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MANAGEMENT INFORMATION SYSTEMS IN HEALTH AND FAMILY WELFARE IN INDIA

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Administrative Staff
College of India,
Hyderabad

Management Sciences for
Health, Boston

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G. Narayana
Paul Auxila

PROJECT TEAM

Indian Institute of Health Management Research, Jaipur
- Dr. S.L. Banerjee
- Dr. S. Joshi

Ministry of Health and Family Welfare, New Delhi
- Mr. R.L. Narasimhan
- Director of Evaluation

National Institute of Health and Family Welfare, New Delhi
- Dr. Prem Talwar

Administrative Staff College of India, Hyderabad
- Dr. G. Narayana
- Dr. K.S. Ramesh
- Dr. A.V. Srinivasan
- Mr. U. Pandey
- Mr. S. Venkatesh
- Dr. H. Rao

Management Sciences for Health
- Dr. Sara Seims
- Mr. Paul Auxila
- Dr. Richard Roberts
- Dr. Henry Elkins
- Mr. Peter Savosnick

ACRONYMS

CMHO	Chief Medical Health Officer
DIE	Demography, Information & Evaluation
DMHO	District Medical Health Officer
EPI	Extended Programme of Immunization
FWD	Family Welfare Directorate
HFWTC	Health and Family Welfare Training Centre
IAS	Indian Administrative Service
ICDS	Integrated Child Development Scheme
IPP	India Population Project
MEM	Mass Education and Media
MPW	Multi Purpose Worker (Scheme)
MTP	Medical Termination of Pregnancy
NIC	National Informatics Centre
NMEP	National Malaria Eradication Programme
PHC	Primary Health Centre
PHC MO	Primary Health Centre Medical Officer
PP	Post Partum (units)
PWD	Public Works Department
SEIO	State Evaluation and Investigation Officer
SFWB	State Family Welfare Bureau
UIP	Universal Immunization Programme

MANAGEMENT INFORMATION SYSTEMS IN HEALTH AND FAMILY WELFARE

SUMMARY OF FINDINGS AND ISSUES

INTRODUCTION

A State-level survey of management information systems (MIS) was conducted in 16 major States in India. The purpose of this study was to review the information systems in place in the States, and the objectives were:

1. To understand the nature of reports that are sent from the Districts to the State
2. To assess the timely flow and periodicity of information
3. To elicit opinions on the adequacy and reliability of information
4. To determine feedback mechanisms and data processing techniques
5. To examine the information utilisation patterns.

The States studied differ from each other in many ways: size, population density, number of eligible couples per 000's population, crude birth and death rates, etc. A table summarizing these variables is shown in Appendix I.

METHODOLOGY

A team of two consultants visited each State to interview the Officers at the Directorate and Secretariat levels concerned with the Family Planning, MCH, Immunisation, and Malaria Programmes. The interview questions gave equal emphasis to input data (personnel, training, supplies, finance, and transport) and output data (programme performance). Two sets of data collection tools were used: for top-level administrators, the consultants used a checklist of discussion points concerning the use of information for planning, monitoring, and evaluation; for Programme Officers, the instrument was an elaborate interview schedule pertaining to reports, registers, and requisitions; this was intended to elucidate how target setting, data processing, and programme performance procedures followed at various levels.

BACKGROUND

All the States surveyed have, on the surface, an elaborate information system for Family Planning, MCH, Immunisation, and Malaria Programmes. However, there is a great difference among the States in the importance that they attach to both the operation and the use of the information system. There are also notable differences within the States in the emphasis given to different programmes. There are also fundamental

differences in the way in which information is collected, registered, summarized, stored, and used by different States.

But there are several common features among the States' information systems, the most obvious being the many similar registers and reports that are used (designed for either the original GOI system or the restructured, integrated MIS of the eighties). This section of the report details the differences and similarities from State to State among the various components of the MIS; the following sections provide State-specific reports, in alphabetical order.

The first portion of the report summarises the findings of the survey. The second portion sets the tone for discussion of emerging issues and strategies for improving and modifying the management information systems.

CHANGES IN THE MIS

All States in the survey have instituted management information systems that were designed by the Centre. None of the State-level Officers interviewed, in any State, was aware of exactly how the information systems were introduced and what, if anything, preceded the Government of India (GOI) system of the sixties. A review of the State MIS's shows that most States have made very few, if any, changes in the original systems. However, a few States have recently started experimenting with their information systems, both with and without external assistance. (A summary of these experiments is given in Appendix II.)

Several reasons were offered why changes have been deemed unnecessary by some States and necessary by others. Several respondents believe that changes in the organisational structure of the Health and Family Welfare Department in their State must precede the introduction of any new information system. Several States are relying heavily on the GOI at the Centre to take the initiative in introducing changes; these same States perceive the need for a uniform system as opposed to several separately functioning information systems in India. The number of changes that have been made should not be equated with the perceived need for change; several respondents mentioned that their States have contemplated changes but failed to mobilize enough external and internal resources.

Among the States making changes in the information systems, there is considerable variation in the magnitude of change, the geographic area covered, the emphasis placed on different components of the MIS, and the strategies followed by the States. It is interesting to note that some States have used external resources (usually in the form of consultants), while others have entrusted the development and introduction of new systems to internal committees set up especially for this purpose. We have not been able to determine through this study which approach has been more successful.

In the implementation process, some States initially introduced changes in a few Districts, with the hope of eventually extending the MIS to all other Districts; other States have introduced the new system in all

Districts at once without any phasing. Some have rigorously experimented with new systems before finalisation, while others have not considered such an approach beneficial. Some were content with changing reporting formats, while others dealt with both reports and registers. Some supplied the reporting units with printed registers and reports, while others could not get their stationery budget increased. Some completely replaced old systems with new systems, while others run old and new systems in parallel.

The Health Intelligence Bureau, recognizing the need for a combined reporting system in place of separate programme component-wise reporting, introduced a new system designed without consultation with the State units. Under this system, the Districts are expected to send the integrated monthly report directly to the Centre. This is a parallel system to the old system of individual reports. Many of the Districts do not report at all, and many others do not report on time. In practice, the new system is not working. It has not been reviewed, and no instructions have been given to the States to either withdraw the system or improve reporting efficiency. Many consider the system a requirement of the Centre without much seriousness attached to it.

