Summer Training at
National Rural Health Mission, Haryana
(April 9 – June 1, 2012)

Assessing the Effectiveness of HMIS on Data Validation and Reporting in Two Districts of Haryana- Bhiwani and Rewari

By
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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
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Institute of Health Management Research,
Jaipur
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Certificate

This is to certify that Ms. Priyanka Sharma from Institute of Health Management Research, Jaipur has undergone Summer Training in State Institute of Health and Family Welfare, Panchkula, Haryana from 9th April, 2012 to 1st June, 2012.

The candidate herself carried out the project. Her approach to the study has been sincere, scientific and analytical. This summer training is partial fulfillment of the course requirement is recommended for the award of post graduate diploma in health and hospital management.

I wish her success in all her future endeavors.

Dr. P.R.Sodani
Dean (Academic and Students Affairs)
IHMR. Jaipur
July, 2012

Dr. Vinod Kumar
Assistant Professor
IHMR, Jaipur

TO WHOM IT MAY CONCERN

This is to certify that Ms. Priyanka Sharma did her summer training under State Institute of Health & Family Welfare, Haryana on the topic **"To assess the effectiveness of HMIS on data validation and reporting in two Districts of Haryana – Bhiwani & Rewari"** from 9th April, 2012 to 31st May, 2012 under the guidance of Mr. Pradeep Kumar, Director (Admn), NRHM Haryana.

Her approach has been sincere, scientific and analytical towards the study. I wish her good luck in all future endeavours.

Dated: 22nd June 2012

Principal SIHFW
Haryana, Panchkula

State Institute of Health & Family Welfare (SIHFW), Behind Topiary Park, Sector 6, Panchkula, Haryana-134109
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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Priyanka Sharma**, student of Institute of Health Management and Research, Jaipur has successfully completed her two months Summer Internship w.e.f. April 9, 2012 – June 1, 2012 from **'State Institute of Health and Family Welfare, Panchkula (Haryana)'.**

She undertook the research project titled, **'To assess the effectiveness of HMIS on data validation and reporting in two Districts of Haryana- Bhiwani and Rewari'** under the guidance of Mr. Pradeep Kumar, Director (Admin), National Rural Health Mission, Panchkula (Haryana).

During the summer training, she has done outstanding work. I appreciate her hard work and dedication towards the assigned project and wish her success in all her future endeavors.

Dated: 29-05-2012

Director (Admn.)
National Rural Health Mission
Haryana

Pradeep Kumar
Director (NRHM), Haryana
Panchkula

EXECUTIVE SUMMARY

The present study objective is to assess the effectiveness of HMIS on data validation and reporting in two districts of Haryana- Bhiwani and Rewari. HMIS (**Health Management Information System**) is an improved and user friendly program geared towards use of information for planning and for taking appropriate actions to improve performance of health services at all levels. All the districts in Haryana are uploading the monthly, quarterly and annual reports on web portal. During Financial year 2011-12, it was proposed to shift to **Facility based HMIS web reporting** in which all the facilities report on their respective web portals. It helps in Planning District/Block Health Action Plans, Health Campaigns and for allocation of budget and resources by state and national level organizations.

The main challenges and gaps in working of HMIS are the misreporting and validation errors, if all data elements are not clearly defined and understood by the staff engaged in data collection, entry, and reporting of data. . Data should be checked for quality to minimize errors so that they can be used for decision making. Data duplication and data reported for nonexistent services is a frequent problem that leads to false higher coverage of services and inaccurate decision making that hampers data quality.

The main purpose of the study is to know whether HMIS acts as a true platform for generating the State's standard monitoring reports and to facilitate the removal of reporting and validation errors through analysis.

The objective of the study is to assess the functional status of human resource, infrastructure, budgetary support, appropriate reporting, trainings and their supervision in HMIS with respect to standard protocols. To check the awareness of HMIS operating team in reporting and validating the data through HMIS and to recommend some corrective measures against the gaps found out through the study.

It is a descriptive cross sectional study. Data was collected from District Headquarters, CHC's, PHC's, SC's and General Hospitals of Bhiwani and Rewari regions by Information Assistants, ANM's, MO's, LHV's and PHN of the respective districts by their scheduled interviews. Multistage random sampling type was the sampling method that has been adopted in which self administered written questionnaires was the data collection tool.

Findings of the study tells that Rewari has greater percentage of facilities reporting on time who are much more aware in terms of uploading the reports on web portals than Bhiwani who has the greater percentage of validation errors but they are more aware of HMIS online web portals. Rewari has greater percentage of computers provided with BSNL's broadband internet and also ANM's, Information Assistants and MO's much trained in HMIS than of Bhiwani. Feedback system to lower levels of health facilities and monitoring field visits were conducted in greater percentage in Bhiwani as compared to Rewari. But **overall validity was quiet better in Bhiwani as compared to Rewari** and in Rewari number of cases having inablity to check due to unavailability of formats was also higher.

In invalid data, errors found when checked with previous months records mainly includes errors of zeros and blanks and not using standardized method of reporting which was higher in Bhiwani than in Rewari by 21 percent and 10 percent respectively. Percentage of other errors like Copying of data, Double/Over Reporting, Under Reporting, Doubling of SC data in PHC Format was quiet higher in Rewari than of Bhiwani.by 3percent,19 percent,6 percent and16 percent respectively. Causes of Reporting Errors found in both the districts were confusion between FBR and HMIS reporting, unablity to understand contents and language of HMIS, not properly trained, lack of motivation in adopting HMIS and non availability of rejisters required at SC level along with overburdened by multiple reporting system and not compilation of male and female records in data entry columns.

Some other observations were that great confusion exists between HMIS reporting and Facility based Reporting. Information Assistants were reporting with their own HMIS format along with the standard HMIS format.(in Rewari).. ANMs face difficulty in understanding the contents and language of the format , are overburdened by multi reporting system and are not much clear and serious with HMIS reporting. They also do not have updated and the separate format for SC. Budget on HMIS cannot be utilized properly as bills don't get passed and not timely receipt of budget by them. Lack of connectivity of the internet that has been provided to the Information Assistants is also a major issue. Monitoring and Supervisory field visits are not conducted. False reporting / copying of data by ANM'S was observed in their filled SC formats.

So, some recommendations would be that the concept of zeros and blanks should be made

understood at all the levels. ANM's, MO's and LHV's should be much more sensitized for properly adopting the HMIS. The confusion between the Facility based Reporting and the earlier reporting system of HMIS should be made clear at every level. · The missing contents of the HMIS format should be corrected.· The updated formats should be made available and made understood to all the ANM's. The language of the Sub Center format should be in Hindi along with English so that it would be much clear to the ANM's. For proper utilization of budget, it should be passed and received by the facilities timely. And much more reliable net connection should be provided to all the Information Assistants.

The concept of HMIS is very much helpful in reducing all the burdens and the errors that occur mainly at SC level. So its proper implementation is very much required at each and every level of the health system. Certain pitfalls are their in its working in terms of validation and reporting which can be reduced by considering the points of suggestions stated earlier.

ACKNOWLEDGEMENT

At the completion of my summer project I would like to show my sincere gratitude to the SIHFW Haryana authority, especially to the Principal, Dr Usha Gupta ma'am for providing me such an opportunity. Without her constant support and guidance it would never be a success. My sincere thanks to Kashmir Sir, Consultant SIHFW and all the respected faculties and consultants at SIHFW, Panchkula.

I wish to express my deep sense of gratitude to my nodal officer and mentor Mr. Pradeep Kumar,Director NRHM, Haryana for their constant help and cooperation, able guidance, valuable suggestions and inspiration. He was kind enough to give his valuable time from his extremely busy schedule when required. I also like to thank NRHM Haryana, HMIS department for allowing and helping me to understand the HMIS data handling at state level and also accompanying me during my field visits.

My study would have been incomplete without the extended support I received from the health administration in both the districts i.e. Bhiwani & Rewari for field survey. I am highly indebted toCivil Surgeons and District Programme Managers of both the districts for allowing me and giving me\the full support to carry out my study in respective districts. My sincere gratitude to Mr. AnilSheoran, DPM Bhiwani and Mr. Munish, DPM Rewari – for their constant cooperation, support,guidance and inspiration during respective district's field work.

My special thanks to DTO Ma'am Dr.Usha Mathur and DIO Sir Dr. Rajesh Sharma of Rewari Not only they have shown great interest but also guided me accordingly and gave valuable inputs to enrich my study. Thank you ma'am and sir.

Words are inadequate to offer my thanks to Dr Puneet Gupta. Consultant SIHFW for his able guidance,support and invaluable suggestions throughout the training period.

Needless to mention that Dr Vinod Kumar , my mentor, Assist. Professor at IIHMR Jaipur, was always supportive to me and gave his valuable feedbacks if and when required. At this note i would like to thank Dr. P.R. Sodhani and all the respected faculty members and staff of IIHMR Jaipur for being kind and always helpful to me.

Priyanka Sharma

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LIST OF ABBREVIATIONS

A.N.M.-Auxiliary Nurse Midwife

CHC – Community Health Centre

DH - District Hospital

FBR -Facility based Reporting

GH - General Hospital

HMIS – Health Management Information System

I.A. – Information Assistant

L.H.V.- Lady Health Visitor

M.O. –Medical Officer

MoHFW- Ministry of Health and Family Welfare

P.H.N.- Public Health Nurse

PHC - Primary Health Centre

SC – Sub Centre

ABOUT THE ORGANIZATION

National Rural Health Mission (NRHM) Haryana has been launched with a view to bringing about dramatic improvement in health system and health status of people, especially those who live in rural areas of the country. The mission seeks to provide universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of people, reduction in child and maternal deaths as well as

population stabilisation and gender and demographic balance. Key features in order to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resource management, community involvement, decentralization, rigorous monitoring and evaluation against standards, convergence of health and related programs from village level upwards, innovations and flexible financing and also interventions for improving health indicators.

GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles.

SIHFW, Haryana

State Institute of Health and Family Welfare (SIHFW), Haryana was established in 1992 and is the apex training institute of Department of Health & Family Welfare, Haryana. Since its inception SIHFW has been envisaged as state level institution for improving the effectiveness of health care delivery system by imparting knowledge and skill based training to the medical and Para-medical health personnel at different levels. Specially, SIHFW is responsible for imparting trainings to identified medical professionals in accordance with the approved training as per the guidelines provided by GoI for individual trainings plans apart from coordinating and supervising the activities of other state training centres.

