Summer Training at
National Health Mission, Bhopal, Madhya Pradesh

Data Triangulation: Comparison of HMIS, NFHS, AHS and MCTS data on RMNCH Indicators in Madhya Pradesh

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr.Pragati Gurjar** student of **MBA Hospital and Health Management 2015-17** from the IIHMR University; Jaipur has undergone summer training at **National Health Mission, Madhya Pradesh from 1st April to 31st May, 2016.**

The candidate has successfully carried out the study designated to her during summer training and her approach to the study has been sincere, scientific & analytical.

The internship is in fulfilment of the course requirements.

I wish her all success in future endeavours.

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National Health Mission

Arera Hills, Bhopal (M.P.)

CERTIFICATE OF SUMMER INTERNSHIP

Dr. PRAGATI GURJAR

In recognition of having successfully completed his/her
Summer Internship in the department of

1. Human Resource
2. Mental Health
3. Health Management Information System (HMIS)

and has successfully completed his/her project on

1. The study & assessment of performance appraisal of contractual Employees of NHM in Districts Alirajpur, Bhopal, Sehore and Ujjain.
2. Assessment of Mental Health training program for MO's and staff Nursing under National Mental Health Program (NMHP) at BMHRC, Bhopal and Indore Mental Hospital, Indore
3. Data Triangulation: Comparison of HMIS, NFHS-4, AHS and MCTS data on RMNCH Indicators in Madhya Pradesh.

1st April 2016 to 31st May 2016.

National Health Mission Madhya Pradesh

He / She comes across as a committed, sincere & diligent person who has a strong drive & Zeal for learning.

We wish him / her all the best for future endeavors.

Dr. Rajeev Shrivastava
Deputy Director

Mr. V. Kiran Gopal (I.A.S.)
Mission Director

ACKNOWLEDGEMENT:

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We perceive this opportunity as a big milestone in our career development. We will strive to use gained skills and knowledge in the best possible way, and we will continue to work on their improvement, in order to attain desired career objectives.

Thank you

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List of abbreviations

AHS	Annual Health Survey
ANC	Ante natal care
ASHA	Accredited social health activist
BCG	Bacillus Calmette Guerin
CDC	Centers for Disease Control
DLHS	District Level Household and facility Survey
DPT	Diphtheria, Pertussis, Tetanus
EPI	Expanded program of immunization
FHW	Frontline Health Workers
FI	Fully Immunized
GNM	General Nurse Midwife
GoI	Government of India
GPS	Global Positioning System
Hep	Hepatitis
HMIS	Health Management Information System
IDC	International Design Centre
IEC	Information Education Communication
IMR	Infant Mortality Rate
MCTS	Mother and Child Tracking System
MDGs	Millennium Development Goals
m-Health	Mobile Health
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
NFC	Near Field Communication
NFHS	National Family Health Survey
NGO	Non-government organization
NHM	National Health Mission
NIHFW	National Institute of Health & Family Welfare
NRHM	National Rural Health Mission
OPV	Oral Polio Vaccine
PNC	Post Natal Care
RCT	Randomized control trial
RI	Routine immunization
RGI	Registrar General of India
RMNCH	Reproductive, Maternal, New born, Child health
SDGs	Sustainable Development Goals
SEA	South east Asia
SBA	Special Birth attendant
STI	Sexually transmitted Infections
TBA	Traditional birth attendant
UIP	Universal immunization program
UNICEF	United Nations Children's Fund
VPD	Vaccine preventable disease
WHO	World health organization

OBSERVATIONAL LEARNING:

About the Organisation:

The National Rural Health Mission (NRHM) is an initiative undertaken by the government of India to address the health needs of under-served rural areas. Launched in April 2005, the NRHM was initially tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators. The Union Cabinet vide its decision dated 1 May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an overarching National Health Mission (NHM), with National Rural Health mission (NRHM) being the other Sub-mission of National Health Mission.

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

Goals

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan, and are part of the overall vision. The endeavour would be to ensure achievement of those indicators in specific goals for the states will be based on existing levels, capacity and context. State specific innovations would be encouraged. Process and outcome indicators will be developed to reflect equity, quality, efficiency and responsiveness. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

1. Reduce MMR to 1/1000 live births.
2. Reduce IMR to 25/1000 live births.
3. Reduce TFR to 2.1.
4. Prevention and reduction of anaemia in women aged 15–49 years.

5. Prevent and reduce mortality & morbidity from communicable, non- communicable; injuries and emerging diseases.
6. Reduce household out-of-pocket expenditure on total health care expenditure.
7. Reduce annual incidence and mortality from Tuberculosis by half.
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts.
9. Annual Malaria Incidence to be <1/1000.
10. Less than 1 per cent microfilaria prevalence in all districts.
11. Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks.

NHM COMPONENTS:

NHM Finance -

Financial Management Group(FMG) working under NHM Finance Division of Ministry of Health & Family Welfare is involved in planning, budgeting, accounting, financial reporting, internal controls including internal audit, external audit, procurement, disbursement of funds and monitoring the physical and financial performance of the programme, with the main aim of managing resources efficiently and achieving pre-determined objectives. Sound financial management is a critical input for decision making and programme success. Accurate and timely financial information provides a basis for informed decisions about the programme, fund release and assists in reducing delays for smooth programme implementation. FMG tries to ensure that all programmes receive their funds in a timely manner after adhering to all the GFR provisions and DoE conditionalties. Under NHM, it is the endeavour of the Government of India to build effective financial management capabilities for managing the funds provided to the State Health Societies. The States have also been encouraged to set up Financial Management Groups (FMG) at the State and Strengthen financial management capacities at District level.

Health Systems Strengthening

Adoption of the Indian Public Health Standards: This defined not only the service package that each facility must provide, but also specified the minimum inputs required to ensure quality of care, in terms of infrastructure, equipment, skilled human resources, and supplies. It was an assurance to the states of financing the gaps between available levels of these inputs

and the levels needed to achieve the IPHS norms. A substantial increase in these inputs was driven by facility surveys to identify gaps and then planning and financing to close these gaps.

Quality standards have been defined with respect to clinical protocols, administrative and management processes and for support services. The Operational Guidelines for Maternal and Newborn care published by the Ministry of Health and Family Welfare comprehensively defined such quality standards for RCH care.

Skill gaps and Standard Treatment Protocols: Skill sets and standard treatment protocols required for provide quality RCH services and training packages that would provide these skill sets were designed. These include the Skilled Birth Attendance (SBA) training package for ANMs, the Navjat Shishu Suraksha Karyakram (NSSK) and the IMNCI packages for ANMs, the Home Based Newborn Care (HBNC) for ASHAs, and the Emergency Obstetric Care (EmOC) package for doctors. These training packages also introduced the standard treatment protocols in each of these areas.

Hospital Management Societies (RKS) and untied funds: The mandatory creation of a hospital management society (Rogi Kalyan Samiti) and empowering this body with untied funds has allowed public participation also contributed to improved quality of care. RKS members were trained and sensitized on quality of care issues. Before the onset of NRHM, many states generated funds from user fees; however the untied grants to all public health facilities were made available under NRHM which reduced financial barriers to access of health care. This is clearly evident from the increased utilization of indoor and outdoor services at health facilities.

Quality Improvement Programmes: NRHM also supports initiatives for building quality management systems. These range from formation of quality assurance committees which use check lists and periodic monitoring visits to assess quality gaps, to more structured quality management systems leading to a third party audit and quality certification- either using ISO 9001: 2008 or NABH. Till date, 82 facilities have been certified by ISO, nine facilities have been certified by NABH and 446 facilities are under process of certification.

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)

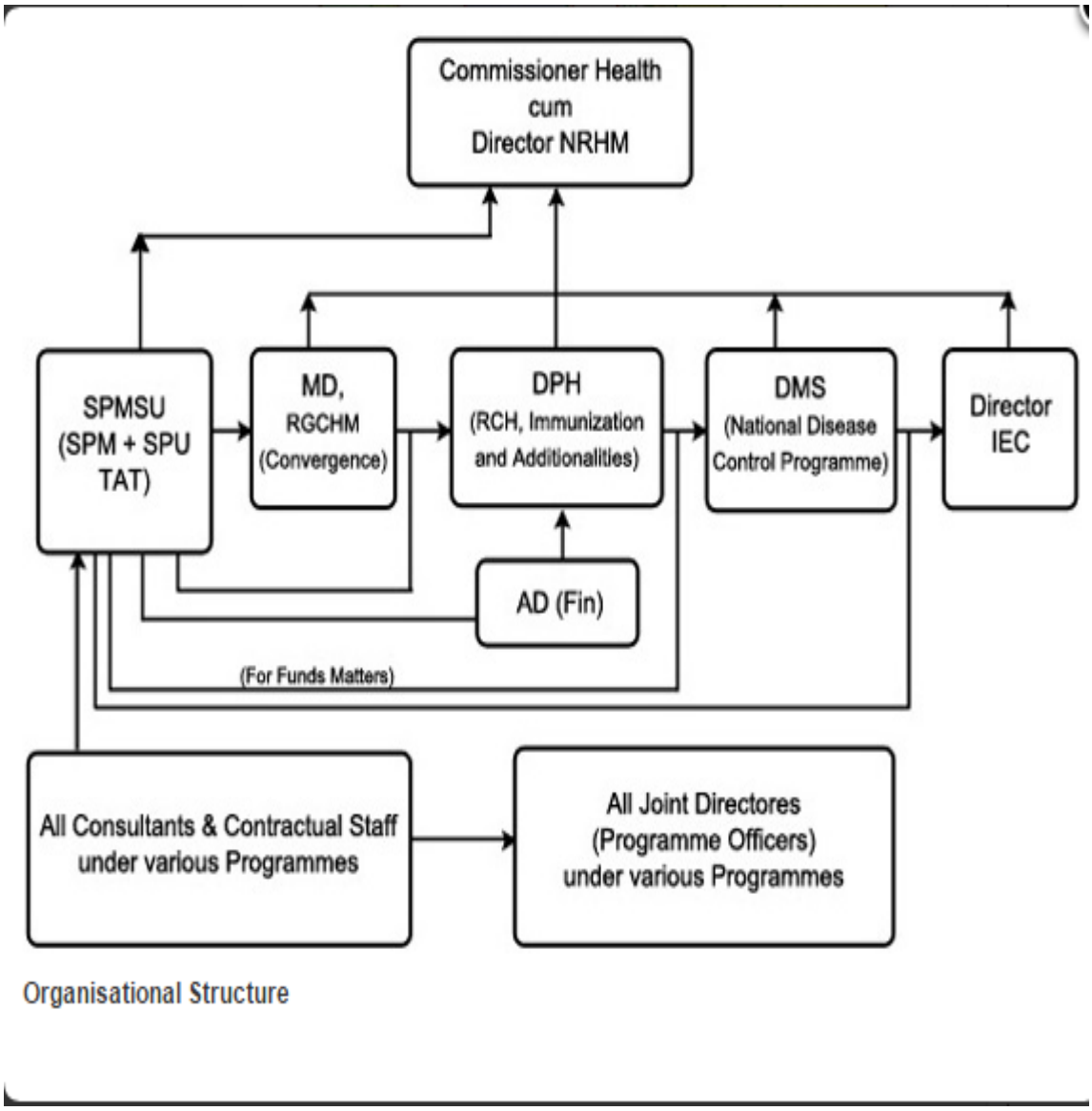
Introduction:

RMNCH+A approach has been launches in 2013 and it essentially looks to address the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services. The RMNCH+A strategic approach has been developed to provide an understanding of 'continuum of care' to ensure equal focus on various life stages. Priority interventions for each thematic area have been included in this to ensure that the linkages between them are contextualized to the same and consecutive life stage. It also introduces new initiatives like the use of Score Card to track the performance, National Iron + Initiative to address the issue of anaemia across all age groups and the Comprehensive Screening and Early interventions for defects at birth , diseases and deficiencies among children and adolescents. The RMNCH+A appropriately directs the States to focus their efforts on the most vulnerable population and disadvantaged groups in the country. It also emphasizes on the need to reinforce efforts in those poor performing districts that have already been identified as the high focus districts.

Objectives:

The 12th Five Year Plan has defined the national health outcomes and the three goals that are relevant to RMNCH+A strategic approach as follows:
Health Outcome Goals established in the 12th Fiver Year Plan
Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017
Reduction in Maternal Mortality Ratio (MMR) to 100 per 100,000 live births by 2017
Reduction in Total Fertility Rate (TFR) to 2.1 by 2017

Organogram of NHM Madhya Pradesh:



Organisational Structure

PROJECT REPORT:

Introduction:

The purpose of *Health Indicators* is to "further understanding of the health of the country, how the health care system works and what needs improvement." A first step in using the indicators to meet these objectives is to see how the values of indicators vary across regions, provinces and territories and how they compare to the national rate. Health care consumers may want to know if their region's health care system performance indicators are comparable to the National average. A health care administrator may want to know if the health outcomes of his or her region is more or less favourable than those in the other.
The health indicators provide insights into the nation's health status and health system characteristics and performance helps to find out various gaps at each level and formulate and implement the policy accordingly in order to enhance the health system.