REPORTING SYSTEMS

Organisation structure to a large extent determines the reporting system. All States have certain common organisational features determined by the funding pattern of the Centre. The Demographic and Evaluation Cell present in all States is responsible for the consolidation and processing of data received from the Districts. However, in most of the States, the D&E Cell is responsible only for the information related to the Family Planning Programme. In a few States, they collect information on MCH and Immunisation but do not process the data, instead handing it over to the concerned Programme Officers for further analysis. A few States have, however, centralized Programme performance data collection and analysis. Information on supplies is maintained by the concerned Programme Officers with the help of Storekeepers. Financial and administrative data are kept by the Administrative and Financial Officers who are generally seconded from the State administrative cadre.

In the case of Family Planning, the data, once processed, are sent to the Programme Officers, Directors, Secretaries, and concerned Officers at the Centre. Since the Programme Officers have little authority and only responsibility for technical supervision, they do not have much work to do with the processed information.

While limited authority of Programme Officers is a common feature of all States, the number and ranks of these Officers varies from one State to another. Some States have Programme Officers at the Joint Director level and others at the Additional Director level. These differences depend more on the size of the State and the demand for promotional opportunities than on Programme needs and requirements.

The number of Directors and Secretaries in the Directorate and Secretariat similarly varies from one State to another. In a large number of States, the functions of Family Welfare and Health are

separate, with each headed by a separate Director. A few States have one Director for Health and Family Welfare combined. While some Directors of Family Welfare are professionals, others are general administrators. In some States, the Secretary is in charge of both Health and Family Welfare, and one Special Secretary has been appointed to oversee only the Family Welfare Programme -- an indication of the importance the programme.

At the Directorate level, there is a constant shift in portfolios of Programme Officers. The positions are merged or separated, and at times the persons are shifted from one position to another. Confusion is further compounded by the fact that in some cases the positions remain vacant for a long time, and in other cases, Officers are promoted to a position just before retirement -- the situation with most Directors of Health and Family Welfare. Since many Secretaries are general administrators, they are regularly shifted from one Ministry to the other. The only Officers who remain in their positions for a considerable time are those in charge of the Demographic and Evaluation Cell and the Mass Education and Information Units. These constant reshufflings of positions and persons, promotions of persons about to retire, and frequent transfers result in lack of continuity and make any change process difficult. In fact, in States where there is more continuity at higher levels, the attempts to change systems have been more effective.

CONTENTS OF REPORTS

There are altogether 28 Family Welfare Programme reports sent from the Districts to the State. These can be divided into four categories: programme performance figures, findings of sample verification of acceptors, supplies, and expenditure statements (see Appendix III). In addition, all States send feedback reports to Districts, though the contents of these reports vary from one State to the other. Programme performance reports deal with institution-wise sterilisation, IUD insertions, oral pill and conventional contraceptive targets and achievements, and medical terminations of pregnancies. A separate report is sent to urban and rural centres distributing oral contraceptives.

The Demographic and Evaluation Cell at State Headquarters is expected to conduct a sample verification of acceptors by method in one or two Districts every month and send the summary of findings to the Centre. Samples incorrectly selected, cases not traceable, discrepant entries, and information not recorded are the common features of all these reports. The summary reports of respective methods also include information on the number of ineligible couples operated on and the reasons for discontinuation of spacing methods. Details of fake cases, cases reported twice, and ineligible cases operated on are furnished in a separate report.

There are two types of schemes under the Immunization Programme: the Extended Programme of Immunization and the newly introduced Universal Immunization Programme. Both programmes have separate monthly performance reports, though the contents are more or less the same. Again, Immunisation performance details form part of the MCH Services

report submitted twice a year, along with data on antenatal and post-natal services provided and number of deliveries conducted. In regard to Information, Education, and Communication activities, there are monthly and quarterly reports on such items such as films shown, opinion leaders' camps conducted, and publicity material distributed. Also included in these reports is information on equipment in use and supervisory tours made by State-level Officers.

There are no standard formats followed for reports on supplies, though the contents of various formats used by the States are same: annual requirement of supplies, delivery schedules, and stock position. Ad-hoc requests for additional requirements are prepared from time to time, depending on the need. Expenditure statements are submitted monthly and quarterly in standard formats head-wise by all States

Under the National Malaria Eradication Program, as many as 44 reports are sent from the Districts to the State. Of these, 12 are annual reports, one is a weekly report, and the remaining are either monthly or quarterly. These reports cover epidemiological information, services provided, spraying operations done, supply requirements, and expenditure statements. Some reports provide information by District, while one contains data by PHC. Almost all State Governments follow the same formats supplied for them by the Centre, though the quality of information collected differs from one State to another.

There are several ad-hoc requests apart from the regular reports, although it is impossible to determine how many are received by each State, as there is no list maintained. Ad-hoc requests can come from different directions. One frequently quoted request is for information to answer questions raised in Parliament and Legislatures. The total number of questions raised and questions that require collection of fresh information differ not only from State to State but also from session to session. While some States promptly answer the queries, others keep them pending for a long time. The other type of ad-hoc request is for information for specially convened meetings at the Centre or to keep information ready for visiting dignitaries. In both cases the requested information is usually the same as that which has been used for regular reporting. Inadequate facilities at the Centre for storing and retrieving data are probably responsible for such requests. When the States experience the same problems of retrieval, they have to turn to the Districts to supply the information. At times there are requests for quarterly and half-yearly information, though the monthly information has already been submitted. Such requests require the compilation of information earlier supplied.

There are no regular reports on personnel, training, or transport. Training for paramedical and medical staff is mainly carried out by Health and Family Welfare Training Centres located in the States. These centres receive from the Training Division of the GOI targets for numbers of training programmes, number of personnel to be trained, and type of programmes. Then the training centres request the Health and Family Welfare Director to nominate personnel for respective programmes. Though the selected personnel are instructed to attend training, no records are maintained by the Department, so there is no

way of knowing who has been trained and who has yet to receive training. Because targets determine training activities, training becomes a routine activity with no basis in genuine programme needs.