LEARNINGS

1. **Field exposure in Panchkula and other two districts by having interactive sessions with ANM's, MO's, LHV's, PHN's and Information Assistants-**

A field visit was organized for all the interns who are undergoing summer training at SIHFW, Haryana with Dr. Anil Sharma and Mr.Vinod Goyal, faculty of SIHFW and NRHM, Haryana, on 18th April, 2012. It was a very fruitful and beneficial approach for all the students as it provided a real time and practical exposure to all of us. This field visit helped us in viewing the actual working of the healthcare facilities from the very basic and grassroot level that very much solved our purpose of being there of knowing the healthcare system in depth.

Under this we visited PHC Old Panchkula, PHC Kot, Anganwadi under PHC Kot, SC Ramgarh under PHC Kot, SC Nada Sahib under PHC Old Panchkula and slum houses under SC Nada Sahib. Their we interacted with all the available healthcare providers like medical officers, department incharges, information assistant, ASHAs, ANM's and tried to acquaint ourselves with their actual functions and roles so as to find out their problems if any and to suggest some solutions regarding the same.

We also visited two slum houses under SC Nada Sahib to know about the health of the two children for checking the effective working of ASHA of that SC following IMNCI Program. So, overall it was quiet a worthful field exposure for all of us.

- **Problems that they are facing**:-

- No sufficient funds released for ASHA's because of which they lack any motivation factor.
- Lack of proper infrastructure.

CONCLUSION AND RECOMMENDATIONS

Though all the departments and the medical staff are been working with full effectiveness in the PHC but in some cases following points need to be considered:-

a. Sufficient funds should be granted for keeping the motivational level high of the ASHA's.

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b. The infrastructure of the facility should be more developed.
c. The payment of salaries should be made regular.

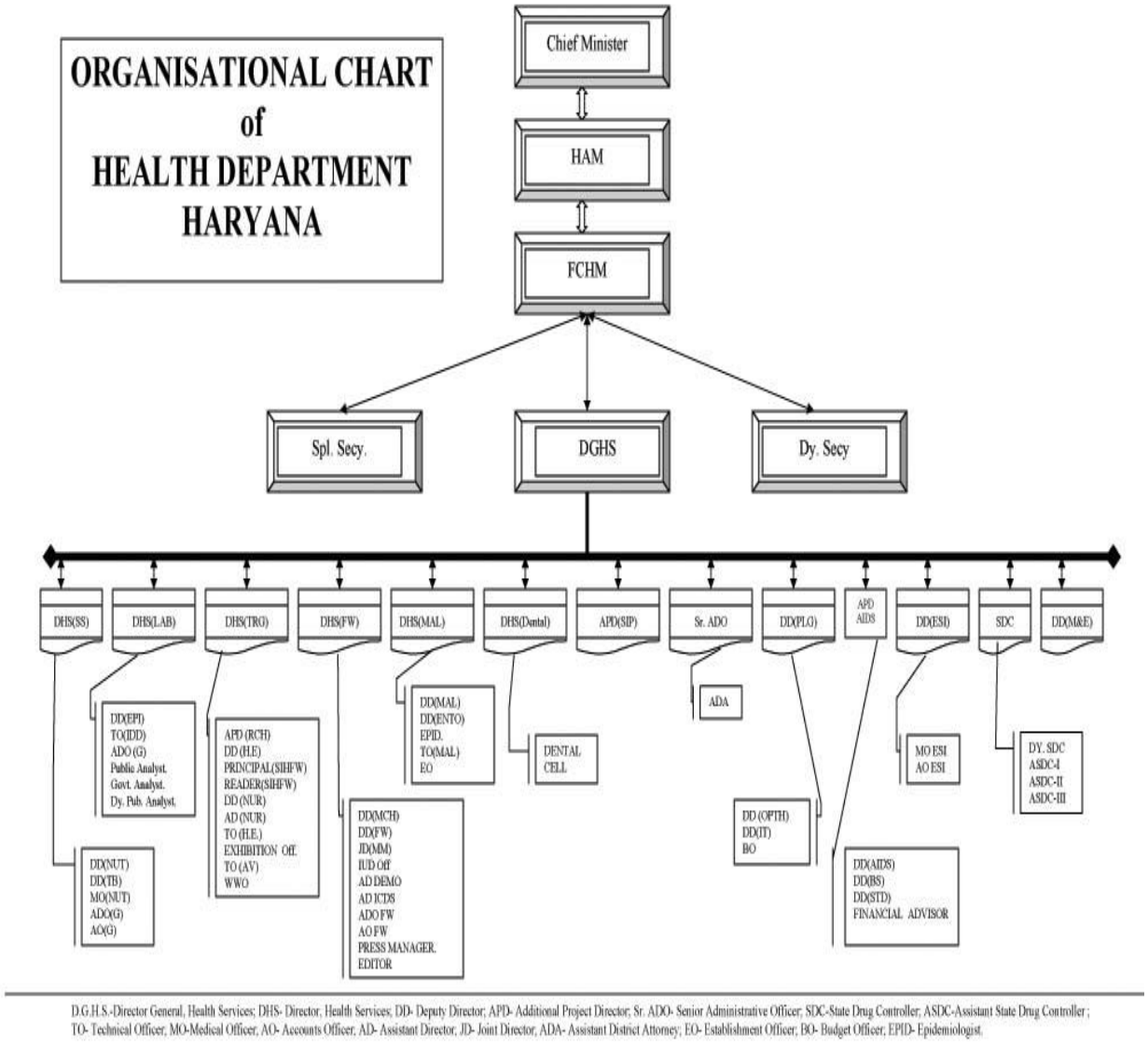
2. **Handled HMIS data at state and district levels and also interviewed staff handling HMIS-**

Learnt about the concepts of data entry on HMIS web portals at state as well as district levels and also got to know about the HMIS functioning at both the levels. Worked under state HMIS Data Manager Mr. Harish Bisht at NRHM office in Panchkula to acquaint myself with the basic functioning of HMIS and the newly started Facility Based Reporting. At the district level also got acknowledged with the working of HMIS Information Assistants under the guidance of District Programme Managers who also introduced me with the Information Assistants, ANM's, LHV's and PHN and with their working at CHC's, PHC's and SC's.

Also got to know about the concepts of HMIS formats, their working at all the levels and their health indicators. At the same time also got to know about the problems and grievances of HMIS staff that they face while doing HMIS reporting regarding the infrastructure provided to them, ambiguity regarding content of HMIS format, shortage of manpower, improper trainings and lack of motivation amongst ANM's and LHV's in seriously adopting the HMIS which are the major reasons of validation and reporting errors in HMIS.

Conclusion and suggestions:- The grievances of HMIS staff should be handled regarding HMIS reporting, infrastructure, problems they face in HMIS formats, shortage of manpower and proper trainings should be provided to them.

3. **Learnt about the organisational management of Health department (NRHM,Haryana)-**



NATIONAL RURAL HEALTH MISSION

(i) Organizational Structure of the Scheme

NRHM FRAMEWORK

State Health Mission

Constituted by Govt. Notification No. 49/71/2005-6HBII dated 27th June 2005

General Body

Chairperson: Chief Minister

Co-Chairperson: Minister of State Health, Medical Education and Ayurveda

Convener: Financial Commissioner & Principal Secretary Govt. Haryana, Health, Medical Education and Ayurveda

Member Secretary: Director General Health Services

Members:

1. Minister, Development & Panchayats
2. Minister, Rural Development
3. Minister Planning
4. Minister, Finance
5. Minister of State Social Welfare and Welfare of SCs and BCs
6. Minister, Urban Development
7. Minister, Urban Development
8. Minister, Public Health
9. MLAs to be nominated by the State Government
10. Nominated Block and Village Panchayat and Urban Bodies (women may be adequately representatives)

Official representatives

1. Chief Secretary
2. Financial Commissioner & Principal Secretary, WCD
3. Financial Commissioner & Principal Secretary, (B&R)

4. Financial Commissioner & Principal Secretary, Development & Panchayats
5. Financial Commissioner & Principal Secretary Urban Development
6. Financial Commissioner & Principal Secretary, Finance
7. Financial Commissioner & Principal Secretary, Planning
8. Commissioner, Public Health
9. Special Secretary, Rural Development
10. Representatives to be nominated by Ministry of Health and Family Welfare, Department of Family Welfare, Government of India
11. Health Experts to be nominated by the State Government
12. Representatives of the Medical Association to be nominated by the State Government.
13. Representatives of the NGOs to be nominated by the Government
14 Representatives of the Development partners.

State Health Society, Haryana (SHSH)

A. Governing Body of State Health Society

Constitution & Members

1. **Chairperson-** Chief Secretary, Haryana
2. **Vice-Chairman-** Financial Commissioner & Principal Secretary, Govt. Haryana, Health, Medical Education & Ayurveda
3. **Member Secretary-** Mission Director (NRHM), Haryana
4. **Members-**
   - Secretary, Finance
   - Secretary, Women & Child Development
   - Secretary, PWD B&R
   - Secretary, Rural Development & Panchayat
   - Secretary, Urban Development & Local Bodies
   - Secretary, Planning
   - Secretary, Water Supply & Sanitation

- Secretary, Town & Country Planning
- Secretary, Environment
- Secretary, Education
- Director, PGIMS Rohtak
- Director General, Health Services, Haryana
- Project Director (NRHM), Haryana
- Director AYUSH .Hrayana
- Representative(s) to be nominated by MOH&FW, Govt. of India.
- President, IMA (Haryana), State Branch.
- Secretary, State Red Cross Society
- Any other member who is deemed fit for as per need

Ordinary Business of the Governing Body

- Approval/ Endorsement of Annual State Plan for the NRHM.
- Consideration of proposals for institutional reforms in the Health Sector.
- Review of implementation of Annual Action Plan
- Inter-Sectoral coordination: All NRHM related sector and beyond e.g. Administrative Reforms across the State
- Status of follow up action on the decisions of State Health Mission.
- Co-ordination with NGOs/ Donor/ other agencies/ organizations.
- Any other issues with permission of Chair.

B. Executive Committee of State Health Society

The Executive Committee would ensure execution of integrated NRHM State Action Plan, follow up action on decision of State Health Mission.

