilities despite the fact that the program was initiated with the objective of major focus on the rural/ remote areas to provide the MCH related services to the population for which it is not easy to reach a health provider/ skilled birth attendants. Detailed below table shows comparison of sixteen Union Councils of Rural areas with the Urban UCs. It was clear that in most of the UCs of rural areas not a single CMW was deployed whereas in urban areas more than 10 CMWs were working in a single UC. Deviation from the program goals was made in the selection/ recruitment of CMWs. Management replied that as per program policy it was not necessary to select and deploy CMWs near RHC or BHU. These had to be selected in rural areas at 10,000 or 5,000 population. CMWs were not available in the rural areas. However, Audit noticed that there were fifty nine UCs in District D.G. Khan and population was 2.250 million. Average population per UC was 38,136. It clearly shows that one CMW in rural areas was deployed over population of 38,136 (16 UCs, 16 Deployed CMWs) while in areas near health facility these were deployed over population of 4,269 (16 UCs 143 CMWs average nine CMW / UC and 38,136 /9). Thus, deviation from the program goals was made in the selection/ recruitment of CMWs.



A- CMWs enrolled, trained and deployed from rural areas

Sr. No.	U/C NAME	ENROLLED CMWs	TRAINED CMWs	DEPLOYED CMWs
1	Haji Ggazi	1	0	0
2	Nawan	4	1	0
3	Sakhi Sarwar	1	0	0
4	Yaroo	4	1	0
5	More Jhangi	0	0	0
6	Bahadurgarh	1	1	1
7	Chabri Bala	2	1	1
8	Wadoor	3	2	1
9	Hero Sharqi	2	2	1
10	Nari	1	1	1
11	Mubarki	2	1	1
12	Darkhast Jamal Khan	2	2	2
13	Jakhar Imam Shah	3	2	2
14	Khakhi	2	2	2
15	Mutafariq Chohan	2	2	2
16	Fazla Katch	3	2	2
Total		**33**	**20**	**16**

B- CMWs enrolled, trained and deployed from urban area

Sr. No.	U/C NAME	ENROLLED CMWs	TRAINED CMWs	DEPLOYED CMWs
1	Kot Chutta	8	7	6
2	Mana Ahmadani	9	9	6
3	Lakhani	8	7	6
4	Nutkani	9	8	6
5	Basti Fouja	8	7	7

Sr. No.	U/C NAME	ENROLLED CMWs	TRAINED CMWs	DEPLOYED CMWs
6	Chotti Zarin	8	7	7
7	Mamoori	9	7	7
8	Shahdan Lund	12	10	7
9	Gaddai	14	12	9
10	Aaliwala	10	10	10
11	Drahma	11	11	10
12	Churatah	12	12	11
13	Shah Saddar Din	13	13	11
14	Kot Qaisrani	14	13	12
15	Vehova	17	14	12
16	Jhok Utra	18	16	16
Total		**180**	**163**	**143**

2. According to PC-I (Page No.II, III): Project Objectives and its relationship with Sectoral Objectives, "The overarching program goal is to improve accessibility of quality MNCH services through development and implementation of an integrated and sustainable MNCH program at all levels of the health care delivery system". Further, according to PC-I page 103, "MNCH Cell will be directly responsible for integration and implementation of all the MNCH related activities including National MNCH Program".

   All the MNCH related activities & vertical programs were not integrated at the district level, under the management of MNCH Cell, due to which quality services were not provided to the targeted population. Management replied that Integrated Reproductive Maternal and Newborn Child Health & Nutrition Program (IRMNCH) was initiated in April 2014. However, the reply of the management was not relevant.

3. As per PC-I (Page No.XVI table 2) of the National MNCH Program, Community Midwifery School was to be constructed in the district during the year 2007-08 and staff for the school was to be hired in the year 2008-09.

   The contract for construction of Community Midwifery (CMW) School was awarded during July 2012 and it was completed during 2014. However, it was observed that the staff of the school was hired in

February 2009 i.e. three years before the award of work for the construction of CMW schools. Management replied that staff was hired against the sanctioned posts. Detail of the staff hired without requirement is as under:

Sr. No.	Designation	Joining Date	Worked at
1	Computer Operator	24.02.2009	O/O EDO (H) D.G. Khan up to 21.01.2013
2	Security Guard	24.02.2009	Nursing School, MNCH Cell D.G. Khan
3	Security Guard	24.02.2009	Nursing School, MNCH Cell D.G. Khan

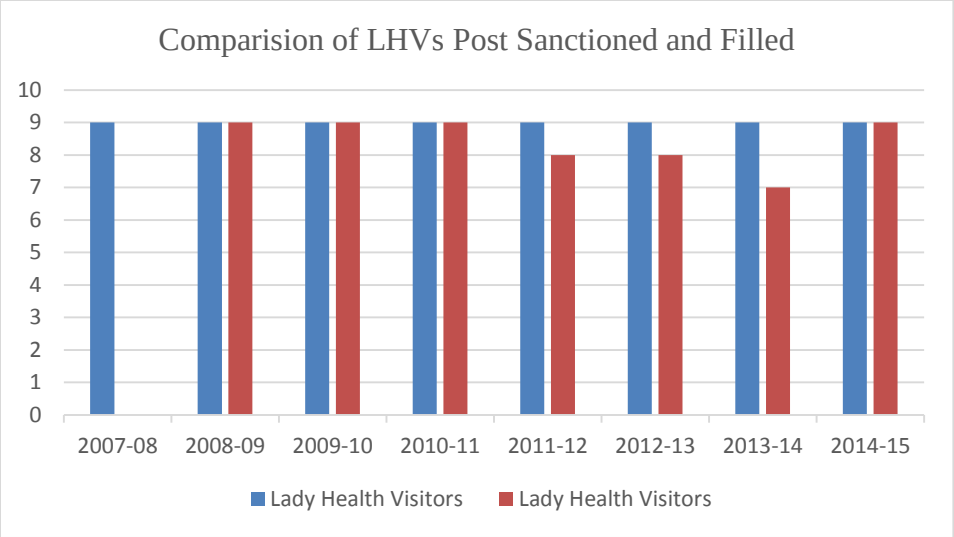
4 Under this program it was proposed to hire at least three tutors for each midwifery school to strengthen the capacity of these schools to impart midwifery training. These tutors will receive recognition from the Pakistan Nursing Council (PNC) based on criteria (to be developed) for midwifery tutors. (As per PC-1 Page 61)