In regard to personnel, it is difficult to get an accurate figure on the total employed. Not even the sanctioned and vacant positions by institution are available. With constant transfers and no regular flow of information, the data collected become outdated in no time. The only way of obtaining authentic personnel information is to check the payrolls, but this is a painstaking and time-consuming effort since the salaries, disbursed under various heads and accounts, are maintained by different administrative Officers. As a result, most of the States rely on estimates.

Added to this is the problem of seniority lists of various categories of personnel. Since personnel records are not properly maintained, promotions based on seniority are a major source of controversy and prolonged legal battles. In cases where the records are properly maintained, the problem is that of retrieval of information. This delays the information process and makes it difficult to arrive at firm decisions. As a result, positions can remain vacant for considerable period of time and people are sometimes promoted with retrospective pay. Thus, more often than not, key positions remain vacant or under dispute.

Similarly there is no information on the number of vehicles, their road worthiness, and maintenance problems. Some States have collected information on vehicles that need to be condemned, replacements for condemned vehicles do not arrive in time; drivers without vehicles and vehicles without drivers are not uncommon.

In the States which have experimented with new management information systems, integrated report formats have been introduced in the form of a single report for all programmes. In most States, the contents of reports and the amount of information collected has remained the same. In one State, only key indicators have been selected for each programme, and an integrated report has been designed with equal emphasis on input and output information. The new integrated system, however, runs parallel to the old programme-based reporting. Where the integrated report format retains all the contents of the programme-based format, replacement is considered possible and easy; where the contents of new report formats are drastically different from the old formats, the new systems are not readily accepted. Many of the Programme Officers at the State level would like to retain the old system because they are asked to provide information on old formats by the Officers of respective programmes at the Centre. Some Programme Officers also think that they lose identity and importance once the new system comes into existence. So any new integrated system, to be successful, should not only be acceptable to the State Officers but also have the concurrence of the Programme Officers at the Centre.

FLOW OF INFORMATION

Flow of information to a large extent depends on the importance given to a particular programme or set of activities. Considerable importance is attached to monthly Family Planning and Immunisation performance figures, as they form part of the Prime Minister's 20-Point Program. All States are strictly instructed to send the information on performance by the 10th of every month. Urgent telephone messages are sent to erring States or routinely to all States, and the highest authorities at the State level are requested to expedite the matter. Given the extent of pressure from above, each State has evolved a system of getting the information on time. All States ask their District Officers to submit the performance reports before the 10th of every month. While most of the Districts report on time, a few Districts in each State delay. Sometimes it is the same Districts over and over again; at other times different Districts are behind schedule in different months. Difficult terrain, poor communication facilities, vacant positions, utilisation of staff for other programme activities, and lack of adequate interest among Medical Officers are considered the main reasons for delays. To overcome the problem of delays, the States sometimes turn to the State Road Transport Corporation.

In all meetings of District Medical Officers, the importance of sending the information on time is stressed. In some States, explanations are called for; in other cases, the concerned Officers are warned in meetings in presence of all other Officers. This is considered the most effective way of dealing with the situation. Since the Districts have to collect data from all institutions within their borders and consolidate the reports before sending the District performance figures to State Headquarters, only provisional figures are supplied in the first week of every month. Sometimes tallying figures becomes a major problem, as there are too many figures either given orally or submitted as provisional reports. Considerable time is spent at the State level arriving at final acceptable figures.

Some States, in addition to the performance figures they regularly send to the Centre, get daily sterilisation performance figures during intensive drives. In these instances, the District Medical Officers telephone to the Director of Family Welfare the number of camps held and the number of operations done during the day. There are no reporting formats for this, and the information is neither recorded nor stored. The purpose is to put immediate pressure on the concerned Districts so that they make every effort to achieve their sterilisation target. In this effort, the State incurs considerable cost for special messengers and telephone bills, but that does not seem to be a consideration.

Monthly reports on Malaria, IEC, and MCH are submitted in the fourth week of every month. There is no pressure to produce results in these programmes. Expenditure statements under different heads are received monthly and compiled into quarterly expenditure reports. These monthly statements are usually delayed, incomplete, and/or inaccurate. While 100% centrally sponsored Programmes like Family Planning have no problems of disbursements, the National Malaria Eradication Program, with 50% State funding, invariably runs into problems in almost all

States because of delayed reports. It is like the problem of the chicken and the egg: money is not disbursed because of delayed expenditure statements, and expenditure statements are not prepared in time because, among other problems, there is no money to spend.

In regard to supplies, special messengers are sent with requisitions whenever a particular item is out of stock. This is particularly true of vaccines. Family Planning items, particularly conventional contraceptives, are supplied through a push strategy, depending on the targets fixed for a particular method. In fact, the supplies in most cases are more than the demand, and at times there is not enough space to store them.

The importance given to various reports thus varies according to the significance attached to the activities or programmes. There is more pressure to get information in on time, and often at exorbitant cost, in regard to Family Planning and Immunisation Programme performance. More emphasis is placed on programme performance data in general than on input indicators.

RELIABILITY OF INFORMATION

Personnel at various levels of the organisation are supposed to conduct reliability checks to determine the accuracy of information reported. Some of the monitoring mechanisms followed are random checks by Programme Officers during their supervisory visits, Regional Directors' field trips, evaluation by investigatory teams of the Demographic and Evaluation Cell, and regular systematic evaluation by the Central Evaluation Teams. Supervisors are expected to go to the field and find inaccuracies in reports, but this never happens in practice. The number of supervisory visits is limited, and supervisors spend most of their visiting time attending meetings, giving new sets of instructions, and finally monitoring target achievements.