What is Data Triangulation?

Triangulation is a powerful technique that facilitates validation of **data** through cross verification from two or more sources. In particular, it refers to the application and combination of several research methods in the study of the same phenomenon.

Types of Triangulation
1. Data Triangulation
2. Method Triangulation
3. Investigator Triangulation
4. Theory Triangulation
5. Fifth type, multiple triangulations, which uses a combination of two or more triangulation techniques in one study

Why data triangulation?

- Health (including immunization) program needs indicators for monitoring and evaluation.
- Data to obtain for such indicators may
  - not be available from a single source,
  - Too expensive to collect or process too time-consuming.

 Synthesis and integration of data from multiple sources for arriving at inferences
 Useful tool for program decision making

Benefits of data triangulation

The triangulation of data strengthens your research and allows you to write a better research paper because of the following benefits:

- Additional sources of information often give more insight into a topic.
- Inadequacies found in one-source data is minimized when multiple sources confirm the same data.
- Multiple sources provide verification and validity while complementing similar data.
- Data and information is supported in multiple places/types of research, which makes it easier to analyse data to draw conclusions and outcomes.
- Inconsistencies in data sets are more easily recognized.

Availability of Data and Health Indicators:

Data collection for the indicators must draw upon the full range of data sources. Each indicator needs to be linked to some data sources in order to compile consistent estimates of the indicators. Data can be from surveys, administrative/secondary sources and primary sources. The data sources which were used for our study were :

1) **The National Family Health Survey (NFHS-4)**
2) **The Annual Health Survey (AHS) 2012-13**
3) **Health Management Information System [HMIS 2011-12, 2013-14, 2015-16]**
4) **MCTS(Mother and Child Tracking System)**

National Family Health Survey (NFHS):

The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted in a representative sample of households throughout India. Four rounds of the survey have been conducted: NFHS-1 (1992-93), NFHS-2

(1998-99), NFHS-3 (2005-06). NFHS-4 (2014-15).The National Family Health Survey (NFHS)-4 2014-2015 is a national sample survey designed to provide information on population, family planning, maternal and child health, child survival, HIV/AIDS and sexually transmitted infections (STIs), reproductive health, and nutrition in India. NFHS-4 will involve interviewing randomly selected women age 15-49 years and a sub-sample of men age 15-54 years. These respondents will be asked questions about their background, the children they have given birth to, their knowledge and use of family planning methods, the health of their children, their awareness of HIV/AIDS and sexually transmissible diseases, and other information that will be helpful to policy makers and administrators in health and family planning fields.

The Annual Health Survey (AHS)

It is a three-year (2010, 2011 and 2012) longitudinal, demographic survey of nine high-focus states: Assam, Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Odisha, and Rajasthan conducted by Office of Registrar General of India. It is one of the largest population based survey. The second round of the AHS drew arepresentative sample of 20,694 primary sample units, covering 4.28 million households and 20.61 million people from the 284 districts in these nine states. The objective is to yield benchmarks of core vital and health indicators at the district level and to map changes therein on an annual basis. State level bulletins contain vital indicators viz. crude birth rate, crude death rate, infant mortality Rate, neo-natal mortality rate, under five mortality rate, maternal mortality ratio, Sex ratio at birth, 0-4 years and all ages. District level fact sheets contain 161 indicators on fertility, mother and childcare, family planning practices, mortality, disability, marriage etc. Data were released in 2011 and 2013 (ORGI 2013).

THE HMIS (HEALTH MANAGEMENT INFORMATION SYSTEM) IN INDIA-

Realising the importance of sound health information system as accurate, relevant and up to-date, information is essential for the health service providers at all levels so that they can

initiate action on the gaps in the system based on evidence and information, as envisioned in the National Rural Health Mission (NRHM), which was launched by the Government of India in April 2005. NRHM has a mandate to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. Apart from several mechanisms that would be established under NRHM, one of the core strategies is the "Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision". As a step in this direction, the Ministry of Health and Family Welfare, GOI, has established a dedicated Health Management Information System (HMIS) portal for all Public Health related information. The HMIS web portal was launched in October, 2008 to enable capturing data from both public and private institutions in rural and urban areas across the country. The portal is envisaged as a "Single Window" for all public health data for the Ministry of Health and Family Welfare.

Mother and Child Tracking System (MCTS):-

To improve the efficiency of maternal and child health services and to facilitate the monitoring of universal access of these services by all the beneficiaries i.e. pregnant women and children, Ministry of Health and Family Welfare jointly with National Informatics Centre, launched a web enabled application , Mother and Child Tracking System (MCTS) (http://nrhm-mcts.nic.in) in December 2009. MCTS cell has been established at NIHFW from 1st October 2012. The cell has been working under Statistics & Demography department with the guidance and direction of MoHFW and NIHFW. It is a name-based tracking system whereby pregnant women and children can be tracked for their ANCs and immunization along with a feedback system for the ANM, ASHA etc., to ensure that all pregnant women receive their ante-natal care check-ups (ANCs) and post-natal care (PNCs); and further children receive their full immunization.

Rationale:

The proposed study was to compare similar data's collected from various data sources and find the disparity between them in Madhya Pradesh which has traditionally had lower indicators than national levels while also performing poorly in other key developmental indicators, IMR of 54 per 1000 born infants and MMR of 221 per 100,000 women of reproductive age and TFR of 2.9. The most recent immunization estimates for this area were assessed in 2013 by the DHLS-4 survey, but data is incomplete for villages outside of the government's catchment area.

Objectives of study:

a) To compare various sources of data for similar indicators.
b) Availability and Analysis of data in Health Statistic.
c) To highlight districts with maximum discrepancies and do a detailed study till block level and try to drill down till facility level, if possible.

Methodology:

Study Design: Qualitative Research
Quantitative Research

Study period: Data used for assignment was collected between April 2015 to March 2016.

Study area: All 51 districts of Madhya Pradesh.

Data Collection:

The data on all indicators was collected from various data sources. The NFHS-4 and AHS data was collected from their respective state bulletins.
The District wise bulletin was also referred for collecting information of districts for particular indicator. The HMIS data (2011-12, 2013-14, 2015-16) was collected from the HMIS portal of the government.

MCTS data was obtained from the database and bulletin of the state.

Data Preparation:

- Data Entry- All the responses were entered into MS excel software
- All the data from respective data sheets was extracted carefully and collected on another master sheet of MS excel where it was meant to be compared with the data from other data sources on similar indicators and reference period.
- Cleaning of data- Missing values were removed from the dataset.

Data Analysis:

- Collected data is analysed on the basis of indicators taken against each objective.
- Indicators taken for each health activities are expressed in terms of average and percentage (%).
- Data is represented is tabular form to find out the average trend and percentage difference between various data sets.
- Data Analysis and Graphical Representation was done using Ms Excel Software.

Limitations:

- Data Analysis is a limitless science, since summer training duration was pf just 2 months it was impossible to touch more aspects of the data sets which are huge.
- The target data was not available facility wise (SH, PHC, CHC& DH), so it was not possible to individually analyse a facility on various indicators from different data sources.

Process of the study:

Since our objective was to compare various data sources and highlight discrepancies at district and block level for same indicators, hence first we select the indicators for Maternal and Child health as these are the two black spots of our country and also the goal 4 & 5 of the Millennium Development Goals (MDGs) as well as Sustainable Development Goals(SDGs) which necessarily needs complete coverage. Thus, we select the following indicators:-

1)Total ANC Registration
2) Mothers who had ANC in First Trimester
3) Mothers who received ANC >OR= 3
4) Institutional Delivery
5)Children who have received BCG
6)Children who have received 3 doses of DPT vaccine
7)Children who are fully immunized

In AHS and NFHS4, the data for the above indicators were collected from the State & District wise fact sheets. In case of HMIS, we calculated the indicators from the raw data (Estimated targets and target achieved) obtained from the HMIS bulletin in order to make them comparable with the other data sources.

The data was compiled for all 51 districts on our selected indicators and compared on excel sheets. Next we observed the trend increasing, decreasing, static or unpatterned in all the 51 districts.

RESULTS

Comparison of (AHS 2012-13) and HMIS (2011-12,2013-14 and 2015-16) for all 51 districts. Fig (1.1)

	B	C	D	E	F	G	H	I	J	K	L	M
1	Districts	Indicators	AHS (2012-13)	% Diff wid AHS		HMIS (2011-12)				HMIS 2013-14		HMIS 2015-16
91	Damoh	Total ANC Registration	71.5	-15.5	Decrease	99.8				89.8		87
92		a) Mothers who had ANC in First Trimester	76.2	11.2		39.2		37.0		100.0		65
93		b) Mothers who received ANC >OR= 3	78.2	1.4	Increase	72.1		6.1		72.8		76.8
94		c) Institutional Delivery	57.6	-1.4		57.9		-0.3		50.4		59
95		d)Children age 12-23 months who have received BCG	92.5	23.5	Decrease	83.3		9.2		69.1		69
96		e)Children age 12-23 months who have received 3 doses of DPT vaccine	59.2	-14.6	DEcrease	80.1		-20.9		77.1		73.8
97		f)Children age 12-23 months fully immunized	42.4	-43	Increase	75.3		-32.9		78.8		85.4
98												
99	Datia	Total ANC Registration	72.2	-27.2	Decrease	111				99.9		99.4
100		a) Mothers who had ANC in First Trimester	67.5	9.5		44.1		23.4		100.0		58
101		b) Mothers who received ANC >OR= 3	49.5	-25.2	Increase	65.1		-15.6		69.2		74.7
102		c) Institutional Delivery	83.9	14.9		78.0		5.9		67.9		69
103		d)Children age 12-23 months who have received BCG	92.5	5.5		78.8		13.7		73.5		87
104		e)Children age 12-23 months who have received 3 doses of DPT vaccine	76.9	-6.2		83.1		-6.2		75.7		83.1
105		f)Children age 12-23 months fully immunized	63.5	-11.9		72.4		-8.9		71.4		75.4
106												
107	Dewas	Total ANC Registration	68.2	-25	Decrease	113				98.3		93.2
108		a) Mothers who had ANC in First Trimester	76	14		68.9		7.1		101.0		62
109		b) Mothers who received ANC >OR= 3	68.6	-11.7	Static	80.4		-11.8		80.6		80.3
110		c) Institutional Delivery	91.2	18.2	Decrease	86.4		4.8		80.2		73
111		d)Children age 12-23 months who have received BCG	96.2	17.2	Decrease	96.1		0.1		93.8		79
112		e)Children age 12-23 months who have received 3 doses of DPT vaccine	79.1	-13.8	Decrease	116.2		-37.1		97.4		92.9
113		f)Children age 12-23 months fully immunized	74.1	-13	Decrease	103.1		-29.0		87.5		87.1
114												

AHS 2012-13 Comparsion | NFHS-4 Comparsion | District list | REWA | JHABUA | SIDHI | SEONI- | BALAGHAT | BHIND | KHANDWA | INDORE | HARDA- | NARSINGHPUR | VIDISHA- | JHABUA

The data for all indicators were keenly observed and calculated in various data sources. The data was also compared within HMIS for 3 years (2011-12, 2013-14, 2015-16).Various pattern were observed in Intra-HMIS in which we took the districts with static pattern of data in last two respective years. Now, we evaluated the difference between the AHS (2012-13) and HMIS (2015-16).The trend was traced and 24 districts were selected on the basis of extreme maximum and minimum variation. Fig (1.2)

	Districts to be studied			
1) Total ANC Registration	REWA	Jhabua	Sidhi	Seoni
2) ANC >or = 3	BHIND	KHANDWA	INDORE	HARDA
3) Institutional Delivery	Narsinghpur	Vidisha	Jhabua	Shahdol
4) Children who received FULL IMMUNIZAT	TIKAMGARH	JHABUA	UJJAIN	NEEMUCH
5) Children who received DPT3	BALAGHAT	KATNI	JHABUA	SHEOPUR
6) Children RECEIVED BCG	JHABUA	SIDHI	SEONI	RAJGARH

Now all the 24 districts were studied for the particular indicator and drilled down till the block level to analyse the cause of the lacunae.