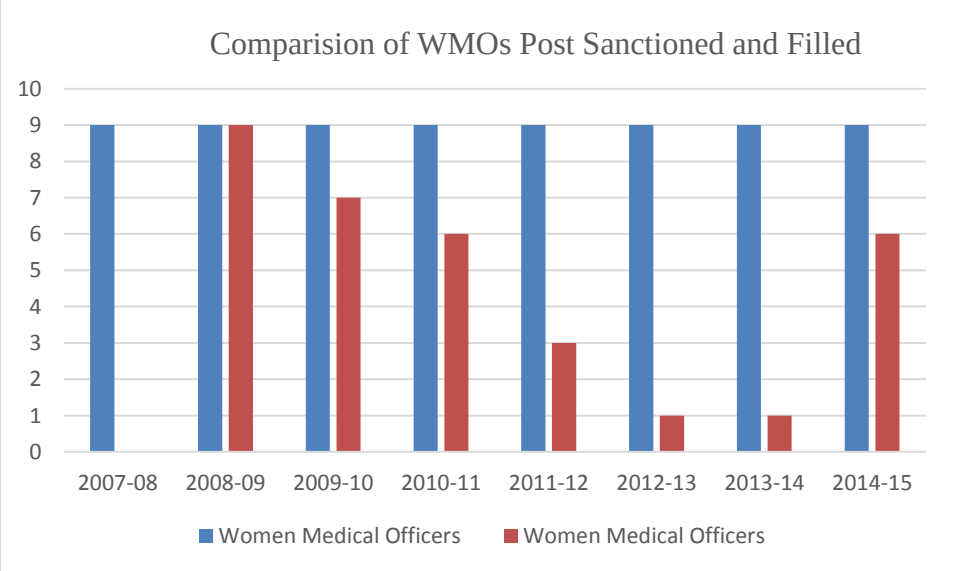
Two midwifery Tutors were hired on 24.09.2009 for CMW's classes. Both tutors resigned during 2012. Due to the absence of designated midwifery tutors, CMWs were not trained as per requirement of the PC-1. Management replied that as per program directions, tutors of public health Nursing School provided services on incentive of Rs 1,000 / month. Thus, CMWs were trained without professional tutors during the period 2012 to 2015.

5. All Rural health centers shall be strengthened to provide 24/7 basic EmONC services, for this purpose there is already a complement of staff available at the RHC and this will be supplemented to enable service provision for 24 hours through existing posts in the health system. The proposal is to place an additional WMO and LHV at these health facilities to improve the availability of staff and allow for 24 hours coverage for basic EmONC. (As per PC-1 Page 39)

Four RHCs (out of nine as per table A below) were those which were working without services of additional WMOs / LHVs. While as per table – B, it was observed that during 2011-12 to 2013-14, out of nine

sanctioned posts six posts of WMOs during 2011-12, eight posts during 2012-14 respectively remained vacant in concerned RHCs. No efforts were made to appoint the WMO's at said RHCs. The health facilities could not be improved at these hospitals which effected the objectives of program. Management replied that WMOs were recruited but they left the job due to non-attractive package.





Lack of Human Resources

Table-A

Name of RHC	Post	Vacant Period
RHC Tibi Qasrani	WMO	05 years (01.07.2008 to 12.09.14)
RHC Sarwar Wali	WMO	02 years (18.09.2012 to 13.09.14)
RHC Barthi	WMO	06 years (July 2009 to June 15)
RHC Barthi	LHV	03 years (29.07.2011 to 30.06.14)
RHC Vahova	WMO	06 years (July 2009 to June 15)
RHC Vahova	LHV	04 years (23.08.2010 to 30.06.14)

Table-B

Year	Lady Health Visitors			Women Medical Officers			Total Reporting MWs (in union councils)
	Sanction	Filled	Vacant	Sanction	Filled	Vacant	
2007-08	9	0	9	9	0	9	0
2008-09	9	9	0	9	9	0	0
2009-10	9	9	0	9	7	2	0
2010-11	9	9	0	9	6	3	108
2011-12	9	8	1	9	3	6	123
2012-13	9	8	1	9	1	8	89
2013-14	9	7	2	9	1	8	74
2014-15	9	9	0	9	6	3	60

6. Under this program (As per PC-1 Page 50-52) it was proposed to train all health facility workers at MNCH centers, BHU, RHC, THQ and DHQ hospital in IMNCI. Training module of the CMWs was designed to promote the knowledge and skills of the CMW to cater for normal deliveries. Similarly Emergency Obstetric and Newborn Care (EmONC) and Integrated Management of Newborn & Childhood Illness (IMNCI) trainings were essential for Women Medical Officers and Lady Health Visitors.

   Detailed below table showed that CMWs / LHWs were not provided essential trainings / refresher courses. The funds provided for trainings

during 2013-14 and 2014-15 (Rs 695,000, Rs 565,000) remained unutilized. It could not be ensured that facility was providing "comprehensive EmONC", "basic EmONC" or "preventive services" Management replied that necessary trainings were conducted.

Sr. No.	Subject	Year 2013-14	Year 2014-15
1	Training of CMW'S for IMNCI Services	0	0
2	Training courses / refresher courses of CMW'S planned	0	0
3	No. of competency based trainings to Midwifes and LHWs	0	0
4	Training of teachers on MCH issues	0	0

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

It was observed that during the years 2009-10 to 2014-15 funds to the tune of Rs 1,940,000 (as detailed below) were allocated for launching of public awareness campaign on MNCH and trainings. In-spite of the availability of funds neither any campaign for public awareness about the MNCH services was launched, nor any material, relating to information of availability of skilled birth attendants in the catchment areas, was displayed in the health facilities for the guidance of beneficiaries. Management replied that awareness programs were conducted but payments were not drawn.