The respondents agree that some performance figures are more reliable than others. For instance, there is unanimity about the nonreliability of performance data related to spacing methods, particularly condoms. They also think that distortion occurs at all levels. According to one Officer, the top-ranking Districts do not need to distort figures, and low-ranking Districts do not gain anything by distortion; it is the marginal Districts that tend to inflate their figures. Intense competition, continuous pressure, and unrealistic targets are considered the reasons for false reporting. At times false reporting also occurs because it is unclear who should take credit for a given acceptor, and the same acceptor is unintentionally listed at two places. It has also been suggested that the way target achievement and couple protection rates are worked out leads to distortions.

The other factor thought to be responsible for distortion is the intense pressure on all levels of the organisation to achieve targets in the last quarter of the fiscal year. From January to March, special efforts are made in the form of media campaigns, sterilisation camps, and additional incentives. All other departments, such as Revenue, Education, and Rural Development, are involved in the motivation of eligible couples. During this time, inter- and intra-departmental

competition reaches its peak and encourages exaggerated figures at various levels.

The Demographic and Evaluation Cell is expected to undertake systematic random checks for Family Planning acceptors in one or two Districts and submit the reports to the GOI. In some States, this is not done because of the large number of vacant positions and the lack of adequate facilities for carrying out such work throughout the year. In cases where the evaluation has been carried out and distortions identified, the Demographic and Evaluation Cell has reported the matter to the Director of Family Welfare. Sometimes no action is taken, and at other times the action taken is later withdrawn for some inexplicable reason. Given these results, it is no wonder that the personnel of Demographic Cell tend to consider the entire exercise futile.

The only way of discovering distortions, therefore, is through the regular, systematic evaluation conducted by the Central teams. These teams prepare evaluation reports and send them back to the State Governments. In cases where information is found to be unreliable, explanations are called for. The States have ready explanations to offer, the two most common being camouflaged names given by acceptors to conceal their identity and shifts in residence. In some cases the blame is squarely put on the Central Teams for not making enough effort to trace the difficult cases at the time of the survey. In general, the opinion is that distortion is on the increase in Family Planning performance figures.

In contrast to Family Planning, there is a general feeling that the MCH figures are under-reported. The female workers do not consider it important to record the services provided, as there is no pressure to achieve targets and performance review is irregular. The Immunisation Programme is evaluated by sending samples of vials from the PHCs to laboratories for potency tests, which generally turn out to be positive. Since cold chain problems are mainly at subcentre and village levels, sample tests of this nature are not as useful as they might be. There is no evaluation of the immunisation doses administered either during the supervisory visits or through systematic surveys. For instance, it is difficult to know how many children are given all four doses of DPT, though information is available on how many first, second, third, and booster doses are given in a particular month. Even in regard to immunisation, according to State-level Officers, there is considerable under-reporting. Immunisations done in private hospitals are difficult to tally, and performance figures of voluntary agencies do not reach the State on time.

No reliability checks are conducted on Malaria performance figures. Officers perceive large-scale distortions in the reporting of blood smear collections and DDT spraying.

Because the performance figures for sterilisation and IUD insertion are more rigorously monitored, they are considered more reliable than those for oral contraceptives and condoms. The general feeling is that inflated performance reporting is on the increase, primarily because of intense performance-pressure and competition among various levels to

bag awards. There are no reliability tests conducted to verify performance figures for MCH and immunisation, but lack of clarity in reporting and under-reporting are widely considered to be prevalent problems. There are no reliability tests conducted for Malaria programmes, though the general perception of supervisors is that the information is accurate on certain parameters and distorted on others.

DATA PROCESSING AND FEEDBACK

Once the monthly performance information is received in its final form, the processing begins. The most crucial aspect for data analysis is the targets given to Districts. Targets are set in all States for all Family Planning activities and for Immunisation. For IEC, MCH and NMEP activities, some States set the targets while others do not.

The Centre has evolved a formula for distribution of targets, and the State Health and Family Welfare Departments are expected to adhere to the formula in allocating targets to the Districts. However, only two of the States surveyed actually follow this procedure: most States, after receiving targets from the Centre, increase the figure and then distribute higher figures among Districts.

Three different procedures are followed to distribute targets to Districts: 1) In some States, the targets are fixed purely on the basis of last year's performance of each District. In this case, the high-performing Districts take a major share of the targets compared to low-performing Districts. 2) In most States, the targets are fixed on the basis of population size and past performance. At times, District Officers complain about targets given under this procedure; this leads to arguments and discussions, and eventually a compromise figure is arrived at. 3) In two States, as mentioned above, the Central formula -- based on female literacy, infrastructure facilities, eligible couples covered and yet to be covered -- is used for target setting.

Compilation and processing of data received from the Districts are centralized activities in some States and programme-based in others. The Demographic and Evaluation Cell either compiles and processes information pertaining to all programmes or to Family Welfare or only to Family Planning, depending on structural arrangements of the Directorate. In cases where only limited information is processed by the D&E Cell, the Programme Officers are given responsibility for analysing data pertaining to their own programmes. Invariably, the D& E Cell produces a more rigorous analysis than the Programme Officers.

A few Directorates use computers for data analysis, but in most States the data is analysed manually. In one State, computers are available but never used due to a lack of operators, and in another State, computers are used merely to store information.

All States rank Districts for sterilisations, IUD insertions, and distribution of oral pills and condoms on the basis of target achievement. A large majority of States also rank Districts on the

basis of Immunisation performance, but only a few States rank Districts on Malaria and IEC activities.

When ranking is done, four different procedures are followed by different States:

- Ranking of Districts based on achievement of targets for that particular month

- Ranking of Districts based on cumulative performance for the period under consideration compared with the corresponding period last year

- Ranking based on scores given to various activities and total score obtained

- Categorization of Districts into either above average and below average performance groups or quartiles, based on performance.

Districts can use their Family Planning performance rankings to understand their relative position, but there is rarely any analysis beyond these rankings. In one State, where experimentation on new report formats is presently being carried out, information is obtained about PHC performance, and PHCs in a particular District are ranked at the State level with the help of a PC-XT. In one other State, elaborate analysis is done along with ranking: graphs are prepared to show a three-year performance review, Programme Officers write notes for each programme, a defaulters' list is prepared, and a note on assistance required from the Directorate and Secretariat is attached.