Comparison of NFHS-4 and HMIS (2015-16) for 51 districts:- Fig (1.3)

S no	Districts	Indicators	NFHS-4	HMIS 2015-16
1)	**Alirajpur**			
		a) Mothers who had ANC in First Trimester	29.8	65
		b) Mothers who received ANC >OR= 3	21.1	79.3
		c) Institutional Delivery	50.5	69
		d)Children age 12-23 months who have received BCG	82.9	114
		e)Children age 12-23 months who have received 3 doses of DPT vaccine	37	95.3
		f)Children age 12-23 months fully immunized	22.6	101.2
2)	**Anuppur**			
		a) Mothers who had ANC in First Trimester	45	68
		b) Mothers who received ANC >OR= 3	35.1	82.6
		c) Institutional Delivery	77.1	52
		d)Children age 12-23 months who have received BCG	95.4	64
		e)Children age 12-23 months who have received 3 doses of DPT vaccine	80.7	74.9
		f)Children age 12-23 months fully immunized	57.8	75.9

HMIS provides new opportunity to link information and communication technology – for data collection, management, creating information products and dissemination to affect policy. HMIS must be seen as a gradual process requiring long-term investment. Institutionalization of key indicators, institutional and capacity-building approach helps in reducing costs and provides better monitoring. Using geographical information system to monitor effective functioning of facilities, availability of services and their readiness can be explored. Field studies, stakeholder consultations and reviews at state level can provide more in-depth information to identify gaps and strengthen the HMIS.

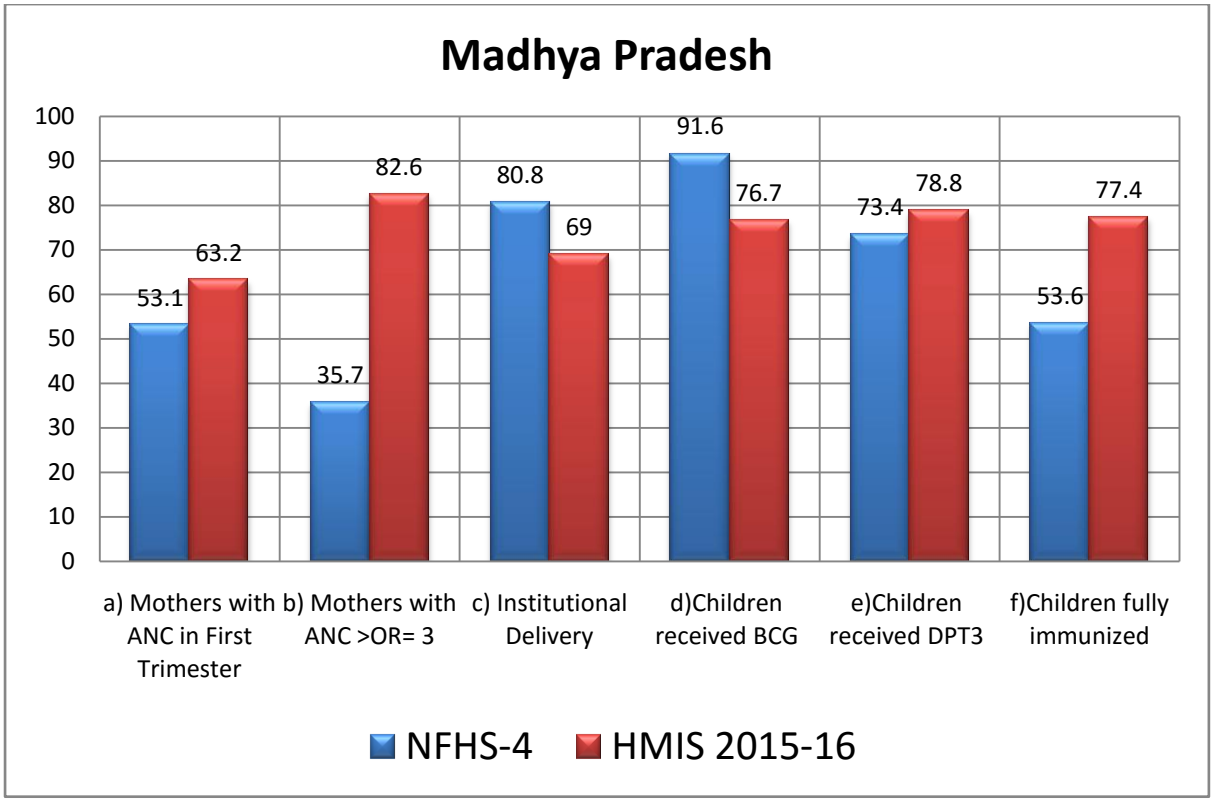


Fig (1.4)

Findings:

The maximum variation between NFHS-4 and HMIS 2015-16 is seen for two indicators namely (**1**) **Mothers with 3 or more Anti Natal Check-up's**

(2)Children who have received full immunization

The minimum variation between NFHS-4 and HMIS 2015-16 is seen for indicator **"Children who have received 3 doses of DPT (Pentavalent also included)**

Comparison of Vidisha and Narsingpur District on basis of RMNCH Indicators:-

Fig (1.5)

HMIS 2015-16 data is compared with MCTS to see the variation among previously selected indicators of all the blocks of two selected districts Narsingpur and Vidisha.

The two districts were selected on the basis of variation seen and at the same time we assumed that it would definitely show the maximum variations and discrepancies at block level.

	Vidisha District										Vidisha	
	Kurwai		Lateri		Nateran		Sironj		Vidisha			
	MCTS	HMIS 15-16	MCTS	HMIS15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16
Total ANC Registration	67.3	64.7	88.4	82.4	68.8	66.4	60	93	79.7	95.9	69.8	77.5
Mothers who received ANC >OR= 3	77.6	80.6	48	78.6	64.2	91.2	49.5	78.2	72.6	77.4	64.3	84.9
Institutional Delivery	74.2	43.3	63.9	42	73.7	37.7	48.1	43.7	68.1	83.5	66.3	53
Children who have received BCG	82.9	54	82.8	68.7	92.2	54.2	82.3	73.5	88.5	89.2	85.9	68
Children fully immunized	75.9	58.6	41.8	63.8	63.9	65.1	55.3	71.5	70.7	68.7	64.4	66.5

	Narsingpur District								Narsinghpur	
	Gotegaon		Kareli		Narsingpur(Dhamna)		Saikheda			
	MCTS	HMIS 15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16	MCTS	HMIS 15-16
Total ANC Registration	58.7	68.2	59.2	71.6	113.1	126.4	79.1	83.7	73	82.1
Mothers who received ANC >OR= 3	44.8	83.7	72.6	78.7	65.8	83.5	78.1	75.7	66.4	82.2
Institutional Delivery	61.3	35.7	63.5	49.5	62.7	110.1	65.4	55.5	67.7	53
Children who have received BCG	86.6	44.8	94.2	56.9	87.8	123.5	91.2	62.6	89.6	61
Children fully immunized	68.4	79.3	82.3	74	57.1	86.8	78.7	68.6	69.3	74.6

In Vidisha & Narsinghpur district maximum variation is seen for **"Mothers who had more than 3 ANC"** in which MCTS data is less than HMIS data.

Fig (1.6)

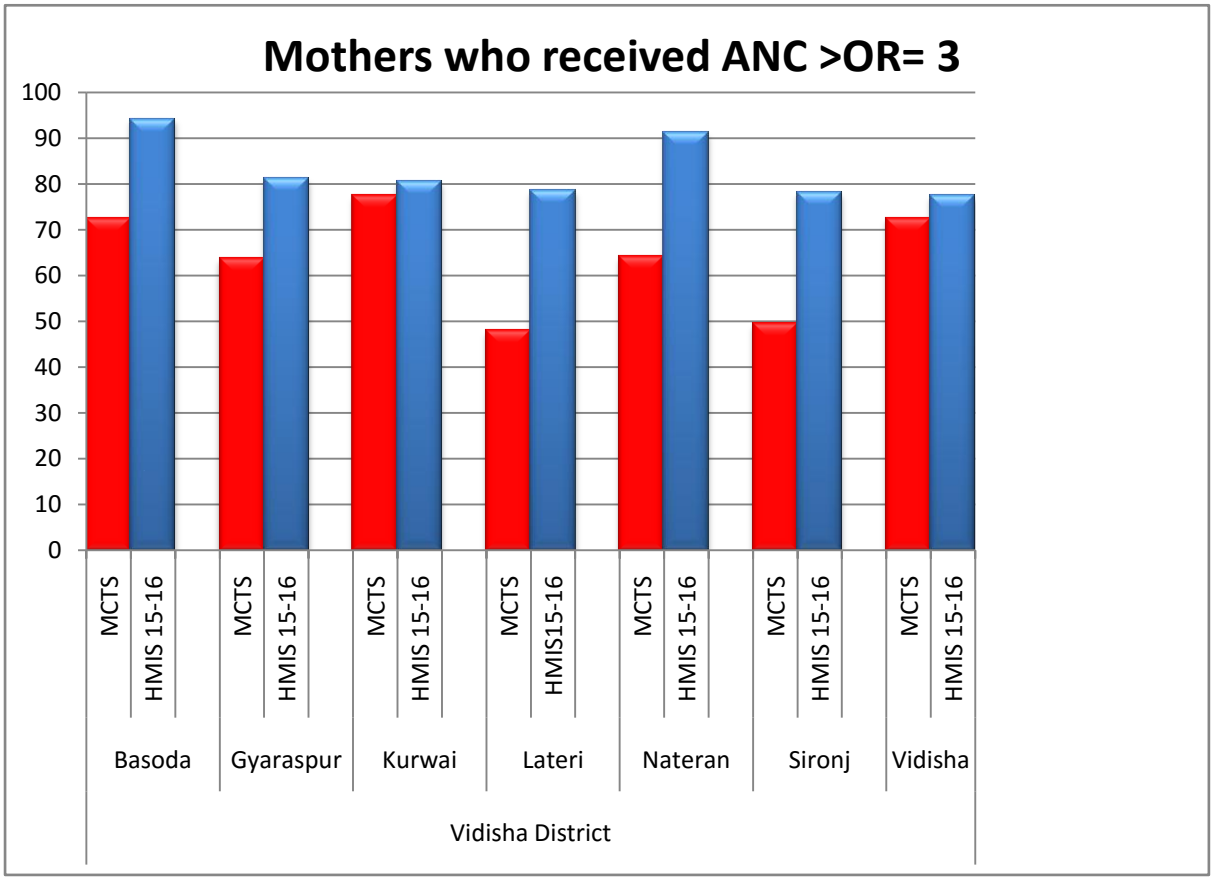
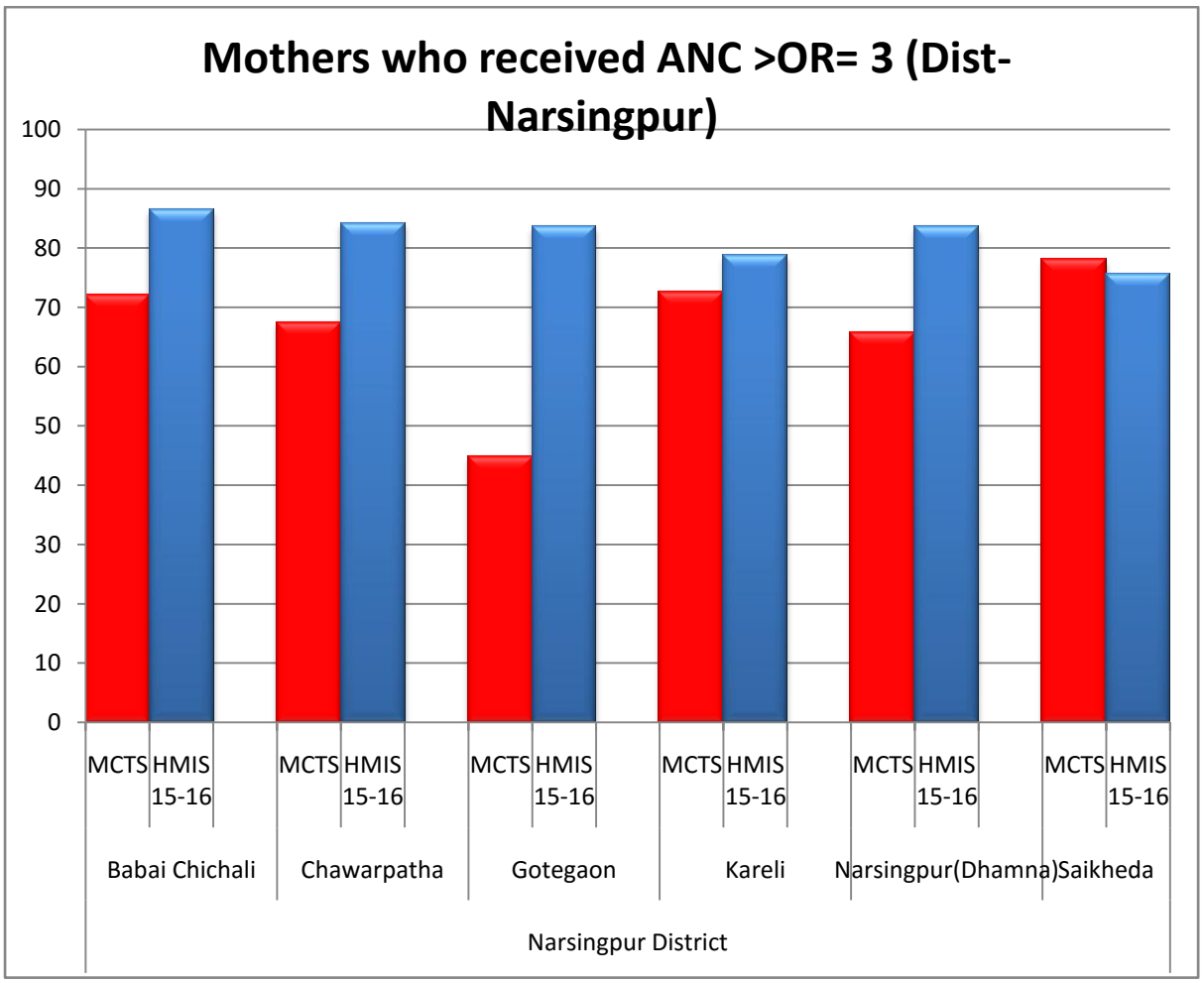