Constitution & Members

1. **Chairperson-** Financial Commissioner & Principal Secretary, Govt. Haryana, Health, Medical Education & Ayurveda.
2. **Member Secretary-** Mission Director (NRHM), Haryana
3. **Members-**
    - Director, Development & Panchayat
    - Chief Administrator, HUDA
    - Chairman, Haryana Pollution Control Board.
    - Special Secretary, Finance dealing with Health.
    - Director, Primary Education.
    - Project Director, Sarv Shiksha Abhiyan.
    - Engineer-in-Chief, Water Supply & Sanitation
    - Engineer-in-Chief, PWD B&R
    - Director General, Health Services, Haryana
    - Director Health Services, Family Welfare
    - Project Director (NRHM), Haryana
    - Director Health Services, Malaria
    - Director, AYUSH, Haryana
    - Project Director, State AIDS Control Society
    - Director, Urban & Local Bodies
    - Director, Women & Child Development
    - Secretary, Red Cross Society, Haryana
    - Representative(s) of GoI
    - Economics & Statistical Adviser, Haryana
    - Non official member nominated by the Govt. Haryana
    - Any other member by the permission of Chairperson

District Health & Family Welfare Society

A. Governing Body of District Health & Family Welfare Society

Constitution & Members

1. **Chairperson-** Deputy Commissioner.
2. **Member Secretary-** Civil Surgeon
3. **Members-**

- Commissioner/ Secretary of Municipal Corporation/ Committee
- Additional Deputy Commissioner
- Executive Engineer PWD and B&R
- Executive Engineer Water Supply & Sanitation
- Estate Officer HUDA
- Distt. Medical Officer, AYUSH
- XEN, Panchayati Raj
- District Social Security Officer
- District Welfare Officer for SCs/BCs.
- District Development & Panchayat Officer
- District Education Officer
- District Primary Education Officer
- Secretary, District Red Cross Society
- Programme Officer (ICDS)
- Representative of District IMA
- NGO Working for Health as approved by Chairperson
- Representative of Beopar Mandal
- Any other member deemed to be necessary as decided by chairperson with a view to associate Civil Societies Groups working in the area of health.

Objective

The Society shall assist District Health Administration in the implementation of various health programmes and projects in the district with special emphasis on priority sectors like Reproductive and Child Health, implementation of health programmes and National Rural Health Mission (NRHM) in the district, Population Control, Control of Malaria. TB & Leprosy and Prevention of Blindness and Malnutrition etc.

B. Executive Committee of District Health Society

The Executive Committee would ensure execution of integrated NRHM District Action Plan, follow up action on decision of State/District Health Mission.

Constitution & Members

1. **Chairperson-** Civil Surgeon
2. **Member Secretary-** Dy. Civil Surgeon, NRHM/ RCH Officer
3. **Members-**
    - All Dy. Civil Surgeons/ Programme Officers
    - Senior most SMO CHC in the district
    - Senior most MO I/c PHC in the district
    - Executive Engineer PWD and B&R
    - Executive Engineer Water Supply & Sanitaion
    - Distt. Medical Officer, AYUSH
    - District Primary Education Officer
    - Secretary, District Red Cross Society
    - Programme Officer (ICDS)

- Any other member deemed to be necessary as decided by chairperson with a view to associate Civil Societies Groups working in the area of health.

Swasthya Kalyan Samiti (SKS) at CHC and PHC

Swasthya Kalyan Samiti have been constituted in all the 336 PHCs, 91 CHCs/ 26 Sub-Divisional Hospitals, (SDH) & 21 District HQ Hospital. All the societies are registered and functioning effectively.

Swasthya Kalyan Samiti (SKS) PHC

Swasthya Kalyan Samiti is a simple yet effective management structure. This committee, which would be a registered society, acts as a group of trustees (for the hospitals/PHCs) to manage the affairs of the hospital/PHCs. It consists of officials from Government sector and members from local Panchayati Raj Institutions and community.

Constitution and members

Composition

A. Swasthya Kalyan Samitis at PHC Level

- MO I/c of PHC – Chairman & Convener
- All MOs including AYUSH – Members
- Sarpanch of village where PHC is located - Member
- 1 Sarpanch by rotation from other villages (Tenure 1 year) - Member
- 1 SMS head of the PHC village – Member

- 1 SMS head of the PHC village by rotation (Tenure 1 year) – Member
- Head of the Village level Committee(VLC) cum VHSC of PHC Village – Member
- 1 member of VLC cum-VHSC by rotation (Tenure 1 year)- Member
- ANM of the PHC village - Member
- ASHA & AWW of PHC Village– Members
- 1 ANM, ASHA, AWW by rotation from other villages (Tenure 1 year) – Members
- Supervisor, ICDS of PHC Village - Member
- Head Master of the PHC village – Member
- Dental Surgeon – Member Secretary

Swasthya Kalyan Samitis at CHC Level (SKS)

- SMO I/c of CHC – Chairman & Convener
- All PHC I/cs & AYUSH at CHC– Members
- Sarpanch of CHC Village – Member
- Head Master of the CHC village – Member
- 2 Sarpanches by rotation (Tenure 1 year) - Members
- SMS head of the CHC village – Members
- 2 SMS head of the PHC village by rotation (Tenure 1 year) – Members
- Head of the CHC Village level committee-cum-VHSC - Member
- 2 head of the village level committee-cum-VHSC by rotation (Tenure 1 year) - Members
- CDPO, WCD – Member
- Representative of the Deptt. of Water Supply & Sanitation – Member
- Secretary, Municipal Committee (wherever applicable)- Member
- BDPO of the area
- **Dental Surgeon – Member Secretary**

Functions/ Powers of SKS (CHC)

The Swasthya Kalyan Samitis shall monitor, evaluate and co-ordinate the work at CHC level under its jurisdiction and will serve as link to the Distt. Health Society. It will review the progress in implementation of NRHM and various heath schemes and policies & shall ensure inter-sectoral convergence and integrated planning.

4. **Learnt about various programmes running under NRHM, Haryana**-

a) ADOLESCENT HEALTH

ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH (ARSH)

Progress so far

The AFHS was being run in 8 districts of the State in 2008-09 i.e. Yamuna Nagar, Kurukshetra, Rohtak, Bhiwani, Rewari, Gurgaon, Sonepat, and Jind. In each district, the AFHS Programme was implemented in each District hospital, 2 CHCs, 4 PHCs and 100 villages being covered under these institutions. It was extended to 9th district Panchkula and all PHC/CHCs and 125 villages in these districts in 2009-10.

In 2008-09, Counselors had been recruited under the supervision of MNGOs for providing adolescent friendly health services. This exercise did not bring the desired results. In 2009-10 the counselors under the AIDS Control Programme were given training and this workforce is being used for counseling of adolescents under the ARSH Programme.

2 peer educators per village (one male and one female) were identified and paid incentives to hold meetings of adolescent groups.

Present Scenario

Name of District	Villages	Institutions Covered

Name of District	Villages	Institutions Covered
Y. Nagar	125	2 CHC, 4 PHC
Kurukshetra	125	3 CHC, 5 PHC
Rohtak	125	2 CHC, 4 PHC
Bhiwani	125	2 CHC, 4 PHC
Rewari	125	2 CHC, 4 PHC
Gurgaon	125	2 CHC, 4PHC
Sonepat	125	2 CHC, 4PHC
Jind	125	2 CHC, 4PHC
Panchkula	125	2 CHC, 4PHC

b). RCH PROGRAMME

Maternal Health

It is one of the most important components of RCH programme. Improvement of maternal health & decline of maternal mortality rate requires availability of large number of health services early in pregnancy. These include early antenatal registration, tablets of Iron Folic Acid as prophylaxis and therapy, regular antenatal check-ups, monitoring of blood pressure, Tetanus Toxoid immunization, Timely detection of high risk Antenatal cases and their timely referral, delivery in safe and hygienic environment by skilled birth attendant, timely referral in case of obstretic emergency for management of hemorrhage with blood transfusions, availability of caesarean section facility and minimum 3 post-natal visits.

Maternal mortality of Haryana as per SRS 2007 is 162 deaths per lac live births. The common causes of maternal mortality are sepsis, hemorrhage (ante-partum & post-partum),

pregnancy induced hypertension, obstructed labour etc. Also countless number of women are morbid due to anaemia, bad obstetrical history, pregnancy wastage, infections etc.

Multi pronged strategies have been adopted by the State to improve maternal health in terms of demand and supply, interventions coupled with enhanced skills of health personnel to provide accessible, affordable and quality health care services from grassroot levels upto district/State level.

c). ASHA Progress

Number of asha as on 31 march 2011 are 13400.

ASHA

The community based health linked workers, ASHAs, are the first port of call for the health related demands of vulnerable section of the population, especially women and children, in the rural areas. The importance of the ASHA programme is well understood by the State of Haryana. Accordingly, all efforts are being made by the State to train the ASHAs, especially for the RCH programmes like early registration of pregnancy, ANC coverage, Institutional Deliveries, Post Partum Care, Home Based New Born Care, Immunization, Management of Malnourished Children etc. The incentive structure has been suitably revised and many new areas of activities for ASHAs have been identified in order to make it more attractive for the ASHAs to work more and to earn more. ASHAs have also been given a distinct identity in the State through uniforms, identity cards and name plates in front of their houses. Regular mentoring of ASHAs is being ensured through ASHA samelan and monthly meetings at the Block levels. The State proposes to give Drug Kits to another 5000 ASHAs in the year 2011-12. It shall be the endeavour of the NRHM State HQ to closely monitor the progress of ASHA programme by appraising the performance of each ASHA in the key areas of RCH programme. The system of appraisals has already been introduced and centralized database of all the ASHAs in the State has already been created. In the year 2011-12 it shall be ensured that only well performing ASHAs are allowed to continue in the system, while dormant and the non-performing ASHAs are weeded out.

c) **Training**

SIHFW has been envisaged as state level institution for improving the effectiveness of health care delivery system by imparting knowledge and skill based trainings to the medical and Para-medical health personnel at different levels.

