CHAPTER 2: PLANNING AND MONITORING OF THE MISSION

2. Planning and monitoring of the Mission

NRHM strives for decentralized planning. The District Health Societies (DHSs) were required to prepare perspective plans for the entire Mission period as well as annual plans consisting of all the components of the Mission. These were to be integrated into the State perspective plan and annual State Programme Implementation Plan (PIP) respectively. The NRHM focused on the village as an important unit for planning. However, realising the requirement of extensive capacity building to make villages capable of taking up a planning exercise, the Mission did not insist on village level plans for the first two years of its existence. Thus, Block Health Action Plans were to form the basis of the District Health Action Plan. Simultaneously, the Mission envisaged an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring.

2.1 District Health Society (DHS) and District Health Mission (DHM)

The NRHM aimed to ensure that need based and community owned District Health Action Plans (DHAP) become the basis for further interventions. The DHAP was to be prepared by the DHS and approved by the DHM. A DHS was to be constituted in each district by amalgamating all existing district level societies engaged in implementing national level health and family welfare programmes. The governing and executive bodies of the DHS were to meet at least twice a year and once a month respectively.

We observed that a DHM had been constituted in all districts of 18 States/UTs[3] and a DHS had been formed in districts of all States/UTs other than Jharkhand[4], Orissa and Puducherry[5] and uni-district UTs. The DHM had not been constituted in any district of Andhra Pradesh, Bihar, Delhi, Jharkhand, Madhya Pradesh, Mizoram and Uttar Pradesh. This meant that decentralised planning, as envisaged in the Mission, was yet to be achieved in these States.

The two bodies of the DHS met at the prescribed frequency only in Andhra Pradesh. The meetings of the DHS's governing and executive bodies were never held in any district of Himachal Pradesh and Puducherry. In Bihar, Manipur and Punjab the governing body had never met. In the remaining States, the meetings of these two bodies did take place intermittently and frequency was much less than prescribed. In Jammu & Kashmir, the governing and executive bodies of the DHS were not constituted separately.

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[3] A & N Islands, Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Meghalaya, Punjab, Rajasthan, Sikkim, Uttarakhand, Karnataka, Kerala, Manipur, Maharashtra, Tamil Nadu and Tripura.

[4] While the Department of Health and Family Welfare, Jharkhand stated that a DHS had been set up in all districts, it was not formed in any of the audited districts. Various disease control societies were functioning separately at the district level.

[5] DHS in three non-contiguous districts were set up as branches of the SHS and not as a registered society.

It is necessary to ensure the formation of DHS/DHM in all districts and conduct their meetings at regular intervals to fulfil the aim of decentralised planning for future health initiatives.

The Ministry agreed that the operationalisation of DHS and DHM had not occurred at the expected pace in some States and that it was being followed up with them. More regular meetings of the DHS were now being convened.

2.2 Baseline surveys

Under the Mission, annual DHAP were to be prepared on the basis of preparatory studies, mapping of services and household and facility surveys conducted at village, block and district level, which would act as the baseline for the Mission against which progress would be measured. The Mission targeted to complete 50 *per cent* of household and facility surveys by 2007 and 100 *per cent* by 2008.

While household surveys were conducted in all villages of eight States/UTs (Chandigarh, Chhattisgarh[6], Dadra & Nagar Haveli, Daman and Diu, Manipur, Punjab, Sikkim and Tamil Nadu), these surveys were not conducted in 20 States/UTs, viz. Andaman & Nicobar Islands, Bihar, Delhi, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Karnataka[7], Lakshadweep, Madhya Pradesh, Meghalaya[8], Mizoram, Orissa, Puducherry, Rajasthan, Tripura, Uttarakhand, Uttar Pradesh and West Bengal as of October 2008. In the remaining States (Assam, Arunachal Pradesh, Andhra Pradesh, Gujarat and Maharashtra) surveys were conducted, but the coverage was incomplete/partial.