Fig (1.7)


Mothers who received ANC >OR= 3 (Dist-Narsingpur)
100
90
80
70
60
50
40
30
20
10
0
MCTS
HMIS 15-16
Babai Chichali
Chawarpatha
Gotegaon
Kareli
Narsingpur(Dhamna)
Saikheda
Narsingpur District

Observations & Learnings:-

Data Quality Issues:data quality issues have reduced the usefulness of HMIS data. The low quality of the HMIS is evident from three factors: **high percentage of missing data, high occurrence of invalid entries and the presence of outliers.** Moreover, HMIS has failed to ensure reporting from all private health facilities. Also, **instances of repeat entries** are common at the lower levels of reporting. Over the past few years, the quality of data has improved. Yet, it still falls short of the requirements of evidence based health policy planning. Data quality has to increase substantially before it can be used for monitoring and planning in the health sector.

Most of the systems are currently working as a reporting tool rather than program management information systems. Part of the problem is due to the **excessive burden of unnecessary data elements** and lack of program monitoring indicators in the system Indicators and reports which are available merely focus on data entry and reporting completeness rather than supporting program management.

Recommendations:

- **Encouraging Data Use at the Ground level**: Having stated the problem of data quality, one question remains, "What could be done to make the health information systems more reliable?"

  a) One way to achieve this is to encourage the use of HMIS data at the micro level. This will improve the understanding about HMIS among the field level workers.HMIS reporting starts with the auxiliary nurse and midwives (ANM). As they become aware of the usefulness of HMIS data, the quality of reporting is going to improve.

  b) Another way is to encourage discussions on HMIS data in regular community meetings. If these small steps are taken, the quality of HMIS reports can be improved substantially.

- Data availability, which links with data sources, communication, dissemination and use of information, should be strengthened even Private sector and facility level data needs strengthening.
  - **a)** Data sources - population based surveys, administration records; disease surveillance data; and institutional survey/records - should be compared, integrated and used to set baselines and targets.
  - **b)** To avoid duplication and costs of additional surveys, mapping and building upon what exists is required.
- **Under Reporting:**
  - **a)** Under reporting may be due to lack of dedicated data entry operator, which should be rectified.
  - **b)** Low reporting of certain indicators in the blocks nearing the district headquarter may be their proximity to a bigger facility of same district or other nearby district.

Following other issues which need to be addressed:

Large scale differences in the two data system due to movement of woman may not occur at the district or state levels but possible at lower levels. The HMIS follows the facility-wise reporting system while the MCTS follows the area-wise reporting system. Thus, in the MCTS, women moving to another area for services will be considered and entered as those who received services and the area from which she receive the service will not be noted. On the contrary, in the HMIS wherever the woman receives services, she will be counted in that facility.

Since the Front Line Health Workers (FHWs) were overburdened with data documentation work, and there were long delays in data capturing. So this should be dealt promptly.

References:-

1) http://mospi.nic.in/Mospi_New/upload/Health_Statistics_17June2014.pdf
2) Assessment of the ability of the health management information system in India to use information for action - http://etd.uwc.ac.za/xmlui/handle/11394/3607
3) Why Triangulate? Sandra Mathison, Evaluation Coordinator- http://edr.sagepub.com/content/17/2/13
4) http://www.write.com/writing-guides/research-writing/research-process/data-triangulation-how-the-triangulation-of-data-strengthens-your-research/

Table 1: Data sources for health statistics and their coordinating agencies

Data Sources	Coordinating agencies	Web Links
Census 2011	Office of the Registrar General of India, GOI	http://censusindia.gov.in/
Annual Health Survey (AHS) 2012-13	Office of the Registrar General of India, GOI	http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_2nd_Updation_Bulletins.html
National Family Health Survey (NFHS) – 4	Ministry of Health and Family Welfare (MoHFW); International Institute for Population Sciences (IIPS), Mumbai Indian Institute of Health Management Research (IIHMR), Jaipur	http://rchiips.org/nfhs/pdf/NFHS4/MP_FactSheet.pdf
HMIS 2011-12, 2013-14, 2015-16 HMIS Bulletin	Ministry of Health and Family Welfare (MoHFW) Government of India	https://nrhm-mis.nic.in/SitePages/Home.aspx

A Report on

Assessment of Mental Health training program for Medical Officers and Staff Nurses under National Mental Health Program (NMHP) at BMHRC Bhopal and Indore Mental Hospital, Indore

Table of Contents:

OBSERVATIONAL LEARNINGS

National mental health programme:

Introduction:-

Health is defined as a state of complete physical, mental and social wellbeing, and not merely absence of disease or deformity (WHO).

Mental health is one of the main dimensions of health and is defined by World Health Organisation (WHO) as,

"A state of well-being in which every individual realizes his or her own potential, Can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"

Mental health therefore forms an essential part of total health and as such forms an integral part of the national health policy. Mental health is one of the essential components of patient care, this aspect was neglected earlier. It is well established fact that mental health principles can improve the health care delivery to patients. The Govt. of India felt the necessity of evolving a plan of action aimed at the mental health component of the National Health Programme. In February 1981, a drafting committee in Lucknow prepared the first draft of NMHP. After several revisions the final draft was submitted the Central Council of Health on 18-20 August 1982, for its adoption as the National Mental Health Programme for India.

Aims:

- Prevention and treatment of mental and neurological disorders and their associated disabilities.
- Use of mental health technology to improve general health services.
- Application of mental health principles in total national development to improve quality of life.

Objectives of NMHP:

1) To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.
2) To encourage application of mental health knowledge in general health care and in social development.
3) To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.

Strategies for Action:

Two strategies, complementary to each other were planned for immediate action;

Centre to Periphery strategy- establishment and strengthening of psychiatric units in all district hospitals, with OPD clinics and mobile teams reaching the population for mental health services.

Periphery to Centre strategy- Training of an increasing number of different categories of health personnel in basic mental health skills, with primary emphasis towards the poor and the under privileged section of the society.

Integration mental health with primary health care through the NMHP

Provision of tertiary care institutions for treatment of mental disorders

Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental health Authority.

District Mental Health PROGRAMME (DMHP):-

Components-

Training programmes of all workers in the mental health team at the identified Nodal Institute in the State. Public education in the mental health is to increase awareness and reduce stigma. For early detection and treatment, the OPD and indoor services are provided. Providing valuable data and experience at the level of community to the state and Centre for future planning, improvement in service and research.

Agencies like World Bank and WHO have been contacted to support various components of the programme. Funds are provided by the Govt. of India to the state governments and the nodal institutes to meet the expenditure on staff, equipment's, vehicles, medicine, stationary, contingencies, training, etc. for initial 5 years and thereafter they should manage themselves. Govt. of India has constituted central Mental Health Authority to oversee the implementation of the Mental Health Act 1986. It provides for creation of state Mental Health Authority also to carry out the said functions.

The National Human Rights Commission also monitors the conditions in the mental hospitals along with the government of India and the states are currently acting on the recommendation of the joint studies conducted to ensure quality in delivery of mental care.

PROJECT REPORT

Introduction:

The training program has been designed to impart basic skills and train Medical officers and staff nurses in Mental Health as per guidelines of National Mental Health Program (NMHP).The study was done to understand the whole process of training of Medical Officers and Staff Nurses in Mental Health at the two centres and to evaluate and compare both the training facilities i.e. Bhopal Memorial Hospital & Research Centre (BMHRC) and Indore Mental Hospital, Indore. For the study purpose we visited BMHRC, Bhopal on 27th April 2016 and to Indore Mental Hospital on 29th April 2016.Both the training facilities were assessed on various parameters and a detailed questionnaire was filled individually for both the institutes and compared accordingly.

Indore mental hospital, Indore:

Medical hospital, Indore was established in 1917 as an asylum in the Holkar state. In 1950 name was changed to Indore Mental Hospital. It was brought under the administrative control of MGMMC Indore in 1998 which is being governed by the Department of Medical Education, Govt. of Madhya Pradesh. The department runs in the premises of MGM Medical College Indore and also has a separate hospital in Banganga area which is about 9-10 km from the Dept. of psychiatry, MGM Medical College Indore.

BMHRC, BHOPAL:

The Bhopal Memorial Hospital and Research Centre (BMHRC) saw the light of day in 1998 with the mission to provide free healthcare to the victims of Bhopal gas tragedy. It is governed by the Indian Council of Medical Research (ICMR) since 2012. With the compassionate care, excellent medical equipment's, high standards of medical treatment BMHRC grew up to be a Hospital par Excellence, one of its kinds, not only in central India but in the world. The glory of the magnificent infrastructure and the warmth of the ambience distinguish BMHRC from the rest of the hospitals in the country. BMHRC focuses on specialization with perfection through a diligent team of professional and highly qualified Doctors. A Bio-psycho-social healing model is the call of the day and hence the focus in past

years has also been on the establishment of rehabilitative programmes to improve the quality of life of the patients.

Rationale:

The purpose of the study is to compare the training process and curriculum at the both the training centres and assess them on the basis of various parameters. Since this type of training in mental health is a relatively new concept in which Medical Officers and Staff Nurses are trained to spot, diagnose and treat some common mental health diseases which are mostly left undiagnosed and untreated due to lack of Psychiatrist at the medical facility.

This study was done because there was a need for designing a uniform training schedule and course content according to the guidelines of National Mental Health Programme.

Objectives of the study:-

1) To assess training of Medical officers and staff nurses on various parameters at both the training centres.

2) To analyse and compare the course curriculum on several factors at both the training centres.

3) To assess and compare the utilization of budget and cost borne per trainee of each cadre at both the training centres.

4) To analyse the quality of training through Pre-test & Post-test at both centres.

5) To find out the gaps or biases present in training process.