SIHFW has now been established as a Society and registered with the Registrar of Societies, Panchkula on 11.11.2010 with the name of "Swasthya Prashikshan Kendra, Panchkula". SIHFW is also a Collaborating institute for UT Chandigarh and Jammu & Kashmir for which NIHFW provide the spots. The institute provides the umbrella spot 21 DTC and one RHFWTC at Rohtak. Apart from this short duration refresher course are being conducted by SIHFW for MO, Staff Nurse, ANM and ASHAs from the State Budgets.

E) IMMUNIZATION PROGRAM

Immunization programme is on the priority list of the Govt. of Haryana, as a result of which there has been a sustained improvement in the evaluated coverage report. Immunization sessions are held on every Wednesday along with outreach session on every

Thursday and fixed day fixed sites (PHCs/ CHCs/ Hospitals) sessions are also been conducted to cover all eligible children. Hepatitis 'B' immunization programme has already been implemented in districts Panchkula & Ambala. Similarly, JE immunization programme has already being implemented in district Ambala, Kaithal, Karnal, Kurukshetra, Panipat, and Yamuna Nagar. The state is doing efforts to reduce the drop-outs in order to achieve 100% immunization coverage. The IMR had declined from 73 (NFHS-I) to 42 (NFHS-III).

Considering high avoidable morbidity & mortality due to Measles, Govt. of India has desired to organize a Measles Catch-up Campaign on recommendations of National Technical Advisory Group on Immunization (NTAGI). This campaign was organized in five districts of Haryana (Jhajjar, Mewat, Palwal, and Gurgaon & Faridabad) on the basis of low measles coverage. More than 13.0 lac children of the target age group (9 months to 10 years) were vaccinated. High quality vaccination campaign was done. No serious AEFI cases were reported. Overall performance under the immunization programme is satisfactory in Haryana and focus now is on uncovered children in the urban areas, upcoming peri-urban inhabitation/ colonies, isolated populations/ hamlets, urban slums and vacant sub-centres.

f). Integrated Disease Surveillance Programme

The integrated disease surveillance project was launched in Haryana State in the second phase in 2005 with the support of World Bank to establish decentralized State based system of surveillance. The aim was to detect early warning signals of impending outbreaks and help in initiating an effective response in a timely manner.

The Haryana state has been able to achieve, improved surveillance and strengthening of data quality, analysis, improved laboratory Support and links to action. Trained stakeholders under IDSP have been able to increase disease surveillance, coordination and rapid action in cases of outbreak.

g) School health program

Indira Bal Swasthya Yojna (IBSY)

The state had launched an integrated Scheme on 26th Jan 2010 for all children between 0-18 years with inter-sectoral convergence of Health, Sarv Shiksha Abhiyan, Women and

Child Development and Social Justice & Empowerment. It covered the issues of 3D's of Nutritional Deficiency, Disability, Disease (including Non communicable diseases). The main components of the Indira Bal Swasthya Yojna include covering school children, Anganwadi Centres and Children out of Anganwadis and School.

h**). IMNCI(Integrated Maternal and Neonatal child illness)-**

Under this, a book is given to ANM's for field visits for checking breastfeeding and nutritional status. Its been a symptomatic approach within 0-2 months as its very fatal here because of severe bacterial infections then after that within 2mnths-5years weight according to age is taken and secondary feeding habits are observed for anaemic patients.

i). **HMIS (Health management Information System)-**

HMIS is also functional there since last two-three years. They have computerized offline reporting system of the data which they take from their manually maintained rejistsers as (FBR) **online feeding system has not started till now which will probably be online by the coming months of this year** .The data that they feed on HMIS webportals is the data of their own PHC and of all the SC's that comes under them. And then they send one copy of that data to the CHC through mail or by hard copies. SC's don't have computerized feeding system ,they report to the PHC where all the compilation of data occurs and then forward it to the CHC. HMIS formats has reduced their manual work load and has also reduced their errors. Trainings get organized for information assistant, ANM's, LHV's and MO's handling HMIS.

j). **MCTS (Mother child tracking system)-**Besides these programmes MCTS is also been working in Haryana, separate formats are there for MCTS like HMIS whose data entry is also done on MCTS online webportals like that of HMIS software.

- **Problems that they are facing**:-

- Lack of sufficient funds been released by the government for different programs been operating there.

- Too much of work load been experienced by the staff working there that has been reduced only a bit by HMIS.

CONCLUSION AND RECOMMENDATIONS

a. Enough funds should be granted for the programmes being implemented their.
b. The effectiveness of HMIS should be increased and should be made online for much more reducing the manual workload and effectiveness.

ASSESSING THE EFFECTIVENESS OF HMIS ON DATA VALIDATION AND REPORTING IN TWO DISTRICTS OF HARYANA – BHIWANI & REWARI

The HMIS (Health Management Information System) is a **tool** for ***Gathering, Aggregating, Analyzing*** **data** & using the **information** for taking **appropriate actions** to **improve performance** of health services at all levels. HMIS is not a new concept but an improved and user friendly program geared towards use of information for planning and action. The HMIS web portal was launched by the Ministry of Health and Family Welfare (MoHFW) on 21st October, 2008. The portal is envisaged as a "Single Window" for all public health data for the Ministry of Health and Family Welfare.

In Haryana, HMIS has been started in October, 2008. All the districts in Haryana are uploading the monthly, quarterly and annual reports in web portal. Officer in-charge in District Hospital of all the districts report data on the new HMIS forms. Presently HMIS rollout is up to district level only. Multi-prolonged strategies have been adopted for strengthening reporting through HMIS web portal during last 2 years. During Financial year 2011-12, it was proposed to shift to facility based HMIS web reporting in which all the facilities report on their respective web portals then it will be functional at PHC level also. In the earlier system of reporting, SC reports to PHC from where data is being reported to CHC's which send their data to districts where compilation of data occurs and the districts send their data to state level so finally state gets the consolidated report of all the districts from where data is finally being sent to ministry at national level. If data is being incorrect and incomplete in the **forward reports by the facilities** then feedback is being sent back to districts as a **draft** in which changes can be done by them.

Genesis of HMIS

The Data requirement by MOHFW is for Planning, Monitoring and Evaluation purposes, fund allocation to States and for their performance assessment that is resources deployment to be equalized with their performance. HMIS is also required for improving the quality of information and making information available in the public domain.

Facility Based Reporting

In Haryana, the system of facility based reporting in HMIS has been started in which the masters were created **for monitoring performance gaps, tracking individual contribution of facilities and for outbreak management** so that the health services/activities that take place at the facility are captured /reported for that particular month. In Haryana it was introduced in the April 2012. In case of sub centre, the services provided at the sub centre or in the outreach area are to be included only in the Sub- Centre report which is to be submitted at primary health centre in sub center format. PHC's by online feeding system, they enter their SC's and their report on online web portal in PHC format after doing validation of received data. Then CHC's enter their reports online in CHC format on web portals and finally districts after doing compilation, gets a consolidated report of all its CHC's and report it on its respective web portal. So, online individual reporting occurs by all the facilities on their respective web portals in their respective formats which ultimately helps in **Planning District/Block Health Action Plans, Health Campaigns and for allocation of budget and resources by state and national level organizations.**

Requirements at Data Aggregation Units

Data Aggregation Unit is place where data is collected and aggregated. The state can decide where the data entry point would be for HMIS portal. This could be District/ Block/ SDH/ PHC depending on the state requirements.

- Availability of the following is required:
  - Computers
  - Internet
  - Trained Personnel – Nodal M & E Officers
  - Regular Feedback to data originator
  - Download latest template from HMIS Portal

Key Features of HMIS

- **Web-based Data capturing system**- Leads to entry of physical performance at District/Block level, entry of FMRs at District Level and Dynamic aggregation and report generation.
- **Makes Key indicators available for local level use.**
- **Generates Standard and Custom Reports** by developing National, State and District Fact Sheets and **Integration of health related information across** ongoing **programmes.**

Usage of HMIS

- Helps in knowing the disease profile- epidemiology which is the study of prevalence and determinants of disease.
- Helps in knowing the burden of disease—*So that we know what are the health priorities and their determinants.*
- Helps in knowing the situation in service delivery/access & utilization of services:- *So that areas/communities which lag behind/have greater need could be allocated more resources and inputs.*

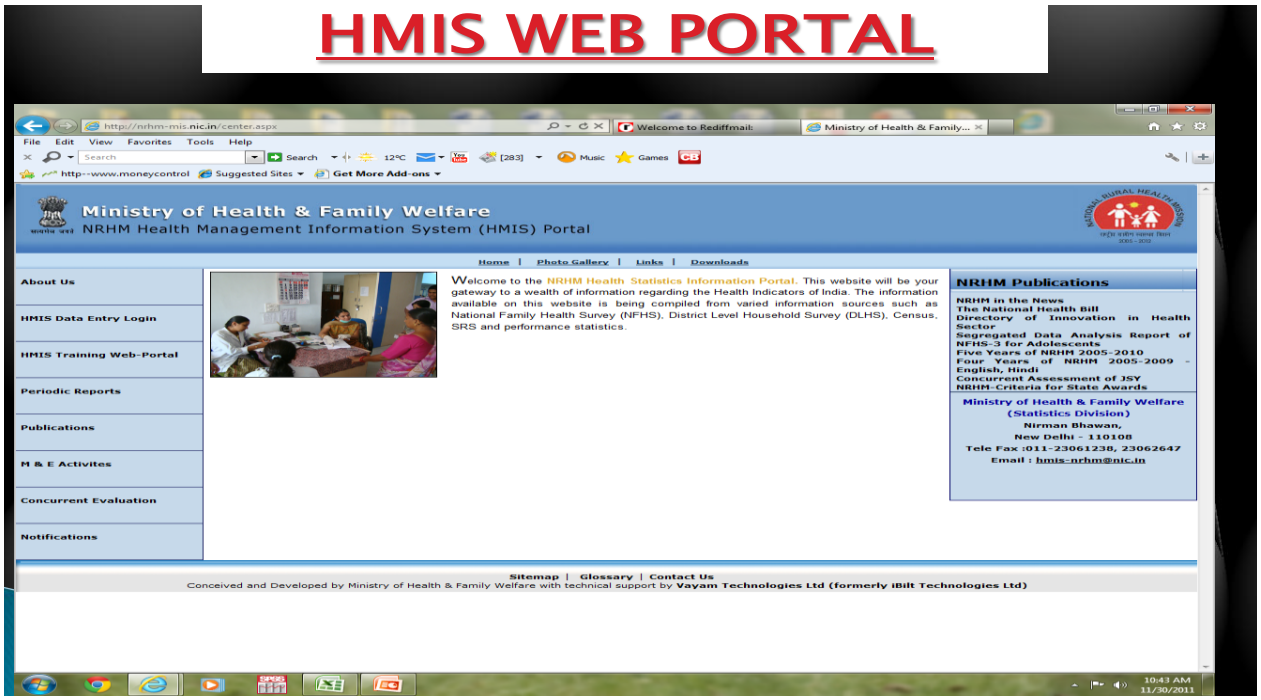
HMIS Formats - Periodicity

1. **Monthly (Services Provided by facilities during the Reporting Month)**
    - SC
    - PHC
    - CHC/SDH
    - DH/DHQ
2. **Quarterly (Infrastructure, Training, NRHM Components/ Financial)**
    - District
    - State
3. **Annually (Demographic Indicators, Infrastructure- detailed, Manpower)**
    - District
    - State