Facility surveys at all levels of health centres were completed in eight States/UTs (Chhattisgarh, Dadra and Nagar Haveli, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Manipur, Puducherry and Sikkim). Facility surveys were completed at the CHC and the PHC levels in Assam; at the CHC level in Kerala and Orissa; at the PHC level in Jharkhand and at the Sub Centre level in Tamil Nadu.

In seven States/UTs (Andhra Pradesh, Bihar, Lakshadweep, Madhya Pradesh, Tripura West Bengal and Chandigarh) facility survey had not been conducted for any health centre. In the remaining 12 States/UTs, the facility surveys were only partially complete (Detailed in **Annex 2.1**).

Further, data on conduct of facility surveys provided by the SHS could not be verified during audit in four States as detailed in **Annex 2.1.**

2.2.1 Quality of baseline surveys

With a view to make the household and facility surveys meaningful for use in planning, these were to be conducted through local community action by engaging

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6 The data of the Community Need Assessment (CNA) Report which covered the demographic profile of the district such as population, actual availability of staff, medicine and vaccines needed, infrastructure and actual need of the concerned sub centre was used for planning.

7 Information on household surveys was not furnished by the SHFS. In six test-checked districts, household surveys were not conducted in any village.

8 DHSs of audited districts reported household surveys in 3701 villages leaving 954 villages uncovered. However, they did not furnish any record in support of conduct of household survey. Further, the SHS records also indicated that household surveys were not conducted in any village of the seven districts.

services of ASHA, Anganwadi Workers (AWW) etc. and district and block planning teams on a pre-approved format. The DHSs were required to organise training for the personnel to be engaged in conducting the baseline surveys.

However, the procedure adopted for baseline surveys did not provide enough assurance regarding quality of survey and usage of its results. In most States/UTs, household and/or facility surveys were conducted without training of the surveyors and without an approved format for the survey. In Jharkhand and Daman & Diu, the Health Society collected information in respect of facilities directly from the concerned health centres, without ensuring trained personnel's visit to the health centres. This compromised the objectivity and integrity of reporting. SHS Punjab stated that facility surveys had been completed, but during the audit it was seen that the two audited CHCs (out of 12), five PHCs (out of 24) and 12 Sub Centres (out of 48) had no information about the conduct of facility surveys.

Further, in 22 States/UTs, where the surveys had been conducted partially or fully, the data on the survey findings had not been consolidated by the SHS and the DHS. Only the SHS of Assam and Puducherry had maintained a database of survey results.

Due to absence of any comprehensive database, the gaps between demand for and availability of services could not be analysed on inter- and intra-district basis to prioritise the future course of health interventions. Moreover, the practice of sample verification of the correctness of surveyed data either by NGOs or by the DHS was not followed in any State/UT nor was the data validated by PRIs, as required under the framework of the Mission.

The Ministry stated that the household survey was an extension of the Eligible Couple Survey that already existed prior to the launch of NRHM. It had circulated the formats for surveys to the States in December, 2005 and the States were requested to follow up on the same. Further, District Level Household and Facility Surveys – III (DLHS-III) findings, published in late 2008, were being used in planning and monitoring. The Ministry also stated that the States were encouraged to undertake a facility survey of the various facilities so as to assess their status vis-à-vis the IPHS norms and prepare a plan for upgrading the facility to attain the IPHS norms.

We feel that the scope of household and facility surveys was designed to cover wider aspects than the Eligible Couple Survey. Moreover, while DLHS-III is a positive development, it can only supplement the household and facility surveys. While the DLHS was based on sample units, facility and household surveys were required to be conducted for all the units to enable preparation of need and gap based decentralized health action plans. The facility surveys conducted through DLHS-III did not take IPHS into account.