Methodology

- **Study Design:** Qualitative Research
- **Study Area:** Indore Mental Hospital, Indore

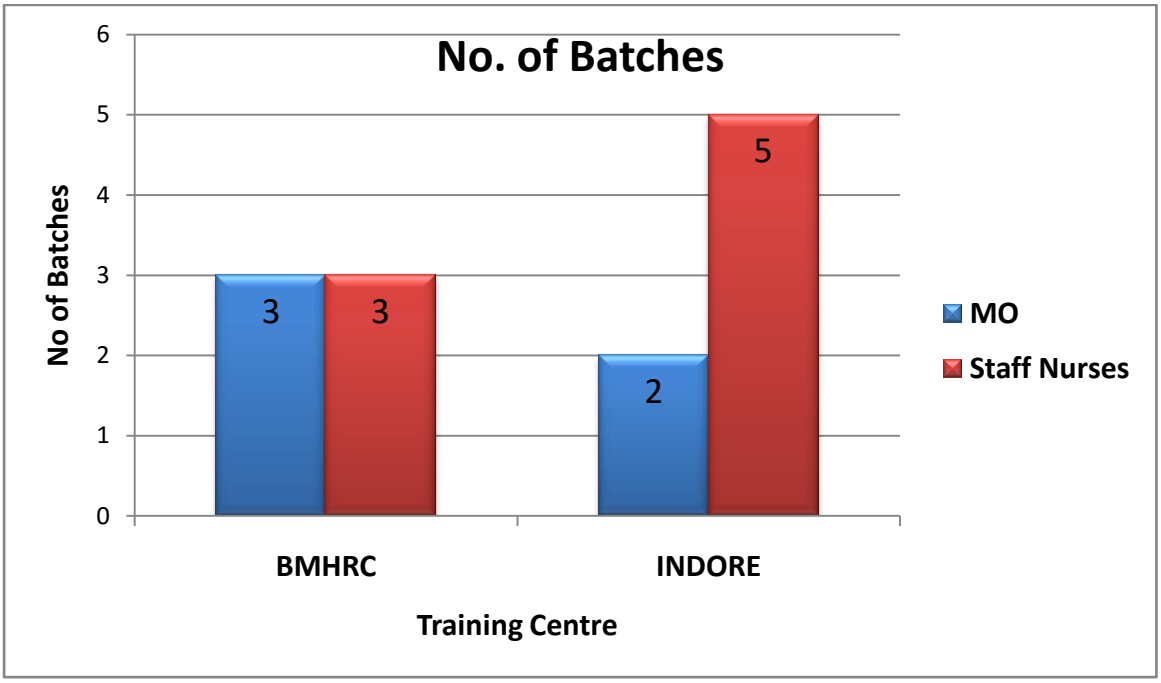
  Bhopal Memorial Hospital & Research Centre (BMHRC), Bhopal
- **Data Collection:**Data was collected by reviewing records and from coordinators.
  - ❖ Interview method - Face to face interview were taken of the staff that were present at the training centres.

- Semi-structured Questionnaire – A questionnaire of close ended and open ended questions was made to get specific and relevant information regarding the training programme and associated aspects of it.

Data Compilation , Analysis & Interpretation:-

1) The number of batches of candidates trained at the centre?

No of Batches	BMHRC, Bhopal	INDORE
1)Medical officers	3	2
2)Staff Nurse	3	5



Note:-At BMHRC, 3 batches of MO and 3 batches of Staff Nurses were trained while in Indore Mental Hospital, 2 batches of MO and 5 batches of Staff Nurses were trained.

2) Actual Number of candidates attended the training program against total asked to attend.

At Indore Mental Hospital Indore

Post	Total(All Batches)	Attended(All Batches)
Doctors	21	12
Staff Nurses	83	77

At BMHRC Bhopal

Post	Total(All Batches)	Attended(All Batches)
Doctors	31	22
Staff Nurses	49	41

Note:-In Indore Mental Hospital it was seen that the attendance of Staff Nurses was more than 90% while that of Medical Officers was nearly 55%.

On the other hand at BMHRC Bhopal, the attendance of Staff Nurses was nearly 83% while that of Medical Officers was approx. 70%.

It makes us conclude that at both the training centres participation of Staff Nurses was more than Medical Officers.

3) Whether schedule was made by the institute or not and if made, was followed or not?

- The schedule was made and followed strictly in both the training facilities. Both the institutes had developed a well verse schedule for the training program which included lectures, OPD, Ward postings.(Copy of schedule in annexures)

4) What is the time frame of the training at the centre?

- **BMHRC**

Timings	Monday-Friday	Saturday	Sunday
Start timings	9 am	9 am	Off
End Timing	5 pm	2 am	Off
Total Hours	7 hrs	5 hrs	Off

- **Indore Mental Hospital**

Timing	Activity
9-10 am	Lecture
10-12 noon	OPD posting
12-1 pm	Lecture
1-2 pm	Lunch
2-4 pm	Ward Postings

Total hours- 6 hrs

Note: - At both the training centres the training duration also included Sundays means on Sundays there was no training but the day was counted.

5) Which training methods were used?

	BMHRC	INDORE
Lectures	✓	✓
PowerPoint Presentation	✓	✓
Videos	✓	
Case Studies	✓	✓
Handouts	✓	✓
Ward Rounds	✓	✓
OPD attended	✓	✓

Note: - The training method used at both the centres was satisfactory.

6) Is there an evaluation included in the training?

-Pre evaluation (questionnaire) - Present in both the centres. (Copy Attached in annexure)
-Post evaluation (questionnaire) - Present in both the centres. (Copy Attached in annexure)

7) Number of trainers per batch,

Names of trainers and qualifications

There were 9 trainers for Medical Officers & Staff Nurses at BMHRC, Bhopal:-

S no	Name of Staff	Qualification
1	Dr Rajni Chatterjee	MD Psychiatry
2	Dr GayatriSaraf	MD Psychiatry
3	Dr ShivaniBhadoria	MBBS
4	Dr Anjali Sahay	PhD
5	Dr RupeshRanjan	PhD
6	Ms Nisha Sinha	MPhil
7	Dr Pooja Khare	Psychiatry Technician
8	Dr Mallika	MD Neurophysician
9	Dr Zafar Ahmad Khan	MPhil

For the Staff Nurses three additional trainers were

1) Smita Johnson – Nursing Superintendent
2) AjiKoshi – Dy. Nursing Superintendent
3) Anulatika – Nursing Supervisor

There were 9 trainers for Medical Officers & Staff Nurses at Indore Mental Hospital, Indore:-

S no	Name of Staff	Qualification
1	Dr Ram Ghulam Razdan	MD Psychiatry
2	Dr V S Pal	MD Psychiatry
3	Dr Ujwal Sardesai	MD Psychiatry
4	Dr Abhay Paliwal	MD Psychiatry
5	Dr Pali Rastogi	MD Psychiatry
6	Dr Kapil Dev Arya	MD Psychiatry
7	Dr Vijay Niranjan	MD Psychiatry

For the Staff Nurses two additional trainers were

1) Mrs Raksha Tiwari - MSc Nursing

2) Mrs Biji Lewy-MSc Nursing

8) What is the course content/material provided for the training by the institute?

At Mental Hospital Indore:-

For Doctors-

1) **"Mental Health Care by Primary Care Doctors"** by NIMHANSE, Bangalore
2) **"Training Manual &A Handbook on Common Mental Disorders"** from Mental Hospital Indore (Dept. of Psychiatry) MGM Medical College Indore.

For Staff Nurses-

1) "Diagnostic and Management guidelines for Mental Disorders in primary care (ICD-10 Chapter V Primary Care Version)"- by Dept. of Psychiatry, MGM Medical College Indore

2द्ध नर्सेस एवं स्वास्थ्य कार्यकर्ताओं के लिए मानसिक स्वास्थ्य कार्यक्रम हेतु आई सी ऍम आर (ICMR) की शोध पर आधारित।

At BMHRC Bhopal:-

For Doctors –

1) Psychiatry book by Neeraj Ahuja

2) Assignment work book

For Staff Nurses-

-Printed materials

Note-On comparing the course material at both the training facility, we conclude that there was no uniformity in course material, So a standardized course material/module should be provided for both Medical Officers and Staff Nurses at BMHRC and Indore Mental Hospital.

9) Case presentation activity done?

Number of case presentation both for Medical Officers and Staff Nurses were 2-3 cases individually at both the centres.

10) Location of the training facility

Particulars	BMHRC	INDORE
• **Distance of Residential site**	2km	8-10km
• **Mode of Transport**	Car	Traveller
• **Time taken in transportation**	5-10 min	30 min
• **Food & refreshment at training centre**	YES	YES

Note: - The hotel for the trainees was far from the training centre in Indore as compared to BMHRC .Though the training was started at its scheduled time but it consumes lot of time of trainee in reaching the training facility. This travelling time can be minimized by providing them accommodation within training facility.

11) Facilities at training room

Adequate facilities were there in both the centres

Training room at Indore Mental Hospital

12) Whether IEC material was present in wards or not?

IEC material was present in wards and training rooms of both the training centres i.e. BMHRC and Indore Mental Hospital.

-Language of IEC material was simple and easily understandable and content was rich in information and useful in spreading awareness about mental disorders and treatment.

13) Assessment of trained candidates?

- Need of refresher course for candidates?

-Indore mental hospital recommended a refresher course after an interval of 1 year. They were in constant touch with the trained doctors on social networks i.e. WhatsApp and Facebook. The doctors shared their queries and those doubts were cleared after discussion on the forum; it proved to be a very useful practice.

Observations & Findings:-

After the visit to BMHRC, Bhopal and Indore Mental Hospital, Indore for the study and assessment of the training program conducted for MOs and Staff Nurses, major findings were:

- A systematic and uniform training program was lacking since it was conducted at two entirely different centres i.e. BMHRC and Indore Mental Hospital which were under Govt. of India and Govt. of Madhya Pradesh respectively so it was lack of coordination.
- A common course material was lacking.
- No clear directions were issued by the Directorate of Health Services regarding faculties for this training program.
- Lack of attendance of Medical Officers was more as compared to the Staff Nurses.
- There was no clear policy regarding absentees, what action should be taken on them was not defined.
- The budget norms were stringent, so proper facilities could not be arranged.
- The training at Indore Mental Hospital under Dr Ram Ghulam Razdan was far better and properly conducted as compared to the one conducted at BMHRC, Bhopal.
- After the training, the trainees were well in contact with the faculties and staff on social media groups at both the training facilities.
- Monitoring by the deputy director was very well.
- In Indore Mental Hospital it was seen that the attendance of Staff Nurses was more than 90% while that of Medical Officers was nearly 55%.On the other hand at BMHRC Bhopal, the attendance of Staff Nurses was nearly 83% while that of Medical Officers was approx. 70%.It makes us conclude that at both the training centres participation of Staff Nurses was more than Medical Officers.

Recommendations:-

- Instead of centralizing mental health skills and expertise in an urbanized community, it should reach village level (PHC & CHC).
- There should be proper referral channel so that patient can be referred by district MO to specialized doctors which will help in treatment of complex cases.
- Training Certificates can be given to the trainees, which will enhance their academic profile so they would be more interested in participating in the training program.
- Refresher/ Reorientation course can be conducted for both Medical Officers and Staff Nurses at regular intervals (6 months or 1 year).This would help in updating and polishing their knowledge.
- The absenteeism of Medical Officers and Staff Nurses should be dealt strictly.
- Public education in Mental Health, to increase awareness and reduce stigma.
- Accommodation should be provided within the premises of the training centre, to minimize unnecessary traveling time.
- Proper feedback mechanism should be developed from the state authority so that Medical Officers and Staff Nurses give direct feedback for future planning and improvement in training program.
- Suggestions should be sought from the trainers also to improve the program.
- The pre-test and post-test questionnaire should be similar for proper evaluation of training.
- It can also be upgraded as a diploma course in Psychiatry, which would help in attracting more Medical Officers towards the training program.
- For Staff Nurses it can also be upgraded to Diploma in Psychiatric Nursing, which would enhance their academic profile also.

References:-

1) National Mental Health Policy of India, Ministry of Health and Family Welfare, Government of India, October 2014.
2) Mental Health Primary Care Basics, Department of Psychiatry Sri Aurobindo Medical College Indore.
3) Guideline of DMHP at DH level 2015 by MoHFW, Govt. of India
4) DMHP at Tertiary level Medical College 2015 by MoHFW, Govt. of India.
5) Assessment and Management of MENTAL HEALTH PROBLEMS in general practice, Directorate of Health Services, Govt. of India.

A Report on

The Study and Evaluation of Performance Appraisal of Contractual Employees in NHM (Madhya Pradesh) in District Alirajpur, Bhopal, Sehore and Ujjain.

Table of contents:

OBSERVATIONAL LEARNINGS

Introduction:

Performance appraisal is a continuous process and annually done as formal HR exercise before completion of the financial year. It was conducted for the first time in National Health Mission, Bhopal (MP) for contractual employees of various cadres. Appraisal has motivational impact on people through meaningful feedback and is a powerful tool for assessment and recognition. Performance appraisal system is explained by this project and also tries to find out how efficiently it is conducted and if it does not meet its objectives then, what are the failure causing factors.

PERFORMANCE APPRAISAL

- **What is performance appraisal?**

  Performance Appraisal is the formal, systematic assessment or tool to assess how well employees perform their jobs in relation to established standards.(Huang 2000)

  Performance:

  Performance is synonymous with behaviour, it is what people actually do. Performance includes those actions that are relevant to the organizational growth and can be measured in terms of each individual's proficiency(level of contribution). Effectiveness Performance refers to the evaluation of results of performance that is beyond the influence or control of the individual.

  Objectives of Performance Appraisal:

  - Corrective action after performance appraisal.
  - Renewal of contract.
  - The right balance of incentives & salary increment for staff to perform well.
  - Head quarter stay.
  - To improve performance through capacity building.
  - Clarify individual responsibility and accountability.
  - To improve the quality and health outcomes.
  - To examine why an appraisal system is important.
  - To reveal the various loopholes in the appraisal system if any.