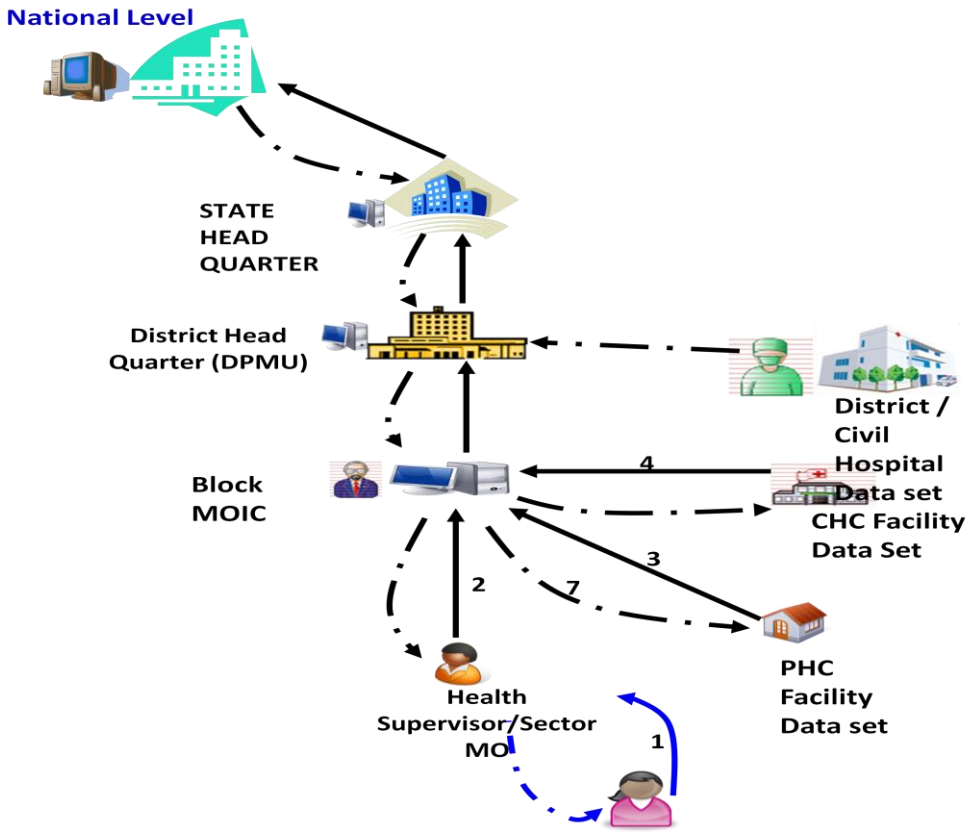
HMIS Formats - Timelines

Reporting Unit	Monthly	Quarterly	Annually
State HQ	20th of following month	20th of month following quarter	30 April
District HQ	10th of following month	10th of month following quarter	5th April
Block		10th of month following quarter	
District Hospital	5th of following month		
CHC	5th of following month		
PHC	5th of following month		
SC	5th of following month		

HMIS WEB PORTAL



DEFINING INFORMATION FLOW



Challenges and gaps in working of HMIS

- **Reporting errors-** Modification of the processes can lead to unintentional misreporting and errors. If all data elements are not clearly defined and understood by the staff engaged in data collection, entry, editing and reporting of data then it leads to misinterpretation and thus misreporting of data. Ambiguous definitions, non standard use of terms and inadequate support to staff in use data are some problems that need to be addressed. Blocks should report all data they have and explain which facilities did not report and what was the reason .Non reporting or inconsistent reporting can be due to shortage and quality of printed forms or the travelling time to submit reports. To compensate or to fix the numbers sometimes lower values or zero values are reported even when services were provided or health events did take place.

- **Data Quality Issues-** Data Quality refers to the extent to which data measures what they intend to measure. It depends on skills and priorities of service provider. Data should be checked for quality to minimize errors so that they can be used for decision making. It is of **Quantitative type** having Gaps Between Recording, Reporting and Uploading the data and **Qualitative type** having Outliers, Validity Checks, uncompleted data as reports are a reflection of services provision and utilization thus an incomplete report will indicate partial service delivery or utilization. Ideally, data/reports should be received from all facilities, public or private in an area to get a complete picture of health therefore it is necessary to encourage private facilities to report using either PHC/CHC format. Inaccuracy of data that will yield incorrect conclusions during analysis and interpretations in terms of actual number of services provided or health events organized as smaller errors at facility will accumulate into bigger mistakes after accumulation of whole data. Poor data accuracy could be due to gaps in understanding of data definition and data collection methods, data recording and data entry errors, systemic errors and misreporting. All data collection tools should be uniform and in harmony so that reports are comparable across facilities and data quality can be maintained. In absence of consistent protocols for incomplete data it is very difficult to produce good quality data. Data duplication and data reported for

nonexistent services is a frequent problem that leads to false higher coverage of services and inaccurate decision making that hampers data quality.

RATIONALE OF STUDY-

Reliable and timely health information is an essential foundation of public health action and health systems strengthening, both nationally and internationally. This is particularly so when resources are limited and funding-allocation decisions can mean the difference between life and death. The need for sound information is especially urgent in the case of emergent diseases and other acute health threats, where rapid awareness, investigation and response can save lives and prevent broader national outbreaks and even global pandemics.

PURPOSE OF THE STUDY:-

- To know whether HMIS acts as a true platform for generating the State's standard monitoring reports.
- To facilitate the removal of the reporting errors through analysis.
- To view the data entered as indicators over time in order to identify abnormalities in the data.

OBJECTIVES OF THE STUDY:-

GENERAL OBJECTIVE: - To assess the effectiveness of HMIS on data validation and reporting for generating the states standard monitoring reports

SPECIFIC OBJECTIVES:-

- To assess the functional status of human resource, infrastructure, budgetary support, timely and appropriate reporting, trainings and their supervision in HMIS with respect to standard protocols.
- To check the awareness of HMIS operating team in reporting and validating the data through HMIS.

- To recommend corrective measures against the gaps found out through the study.

METHODOLOGY:-

- **STUDY AREA**:- The study was conducted in Bhiwani and Rewari districts of Haryana.

- **STUDY APPROACH:-For conducting the study** data was collected from (District Headquarters(DH), 3 CHC's, 9 PHC's,13 SC's, 2 General Hospitals of Bhiwani region and District Headquarters,3 CHC's, 9PHC'S, 11 SC's of Rewari region).

- **STUDY POPULATION**:- It mainly includes Information Assistants, ANM's, MO's, LHV's and PHN of the respective districts.

- **SAMPLE SIZE**:- The data was collected from 52 facilities in total (28 facilities in Bhiwani and 24 facilities in Rewari) from (15 Information Assistants, 13 ANM's, 9 Medical Officers, 9 LHV's & 3 PHN's of Bhiwani district and 13 Information Assistants, 11 ANM's, 9 Medical Officers, 9 LHV's & 3 PHN's of Rewari district).

- **SAMPLING METHOD**:- Multistage random sampling type was the sampling method that has been adopted.

- **DATA COLLECTION TECHNIQUE**:- Interviews were conducted of Information Assistants, ANM's, MO's, LHV's and PHN of the respective districts.

- **DATA COLLECTION TOOL**:- Self administered, semi structured questionnaires was the data collection tool.

- **STUDY DESIGN**:- descriptive cross sectional study.

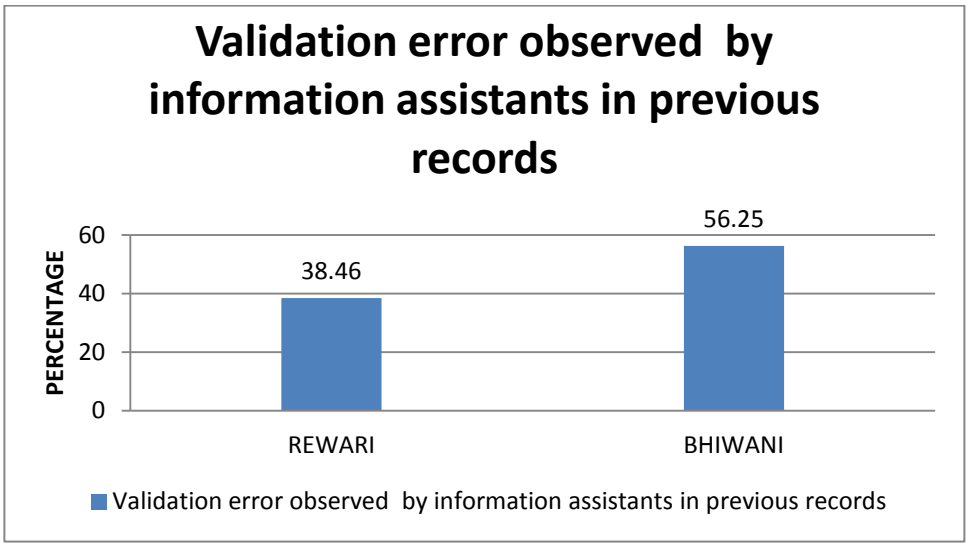
ANALYSIS OF THE FINDINGS:-

Table1:- REPORTING OF FACILITIES

	BHIWANI	REWARI
	n=28	n=24
Timely	23 (82.14)	20 (83.33)
Not timely	5 (17.86)	4 (16.66)

Above (Table 1) indicates that timely reporting of facilities(CHC,PHC & SC) was observed more in Rewari than Bhiwani by 1.2 percent only out of the 24 facilities in Rewari and 28 facilities visited in Bhiwani ,so the percentage of facilities that don't report on time was more in Bhiwani than Rewari by 1.2 percent.