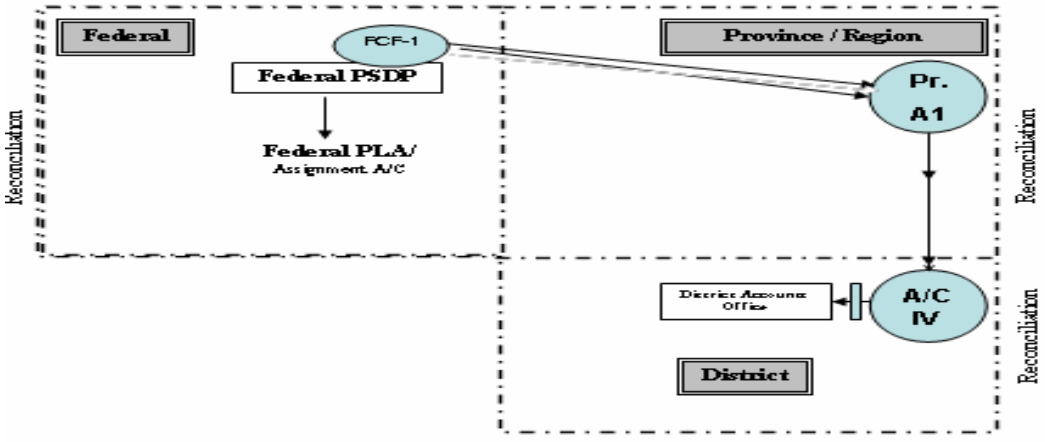
(Amount in Rupees)

Year	Seminars	Trainings	Total
2009-10	60,000	-	60,000
2011-12	80,000	-	80,000
2012-13	180,000	-	180,000
2013-14	180,000	695,000	875,000
2014-15	180,000	565,000	745,000
Total	**680,000**	**1,260,000**	**1,940,000**

B- Financial Management

During special study following issues were noticed:

1. Funds for construction of community midwifery school, renovation at DHQ / THQ Hospitals and payment of stipend were being regularly released by the Provincial Program Coordinator National MNCH Program Punjab, Lahore as tied grant to the District Government D.G. Khan. The flow chart (As per PC-1 Page 94) of funds is as under:



It was noticed that Provincial Govt. provided funds through A/C-IV for further release to the DDO of MNCH Program. The funds were not released well in time by the District Government Dera Ghazi Khan due to which the program activities were badly affected. It resulted in non-completion of civil works and delayed payment of stipend etc. Management replied that the funds from the Account IV were released to the Program Coordinator as per his demands.

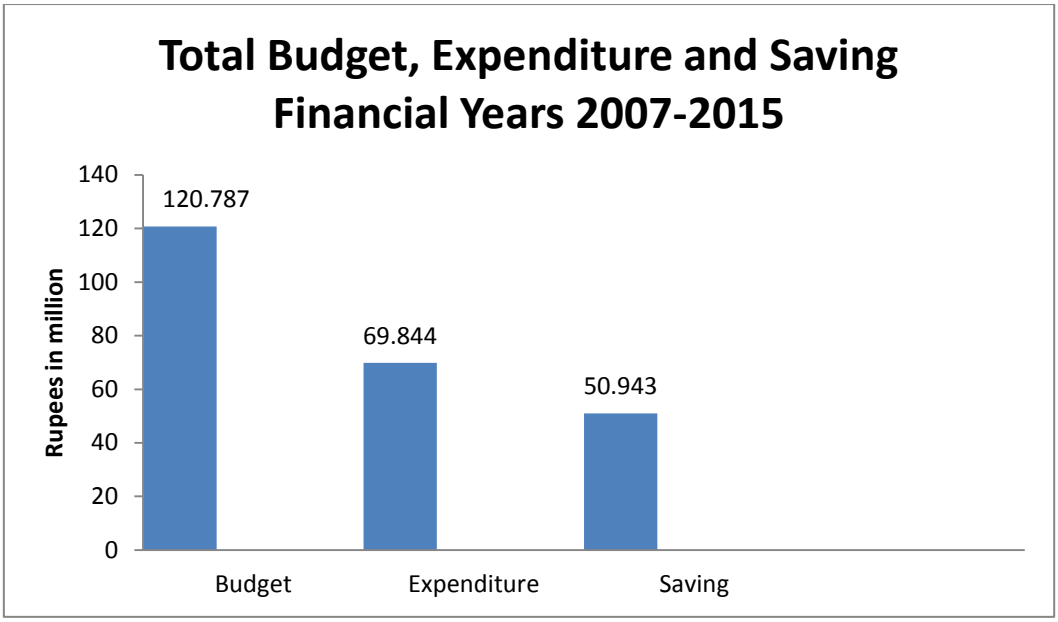
(Amount in Rupees)

Date of Fund Released By Finance Department	Date of Fund Released By Dist. Government	Amount
07.12.2007	02.06.2008	813,000
27.08.2009	25.10.2009	3,697,000
20.04.2009	06.03.2010	7,979,000
27.08.2009	11.12.2009	4,750,000
16.03.2010	19.04.2010	970,000

Date of Fund Released By Finance Department	Date of Fund Released By Dist. Government	Amount
20.08.2010	12.10.2010	1,340,000
01.02.2011	08.04.2011	1,000,000
31.05.2011	17.06.2011	9,770,000
28.10.2011	15.12.2011	1,000,000
03.05.2012	23.06.2012	13,469,000
20.10.2012	28.11.2012	11,854,000
16.01.2013	02.05.2013	4,650,000
28.08.2013	28.10.2013	6,443,000
Total		**67,735,000**

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

During Special Study of National MNCH Program Dera Ghazi Khan it was observed that budget of Rs 120.787 million was released to EDO (Health) Dera Ghazi Khan during the financial years 2007-08 to 2014-2015. An amount of Rs 69.844 million (up to June 2015) was utilized under this program and Rs 50.943 million remained un-utilized. Resultantly some major activities of the program were not performed for which the budget was allocated.



(Amount in Rupees)

Year	Budget			Transferred from previous year	Expenditure			Excess / Savings
	Salary	Non Salary	Total		Salary	Non Salary	Total	
2007-08	783,660	29,840	813,500	0	63,981	0	63,981	749,519
2008-09	8,105,000	3,571,000	11,676,000	749,519	2,446,921	3,443,716	5,890,637	5,785,363
2009-10	10,523,370	1,605,000	12,128,370	5,785,363	8,156,781	560,947	8,717,728	3,410,642
2010-11	11,951,000	456,000	12,407,000	3,410,642	8,969,096	312,000	9,281,096	3,125,904
2011-12	16,656,000	12,029,000	28,685,000	3,128,904	8,157,875	11,981,000	20,138,875	8,546,125
2012-13	20,490,701	572,000	21,062,701	8,546,125	7,952,884	725,000	8,677,884	12,384,817
2013-14	17,571,817	1,256,000	18,827,817	12,384,817	8,607,698	875,629	9,483,327	9,344,490
2014-15	6,616,012	8,571,256	15,187,268	9,344,490	3,237,614	4,353,279	7,590,893	7,596,375
Total	**92,697,560**	**28,090,096**	**120,787,656**	**43,349,860**	**47,592,850**	**22,251,571**	**69,844,421**	**50,943,235**

3. According to PC-I (Page 37) of the National MNCH Program, "All the DHQ hospitals will be provided with funds for repair and maintenance. The amount has been estimated at an average cost of Rs 1.2 million per DHQ Rs 1 million per THQ providing Comprehensive EmONC services".