The State Directorates provide monthly feedback to the Districts on Family Planning and Immunisation performance. The type of feedback varies from one State to another. In some cases, monthly bulletins are prepared and sent to the Districts, and in other cases feedback is given in the form of a report. Some States indicate appreciation of the high-performance Districts and ask low-performance Districts to improve, while in other States, feedback is concentrated only on low-performance Districts. Generally, low-performance Districts are asked for explanations and given warnings. In some cases, the Director of Family Welfare addresses a letter to all PHCMOs of low-performance Districts asking them to improve performance.

Except for a few States, no regular meetings of District Officers are conducted at the Directorate level. Performance is analysed in a meeting of Programme Officers chaired by either the Director or the Secretary. During their field trips to Districts, the Programme Officers are expected to brief District Officers on the discussions and decisions from the State-level meetings. Sometimes Programme Officers make special trips to the Districts to enquire about reasons for low performance.

Oral and written explanations given by the Districts for low performance remain more or less the same: a large number of vacancies, low literacy rates, resistance pockets, difficult terrain, inadequate infrastructure, natural calamities, and festival occasions.

Interestingly, the low-performance States, when asked for an explanation by the Centre, give more or less the same reasons.

All in all, the process of performance review and feedback is more or less ritualistic. Data processing is more rigorous for Family Planning and Immunisation than for other programmes. Feedback, both written and oral, exerts more pressure on Districts to improve performance in this area. In review meetings and written explanations, environmental factors and inadequate inputs are generally cited as reasons for low performance. There is no analysis of inputs except for ad-hoc decisions based on special meetings. The MCH, IEC, and NMEP Programmes receive less attention and hardly any feedback. Many State-level Officers consider the review of performance based on ranking not very useful for improving performance.

UTILISATION OF INFORMATION

Most of the Programme Officers consider the first use of information received from Districts its transmission to the Centre to meet the requirements. After this, the consolidated and ranked information is used to monitor select programmes, particularly Family Planning, mainly in terms of targets achieved. Information on target achievement is used primarily to introduce an element of competition among Districts and to put pressure on low-performing Districts. The pressure mounts in the last quarter of the fiscal year. Review meetings of District Officers conducted by the Directorate, supervisory visits of Programme Officers to Districts, and written communication stress the need for target achievement. There is no thorough analysis of reasons for high and low performance, no identification of problems, and no alternate strategy development. A few States have, however, attempted to analyse the information for the past three years and to identify trends; though a step in the right direction, such analysis is merely helpful in making District Officers aware of shortfall in performance.

A couple of States have conducted special studies to identify factors that contribute to low and high family planning performance. Behavioral variables -- leadership and attitudes of District Officers -- were found to be significant, but no strategy was evolved to either strengthen the leadership or to bring about attitudinal changes.

In most of the States, the information is not at all used for planning purposes. Even the Secretaries and Directors feel that the State has no planning role. Manpower norms, technology selection, financial allocations, target allotment, incentive schemes, and even design of training p are done by the Centre. Therefore, States think that they have a very limited role to play in planning exercises. They perceive their role as implementors of the Central schemes and monitors of programme performance. As part of the Minimum Needs Program, the States have to supply details of planned infrastructure development, like the number of new subcentres and PHCs to be created each year. However, most States have no information to facilitate this process: they do not know how many subcentres have buildings, electricity connection, water supply, and quarters.

Either information is collected to serve an immediate purpose or decisions are taken on an ad-hoc basis. Creation of a data bank is considered important and useful by some State-level Officers, but no action has been taken to accomplish this.

The Programme Officers at the State level consider themselves technical supervisors with no authority. They see their main function as advising the Directors. As a result, they are not willing to take risks or display any initiative. In turn, the pressure of their own work leaves the Directors and Secretaries hardly any time to critically look into present programme strategies and think about alternatives. Short-term measures like circulars and meetings are therefore given priority over long-term strategy development exercises.

Considerable importance is attached to Family Planning and Immunisation information because these activities are included in the PM's 20-Point Program. Various innovative measures, though expensive, have been evolved by the State Governments to transmit this information to Centre before the tenth of every month. There are no systematic checks on the reliability of information. No State takes any action based on the findings of reliability checks conducted by the Central Teams. Perhaps the State Officers consider that such action would demoralize all personnel and be detrimental to improved programme performance. In the absence of corrective measures, the general feeling is that the reliability of information is a major casualty, though it is taken more seriously in some States than in others. Information on sterilisation and IUD insertions is considered more reliable than data on condoms and oral contraceptives.

Performance is measured against targets given; Districts are ranked for Family Planning and Immunisation activities in all States and for other activities and programmes in a few States. This information is used to put more pressure on Districts to improve performance, but the Districts tend to come up with routine reasons for low levels of performance.

Monitoring of other programme activities such as MCH, IEC and malaria are given less importance. In many States, targets are not fixed, no analysis of performance is done, and no feedback is given. There is no systematic input-based information to cover personnel, training, supplies, finance, and transport. As a result, there is no match made between inputs and outputs.

Utilisation of information for planning and strategy development is low. In general, ad-hoc decisions prevail, and even the limited processed information available at the State level is not used. The centralized authority system is considered responsible for non-use of information for decision making.

KEY ISSUES

Based on the above findings, a number of crucial issues have been identified. Further discussion of these issues would help to focus on decision areas that have the potential to improve the efficiency of

management information systems. The major identified issues are: (1) structural relationships, (2) input and output indicators, (3) identification of key indicators, (4) frequency of information flow, (5) reliability checks, (6) introduction of new technology, and (7) maintenance of new MIS's.

1. Structural Relationships

Implementation of multipurpose workers' scheme at the operational levels of the organisation,alongside retention of unipurpose Programme Officers at State levels, is considered a main stumbling block for the introduction of new integrated management information systems. It has been said that the Programme Officers more often than not insist on continuation of the old systems either to maintain their separate identity or to respond to requests from the Centre. Added to this factor is the lack of power given to the Programme Officers to take corrective action or initiate new strategies.