Figure 1:- PERCENTAGE OF VALIDATION ERROR OBSERVED



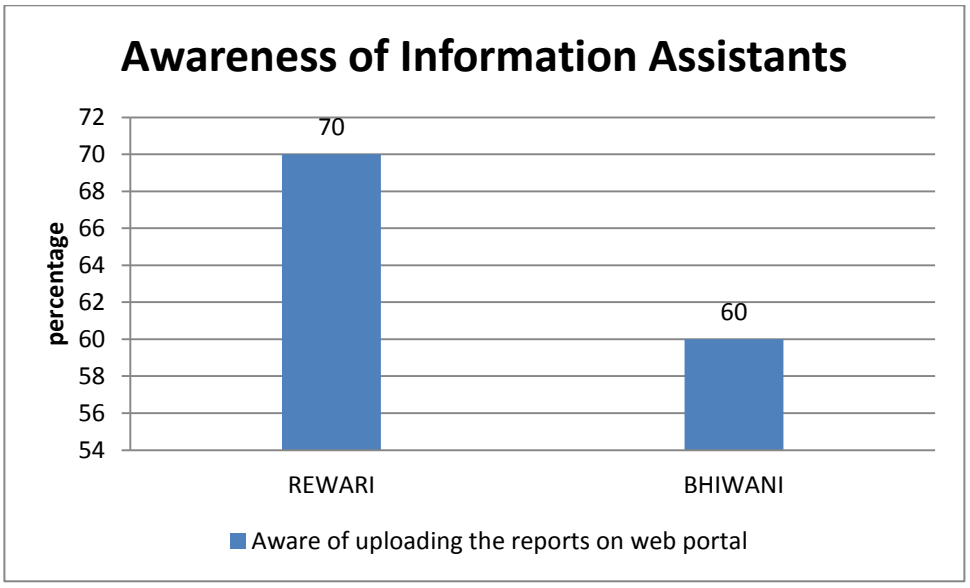
Above (Figure 1) indicates that percentage of validation error observed in Bhiwani was 18 percent more than was observed in Rewari. The main reasons behind observing the validation errors by information assistants are mainly the errors in reporting by ANM's & LHV's and the compilation errors done by information assistants.

Table 2:- AWARENESS OF INFORMATION ASSISTANTS, LHV'S, ANM'S AND PHN REGARDING HMIS PORTALS AND ONLINE WEB REPORTING

	REWARI n=36	**BHIWANI** n=40
Aware of HMIS Portals	22 (61.2)	37 (91.66)
Not aware of HMIS Portals	14 (38.8)	3 (8)
Aware of HMIS online web reporting	31 (85.71)	25 (62.96)
Not aware of HMIS online web reporting	5 (13.88)	15 (37.5)

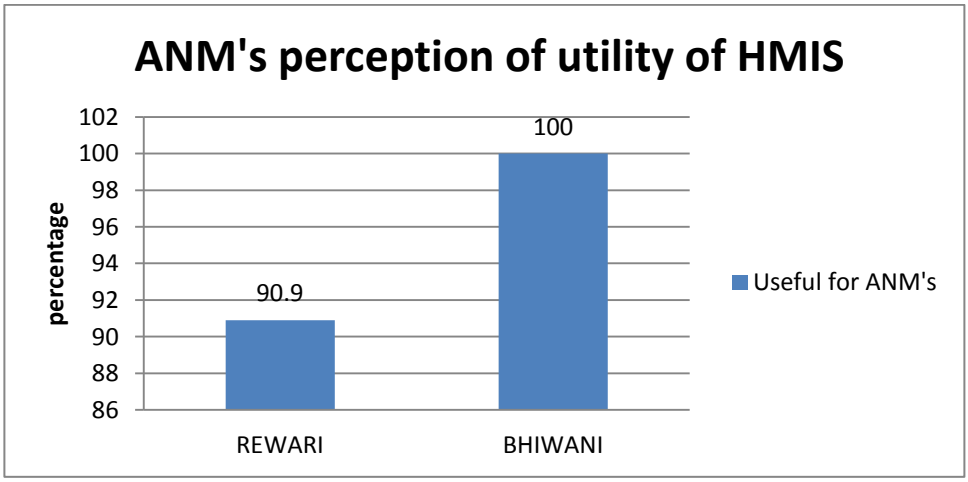
The above (Table 2) indicates that awareness of HMIS portals was found more in Bhiwani than of Rewari by 30.46 percent so, much unawareness regarding HMIS portals was seen in Rewari. But on the other hand, awareness regarding HMIS online web reporting was seen more in Rewari than of Bhiwani by 23 percent ,so in Bhiwani amongst the 40 people who were interviewed awareness regarding HMIS online web reporting was found lesser than of the 36 people who were interviewed in Rewari. The main reasons behind these were the improper training and the lack of motivation in seriously adopting the HMIS.

Figure 2:- PERCENTAGE OF INFORMATION ASSISTANTS AWARE OF UPLOADING THE REPORTS ON WEB PORTAL



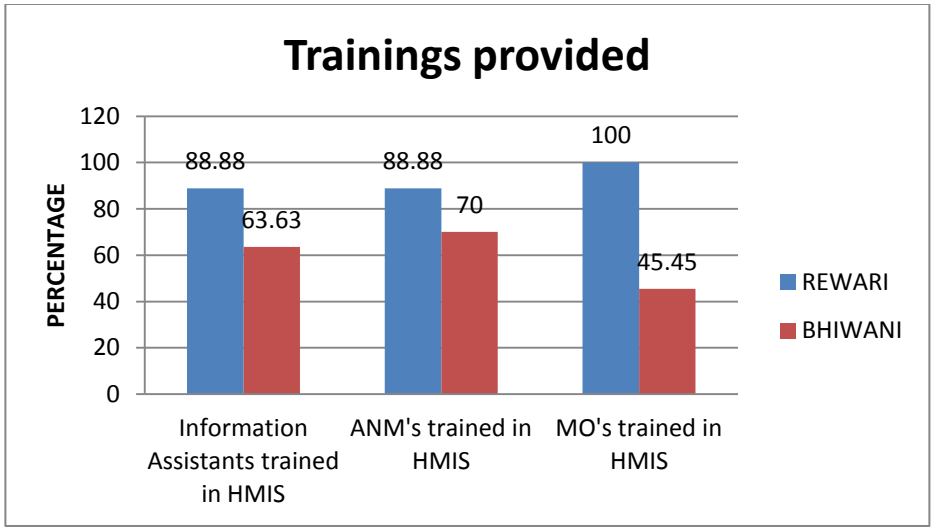
The above (Figure 2) indicates that awareness of Information Assistants in uploading the reports on web portal was 10 percent more in Rewari than of Bhiwani that may be due to their proper training and increased awareness in Rewari regarding online web reporting as stated earlier which was less in Bhiwani.

Figure 3:- PERCENTAGE OF ANM's PERCEPTION REGARDING THE UTILITY OF HMIS



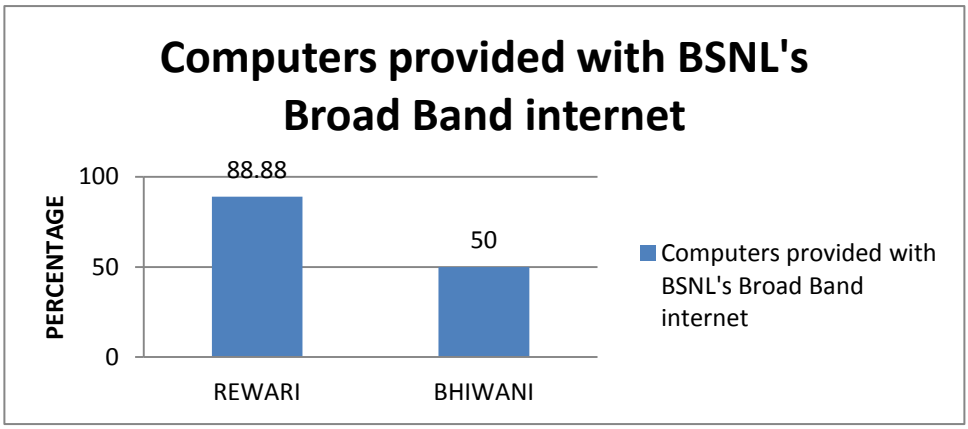
Above (Figure 3) indicates that perception of ANM's regarding usefulness of HMIS was much more positive in Rewari than of Bhiwani as out of the 14 ANM's that have been interviewed in Bhiwani, all 14 considered HMIS useful for them whereas in Rewari only 91 percent of ANM's considered it as useful for them, remaining 9 percent considered it as burden for them as HMIS has just increased their workload of reporting and did not appear beneficial to them.

Figure 4:- PERCENTAGE OF TRAININGS GIVEN TO INFORMATION ASSISTANTS, ANM'S, AND MO'S OF BHIWANI AND REWARI



Above (Figure 4) shows that the percentage of trainings given to Information Assistants, ANM's & MO's was higher in Rewari than of Bhiwani by 25.25, 19 and 54.5 percent respectively. This can be the main reason for the unawareness that was found in HMIS staff in Bhiwani regarding the online web reporting and uploading the reports on web portal which was better in Rewari due to proper trainings that has been provided to them.

Figure 5:- PERCENTAGE OF COMPUTERS PROVIDED WITH BSNL's BROADBAND INTERNET



The above (Figure 5) indicates that the percentage of computes that have been provided with BSNL's broadband internet that should be provided as stated in the standard norms was nearly 89 percent in Rewari and about just 50 percent in Bhiwani. At the rest of the places the Information Assistants have been provided with Vodafone netsetter that shows very poor connectivity mainly in the PHC's which was a major issue that has been observed as it delays and obstructs the uploading of reporting on the web portals by information assistants.