Appraisal Rating:

Good	Average	Poor
65 and above	**64 to 55**	**54 And below**
5% increment & Renewal of contract	3 Month Notice to improve performance	Termination

Cadre	Total Numbers	Total Team
ANM	5451	51
Staff Nurse	2500	51
Lab Technician	800	51
Pharmacist	1500	51
Feeding Demonstrator	287	25
AYUSH -MO	1011	25
DEO	2508	25

Purpose of performance appraisal:

The Human Resource Development oriented performance appraisal is used as a mechanism to:

- ✓ Understand the difficulties of employers and employees and try to remove these difficulties and encouraging them to accept more responsibilities and challenges.
- ✓ Understand the strength and weaknesses of their employees and help them to realize these.
- ✓ Help the employees to become aware of their positive contributions.

Potential appraisal and Development:It is assumed under this system that the mission is under process of continuously achieving its goals. A growing and dynamic organization needs to review its structure and systems continuously to achieve the following:

- ➢ To continue the roles and responsibilities of employees (on contractual basis) who has performed better in their tenure with incentive as their reward.
- ➢ To create new roles and assigning new responsibilities.
- ➢ To give chance of second assessment and improvement in the work, to those who performed near average.
- ➢ Terminate those who were not at all sincere and poorly performed.

Good	Average	Poor
65 and above	**64 to 55**	**54 And below**
5% increment & Renewal of contract	3 Month Notice to improve performance	Termination

Performance Appraisal Management Cycle:

SMART Goals [Specific, Measurable, Agreed, Realistic, Timed]

Higher-level strategies and objectives

Agreeing on performance and feedback

&

Evaluation of period's performance objective

Deciding on training And development plans & Focus and Career planning and counselling

Key issues: Procedural and distributive justice, effectiveness of incentives

Performance based Compensation

Research Methodology:

Data source: Primary as well as Secondary

Research approach: Survey Method

Research Study: Descriptive Study through Observation

Research Instrument: Verbal Questionnaire

The Respondents: Employers and Employees

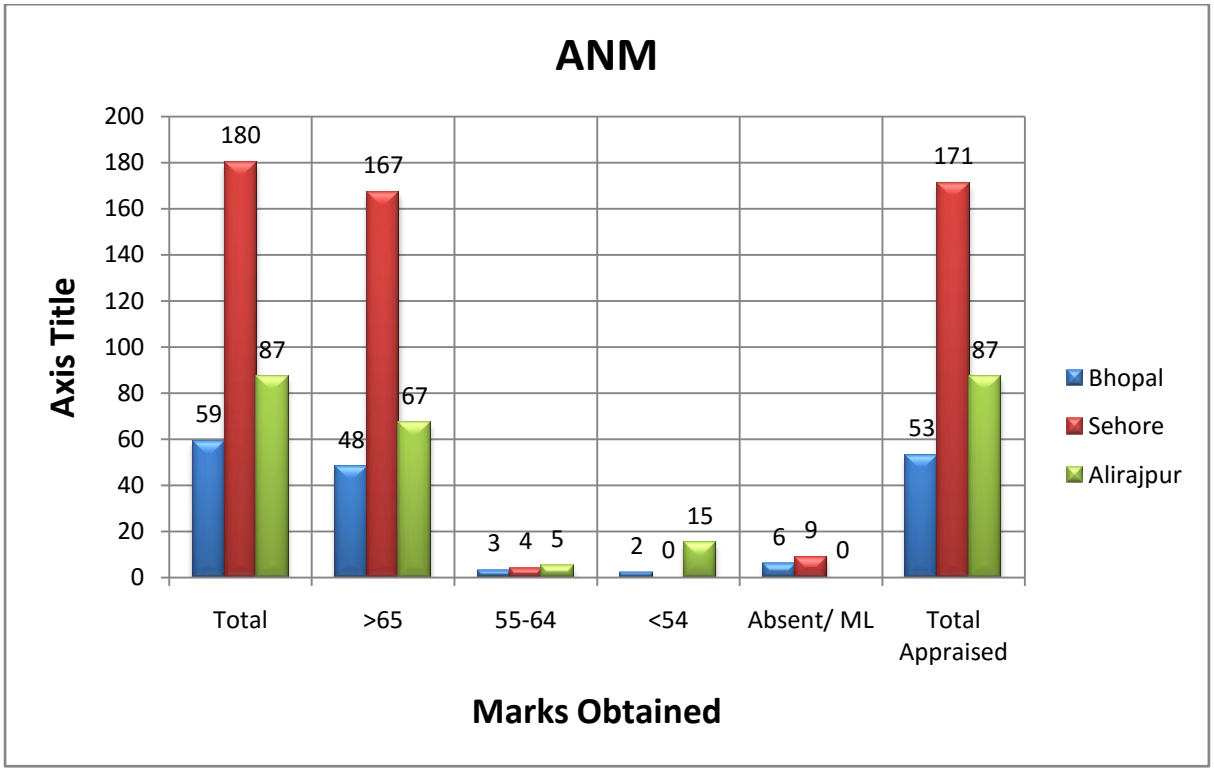
The primary data was collected with the help survey information by the means of concise simple questionnaire which was prepared by keeping in mind the information specifications.

The secondary data was collected from literature (books, performance appraisal of other states and internet) to compare the performance appraisal conducted in NHM (M.P.) and standard performance appraisal. Also to identify gaps and loop holes in the process if exist to improve the effectiveness of the process.

Results and Findings:-

1.1 Comparison of Performance of ANMs of various districts:

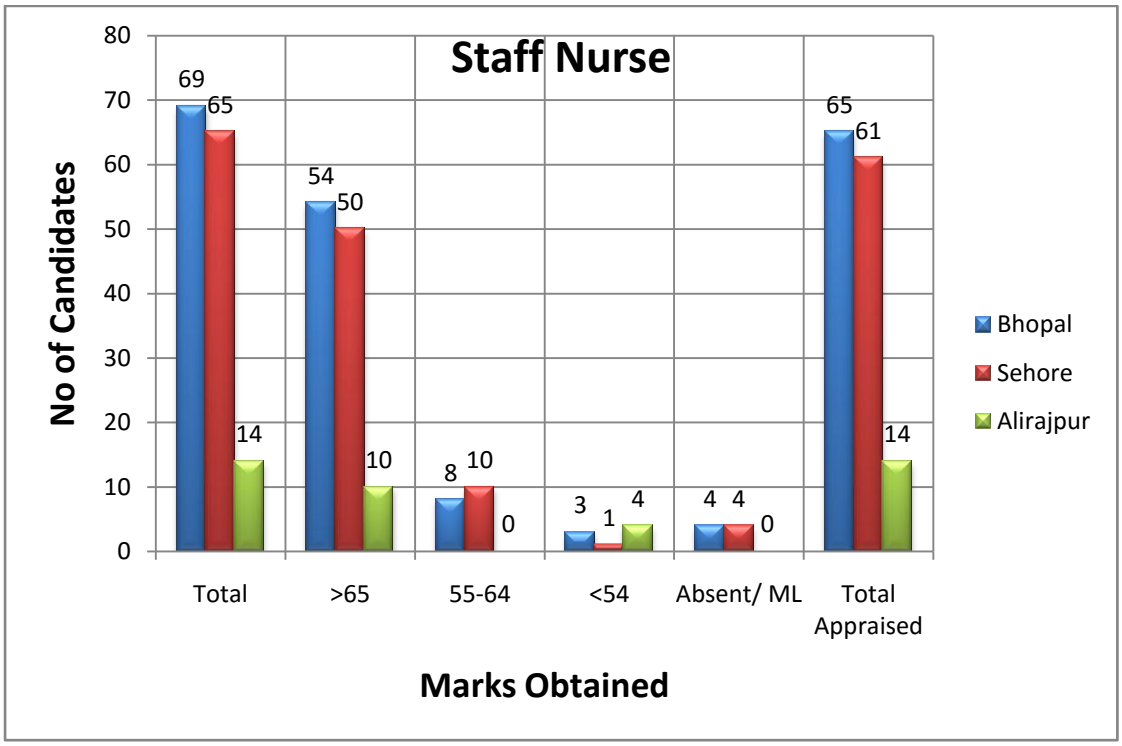
	ANM					
District	**Total**	**>65**	**55-64**	**<54**	**Absent/ ML**	**Total Appraised**
Bhopal	59	48	3	2	6	53
Sehore	180	167	4	0	9	171
Alirajpur	87	67	5	15	0	87



1.2Comparison of Performance of Staff Nurses of Districts:-

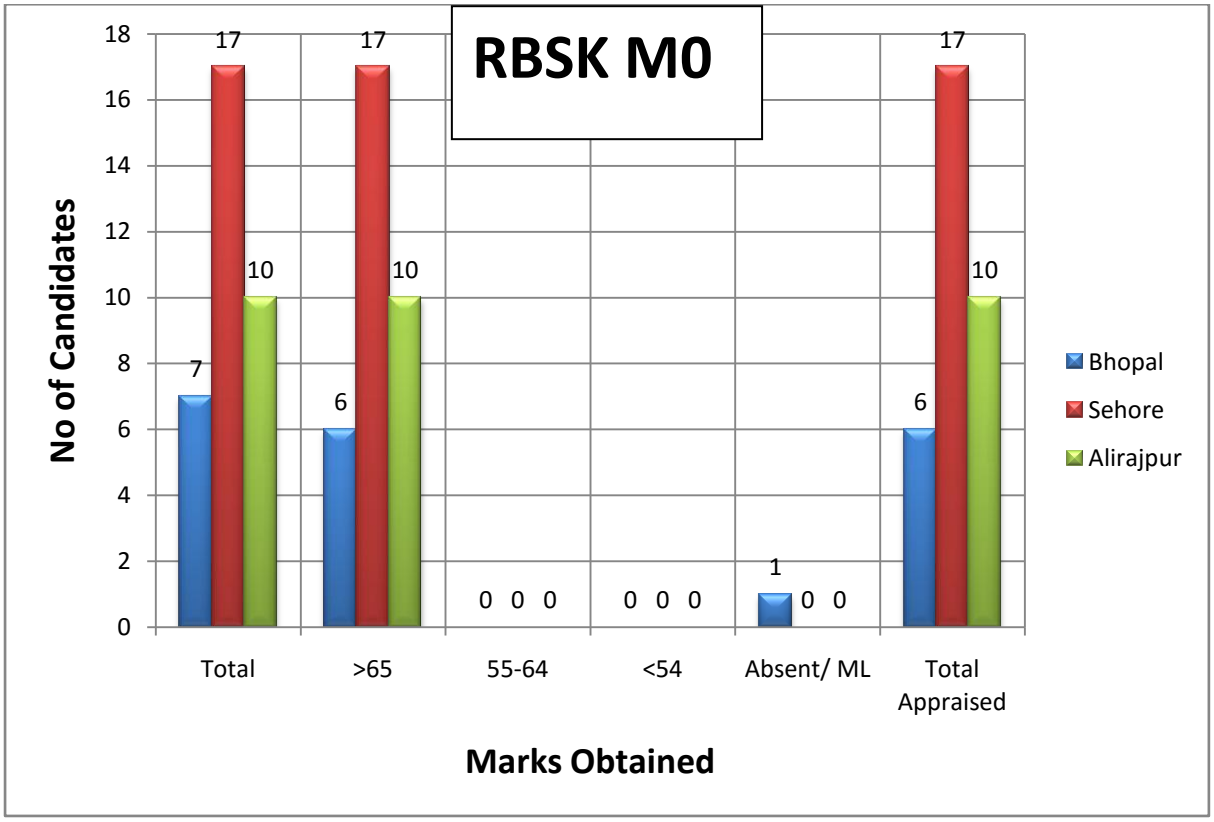
Staff Nurse

District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	69	54	8	3	4	65
Sehore	65	50	10	1	4	61
Alirajpur	14	10	0	4	0	14