In the absence of complete household and facility surveys, the SHS could not assess pre-NRHM availability of healthcare services. Consequently, the evaluation of the requirement of future interventions based on relative need analysis and orientation would be inadequate. The discrepancies between data provided by the SHS and data verified during audit indicated weak reporting and monitoring.

2.3 Perspective and annual plans

2.3.1 Perspective Plan

Positive development

The perspective plan for the entire period was prepared for the state as well as each district in seven states/UTs, viz. Chandigarh, Chhattisgarh, Dadra and Nagar Haveli, Jammu & Kashmir, Punjab, Maharashtra and Sikkim.

The DHS and the SHS, under the NRHM guidelines, had to identify the gaps in the health care facilities, areas of intervention, probable investment, Central and State share that would be required for the entire Mission period (2005-12) as well as financial and physical targets. They were to prepare a perspective plan for each district and an overall perspective plan for the whole State for the Mission period (seven years) outlining the overall resource and activity needs.

We found that the progress regarding preparation of perspective plans was slow. In 18 States/UTs (Assam, Arunachal Pradesh, A & N Islands, Bihar, Daman and Diu, Delhi, Haryana, Himachal Pradesh, Kerala, Lakshadweep, Manipur, Meghalaya, Mizoram, Orissa, Puducherry, Rajasthan, Tamil Nadu and West Bengal), no perspective plan was prepared by the districts or by the State. In Jharkhand[9] and Uttar Pradesh[10], the perspective plan was prepared only by a few districts leading to non-preparation of the overall plan for the State.

In six States, viz. Andhra Pradesh[11], Gujarat, Karnataka, Madhya Pradesh, Maharashtra, and Tripura, the perspective plan for the State was prepared without the finalisation of perspective plans for districts.

The Ministry agreed that the process of preparation of perspective plan by the States and Districts for the Mission period was slow as it was a novel context which took time in getting internalized by the States. It also added that the NRHM framework for implementation was generic/non prescriptive which provided complete flexibility to the States to plan as per local requirements and did not prescribe fixed guidelines.

However, of the seven years of the Mission period, which was to be covered under the perspective plan, three years have already elapsed. In the absence of clear feedback on long term requirements of resources and activities, interventions under the Mission could become *ad hoc*. Significantly, out of 18 Special Focus States, perspective plans for districts and State were prepared in only three States.

2.3.2 State and district annual plans

The NRHM framework stipulated that the Project Implementation Plan (PIP) for the State be prepared annually by the SHS by aggregating the DHAPs of each district. The National Programme Coordination Committee (NPCC) of the Ministry under the chairmanship of the National Mission Director was to appraise the PIP and the

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[9] Two out of three test checked districts.
[10] 35 out of 70 districts.
[11] Rs. 2.30 crore @ Rs. 10.00 lakh per district was released during 2006-07 by the Commissioner of Family Welfare, AP, Hyderabad for preparation of perspective plan for the entire mission. However, Rs. 1.71 crore was spent for Dengue and Chikungunia and the balance of Rs. 58.75 lakh remained with District Medical and Health Officers concerned.

representatives of the State and National Health Missions were to appraise district annual plans. The guidelines issued by the Ministry prescribed a time schedule for all the activities under the planning process.

However, during 2005-08, the DHAP was prepared by all districts only in three State/UTs (Chhattisgarh, Chandigarh and Puducherry) while the annual district plan was not prepared by any district in nine States/UTs (Bihar, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Punjab, Tamil Nadu, Uttar Pradesh and Uttarakhand). In the remaining States/UTs, the district plan was not prepared by most districts in 2005-06, but the situation improved by 2007-08, detailed as below:

Table No.2.1: State wise status of preparation of DHAP during 2005-08

States where DHAP was prepared by SOME districts during 2005-08							
States/UTs	**No. of Districts**	**Districts NOT preparing DHAP**					
		2005-06		**2006-07**		**2007-08**	
		Number	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Information collected from SHSs							
Andhra Pradesh	23	22	96	22	96	22	96
A & N Islands	3	3	100	3	100	1	33
Madhya Pradesh	48	48	100	0	0	0	0
Maharashtra	33	33	100	33	100	0	0
Manipur	9	9	100	0	0	0	0
Meghalaya	7	7	100	7	100	0	0
Mizoram	9	9	100	9	100	0	0
Orissa	30	30	100	0	0	0	0
Rajasthan	32	32	100	32	100	19	59
Sikkim	4	4	100	4	100	0	0
Tripura	4	4	100	4	100	0	0
Delhi	9	9	100	0	0	0	0
Haryana	20	20	100	20	100	11	55
West Bengal	18	18	100	18	100	0	0
Information collected by Audit from sample districts							
Arunachal Pradesh	5	5	100	5	100	0	0
Assam	5	5	100	0	0	0	0
Karnataka	6	2	33	2	33	1	17
Gujarat	4	3	75	1	25	1	25
Kerala	3	Information not available				0	0

(Source: Information provided by SHSs and DHSs)

Further, in 11 States/UT (Haryana, Maharashtra, Meghalaya, Mizoram, Rajasthan, Arunachal Pradesh, Kerala, Orissa, Tripura, West Bengal and Delhi) DHAP was not prepared before the scheduled date of 31 October of the preceding year. Only in four States (Andhra Pradesh, Madhya Pradesh, Sikkim and Manipur) had the districts prepared their annual plan before the scheduled date. Moreover, the Ministry did not

participate in the appraisal of the DHAPs as required under the NRHM framework. In four States/UTs [Karnataka (Rs. 2.70 crore), Orissa (Rs. 2.58 crore), Puducherry (Rs. 39.43 lakh) and Daman and Diu (Rs. 20 lakh)] funds received for preparation of DHAPs remained unspent with SHS/DHS as of March 2008 for periods ranging from one to two years.

The State PIP was to be sent to the Ministry by the SHS for appraisal by 15th December of the preceding year and was to be approved by the NPCC by 31st January so as to ensure the finalisation of State PIP before the commencement of the financial year. The Ministry stated that during 2005-06 and 2006-07 the progress towards preparation of State PIP was not significant; in 2007-08 it received PIP from all the States/UTs. The NPCC appraisal of PIPs for the year 2007-08 did not take place before the commencement of the financial year and the PIPs of seven States were appraised in June 2007, of 24 States/UTs in July 2007 and four States/UTs in September 2007.

However, it is noted that there has been an improvement in the submission of DHAPs from 2007-08 onwards and that the appraisal of State PIPs for 2008-09 was completed before the commencement of the financial year.

The Ministry stated that the institutionalization of NRHM framework took some time, as planning required skills which were hitherto nonexistent and building capacity for the same at grassroots level takes time.

However, certain basic skills and systems for planning already existed in the form of State Planning Boards and District Planning Boards and institutional memory was already available in all the departments including the Health department. Moreover, in terms of the NRHM framework, the first year of the Mission was to be specifically devoted to institution building. There is, therefore, a need to coalesce already available knowledge in order to facilitate institution building. The initial years of the Mission period (2005-12) have elapsed without annual plans being prepared for all districts, diluting the very concept of decentralized planning.

2.3.3 Block and village level plans

Village and block level plans were to be prepared and consolidated into the DHAP forming the basis of all interventions under the Mission. Realising the requirement of extensive capacity building to make villages capable of taking up the planning exercise, the Mission did not insist on village plans for the first two years and therefore, Block Health Action Plans were to form the basis of DHAP.