It was observed that DHQ / THQ was not upgraded and renovated. Neither well baby clinics were established nor labor rooms were got repaired up to June 2011. Program objectives / targets to be achieved by

the end of 2nd and 3rd year, could not be achieved in spite of the availability of funds for repair.

4. According to PC-I (page 65) of National MNCH program, "As the institutional training will be residential in nature, the schools will be provided funds of Rs 6.2 million for constructions of hostels for 35 students.

It was noticed from scrutiny of record that school and hostel building for CMW students was required to be started during 2007-08, while the work was awarded by W&S department on 18.07.2012 with estimated cost of Rs 9.918 million. The date of completion was 17.04.2013 whereas it was completed during June 2014 which resulted in cost overrun of Rs 3.450 million as detailed below:

Name of Work	Date of Start	Date of Completion	Cost	Up dated status
Construction of CMW school/hostel	18.07.2012	17.04.2013	Rs 9,739,295 9th Running bill dated 24.06.14	The work completed at the end of Year 2014.

5. In the PC-I (page 30 table 3) of the Program funds amounting to Rs 3.550 million for purchase of three vehicles for the district (two for CMW School and one for District MNCH Cell) were allocated.

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

(Rupees in Million)

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

Details given in the above table show that despite procurement of two instead of three vehicles, an excess expenditure amounting to Rs 0.720

million, over and above the allocation for the district, was incurred. Cost overrun in this component is calculated as under:

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

Delayed procurement and excess engine capacity/ luxurious vehicles resulted in extra burden on the National MNCH Program as well as low standard monitoring and supervision activity. Management replied that said vehicles were purchased by the Provincial Government.

C- Health Related Issues

During special study following Health related issues were noticed:

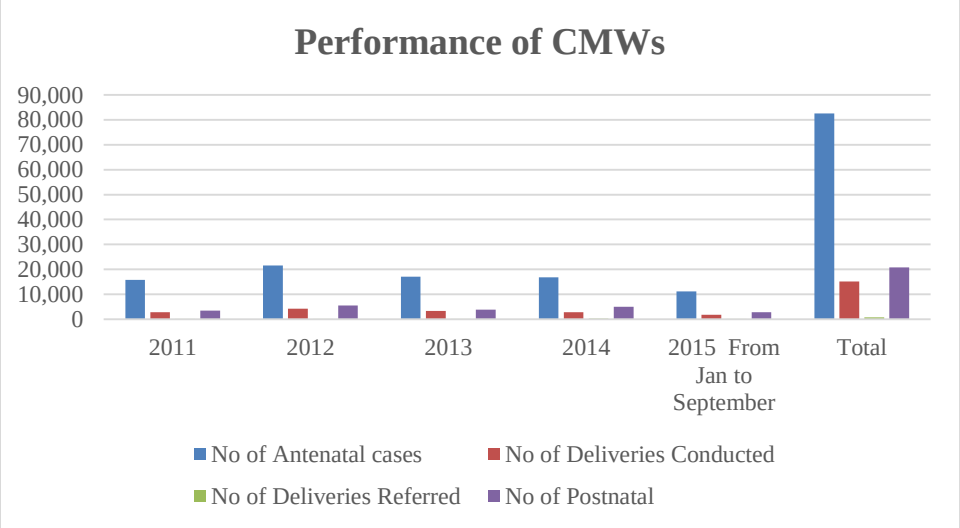
1. According to PC-I, "Once qualified and registered with the Nursing Examination Boards, midwives shall be facilitated to establish safe delivery practices in the community to provide antenatal and post natal checkups, birth preparedness counseling, Family Planning Advice, and providing safe delivery".(logistics from the program through the DPIU list of equipment's as per table 29 proposed CMW Kit as per PC-1 Page 60,141)

   During Special Study of National MNCH Program (2009 to 2015) it was noticed from the monthly reports of CMWs (selected) that CMWs did not utilize the Safe Delivery Kits during deliveries. Safe delivery kits were provided to all CMWs to avoid complications during delivery and safe delivery the same were not utilized in spite of stock provided to them for the said purpose. Further, it was observed that most of equipment's / medicines were not issued to CMWs (as per table 29) due to which quality services were not provided by the CMWs. Management replied that safe delivery kits and medicines were provided to CMWs.

2. Once CMWs are in field and providing services, one of the main hurdles is to transport the complicated patient to the appropriate level of care. In order to encourage the CMWs for referrals of complicated cases, MS / DMS of the hospital shall certify the CMW referral slip and these will then be submitted to the EDO(H) for payment of the delivery fees of the CMWs i-e Rs 150 (As per PC-1 Page 71-72)

   CMW's monthly reports showed that detailed below complicated cases were referred to the nearest health facilities. Scrutiny of record revealed that no payment was made against reimbursement of referring cases. It shows the data regarding number of refer cases was either fictitious and complicated cases were not actually referred or CMWs were not encouraged in shape of reimbursement of referral cases. Management

replied that CMWs did not provide certified referral slips so no payment was made.



(Amount in Rupees)

Year	No. of Antenatal cases	No. of Deliveries Conducted	No. of Deliveries Referred	No. of Postnatal	Referral Fee
2011	15,863	2,894	126	3,476	18,900
2012	21,595	4,222	134	5,548	20,100
2013	17,062	3,404	126	3,938	18,900
2014	16,848	2,899	346	4,976	51,900
2015 From Jan to September	11,192	1,795	111	2,897	16,650
Total	**82,560**	**15,214**	**843**	**20,835**	126,450
% age of Total		**20.94**	**1.16**	**28.18**	

3. As per PC-I (page 90) of the program, to ensure sustainability of the inputs, the procurement of essential drugs for IMNCI will be made at the district level from the regular health Budget as well as from provincial level.

As per record it was observed that the medicines and supplies including small equipment were not supplied to CMWs during the period 2009 to 2014. After 2014, 50% of 48 essential medicines were supplied to CMWs (as per proforma filled by CMWs). Similarly following

important equipment were also not provided to CMWs. Due to non availability of medicines / equipment, free EmONC for the poorest segment of population was not ensured. Management replied that whenever any medicine was provided it was disbursed immediately to CMWs.