Introduction of these structural changes, though important and needed, will take considerable time. The course left is to seek alternatives as part of the existing structure. One striking feature of the present MIS is the differences in the extent of information analysis done for various programmes. Besides differential emphasis on programmes, this depends on the type of Officers responsible for analysing information. In States where the Demographic and Evaluation Cell is responsible for compiling and analysing data on all programmes, the analysis is more vigorous than in States where responsibility is spread among several Programme Officers. Therefore, it is necessary to create a centralized data processing unit for all Programmes. This would involve either merging several small data processing units in Health and Family Welfare wings or strengthening the present D&E Cells.

Once data analysis is done, the Programme Officers should be entrusted with responsibility to prepare detailed reports on their programmes. To meet this requirement, the Programme Officers should possess a level of data interpretation skills which they do not have at present. Training of Programme Officers in data interpretation skills and report writing is a necessary prerequisite to improving management information systems.

2. Input and Output Indicators

At present, most of the States give importance to only output indicators: performance figures against targets given. Information on inputs is generally not taken into consideration. Ad-hoc requests or complaints pertaining to personnel are made from time to time, but not many States have a figure readily available on various categories of personnel and their placement. Similarly, information on supplies, transport, training, and other facilities is not readily available.

The District Officers usually consider inadequate inputs responsible for low levels of performance. Unless Programme Administrators have access to both output and input information and examine their relationship, they cannot be expected to arrive at a realistic analysis of the situation, to take corrective measures, or to efficiently

allocate resources. Therefore, it is necessary to give equal importance to input indicators.

3. Key Indicators

At present, considerable information has been collected under various programme components, its utilisation is extremely limited. This information includes a great deal of repetition and a variety of minor details. There are additions to the MIS report formats from time to time, but no deletions. No one has reviewed the relevance of each report format, and no one has made the decision to prune the present report formats to include only relevant data. There is a general feeling that having more information leads to better decision making. Actually, in order to be useful in arriving at decisions, information should be closely connected with the decision-making structure of the organisation. The emphasis should be on crucial and relevant information. For this purpose, each programme should be monitored on the basis of selected key indicators rather than on a variety of less relevant indicators.

4. Frequency of Flow

Most of the information flows on a monthly basis from subcentre to Central levels. Monthly analysis of performance, ranking of Districts on performance, review meetings, and written communication are helpful in putting pressure on the system to improve performance. But all these are short-term measures. To evolve long-term strategies based on a clear understanding of strengths and weaknesses, analysis and review need to take a long-range look at programmes, beginning with quarterly reviews and extending the review over even longer periods of time. Further analysis of the identified aspects, with the help of special studies, would help point the way to new strategic decisions. In the absence of this, the same explanations for low performance will continue to be made, and review meetings will remain more or less ritualistic and less helpful.

5. Reliability Checks

When pressure on performance is high and competition is intense, the reliability of information is a major casualty. As stated earlier, most Programme Officers at the State level think that information is less reliable for some programme activities than for others. They also think that the information provided from the Districts is becoming less and less reliable over time. With all this awareness at various levels, it is surprising that no corrective actions have been initiated. The general attitude is that one must somehow show high levels of performance. However, such an attitude is detrimental to programme policy formulations. Decisions based on false information will lead to wrong policy directions. Besides non-realization of objectives, the costs involved are enormous. It is therefore necessary to pay utmost attention to reliability and to take necessary corrective action before non-reliability of information becomes a major issue. Independent studies from time to time and immediate strengthening of State Evaluation Teams for regular evaluation are needed. The Centre should insist that the findings of these studies be seriously

considered by the States, and performance figures of States should be adjusted based on these findings.

6. Introduction of Computers

Many States have computers and use them mainly for the purpose of ranking Districts on monthly performance. The introduction of computers should be accompanied by the training of staff and also by the introduction of the concept of the data bank. At present, the Districts are asked for the same information again and again, largely due to inadequate storage and retrieval facilities. A data bank should not only help in time series analysis but also reduce the work of the District-level staff.

7. Maintenance of MIS

Many States consider maintenance of management information systems very expensive, and the Officers commented on the lack of financial resources to do so. One important cost that most States cannot meet is maintaining a supply of printed registers and reports. As a result, there is little uniformity in reporting. Those States which have introduced new systems have done so with the help of project funds, but there is no assurance that the new systems will continue once the project comes to an end. To avoid these problems, there is a need to create a line item for MIS in the Central budget and to transfer funds to States based on their requirements.

STATE REPORTS

Nov

ANDHRA PRADESH

STATISTICS

Area: 275,068 sq km

Number of Districts = 23

Population 1981 census : 53,549,673
Projected Population 1988: 61,010,000

Number of Eligible Couples per 1000 pop. = 181.6

Eligible couples (000's) = 10,845

Crude Birth rate = 29.9

Crude Death rate = 10.3

Infant mortality rate = 83

CPR (%) = 32.6

BACKGROUND

The old GOI management information system is still in force in the State of Andhra Pradesh. In 1982, the Population Centre of Bangalore and the Directorate developed a new MIS system for the State. This system has been implemented in only three Districts selected under the IPP. Even in these three Districts, however, the old system is considered to meet the requirements of the Health and Family Welfare Programme, so it continues to be used alongside the new system.

Some of the respondents cited lacks in the old system: it does not provide enough information on urban areas, and it does not give enough emphasis to mass education. The former deficiency has been reviewed several times with the Government of India and Directorate officials, but the discussions have not resulted in any tangible improvement. One of the respondents strongly felt that all information collection must be integrated.

ORGANISATION STRUCTURE

The Officers in the Health and Family Welfare Directorate are responsible for providing technical support to the programmes, monitoring progress, supervising, and evaluating programme performance. They control supplies, carry out office administration in the traditional manner, and receive and attend to complaints on their programme activities.

Recently the Directorate has been divided into Health and Family Welfare, each headed by a Director. (See Appendix I.)