However, the annual block plans during 2005-08 and village plan during 2007-08 were not prepared at all in 24 States/UTs[12]. In the remaining States/UTs, only partial preparation of block and village health plan had been done, and the progress was very slow. The absence of complete block and village plans hinders the achievement of the goal of decentralised planning. Under decentralised planning, the Mission provided untied funds and annual maintenance grants to the health centres up to the village

[12] Arunachal Pradesh, A & N Islands, Bihar, Chandigarh, Delhi, Dadra & Nagar Haveli (no block level office), Daman & Diu, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Lakshadweep, Maharashtra, Manipur, Mizoram, Orissa, Puducherry(no block level office), Punjab, Sikkim, Tamil Nadu, Tripura, Uttarakhand and Uttar Pradesh

level, allowed them to retain user charges levied for health services; gave untied grants to the Village Health and Sanitation Committees; set up Rogi Kalyan Samitis for facilitating autonomy to health centres; sought to bring health centres under community monitoring framework and aimed to ultimately bring the health centres under the community ownership. Thus, a weak planning effort meant that consequent positive spin offs were diluted and progress on related issues was delayed.

The Ministry admitted that building up of the capacity at the grass roots level to be part of the planning process took time and added that improvements in this regard had been noticed.

2.3.4 Outsourcing the task of planning

As per the NRHM guidelines, district and lower level plans were to be prepared annually by planning teams to be formed at each level under the leadership of the Panchayati Raj Institutions. However, in 11 States (Bihar, Haryana, Himachal Pradesh, Jammu and Kashmir, Meghalaya, Mizoram, Punjab, Rajasthan, Sikkim, Tripura and Uttarakhand) the SHS outsourced the task of district planning to private agencies which meant that the growth of in house capacity in decentralised planning was not fostered. Nor was work quality and output standardised.

In Mizoram, Punjab, Rajasthan and Tripura, planning was outsourced to a private agency without recording any justification for the same. In Bihar, Haryana, Himachal Pradesh, Meghalaya, Punjab, Rajasthan, Tripura and Uttarakhand the agency did not complete preparation of district plans within the stipulated time-frame. Moreover, in Haryana, Meghalaya, Punjab, Sikkim, Tripura, Uttar Pradesh and Uttarakhand the plans were not based on findings of the household and facility surveys, nor were the views of the Panchayati Raj Institutions taken into account. In Jammu & Kashmir, where the task of facility survey and district planning was outsourced to a private

Case study: Outsourcing planning

Bihar: The SHS paid Rs. 48.05 lakh to a private agency (April-June 2006) in contravention of the clause of contract signed with the agency, as the firm neither submitted any evidence of achievement of certain benchmarks along with its bills nor did it send a weekly report to the nodal officer of the SHS, as required under the agreement. The SHS terminated the contract with the agency in August 2006, after receiving reports on the poor quality of work from the Civil Surgeons of 17 districts and District Magistrates of four districts. The SHS did not redeem the bank guarantee of Rs. 25.47 lakh given by the firm (valid up to November 2006) and failed to safeguard the interest of the government.

Punjab: Payments to the agency were to be made in instalments after achievement of certain benchmarks prescribed in the contract. However, the SHS paid the entire dues of Rs. 44.94 lakh to the agency in January 2008, despite delays of 72 days in submission of the report on the benchmarks by the agency and deficiencies in the report pointed out by the Mission Director. The penalty clause for sub-standard work and clause for liquidated damages for delay in work were not included in the agreement signed with the agency. Moreover, while the agency submitted their report, the initial record/data from which these reports were complied were not available with the consultant itself and were reported to be lost. In the absence of supporting databases the report's utility was minimal. For instance, number of health centres without a good quality building or without electricity connection was given in the report, but health centre wise data on these issues were not available.

agency, the agency did not actually visit the health centres, but instead called health centre functionaries to the block level for filling up the facility survey forms.

The Ministry stated that outsourcing the task of planning adopted by some of the States has not diluted the building up of the capacity of the States. In Bihar, the outsourcing of district planning led to litigation; but, this should not be taken as derailment of planning process as considerable progress in facility access and improvement in maternal and child health indicators had occurred in Bihar. Further, in Tripura and Rajasthan, Joint Review Mission (JRM) findings indicated that PRIs had participated in the planning process.