List of Equipment's Not Provided to CMW's	
Office Table	Nail Brush
Office Chair	Screen
Client Stool	Baby Bulb Sucker
Examination Couch	Fetoscope
Delivery Table	BP Apparatus
Examination Lamp	Thermometer

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

It was observed, during the field visit of RHC Qadir Abad that concerned RHC was not provided generator facilities to cope up with load shedding problems whereas RHC Barthi was working without electricity since its establishment due to which sterilization of the instruments, used in the deliveries, could not be carried out. The generator was also not being utilized. The laboratory of the hospital was also not functional due to non-availability of electricity required for its operations. The health facility was also out of stock of necessary equipment's like safe delivery kits and necessary medicines. Deliveries were being conducted in unsafe and infectious environment. Management replied that RHC Barthi is without electricity due to non availability of electricity in whole UC. Now solar system has been installed. At RHC Qadir Abad small generator is available for

providing electricity. But no documentary evidence was provided in support of availability of solar system and small generator.

5. According to PC-1 Page 89, Districts will be encouraged to involve the private sector for improving access and availability of services. Efforts will be made by the District Government authorities to ensure that people get value for their money. Private clinics will be franchised under national MNCH Program.

   For developing Public-Private partnership in order to improve / ensure MNCH services, local NGOs and private sectors were not selected. There was no involvement of the private sector to impart training to CMWs as it required special agreement (a formal Service Agreement) between the selected private hospitals and the District Government. Similarly no advocacy committee was formed and functional. Management replied that maximum efforts were made to ensure that people may get value for their money.

D- Monitoring, Evaluation and Internal Controls

During special study following weaknesses of Internal Controls were noticed:

1. According to PC-I (page 44), certification that the facility is providing "comprehensive EmONC", "basic EmONC" or "preventive services" shall be done by a committee. An external firm which is accredited with the ISO shall be given the task to undertake evaluation of the management and environmental standards of the health facilities. The committee would visit the concerned health facility and record their observations in a meeting register, copies of which shall be kept at the district health office and the concerned facility, information will also be sent to the Provincial MNCH Cells / Directorates and Federal MNCH PIU. The certification would automatically expire at the end of one year and will have to be renewed by the committee in order to disburse the incentives. The certification could be revoked at any time upon non-performance.

   The certification committee was not constituted for certification and it was not ascertained whether the facility was providing "comprehensive EmONC", "basic EmONC" or "preventive services". Management replied that the third party evaluation is for monitoring and evaluation of all services of health i-e preventive or curative.

2. It is assumed that BHUs are being strengthened under respective health sector reforms in the district which are already scaling up MNCH activities. BHUs are expected to be equipped to provide preventive obstetric care services. These BHUs can be linked with the CMWs and LHWs to promote institutional based deliveries. (As per PC-1 Page 40).

   As per record it was observed that monitoring and evaluation reports regarding MNCH services at BHU level were not available in the office nor these reports were entered in MIS (Management Information System) The data regarding MNCH services at BHUs i-e preventive obstetric care services was not available at MNCH cell DG Khan. The health facilities could not be improved at these health units which effected the objectives of program. Management replied that MNCH

activities and services are being provided at BHUs by the Health Department. Due to unavailability of sanctioned posts of LHVs at BHUs, data could not be collected and incorporated in MIS.

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

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

The vehicle provided for CMWs visits to practical training sites and monitoring / supervisory visits by the CMW tutors to CMW clinics was used for the period 2009 to 2012. After 2012 no visit was shown on the log book. It was stated that vehicle was not used because driver resigned from service during 2012. Due to this most important function of monitoring and clinical supervision was entirely ignored.

- The said vehicle was also used for some other purposes during the period 2009 to 2012. Due to which the most important function of monitoring and clinical supervision was entirely ignored. Constraints in the logistic system usually disrupt field operation particularly those related with supervision.

Date	Nature of visit	Distance covered (KM)	POL Consumed (Liters)
6.10.09	Attend the meeting regional MNCH	215	31
Nill	Attend the Oath taking ceremony	220	31
29.4.10	Director HQ meeting	480	69
1.05.10	Back to D.G.Khan	480	69
12.05.10	Director General Meeting Lahore	480	69
14.5.10	Back to D.G.Khan	480	69
28.5.10	Examination Duty at Multan	220	31
30.5.10	Viva Examination duty Lahore	480	69
01.06.10	Back to D.G.Khan	480	69
24.10.10	Flood relief Camp	270	39
6.12.10	Attend the office of Secretary Health	480	69
7.12.10	Back to D.G.Khan	480	69
20.12.10	MNCH seminar at Lahore	480	69
22.22.10	Back to D.G.Khan	480	69
15.01.10	Prime Minister Security Officer to Drop at Dawoo Multan	200	29
24.6.10	Monthly review meeting Lahore	480	69
26.6.10	Back to D.G.Khan	480	69
11.6.10	PHNS to Forensic Lab Lahore an Back	1000	143
10.8.12	Attending meeting National program Bhor Ban and back	1560	223
	Total	**9445**	**1,349**

- The vehicle provided for CMWs visits was misused by making wrong calculation of distance from Nursing School to DHQ Hospital. Actual distance from School to DHQ was ½ km while it was recorded 10 times more than the actual as per detail. Resultantly, vehicle was misused and kilometers were covered by making wrong calculation of distance. Management replied that various visits were made at DHQ during a single day.

Year	No. of Visits shown (KM covered per visit)	Distance Covered (45km/visit)	Maximum Actual Distance covered on said visits	Excessive POL consumed (Liters approx.)	Excessive POL consumed (Liters approx.)
2009-10	70 (30 KM/Visit)	2,100	210	300	270
2010-11	55 (50 km/visit)	2,750	275	393	354
2011-12	70 (50 km/visit)	3,500	350	500	450
2012-13	30 (50 km / visit)	1,500	150	214	193
Total		**9,850**	**985**	**1,407**	**1,266**

4. In light of PC-1 Page 36, Key indicators of health sector to achieve the millennium development goals could not be followed due to which these goals remained unachieved.

As per questionnaire filled by management of MNCH Cell (Annex-1) key indicators of health sector to achieve the millennium development goals could not be followed due to which these goals remained unachieved. Due to poor performance of the department the program objectives were not achieved till F.Y.2015. As per MICS of Punjab key finding December 2015, the program indicators depicted poor picture at the provincial level. Management replied that maximum efforts were made to achieve the said targets. Detailed below table shows the progress of last three years.