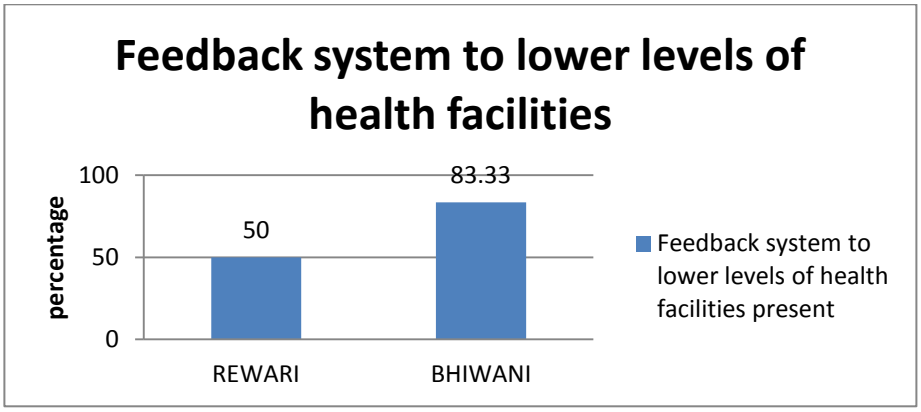
Table 3:- MONITORING FIELD VISITS CONDUCTED BY LHV's AND PHN's

	BHIWANI	REWARI
	n=12	n=12
Conducted	10 (83.33)	8 (66.66)
Not conducted	2 (16.66)	4 (33.33)

Above (Table 3) indicates that monitoring field visits conducted by LHV's and PHN's for the supervision of ANM's was 17 percent more in Bhiwani than of Rewari. These field visits are

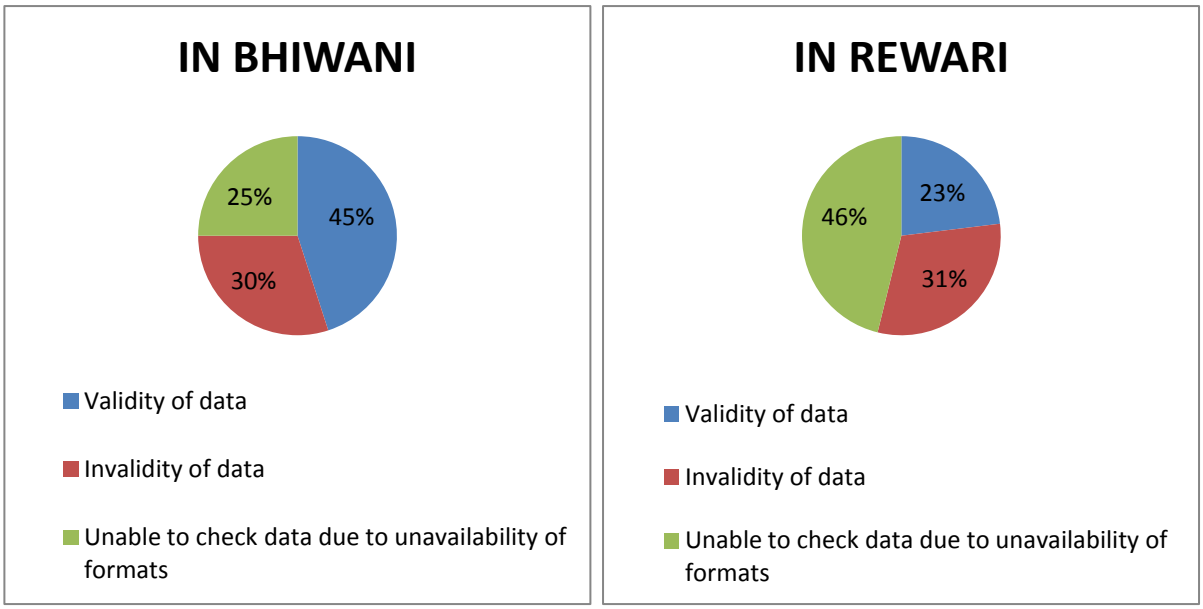
required for evaluating the working of ANM's and to keep a check on their performance. Its also required for sensitizing them, updating them with the new formats and solving their queries and problems.

Figure 6:- PERCENTAGE OF FEEDBACK SYSTEM TO LOWER LEVELS OF HEALTH FACILITIES



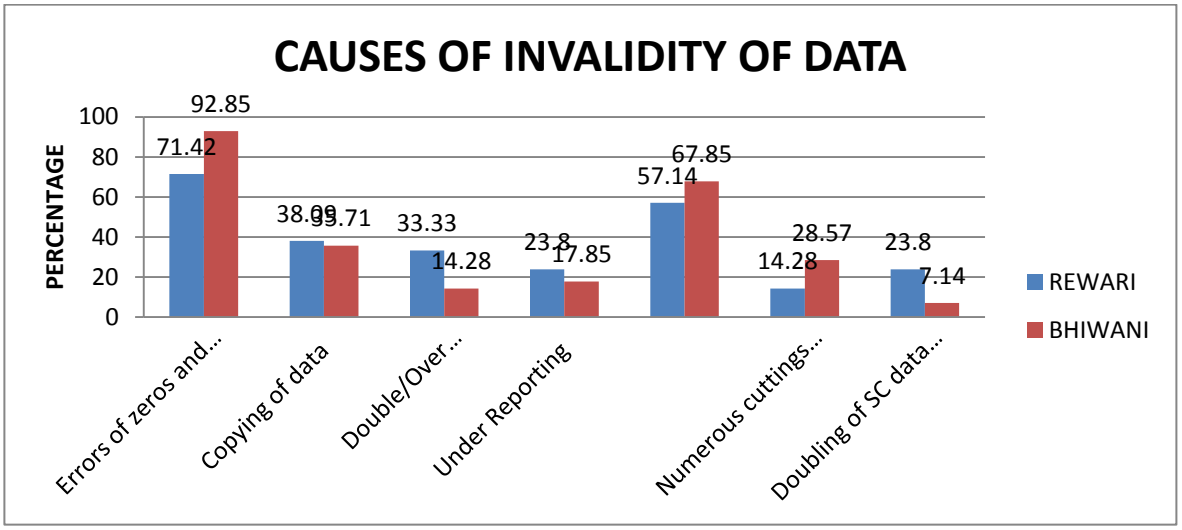
Above (Figure 6) indicates that the system of feedback to lower levels of health facilities was quiet good in Bhiwani as compared to Rewari where it was just 50 percent. The main reason for its non availability is the unawareness regarding this concept amongst the LHV's, MO's and PHN. They are not aware that the feedback should be given to the ANM's by the LHV's, MO's and PHN for improving their performance, to rectify their errors and to monitor and evaluate their performance.

Figure 7:- PERCENTAGE OF VALIDITY ,INVALIDITY AND INABILITY TO CHECK DATA FOUND IN BHIWANI AND REWARI



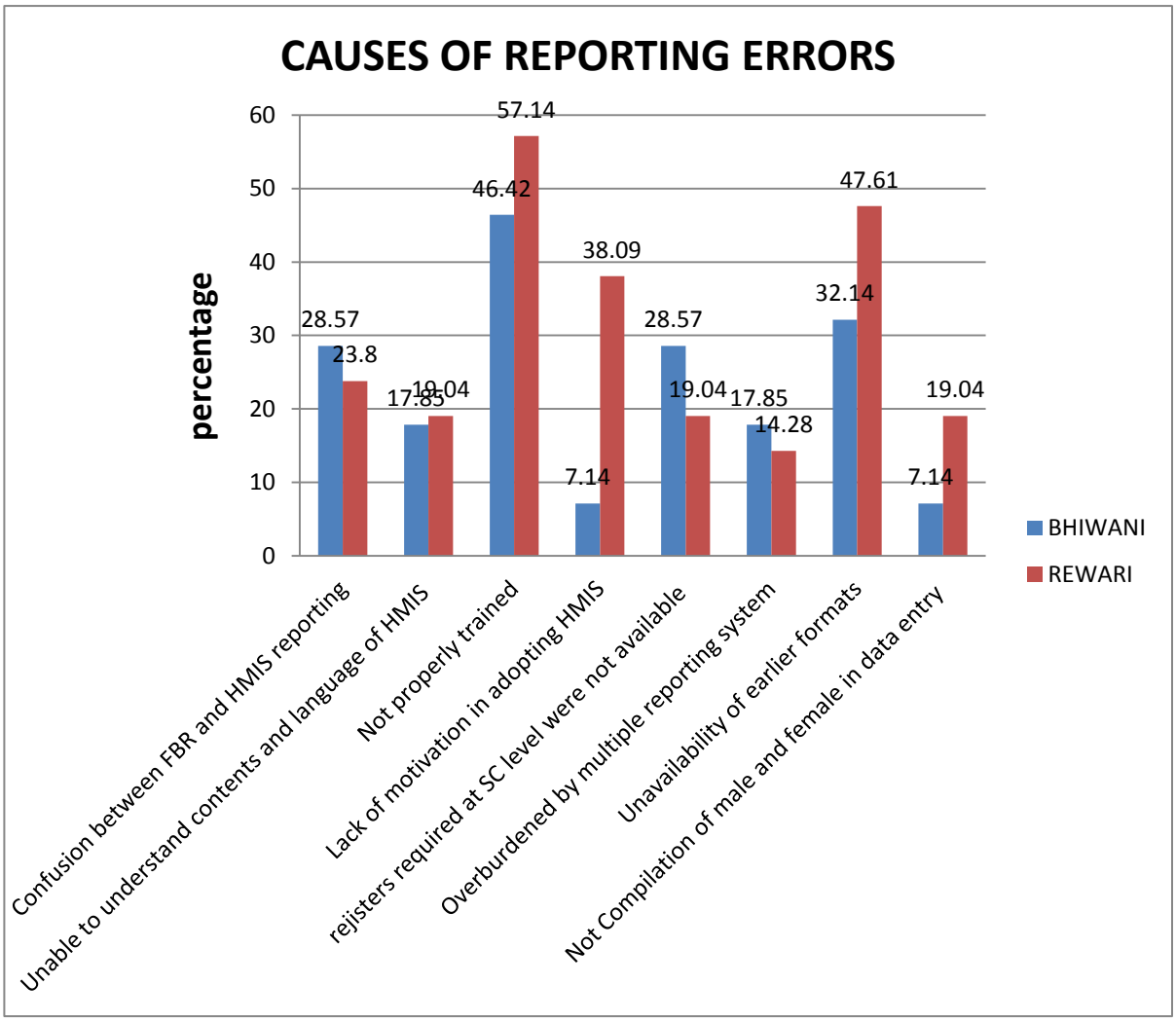
As above figure 7 indicates validity of data was nearly double in Bhiwani as compared to Rewari where it was just 25 percent only. The data invalidity that was mainly due to errors found in data like errors of zeros and blanks, incomplete data, false or double reporting was nearly same found in both the districts. And another major issue that was very much prevalent is the non availability of formats with the ANM's because of which I was unable to check their data that was found double in Rewari than of Bhiwani.