However, in all the eight States where decentralised planning was outsourced, plans were neither prepared within the stipulated time nor in accordance with guidelines for district planning. In Bihar, the district plan was not prepared by any district even in 2008-09.

The NRHM made progress but was slow in initiating decentralised bottom-up planning primarily due to non-completion of the work of household and facility surveys and State specific perspective plans for readiness assessment. The salient feature of the scheme was localised bottom-up planning yet NRHM interventions proceeded without baseline surveys leading to, in effect top-down planning due to the skill gap at the grass root level. While the Mission succeeded in setting up health societies at the district and State levels in most of the States, it did not succeed in mainstreaming them. Since, capacity building appeared to be taking time; some states outsourced planning, resulting in lack of community participation which was one of the primary objectives of the Mission. These surveys were also not very productive as the plans were not prepared in time nor were standardised in accordance with the NRHM guidelines.

2.4 Monitoring of activities under the Mission

2.4.1. Meetings of Mission Steering Group

The NRHM framework was approved by the Cabinet in July 2006, i.e. a year after the formal launch of the Mission. The Cabinet empowered the Mission Steering Group (MSG) to approve financial norms in respect of all schemes and components which were part of NRHM and allowed the Empowered Programme Committee (EPC) the flexibility to change financial norms approved by the MSG within a range of (+) 25 *per cent*. The MSG was required to periodically monitor progress of the Mission and to meet twice a year. To review the progress, Secretaries (Health & Family Welfare) of four high focus states were to be nominated by the Ministry as members of the MSG for a period of one year each by rotation.

The MSG, however, met only four times in four years, during 2005-09, instead of eight times as envisaged. The delegation of powers to the MSG and EPC was subject to the condition that a progress report regarding NRHM, also indicating deviation from the financial norms and modifications in ongoing schemes would be placed before the Cabinet on an annual basis. However, during the past four years, the Mission had submitted a progress report to the Cabinet only once in August 2008.

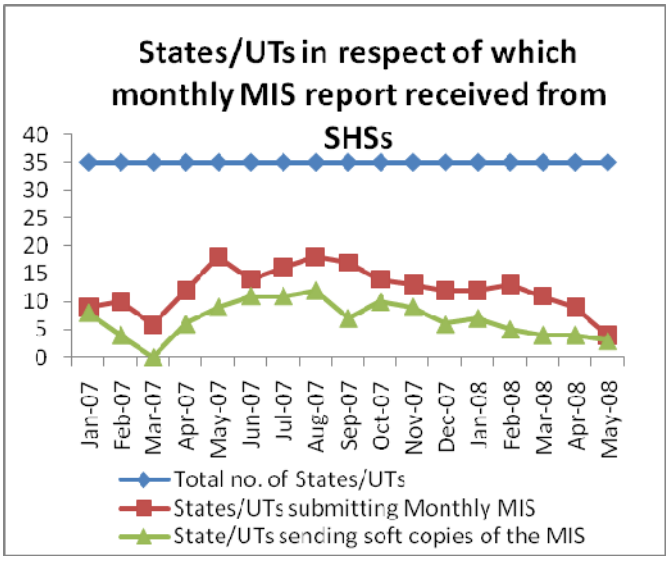
The Ministry stated that the empowerment of the MSG was received from the Cabinet in July, 2006 and since then, the MSG had held four meetings till May 2009.

However, the order of 4 May 2005 establishing the MSG had stipulated that it would meet at least twice a year. The first meeting of the MSG was held on 30 August 2005 and only three meetings (in September 2006, July 2007 and August 2008) of the Group had been held since then, against the requirement of seven meetings up to May 2009.

2.4.2 HMIS reporting system

The NRHM framework envisages intensive accountability structures based on internal monitoring through computer based monthly Health Management Information System (HMIS).