PROFILE OF RESPONDENTS

Interviews were held with the Director (Health and Family Welfare); six Deputy Directors of Medical and Health Services, for Demography, Mass Education and Media, MCH, Malaria, Vital Statistics, and IPP; and an Additional Director of MCH & Family Welfare. The Secretary to the Department was very recently appointed and was not available to provide any information. Two respondents were qualified doctors: MBBS, DPH. The rest had masters' degrees in Statistics, with additional qualification in MPH, CPS, & DPS. They were all over 48 years of age and had been working in this discipline for more than 25 years. (See Appendix II.)

REPORTS AND THEIR RELIABILITY

A list of reports generated in the Directorate, their periodicity, and their use are presented in the following chart.

REPORTS ON FAMILY WELFARE

P1	Monthly	From DMHO	Used for consolidation and reporting to Government of India
MTP	"	"	"
Telegram on PP	"		"
P2	"	"	"
FWP Organisation of camps	"	"	Used for consolidation, monitoring and assistance
Post Partum	"	Superintendent of Hospitals	Used for consolidation, reporting to Government of India, review
Post Partum Programme	"	"	"
PP units	"	"	Used for consolidation, monitoring and assistance
MEM	"	"	"
FW Performance Telegram	Weekly	DMHO	Used for consolidacion, and internal review
PP	Quarterly	Deputy Civil Surgeon	Used for consolidation, review and reporting to Government of India
Technique wise tubectomy	"	DMHO	"
Method wise performance of programme	"	"	"

Demographic characteristics of FW acceptors	Annual	From Principal Regional H&FW Training Centre	"
Telegram Part A&B	"	"	Used for reconciliation
REPORTS ON MCH, EPI			
UIP	Monthly	DMHO	Used for consolidation and reporting to Government of India
Vaccine Stock	"	"	"
Immunisation	"	"	"
ICDS	"	"	"
Target achievement	"	"	"
MCH	Biannual	Principal Regional H&FW Training Centre	Training report
REPORT ON BCG			
BCG	Monthly	DMHO	Used for reporting to Director (HS) and King Institute, Madras
REPORT ON ALL PROGRAMS			
District Report	Monthly"	"	Used for program review
PHC	"	PHC MO	Used for consolidation, analysis and feedback
Tour diary	"	"	"

Expenditure statement	Monthly	From PHC MO	Used for consolidation, analysis and feedback
"			
Vehicle Utilization	"	"	"
Vehicle Collection	"	"	"
Training Status	as and when conducted	DMHO	Used for review
MTP Service Units	"	"	"

REPORTS ON IPP

IPP reports	Quarterly	MHO	Used for consolidation, review and reporting to Government of India

REPORTS ON TRAINING

Consolidated from DMHO

REPORTS ON VITAL STATISTICS

Vital Statistics Return		Village/ Mandal R.O.	Used for compilation and consolidation
Vital Statistics Return		Municipal Commissioner/ Panchayat Executive Officer	"

REPORTS ON MALARIA

MF 4	Monthly	D. Malaria O.	Used for analysis and review
MF 5	"	"	"
MF 6	"	"	"

Technical reports	Monthly	From D. Malaria O.	"
MF 12	"	"	Used for inspection and review
Zonal Officers reports	"	"	Used for control and review
Epidemiological Report	"	DMHO	Used for review
MF 11	"	PHCMO	"
Spray operation	"	D. Malaria O.	Used for analysis and review

The respondents consider the information collected on the Family Welfare Programme, Immunisation, ICDS, MEM, OTC, expenditure statements, and vehicle allocation insufficient in both quantity and quality for decision making. The information on other programmes is considered adequate. About 5% of the proformas are randomly checked and reviewed by the Supervising Officers at the time of inspection, and 90% of the reports are estimated to carry correct information. Approximately 60% of the reports arrive at the State level in time for collection and consolidation. The rest are received as long as ten days after the stipulated time. The causes for delay are cited as incomplete data collection or delays in information reaching the Districts from the PHCs. The respondents suspect that there is a certain amount of distortion at the subcentre and PHC levels, attributed to the desire to achieve targets. At the PHC level, the Medical Officer is supposed to check the data, but due to the high priority given to the Family Planning Programme, this does not take place.

The District Officers understand the data needs of the Government of India and generally provide sufficient information to meet GOI requirements. MCH and Immunisation reports are often sent late to the Centre because they are received late from the Districts. From time to time, the State receives requests from the Centre for information on various aspects of different programmes.

FEEDBACK

From the Directorate, feedback is sent to District Medical Officers on their achievement in different programmes and on the stock level of supplies, so that corrective measures can be taken to improve achievement and supplies can be reallocated where necessary. The Director provides this feedback monthly in the Bulletin and D.O. letters. If there has been a shortfall in the achievement of the targets, explanations are called for.

The Districts are ranked by the percentage of achievement of the targets. High rankings are viewed as the result of dedication and managerial skill, along with the availability of transportation. The performance of each District is monitored closely for possibilities of improvement during frequent visits by the Deputy Director and higher officials.

UTILISATION

The current MIS is used for planning, monitoring, and evaluating the programmes; for training staff; and for personnel management. Personnel at all levels have received some training pertaining to management information systems. At the State level, the District Officers are trained in managerial aspects, objectives, advantages and disadvantages of programmes. At the District level, PHC Medical Officers and Programme Officers receive training in managerial aspects, timeliness of reporting, and completion of information. At the PHC level, workers and supervisors are trained in filling out forms and registers, maintenance of diaries, submission of reports, and the

advantages of MIS. Under the IPP, selected District Medical Officers were given training in management skills by management institutes. Plans are afoot to provide similar training in management skills to Medical Officers of all Districts. There is, however, a general feeling that refresher training for the Officers and training of PHC staff is needed if the MIS is to be used effectively.