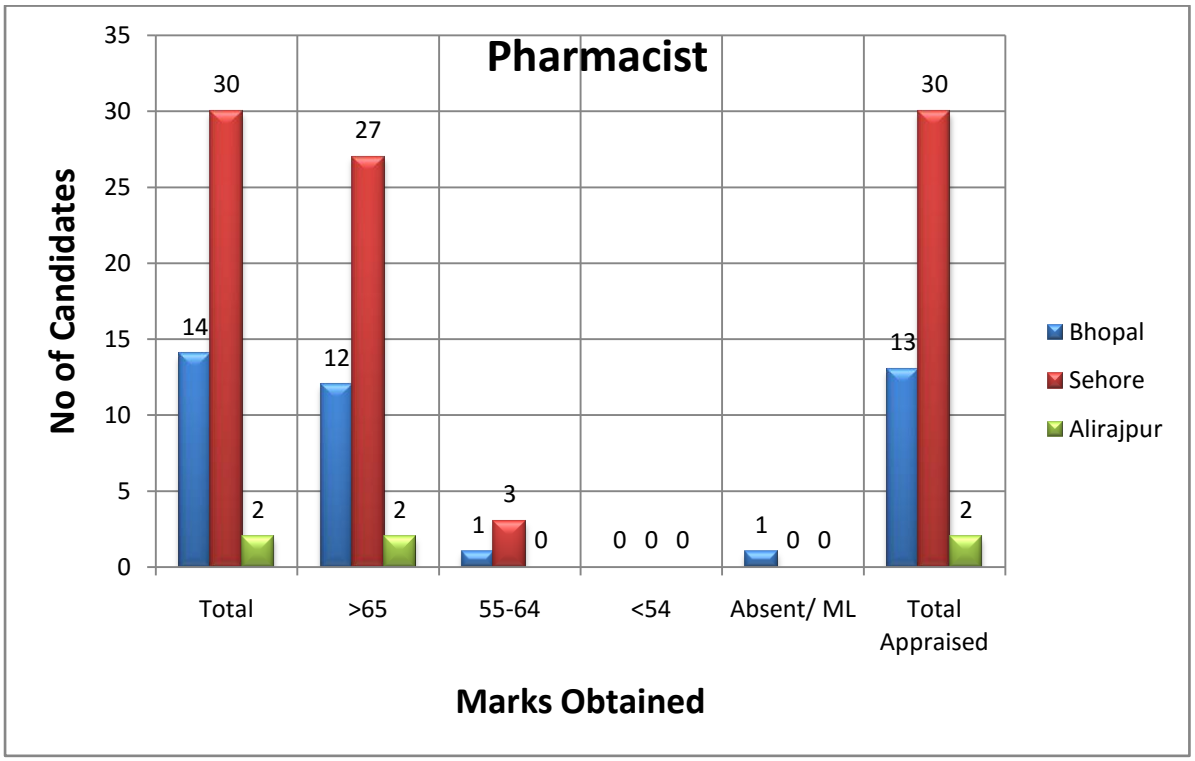
1.3 Comparison of Performance of RBSK MO of various districts:-

RBSK MO						
District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	7	6	0	0	1	6
Sehore	17	17	0	0	0	17
Alirajpur	10	10	0	0	0	10



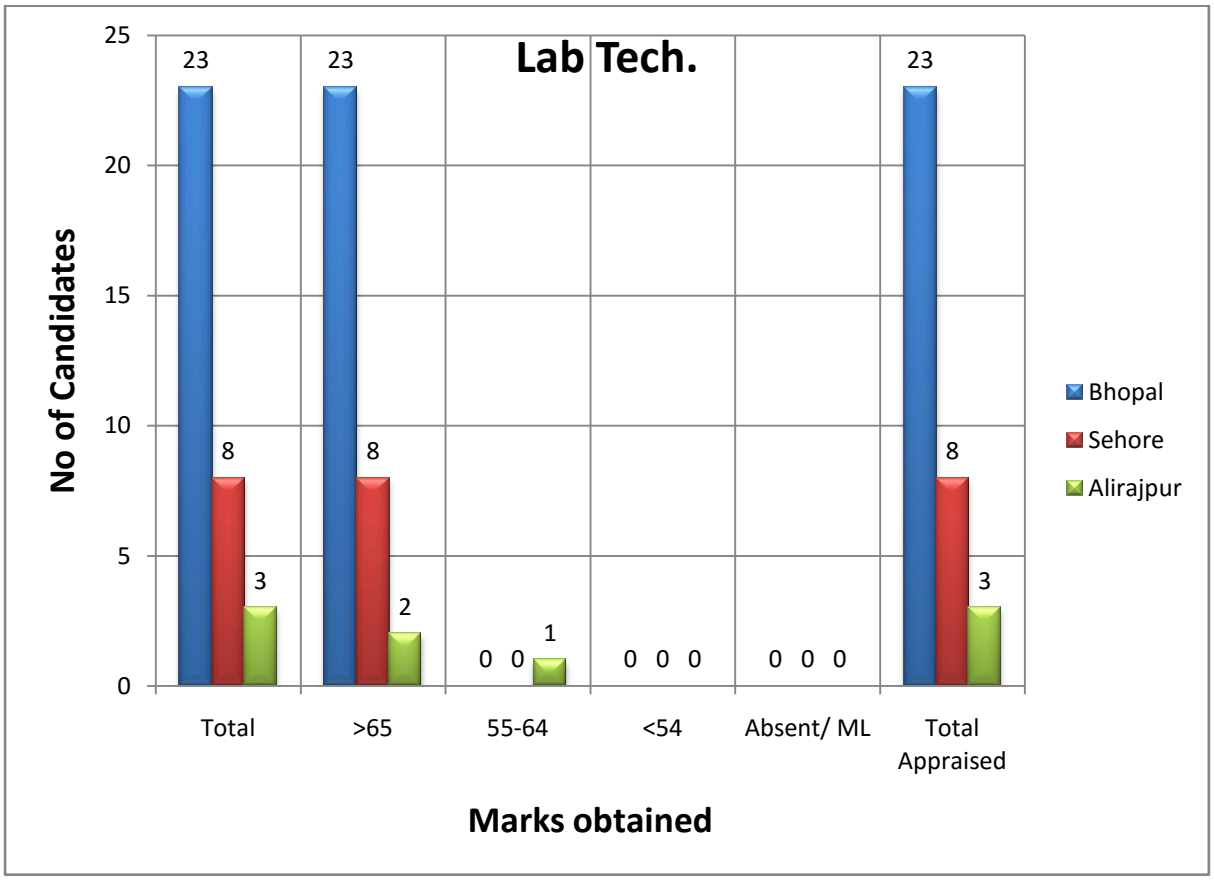
1.4 Comparison of Pharmacist of Districts:-

Pharmacist						
District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	14	12	1	0	1	13
Sehore	30	27	3	0	0	30
Alirajpur	2	2	0	0	0	2



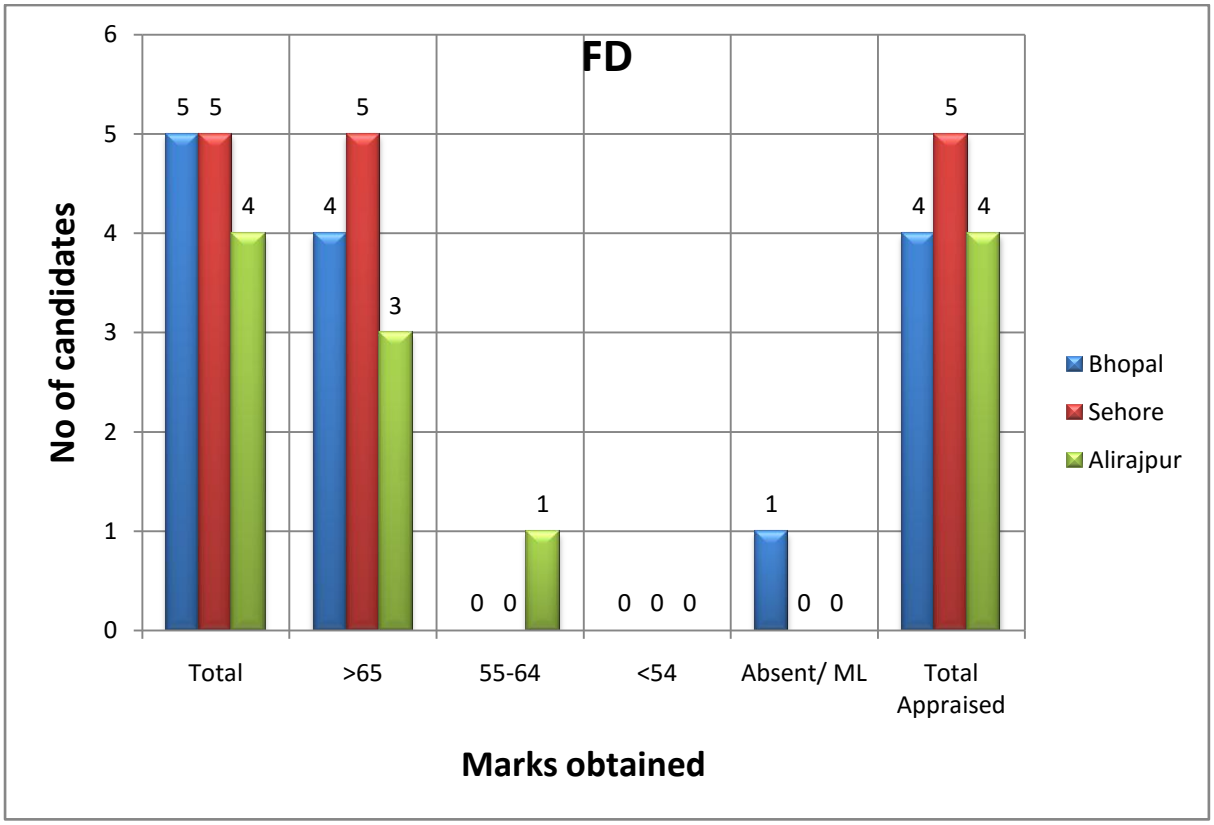
1.5 Comparison of Performance of Lab Technicians of Districts:-

LT						
District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	23	23	0	0	0	23
Sehore	8	8	0	0	0	8
Alirajpur	3	2	1	0	0	3



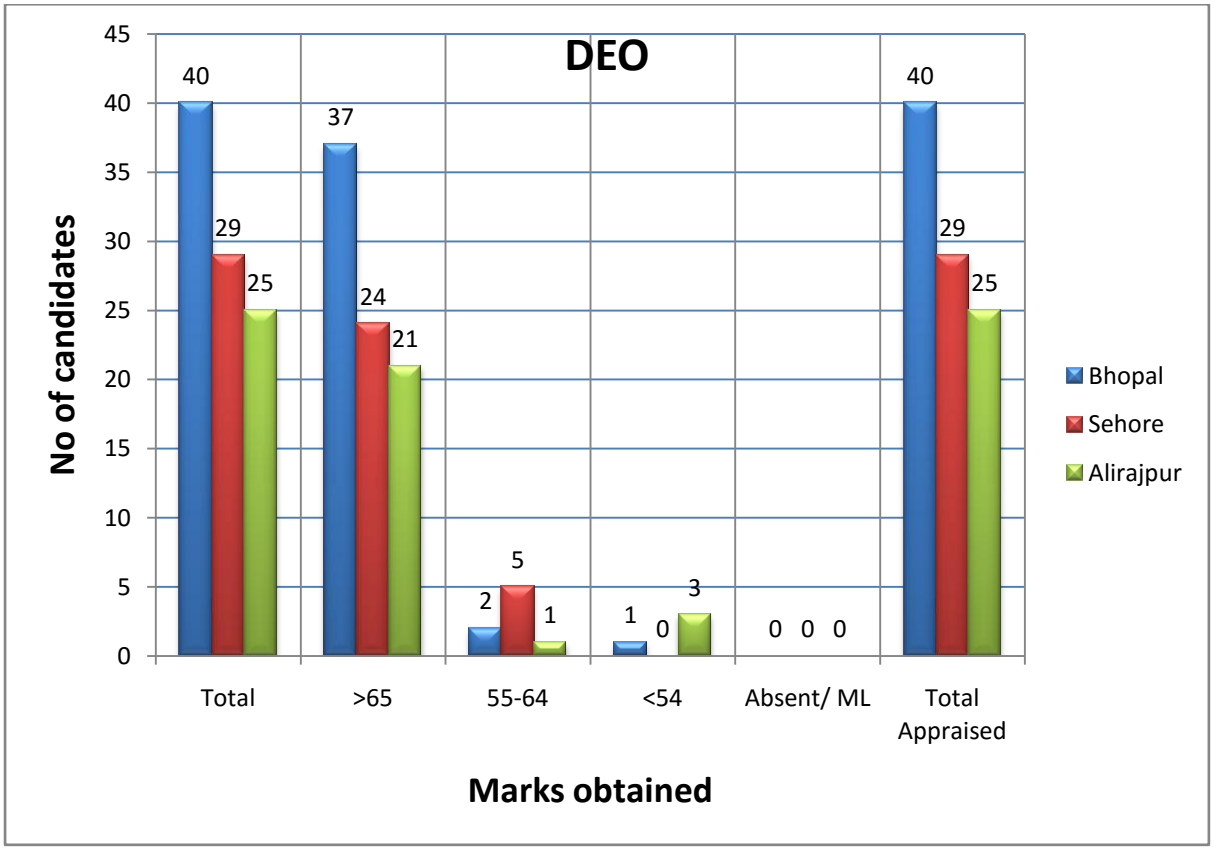
1.6 Comparison of Performance of Feeding Demonstrators of Districts:-

FD						
District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	5	4	0	0	1	4
Sehore	5	5	0	0	0	5
Alirajpur	4	3	1	0	0	4



1.7 Comparison of Performance of Data Entry Operators of Districts:-

DE0						
District	Total	>65	55-64	<54	Absent/ ML	Total Appraised
Bhopal	40	37	2	1	0	40
Sehore	29	24	5	0	0	29
Alirajpur	25	21	1	3	0	25



Observations & Findings:

1) From the observation through descriptive survey its evident that the performance appraisal program should be designed in such a way that the appraiser would be able to analyse the contribution of the employee to the organization periodically and all the employees who have been performing well would be rewarded suitably by continuing the job with an incentive. Whereas those who performed on average should be given time for improvement in their work and given chance for reassessment after few months. And those who performed very poor should be terminated. Thus performance appraisals can be used as a significant tool for boosting the employees and their career upliftment.
   Hence it is suggested that performance appraisal would be more beneficial if it is designed to satisfy needs of not only appraiser but also of appraisee.