The Ministry could not adhere to the proposed date of December 2005 for implementation of the computerised MIS due to continuous revisions in the MIS format by the Ministry. The revised MIS format was sent to the States/UTs in August 2006. MIS user guidelines were subsequently being developed by the Ministry, but remained unfinalised until July 2008.



State/UT sent the quarterly and annual MIS reports to the Ministry regularly. Feedback received from the States via the revised monthly reports was also poor and the quantum of reports received showed a declining trend as indicated in the graph.

In the absence of adequate data for analysis, no formal performance report of the Mission could be prepared despite the NRHM moving into its fourth year of operation. The Ministry prepared a report on key indicators but that too was limited and based on the reports furnished by only 13 States. As the States/UTs were not providing data on a regular basis and the Ministry had also not emphasised on the same, the funds release could not be linked to performance as envisaged in the NRHM framework.

The Ministry accepted that the reporting was weak. It stated that based on the feedback from the States, a MIS format was developed and the HMIS portal was launched in October, 2008 which was followed by State and District level training and orientation. It added that a majority of the districts had uploaded data on the portal for 2008-09.

2.4.3 Computerisation and MIS in States

Under the NRHM framework, each DHS was to develop a computer based Management Information System and report monthly to the SHS. The computerisation of health centres under the NRHM up to block level and networking under the Integrated Disease Surveillance Project (a component of the NRHM) were necessary for reporting through the MIS.

Computerisation of block level health centres had not taken place in any block in Delhi and Uttar Pradesh or only in some blocks in Jharkhand and Uttarakhand. In Bihar and Karnataka even all the districts had not been computerised. The SHS Lakshadweep and A & N Islands had not started the computerisation of health facilities at all.

Success story

In 13 states/UTs (Assam, Chhattisgarh, Chandigarh, Dadra and Nagar Haveli, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Maharashtra, Orissa, Punjab and West Bengal) district as well as block level computerisation of health facilities was complete. In Andhra Pradesh all districts, except one, and all blocks, except 183, were computerised.

The targeted installation of 796 broadband connections under the Integrated Disease Surveillance Project for district level networking was only complete in 555 cases (70 *per cent*) and the remaining 241 sites (30 *per cent*) were not connected through a network. In D & N Haveli, Daman and Diu, Delhi, Lakshadweep and Sikkim, none of the districts were connected through a network, while in Arunachal Pradesh, Bihar, Jammu and Kashmir, Jharkhand, Manipur, Mizoram and West Bengal more than half of the districts were not connected through the network. In the remaining States, district level networking had been mostly completed under the IDSP.

DHSs were sending the monthly MIS reports to the SHS in time in seven States/UT (Andhra Pradesh, Assam, Karnataka, Gujarat, Himachal Pradesh, Maharashtra and Puducherry) or with delays in five States (Arunachal Pradesh, Chhattisgarh, Haryana, Orissa and Rajasthan).

Case study: Computerisation of health centres in two states

Jharkhand: An MOU was signed between Jharkhand Health Society (JHS) and a private agency to install Healthcare Information Management System (HIMS) in Ranchi district in December 2004. JHS awarded the project to the agency on selection basis without inviting tender and paid Rs. 3.15 crore from April 2005 to December 2005 as advance. However, the internet connections were either not provided or were out of order since installation of HIMS and data/information for compilation of reports at district level were being collected manually from the PHCs and consolidated by the agency. At district level, no analytical reports were generated. The agency never made the system fully functional. The training provided to the officials to run the system was inadequate and in some cases the lone trained PHC staff were subsequently transferred elsewhere. The agency was to provide maintenance of the system up to 31.10.2008 but the department cancelled the work order in March 2008 without adjusting the advances. Consequently, the HIMS project failed and resulted in infructuous expenditure of Rs. 3.15 crore.