Sr. No.	Subject	Year 2013	Year 2014	Year 2015
1	Number of RHC's Upgraded / Renovated	0	0	0
2	%age of BHU'S where LHV / Midwife Residences renovated	0	0	0
3	No. of Health Facilities (BHU's) strengthened (adequate, regular supply of medicine and equipment) to provide basic EmoNC SERVICES	0	0	0
4	No. of Health Facilities (RHC's) strengthened (adequate, regular supply of medicine and equipment) to provide basic EmoNC SERVICES	8	8	8
5	No. of Health Facilities (BHU's) with well baby clinic established	0	0	0
6	No. of Health Facilities (RHC's) with well baby clinic established	4	4	8
7	Conditional cash transfer for intuitional deliveries	0	0	0
8	Incentive Package for women health care providers	0	0	0

Multiple Indicator Cluster Survey (MICS) Punjab Key Findings December 2015 (By unicef)

Area	At the time of PC-I (F.Y. 2004)	Target 2015	As per MICS 2015
Under 5 mortality rate	105(2001)	65/1000 L/B	93/1000 L/B
New born mortality rate	77/1000 L/B	40/1000 L/B	Not Available
Infant Mortality Rate	81/1000(**RAF)	55/1000 L/B	75/1000 L/B
Maternal Mortality Rate	300/100000 L/B	200/100000 L/B	Not Available
To increase Contraceptive Prevalence Rate	36%	55%	39%
Attendance at home by SBA	30%	90%	61%

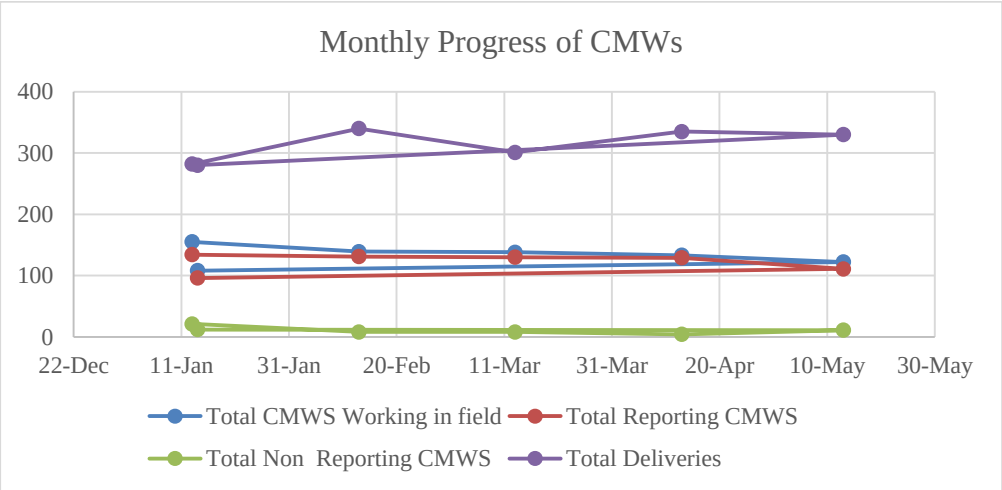
5. The EDO (H) Dera Ghazi Khan vide his letter No 14784-85/MNCH dated 28.11.2011(Also as per job description of CMW) deployed CMWs in their catchment areas with the instructions to provide antenatal, natal, postnatal services, and keep record of all activities. CMW will submit monthly report to District MCH Cell duly verified by LHS of her area. CMW will mark attendance on every Monday of every weak in the health facility and will be paid Rs 2,000 per month as remuneration.

   It was noticed from record including monthly reports, daily registers of CMWs, correspondence files etc. CMWs (list attached at Annex-2) did not submit their monthly reports. It clearly showed that concerned CMWs did not work during specified period. In spite of this they were paid monthly remuneration due to which Government sustained loss. Management replied that reports of CMWs were not incorporated in MIS.

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

   It was noticed from scrutiny of record like, monthly reports, daily registers of CMWs, correspondence files etc. that various CMWs submitted their monthly reports below the targets. Detailed below table shows that in most of the month average deliveries conducted by each

CMW was below 3. It clearly showed that those CMWs were not being monitored regularly.



Month	Total CMWS Working in field	Total Reporting CMWS	Total Non Reporting CMWS	Total No. of Deliveries	Average Deliveries / CMW
13-Jan	155	134	21	282	2.10
13-Feb	139	131	8	340	2.60
13-Mar	138	130	8	301	2.32
13-Apr	133	129	4	335	2.60
13-May	122	111	11	330	2.97
14-Jan	108	96	12	280	2.92
Total	**795**	**731**	**64**	**1,868**	**1.7**

7. As per PC-1 Page 46, The MS with EDO (H) shall prepare plans for provision of EmoNC services for comprehensive or basic services.

During Special Study of National MNCH Program (2009-15) it was noticed from scrutiny of record consisting of monthly reports, correspondence files etc. that performance of WMOs / LHVs of RHC Sarwarwali, RHC Qadirabad and RHC Barthi was very poor. In most of the months no deliveries were conducted while rest of months showed very small number of deliveries. It proves poor performance as well as weak monitoring of the said RHCs. (Annex-3) Management replied that deliveries in RHCs were conducted regularly. There may be fault in the reporting system.

Key Project Constraints

The cornerstone of this program is the availability of residential CMWs in the rural areas which depended on the proper selection of site by the selection committee. In order to obtain maximum benefits from the resources available within the district, it is proposed that the district management be fully involved in the program. Five batches of trained CMWs have been deployed in their catchment areas to deliver the services as Skilled Birth Attendants (SBAs) in replacement of Traditional Birth Attendants (TBAs), but up to 2014 not a single CMW has been provided with MNCH related medicines. During six months practical training in health facilities they could not complete their tasks to conduct independent deliveries. Total 231 CMWs were deployed in the community but they were not provided with delivery tables. As far as the program vehicle is concerned the same was not used for program activities.

Time and cost overrun

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

Cost overrun is also noticed as detailed below:

- Budget was released in the financial year 2007-08 against the allocation for the year 2006-07 for stipend to CMWs students only. Funds for all other activities of the program were ignored.
- Inflated cost for late procurement of vehicles as those were to be procured in the year 2006-07 and 2007-08 but procured on 30.06.2009.
- Funds amounting to Rs 50.943 million were not utilized for program activities.
- Supply of Safe Delivery Kits to health facilities & CMWs was not proportionate to the utilization.