2) Analysing one's own strengths and weaknesses is the best way of identifying the available potentials, rather than the other person telling or showing. Self-appraisal is a tool to analyse oneself which was not undertaken during the process conducted. One of the most important findings was that self-rating was not encouraged which is an established fact that **"Change is faster when it is self-initiated".** If an employee has to improve or do better, he/she must first feel the need to do so and improve more upon his/her strengths and weaknesses.

3) Another point to be notice is that they should be given a chance to rate their own performance, this gives them new insights on how one is performing and what are the critical points where he/she has to put his best and improve upon.

4) It is also suggested that a proper complain channel should exist which gives them a chance to convey their grievances to the top management to avoid unnecessary time and money consuming activities like strikes, '*gherao'* etc.

5) It is been noticed and hence suggested to take suggestions and comments of appraises while conducting the appraisals as they expect this, which is not fulfilled as the appraisers do not take this into consideration. Therefore this matter should also be look upon before it leads to dissatisfaction among the employees.

6) Communication Gap & Lack of Timings, Knowledge and Co-ordination: There is no communication of top management plans and goal to the appraisee. The appraisers on the other hand feel it has been clearly communicated to the appraisees. On general level; appraisees are neither aware with their basic concepts nor the Mission ultimate goals.

   On process level; it was found that many employees were not aware and ready with their proper records either due to lack of time or lack of communication during appraisal process, which obviously affects their performance and ratings during the process. However some were kept waited for the next day till they brought all verified documents and records. But again it was inconvenient for both appraisers and appraises and also not done in every district. Some nurses and ANMs which were on night shifts had to wait until evening of other day for performance appraisal and had to continue with their night shift again without break. Inconvenience was observed at each level due to insufficient time. Demonstration and skill test does need time for assessment which was less; as complained by team of appraiser. Hence it is suggested to give sufficient time for appraisal process which can avoid many errors automatically like communication gap, untimeliness and tiresomeness etc.

7) The findings suggest that credibility of appraiser is of utmost importance for the success of appraisal system.

8) According to the Appraiser, a poorly conducted appraisal system would lead to demotivation and ineffective teamwork results in inefficient functioning and low productivity in the organization. Recognition, achievement, involvement, job satisfaction and development, satisfactory working conditions and appropriate awards plays an important role in motivate employee to the large extent.

9) Majority of employees were satisfied with the current appraisal system although they requested for little improvement and some changes.

10) Most of the employers were also not clear about the criteria on which ratings were given to each employee as it had to be designed different among ANMs doing different or multiple work. As ANM appointed for particular work in particular centre but doing different work as per requirement were having problem in getting assessed. Same happened with the ANMs doing multiple works; as on which skill they should be assessed.

11) Employees were also not clear about the criteria of ratings. Instead of secrecy there should be openness. The standards by which employees think they are being judged are sometimes different from those their superiors actually use. Proper communication of these ratings can help the employers achieve the level of acceptability and commitment which is required from the employees.

12) It is also observed that appraisee's expect proper feedback on their performance put forward their complaints if any through post appraisal interview.

13) It is suggested if possible appraisal should also be followed up with a session of counselling which is often neglected in many organizations. Counselling involves helping an employee to identify his strengths and weaknesses to contribute to his development and growth.

14) While doing performance appraisal one should give attention towards counselling; as purpose is to help employee improve his/her performance level, maintain his/her morale, guide him/her to identify and develop his/her strong points, overcome his/her weak points, develop new capabilities to handle more responsibilities and to identify his/her training needs.

15) If possible time punctuality can be followed and irregularity and little unethical means can also be avoided not only here but in the whole system of our country. On the other hand; hard work, dedication of appraisers and cooperation of appraisee is appreciable.

An excellent initiative had taken in NHM (M.P.) for employees on contractual basis. It should also be done for employees on regular basis because some of them are insincere as they are permanent and some have lost their reflexes (above 60 years of

age); should be adjust on other work areas to improve the effectiveness of the mission.

Specific Findings:

Upright findings-

- Guidelines given were managed and followed properly and systematically especially in District Bhopal (JP Hospital), & sehore (district hospital) satisfactory performance in District Alirajpur, and not as per guidelines in Ujjain.
- The teams in respective districts were well formed especially in Dist. Bhopal, Dist. Alirajpur, Dist. Sehore but not in Ujjain.
- Facilities in some districts provided were average but improved from second day. In Alirajpur and Bhopal lack of space and mismanagement was seen that led to chaotic situation .Lack of coordination in team on first day was also seen. From second day in Bhopal different rooms were available for different purposes.
  In Ujjain due to '*Simhastha'*, the DPM was very busy so mismanagement occurred.
- Staffs were well managed, cooperative, available and easily approachable.
- Targets of each day were completed irrespective of time.
  The teams and employees cooperated irrespective of stretched time schedule like in Sehore district it stretched up to 11pm and in Ujjain it stretched up to 9:30pm.
- No absenteeism or chaos observed except for some who resigned, got selected in PSC etc. exams or females who were on maternity leave.
- Apart from first day which was obviously a learning day or period, whole process was executed more properly from next day and sustained with same accuracy except in Dist. Ujjain.
- In Dist. Ujjain inconvenience was seen mainly due to '*Simhastha Mahakumbh*'. The CMHO was not present during the whole procedure.

Shortcomings:

- Mission '*Indradhanush*' caused inconvenience in whole performance appraisal in Dist. Alirajpur.
- Similarly '*Mahakumbh Simhastha*' caused trouble in performance appraisal process in Dist. Ujjain.
- Space availability was an issue in almost all the districts except Dist. Ujjain where adequate space was available (but not up to date facilities).
- Communication gap witnessed due to which records were not properly maintained or not brought on time or were not verified by BMO.

  The employees were not informed prior about the records which were supposed to be brought with them. So some of the employees didn't bring their records on the spot were told to bring their record next day, which created chaos.

  Some brought their data without verification because they were not prior informed about this.
- Time provided was less between announcement and implementation of performance appraisal exercise.
- Team mainly complained of time limitation. Demonstration or Skill test process was time consuming for each ANM or Staff Nurse.
- Frequent confusion in Formats was the major issue e.g.
  (i) Varied formats were not there for ANM working for different position.
  (ii) ANM appointed for particular work in particular centre but performing different work on different centre was cause of major confusion during process.
  (iii) Markings were inappropriate in some sections (viz. totalling and division of marks) of ANM and Staff Nurse. Also seen in case of pharmacist.
  (iv) Software was not available at working station on which their performance skill was getting assessed in case of Pharmacist and Data Entry Operator especially in Dist. Ujjain.

- Many candidates were lacking even in their basic concepts, few lab technician were unable to explain the procedure of basic tests like sugar, protein, haemoglobin. However some of the candidates were very knowledgeable and with excellent skills.

- In contrary to other districts, in Ujjain it was seen that first day it was strict then the whole process went lenient.

  This happened in Ujjain district because of lack of monitoring and lack of seriousness of both team members and employee .There was a presumption that this activity would get stayed by the High Court so they were taking it for granted.
- Errors should be given attention as those who were recently trained were fresh with their knowledge and concepts but e.g. an ANM joined 8 months ago with 6 months maternity leave performed weakly.
- Errors in marking as some were lenient while some were strict in their marking procedure.
- Those ANM and Nurses who were doing night shifts had performance appraisal on next morning had to stay for long until evening.
- The headquarter stay was major concern in Dist. Alirajpur.

  Mainly malpractice was observed in getting authentication; though people were not staying there still they were getting verification for staying from the BMOs.
- Team also complained of identification proof of candidates as there was doubt that some other persons were appearing in place of applicants especially in Dist. Ujjain.
- ANMs working in two different fields should be appraised on which skill.

  In Sehore district ANM was working simultaneously in two departments at the same time and they were assessed on the basis of what they knew well means according to their choice.

  In Bhopal district ANMs were recruited for one department say delivery check point and assigned work of other department say Operation Theatre,and at the time of appraisal question were asked on their present work rather than there recruited post. In that scenario questions were framed on the spot and they were assessed on that.
- Data entry operators on whom performance appraisal was being done were also managing the whole process.

  In Ujjain due to lack of manpower people who were supposed to give interview were also managing the entire process of performance appraisal.
- Skill and records should be assessed on what basis for the newly appointed employees.

  In Ujjain district, newly appointed employees who have not even completed a couple of months were facing problems in answering the questions because of their less work time frame and same problems existed in case of records also.

- The guidelines regarding headquarter stay was not followed appropriately like performance appraisal for the employees not staying at the headquarters was also done.
- Transparency was an issue in marking and assessment of the employees.
  In almost all the districts more or less fairness was missing .Some employees were passed on the basis of money, power and source in spite of lack of knowledge and skill and which was not objected by the concerned authorities.
- Many members in the team were absent during training so lacked knowledge of procedure.
  In all the districts there were some team members who missed the training and were not aware of the guidelines, formats and marking procedure and they were dependent on other members of the team which created a lot of confusion which affected the smoothness of the whole process.

Conclusion:

With rewards (incentives) being directly linked to achievement of objectives, goal setting and Performance Appraisal assumes utmost importance. The Performance appraisal has been professionally designed and monitored by Human Resource Development Department. The implementation is the responsibility of each and every employee along with their supervisor. There should be adequate training to the evaluator that will go a long way in answering the quality of Performance Appraisal.

In conclusion, a Performance Appraisal is a very important tool used to influence employees. A formal Performance review is important because it gives an opportunity to get an overall view of job performance and employee development; it also encourages systematic and regular planning for the future. Thus good performance reviews do not just summarize the past but help in determine future performance.

Rewards: Rewarding employee performance and behaviour is an important part of this process. Appropriate rewards help to recognize, motivate employees and also communicate the health mission values to the employees.Innovations and use of capabilities are rewarded in order to encourage the acquisition and the application of positive attitudes and skills.

Importance of Performance Appraisal:

In today's working environment a great deal of commitment and effort from employees is demanded, who in turn naturally expect a great deal more from their employers.

Performance appraisal is designed to maximize effectiveness by bringing participation to more individual level. It provides forum for consultation about standards of work, potential, aspirations and concerns. It also provides an opportunity for employees to have significantly greater influence upon the 'Quality' of their working lives.

Performance Appraisal must be seen as an essential part of manager's responsibility and not an unwelcome and time consuming addition to them. It is about improving performance and ultimate effectiveness.

Benefits of Performance Appraisal:

a) For the Appraisee

- Better understanding of his/her role in the organization- what is expected and what needs to be done to meet those expectations.
- Clear understanding of his/her Strengths and weaknesses and to perform better in future.
- Increased self-esteem, motivation and job satisfaction.
- Opportunity to discuss work problems and how they can be overcome.
- Opportunity to discuss aspirations and any guidance, support or training needed to fulfill those aspirations.
- Improved working relationships with supervisors.

b) For the Management

- Identification of performers and non-performers and their development towards better performance.

- Opportunity to prepare employees for assuming higher responsibilities
- Opportunity to improve communication between the employees and management.
- Identification of training and development needs.
- Generation of ideas for improvements.
- Better identification of potential and formulation of future plans.

References:

Books

- The Art of HRD, Reward Management, Volume 9 by Michael Armstrong and Helen Murlis.
- Performance Management, Concepts, Practices and Strategies for Organization success by S.K. Bhatia.