Tripura: The SHS awarded work order to a private agency in January 2007 for implementing the first phase at a cost of Rs. 1.32 crore of the three-phase work of implementing MIS system. The work was to be completed by July 2008 and Rs. 66.22 lakh (50 *per cent* of the work order) was given as advance against the bank guarantee. The work was not completed till August 2008. One of the major component of work, i.e. supply of battery operated SIMPUTER or Monochrome PDA Units' (which was required for field level entry in 243 sub-centres) costing Rs. 32.50 lakh, was kept in abeyance by the SHS without any reason on record. The company took up only 33 health institutions (out of targeted 37) for development of HMIS and out of 33, works at 10 centres was held up due to absence of data entry operators.

However, in Meghalaya, Mizoram and Punjab despite internet connectivity in all the districts, monthly MIS reports to the SHS were not being sent. In Tamil Nadu, the MIS had not been developed as the network under IDSP was still under testing process by National Informatics Centre at State and District levels. In Bihar, the MIS reports were prepared on the basis of telephonic conversations with the lower level functionaries without validation of data, thus making these unreliable. In Jammu and Kashmir, reports were being collected by health centres and submitted to DHS and SHS without any analysis of data collected. In Orissa, data furnished in three MIS reports of a district did not match with the data furnished by the CHCs, PHCs and Sub Centres. Thus it was clear that the networking and generation of reports through the MIS was not achieved according to a phased timeline and data flow, availability and integrity was intermittent and doubtful.

2.4.4 Public report on health

As envisaged under the NRHM, each district was required to publish a public report on health annually. During 2005-08, in most districts DHSs did not publish an annual report on public health[13].

The Ministry stated that that annual public report on health depended on the level of community participation and hence had a long gestation period. As the health MIS and local capacities improved; more districts would be able to publish the annual public report on health.

However, while the presence of a long gestation period can be appreciated, district-wise annual reports on health can be made a part of overall reporting framework. The annual report need not necessarily be a comprehensive document and in the initial years it may contain only output and outcome indicators, survey results etc., but these would provide signposts for further progress and a record of development would be in place.

The monitoring of the activities under the Mission needed strengthening. Delay in the issue of the final guidelines on reporting by the Ministry resulted in deficient reporting through monthly MIS report from the DHS to the SHS and from the SHS to the Ministry. In the absence of a strong monitoring mechanism, the planning process did not receive regular inputs and feedback on the nature and direction of required future interventions. It is expected that the newly launched HMIS web-portal will add adequate strength to the monitoring framework, but the veracity of data uploaded by districts will remain a challenge for the Mission.

Recommendations

- ***The SHSs may be asked to undertake household and facility surveys as per programme guidelines without delay so as to frame district and lower***

[13] Only one district of Andhra Pradesh had published the public report annually. Four districts of Assam in 2007-08 and one audited district of Rajasthan in 2006-07 had also published the report. In Puducherry, the SHS published the public report annually district wise. In Chandigarh, an annual public report (AAKAR) on health was published in August 2007 and June 2008, but the data published in the report in June 2008 under the Family Welfare Programme did not match with data reported to the Ministry.

level plans compatible with current service availability and future need/demand interventions.

- ***A comprehensive central database may be prepared for all districts and the State as a whole, in electronic form and may be uploaded on the SHS's website for easy access by district planning teams.***
- ***SHSs may be asked to adhere to the framework of decentralised planning to ensure that the State PIP reflects the requirements based on actual demand.***
- ***Outsourcing of the task of decentralised planning should be reduced and phased out gradually and community capacities fostered instead.***
- ***Skill gap in planning at the grass root level may be bridged through capacity building and training, if necessary.***
- ***Monitoring framework may be strengthened so as to ensure periodic impact assessment of activities for timely interventions. A mechanism for sample verification of data by competent authorities may be put in place.***
- ***A monthly and annual report on issues pointed out by lower level monitoring committees and action taken thereon may be prescribed for DHSs and SHSs so as to make monitoring more effective.***