Figure 8:-PERCENTAGE SHOWING CAUSES OF DATA INVALIDITY IN BOTH THE DISTRICTS



The above figure 8 indicates that the major cause of data invalidity is the errors of zeros and blanks which was greater in percentage in Bhiwani as compared to Rewari. Then using non standardized method of reporting like cuttings and overwriting is also another major cause of data invalidity which was also higher in Bhiwani as compared to Rewari. Besides these another causes of data invalidity like double reporting, false reporting, under reporting were found in greater percentage in Rewari than in Bhiwani.

Figure 8:- PERCENTAGE OF CAUSES OF REPORTING ERRORS IN BOTH THE DISTRICTS



Above figure 8 indicates that main causes of reporting errors are the Improperly trained staff, unavailaibility of earlier formats with ANM's and lack of motivation in adopting HMIS amongst the ANM's and LHV's that was majorly found in Rewari than in Bhiwani. Other errors were mainly found in greater percentage in Bhiwani that are confusion between FBR and HMIS reporting, inability of the ANM's in understanding the contents and language of HMIS formats, unavailability of registers at SC level, improper data entries and overburdening of ANM's by multiple reporting system.

OBSERVATIONS:-

- Large number of errors of zeros and blanks in the HMIS format were found as ANM's and LHV's are totally unaware of its concept.
- Great Confusion exists between HMIS reporting and Facility based Reporting.
- Information Assistants were reporting with their own HMIS format along with the standard HMIS format.(in Rewari)
- **Certain issues regarding HMIS format that have been observed were-**

- ❑ Not having Home Delivery column in PHC format but its present in SC format.
- ❑ Do not have murder and cancer cases in the format.
- ❑ Difficulty in understanding the contents and language of the format by the ANM's.

- ANM's are overburdened by multi reporting system.
- ANM's LHV's and MO's are not much clear and serious with HMIS reporting.
- Do not have updated and the separate format for CHC or SC as according to them PHC format covers all the data.
- Budget on HMIS can not be utilized properly as bills don't get passed and not timely receival of budget by them.
- Connectivity of the internet that has been provided to the Information Assistants is a major issue.

- Monitoring and Supervisory field visits are not conducted as TA/DA is not provided to them.

- At SC level copying of data by ANM'S was observed in their filled SC formats.

RECOMMENDATIONS:-

- The concept of zeros and blanks should be made understood at all the levels.
- ANM's, MO's and LHV's should be much more sensitized and motivated for properly adopting the HMIS.
- The confusion between the newly started Facility based Reporting and the earlier reporting system of HMIS should be made clear at each and every level.
- The updated and correct formats preferably in Hindi should be made understood and available to all the ANM's.
- The language and the contents of the HMIS format should be made understood to the ANM's.
- Much more reliable net connection should be provided to all the Information Assistants.
- The burden of Multi reporting system with numerous registers should be made reduced at SC level.
- For proper utilization of budget, it should be passed and received by the facilities timely.

CONCLUSION:-

The concept of HMIS is very much helpful in reducing all the burdens and the errors that occur mainly at SC level. So its proper implementation is very much required at each and every level of the health system. Certain pitfalls are there in its working in terms of validation and reporting which can be reduced by considering the points of suggestions stated earlier.

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ANNEXURE

Questionnaire 1:-

QUESTIONNAIRE

SIHFW Panchkula – Haryana

CONFIDENTIAL
(for research purpose only)

ASSESSING THE EFFECTIVENESS OF HMIS ON DATA VALIDATION AND REPORTING - APRIL 2012

District Name –

Name of the Facility –

Questionnaire Identification Number -

A. **Basic information**

Serial Number	QUESTIONS	RESPONSES
i.	What is the No. of Reporting Units?	
ii.	Out of above, what is the no. of units that reported on time?(should be asked from the higher level of the respective facility)	
iii.	What is the reason for delay of those who didn't report on time? (should be asked from the respective facility)	
iv.	What is the date of submission of report by District?	

v.	If delayed, what is the reason for delay?	
vi.	Who in the state certifies/validates the data? (for district)	
vii.	Validation error if any in previous year?	1. YES 2. NO 99. DON'T KNOW
viii.	If yes, has the above error been resolved or not?	
ix.	Do you make use of the data generated through HMIS to assess gaps/effectiveness in service delivery?	1. YES 2. NO
x.	If no, why?	
xi.	Whether HMIS is useful or a burden for you? (for ANMs)	1. USEFUL 2. BURDEN
xii.	What should be done to make it more effective for you?	

B. Awareness

i.	Are you aware of HMIS Portals?	1. YES 2. NO
ii.	If no, why?	

iii.	If yes, aware of HMIS online web portals?	1. YES 2. NO
iv.	If no, why?	
v.	If yes, aware of using HMIS online web portals?	1. YES 2. NO
vi.	If no, why? Give reasons.	
vii.	Are you aware of uploading the reports on web portal? (not for SCs)	1. YES 2. NO
viii.	If no, why?	

C. Manpower, infrastructure and Logistics

i.	What is the No. of Reporting Units?	
ii.	Is the Nodal Officer available?	1. YES 2. NO
iii.	If no, why?	

iv.	Are the Information / Computer Assistant and Statistical Assistant available in all reporting units?(at all levels)	1. YES 2. NO
v.	If no, why?	
vi.	Are they trained in HMIS?	1. YES 2. NO
vii.	If no, why?	
viii.	Are there any vacant posts of Information Assistant and Statistical Assistant?	
ix.	If yes, how many and why?	
x.	Is the Data Manager Available?(at district level)	1. YES 2. NO
xi.	If no, why?	
xii.	Are any posts vacant of Data Manager?	1. YES 2. NO
xiii.	If yes, how many and why?	
xiv.	Is Computer available in all reporting units?(not for SC's)	1. YES 2. NO
xv.	If no, why?	

xvi.	Are they provided with Broad Band internet connectivity from BSNL's in line?	1. YES 2. NO
xvii.	If no, why?	
xviii.	Is there any other problem regarding manpower & infrastructure?	1. YES 2. NO
xix.	If yes, what is it?	

D. Training Status

i.	Are MOs Trained in HMIS?	1. YES 2. NO
ii.	If no, why?	
iii.	Is ANM posted at Sub Centre trained (for SC)?	1. YES 2. NO
iv.	If no, why?	
v.	Is Computer/Information Assistant trained?	1. YES 2. NO
vi.	If no, why?	

vii.	What is the current load of training? (Give detail)	

E. Field Visits and Workshop

i.	Are Monitoring & Evaluation supportive Supervisory field visits conducted?	1. YES **2.** NO
ii.	If no, why?	
iii.	Is monthly workshop at district level conducted for improvement of data quality and dissemination of analysis to all stake holders?	1. YES **2.** NO
iv.	If no, why?	

F. Budgetary Support

i.	How much budget is being allocated for implementing HMIS?	

ii.	Is it sufficient or falling short?	1. SUFFICIENT 2. FALLING SHORT
iii.	Is consumable budget being utilized or not?	1. YES **2.** NO
iv.	If yes, how and where?	
v.	If no, why?	

G. Format of reporting

i.	In which format SCs / ANMs do their reporting? (for PHC's)	1. Printed/hard copy format **2.** Online format
ii.	What is the frequency of ANMs reporting their data and on which date of the month they come? (for PHC's)	
iii.	In which format PHCs do their reporting?(for CHC'S)	1. Printed/hard copy format 2. Online format
iv.	In which format CHCs do their reporting?(for district)	1. Printed/hard copy format 2. Online format

H. Monitoring & Reporting

i.	Do you assess the data received from Sub Centre for any gaps while making entries?	1. YES 2. NO
ii.	If no, why?	
iii.	Is there any specific format for reporting the diseases?	1. YES 2. NO
iv.	If no, why? Give reasons.	

I. Feedback System

i.	Is a system of feedback to lower levels of health facilities present?	1. YES 2. NO
ii.	If no, why?	

Date:- **Signature:-**

THANK YOU

END OF SURVEY

Questionaaire 2:-

OBSERVATIONAL KEY QUESTIONS ON VALIDATION, REPORTING SYSTEM AND ROLES OF HEALTH WORKERS AT PERIPHERY LEVEL

	QUESTIONS	RESPONSES
1.	What is the number of reporting units?	a. 1 b. 2 c. Not present d. Don't know
2.	Who is the relevant reporting person and what is his designation?	Name of the person:- _____ _ Designation:- a. Information / Computer Assistant b. Data Manager c. ANM d. LHV e. PHN
3.	In which format they receive the data?	a. Hard copy format b. Online format c. Both d. Not applicable

4.	In which format they send the data?	a. Hard copy format b. Online format c. Both
5.	The errors found when checked and compared recently available HMIS reports with previous years or months reports are:	a. Errors of zeros and blanks. b. Copying of data. c. No error was found.
6.	Does ANMs' registers contain all the data that is needed to feed in HMIS for reporting?	a. Yes b. No
7.	If no, what type of data is missing?	_____
8.	Is the data that ANMs/LHVs enter in the formats from their registers actual /valid?	a. Valid b. Invalid
9.	If invalid, what type of error was found?	a. Copying of data from other ANM's registers. b. False reporting (double reporting, under reporting or over reporting). c. Not using standardized method of reporting.

10.	If invalid, what were the problems found?	a. Unaware of the concept of zeros and blanks. b. Not able to understand the contents and the language of the HMIS format. c. Not properly trained. d. Lack of motivation towards adopting HMIS e. All the registers required at SC level not available with them. f. Overburdened by multiple reporting system. g. Unavailability of earlier formats with them.
11.	What is the role of Lady Health Visitor at the facility?	_____ _____ _____
12.	What is the role of Public Health Nurse present at the facility?	_____ _____ _____