Sustainability

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

Lessons Learnt

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

Overall Assessment

- **Relevance**

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

- **Efficacy**

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

- **Economy**

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

- **Efficiency**

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

- **Effectiveness**

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

- **Ethics**

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

- **Environment**

  Although the program had a minimal environmental impact, no attention was paid towards provision of incinerators at hospital levels for disposal of delivery wastes. Further the CMWs/ LHVs were also not properly equipped for wastes of home based deliveries. So the environmental factor had been neglected in the program.

- **Performance Rating of the Program**

  Moderately satisfactory

Possibilities and opportunities for scaling up / Options

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

i. Timely Release and proper utilization of funds.

ii. Proper monitoring & supervision in the field.

iii. Transparent administrative and financial discipline.

iv. Mechanism for gathering and compilation of data regarding achievement of objectives.

v. Timely completion of program activities.

vi. Consistency in program activities.

vii. Completion &utilization of CMW School and Hostel.

viii. Supply of MNCH related medicines to health facilities & deployed CMWs.

ix. Intensive training programs for the MNCH related staff.

Conclusion

Economic, management slackness, poor monitoring whatever may be the reasons the program is incomplete. There are certain deficiencies in supply and disbursement of medicine, equipment & machinery. Delayed and inadequate supply of equipment to the deployed CMWs, non-utilization of budget for construction of training center and public awareness campaigns, deployment of CMWs in the areas adjacent to health facilities instead of underserved areas are some of the reasons due to which the program activities suffered. Major portion of the civil work and repair & maintenance has also not been completed in spite of the availability of funds. Non-constitution of certification committees for proper monitoring and evaluation of services provided by the health facilities also contributed in non-achievement of objectives set in the PC-I. Non-availability of data regarding achievement of Program objectives is also a major

impediment to evaluate the effectiveness of the Program. Third party evaluation of the Program was also a must which was not carried out. Although, the program could not achieve all of its objectives, yet its management has learnt a lot of lessons. It has generated a thought process among the MNCH program management. The lessons learnt would improve the results of upcoming programs.

Recommendations

- CMWs should be selected from and deployed in the villages where there was no public health facility.
- The staff should not be hired without requirement or long before the commencement of construction of the capital component.
- Midwifery Tutors should be hired to strengthen the capacity of CMW school to impart midwifery training.
- All rural health centers should be strengthened to improve the availability of WMOs / LHVs.
- Trainings should be conducted regularly to train health facility workers.
- Proper awareness campaign may be launched for the knowledge and facility of the public.
- Separate SDA Account should be opened for National MNCH Program district Dera Ghazi Khan and funds should be directly released in that account instead of releasing them in A/C-IV as tied grant.
- All Funds released should be utilized properly to achieved the goals as required in PC-I.
- Use of safe delivery kit (fully equipped) must be ensured.
- System of reimbursement of referral charges should be developed to encourage the CMWs.
- Necessary equipment and medicines be provided to the CMWs for safe deliveries.
- It must be ensured that deliveries should be attended after proper sterilization of the instruments so that the spread of infectious diseases may be avoided in mothers and newly born children.
- Private sector should be involved for improving access and availability of service.

- Certification committee should be constituted to undertake the evaluation of management. .
- Department should use the vehicle only for the purpose of monitoring, supervision and transportation of CMWs for hands on practical training to increase the service quality of health providers.
- Efforts should be made at all levels of Government Health Facilities to achieve the millennium development goals.

Project Photo Gallery










Acknowledgement

We wish to express our appreciation to the management and staff of National MNCH Program Dera Ghazi Khan for the assistance and cooperation extended to the auditors during this assignment.

Annexes

Annex-1

QUESTIONNAIRES

QUESTIONNAIRE TO ASSESS MNCH SERVICES

Millennium Development Goals for development of a better world by year 2015 aims towards improved health of mothers and children under five. This requires a series of proven, cost effective measures for provision of maternal, neonatal and child health services in the communities on equity basis. You are kindly requested to provide the following information in order to assess the status of MNCH services in your area.

1. Basic Information
   - Respondent's name Dr. Muhammad [illegible]
   - Designation [illegible]
   - Contact details: Tel No. 06447672 [illegible] Email address [illegible] yahoo.com
   - Province [illegible]
2. Physical Infrastructure, Transport, Supplies and Equipments
   - Number of current health facilities in the area and plans for expansion till 2015

	Current	2013	2014	2015
BHUs	57		57	57
RHCs	9		10	10
THQs	1		1	1
DHQs	1		1	1

   - Number of RHCs which have been upgraded/renovated and yearly plan for up-gradation/renovation of remaining RHCs until 2015.

Current	2013	2014	2015
—	—	—	—

   - Percentage of BHUs where LHV/Midwife residencies have been renovated and yearly plan for renovation of remaining BHUs until 2015.

Current	2013	2014	2015

   - Number of health facilities with ambulance service.

	Current	2013	2014	2015
THQs	1	1	1	
DHQs	1	1	1	

   - Number of health facilities, which have been strengthened (adequate, regular supplies of medicine and equipments, well trained staff), to provide *Basic* EmONC services and future expansion plan.

	Current	2013	2014	2015
BHUs		—	—	—
RHCs	10	8	8	8

   - Number of health facilities which are fully equipped to provide Comprehensive EmONC services and future plans.

Current	2013	2014	2015

1

- THQs 1 1 1
- DHQs 1 1 1

- Number of health facilities in which Provision ... and future plans

	Current	2013	2014
THQ	1	1	1
DHQ	1	1	1

- Number of health facilities in which Well Baby Clinics have ... and future plans

	Current	2013	2014	
DHQ	1	1	1	1
THQ	1	1	1	1
RHCs		4	4	8
BHUs				

3. **Training and Development of Service Providers.**
   - Number of training courses planned in the next three years for CMWs on midwifery skills

	2013	2014	2015
Basic	2	2	2
Refresher	1	1	1

   - Number of trainings planned for health personnel for IMCI services

		Current	2013	2014	2015
Doctors:	F	16	51	62	68
	M	10	19	23	29
Nurses		6	17	21	25
LHVs		21	52	47	
FWWs		5	5	6	3
Community Midwives					
LHWs		961	1054	1164	

   - Number of training courses planned for Comprehensive Family Planning services.

		Current	2013	2014	2015
Doctors	F	16	51	62	68
	M	10	19	23	29
Nurses		6	17	21	25
LHVs		21	52	47	51
Midwife		5	6	6	7
LHWs		961	1164	1164	1164

   - Number of Competency-Based training courses planned for service providers for EmONC services.

		Current	2013	2014	2015
Doctors	F	21	33	52	64
	M	9	18	21	32
Nurses		6	13	17	21
LHVs		18	51	51	51

- Midwife
- LHWs

- Number of training courses planned for service providers for [illegible]
  Exclusive Breast feeding and Complementary feeding

	Current	2013	2014	2015
LHVs	2	2	2	3
Midwife	1	1	1	2
LHWs	1	1	1	1

- Number of training courses planned for service providers on management of severe malnutrition and minerals and micronutrient supplementation.

	Current	2013	2014	2015
LHVs	1	1	1	1
Midwife	1	1	1	1

4. **Collaboration with other sectors**
   - Education

	Current	2013	2014	2015
Workshops to include MCH issues in curricula	—	1	1	1
Training of teachers on MCH issues	-	-	-	-
Health Education Sessions in Schools	4	5	5	5

5. **Advocacy**

	Current	2013	2014	2015
IEC activities for demand creation of MNCH services	2	4	4	4
Sensitization of journalists, Parliamentarians on MCH issues	1	1	1	1

6. **Incentive Approaches planned**

	Current	2013	2014	2015
Conditional Cash transfer for institutional deliveries	—	—	—	—
Incentive packages for women health care providers	-	—	—	—

7. **Any other activity that you have planned for the next three years (2013-15) related to MNCH services, but has not been included in this questionnaire, may also please be mentioned**

Capacity building and refresher trainings

Thank You

Annex-2

Monitoring, Evaluation and Internal Controls

Non Reporting CMWs

Month	Total CMWS Working in field	Total Reporting CMWS	Total Non Reporting CMWS	Total Deliveries	Average Deliveries / CMW	%age of Non Reporting CMWS	Loss of Remuneration (Rupees)
13-Jan	155	134	21	282	2.10	13.55	42,000
13-Feb	139	131	8	340	2.60	5.76	16,000
13-Mar	138	130	8	301	2.32	5.80	16,000
13-Apr	133	129	4	335	2.60	3.01	8,000
13-May	122	111	11	330	2.97	9.02	22,000
13-Jun	111	100	11	337	3.37	9.91	22,000
13-Jul	105	93	12	316	3.40	11.43	24,000
13-Aug	100	92	8	332	3.61	8.00	16,000
13-Sep	99	85	14	289	3.40	14.14	28,000
13-Oct	99	85	14	333	3.92	14.14	28,000
13-Nov	99	90	9	325	3.61	9.09	18,000
13-Dec	109	87	22	381	4.38	20.18	44,000
14-Jan	108	96	12	280	2.92	11.11	24,000
14-Feb	105	96	9	458	4.77	8.57	18,000
14-Mar	104	97	7	434	4.47	6.73	14,000
14-Apr	103	96	7	492	5.13	6.80	14,000
14-May	102	92	10	477	5.18	9.80	20,000
14-Jun	101	92	9	522	5.67	8.91	18,000
14-Jul	98	82	16	431	5.26	16.33	32,000
14-Aug	98	80	18	415	5.19	18.37	36,000
14-Sep	98	80	18	429	5.36	18.37	36,000
14-Oct	98	74	24	417	5.64	24.49	48,000
14-Nov	67	59	8	336	5.69	11.94	16,000
14-Dec	61	54	7	277	5.13	11.48	14,000
15-Jan	62	57	5	275	4.82	8.06	10,000
15-Feb	51	44	7	233	5.30	13.73	14,000
15-Mar	62	56	6	190	3.39	9.68	12,000
15-Apr	62	53	9	166	3.13	14.52	18,000
15-May	63	57	6	180	3.16	9.52	12,000
15-Jun	66	63	3	192	3.05	4.55	6,000
15-Jul	64	59	5	185	3.14	7.81	10,000
15-Aug	66	56	10	188	3.36	15.15	20,000
Total	**3,048**	**2,710**	**338**	**10,478**	**3.87**	**11.09**	**676,000**

Annex-3

Weak monitoring of RHCs, Poor Performance of WMOs / LHVs

Month	RHC Sarwar Wali	RHC Qadir Abad	RHC Barthi
9-Jan	0	0	0
9-Feb	0	0	0
9-Mar	0	0	0
9-Apr	0	0	0
9-May	0	0	0
9-Jun	0	0	0
9-Jul	0	0	0
9-Aug	0	0	0
9-Sep	0	0	0
9-Oct	0	0	0
9-Nov	0	11	0
9-Dec	0	11	0
10-Jan	0	14	0
10-Feb	3	0	0
10-Mar	5	0	0
10-Apr	8	0	0
10-May	11	0	0
10-Jun	17	0	0
10-Jul	0	0	0
10-Aug	12	0	0
10-Sep	0	0	0
10-Nov	16	0	0
10-Dec	0	0	0
11-Jan	0	0	0
11-Apr	0	0	6
11-May	0	5	0
11-Jun	0	0	0
11-Jul	0	0	0
11-Aug	0	0	0
11-Oct	0	0	6
11-Nov	0	16	0
11-Dec	0	0	0
12-Jan	0	0	6
12-Feb	0	0	2
12-Mar	0	0	6
12-Apr	0	0	0
12-May	0	0	0
12-Jun	0	0	0
12-Jul	0	0	0

Month	RHC Sarwar Wali	RHC Qadir Abad	RHC Barthi
12-Aug	0	0	0
12-Sep	0	19	0
12-Oct	0	13	0
12-Nov	0	12	0
12-Dec	19	0	0
13-Jan	13	18	10
13-Feb	15	14	16
13-Mar	17	12	12
13-Apr	14	0	14
13-May	16	13	10
13-Jun	0	17	12
13-Jul	0	17	16
13-Aug	0	18	0
13-Sep	0	17	0
13-Oct	0	16	6
13-Nov	0	16	10
13-Dec	0	0	6
14-Jan	0	17	0
14-Feb	0	16	4
14-Mar	0	18	6
14-Apr	18	16	4
14-May	0	0	4
14-Jun	0	13	0
14-Jul	0	11	4
14-Aug	0	14	6
14-Sep	0	13	8
14-Oct	0	14	8
14-Nov	0	10	12
14-Dec	0	13	0
15-Jan	0	14	0
15-Feb	0	13	0
15-Mar	16	13	0
15-Apr	0	15	0
15-May	0	12	0
15-Jun	0	12	0
Total	**200**	**493**	**194**