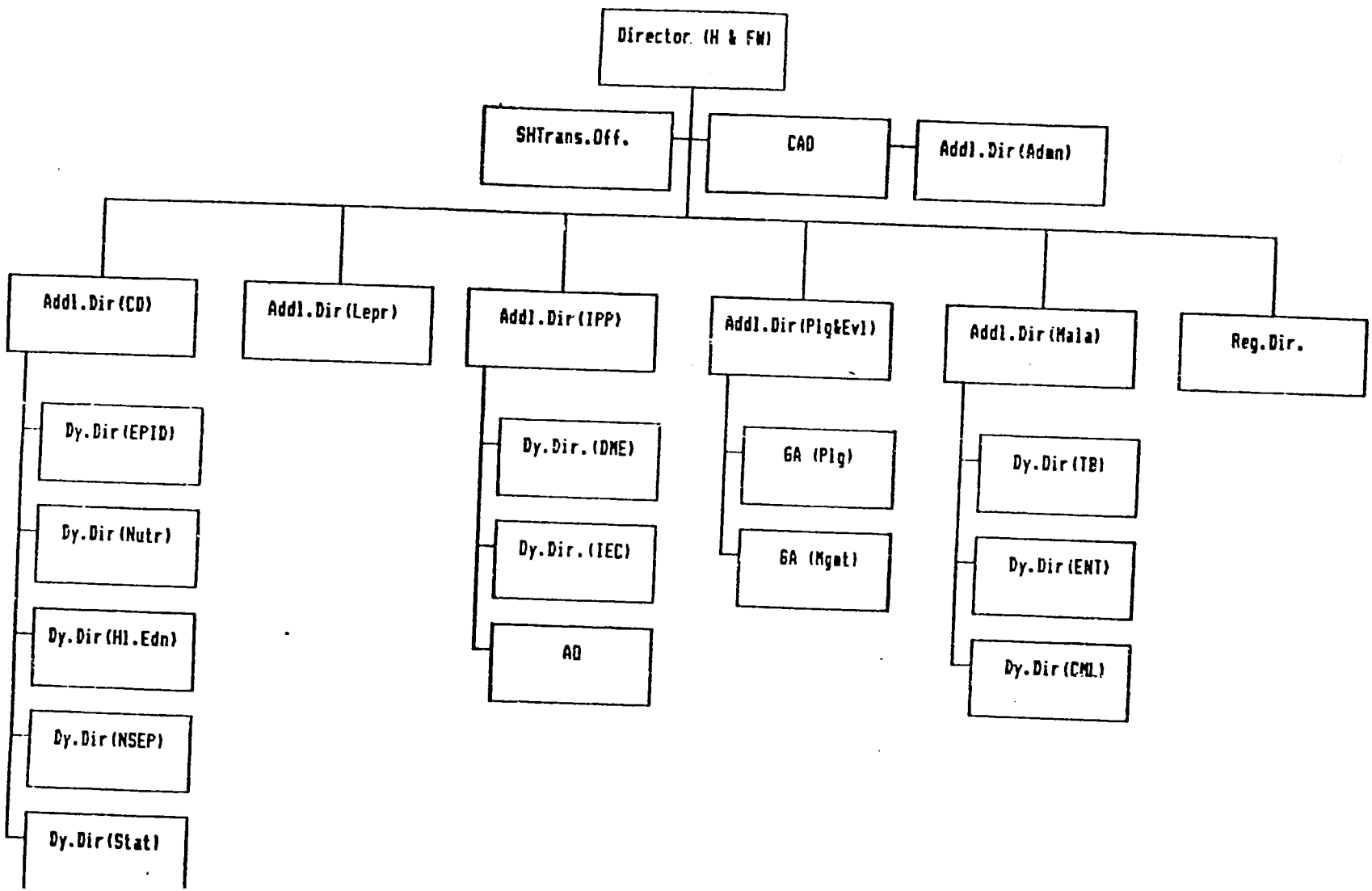
The Districts provide to the State monthly consolidated information and expenditure statements on supplies, personnel, funds, IEC, and performance. These are usually prepared according to requirements, submitted regularly, and found adequate for evaluation and decision making. All programmes are monitored through telegrams, reports, monthly zonal reviews, and personal inspection three to four times a year. Many times District Collectors are also involved in programme implementation and review.

The State provides information to Government of India on cold chain equipment, training of dais, expenditure data, and utilisation, in addition to performance information on MCH and UIP. Information is provided to the Development Commissioner and Collector on women's welfare, tribal welfare, and relief measures.

At the State level, the Officers would like the MIS to provide more precise information on programme implementation, along with performance level. They would like to be able to use the MIS to identify difficulties and hurdles and to find ways to overcome them. They feel the present system can be improved through Zonal reviews.

ORGANIZATIONAL CHART
OF AP MOHFW

SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN ANDHRA PRADESH

1. Director (Health and Family Welfare)
2. Additional Director (Family Welfare and MCH)
3. Deputy Director (Demography)
4. Deputy Director (Mass Education and Media)
5. Deputy Director (MCH)
6. Deputy Director (IPP)
7. Deputy Director (Statistics)
8. Deputy Director (Malaria)

ASSAM

STATISTICS

Area: 78,438 sq km

Number of Districts = 10

Population 1981 projected: 19,580,647
Projected Population 1988: 23,363,000

Number of Eligible Couples per 1000 pop. = N.A.

Eligible couples (000's) = 3,363

Crude Birth rate = 34.3

Crude Death rate = 13.2

Infant mortality rate = 111

CPR (%) = 24.3

BACKGROUND

The Integrated Management Health and Information System designed by the Centre has been introduced in all 10 Districts of the State. The old Government of India (GOI) reporting system is still being used alongside the new integrated information system. This combination of systems has increased the workload and duplication at the District level. With the integrated system, Districts are expected to complete a monthly proforma using selected indicators to outline the performance of all programmes. These proformas are then forwarded directly to the Central Bureau of Health Intelligence and a copy sent to the State headquarters. There are few incentives for providing this data and only about half of the Districts furnish this information on a regular basis. The Districts are not reprimanded for failing to supply the completed proformas and they do not receive feedback on the information that they have supplied to the Bureau.

Many of the Officers who were interviewed believe that the system is not practical, and that therefore little if any attention is paid to its systematic implementation. Also, nearly all the Officers are of the opinion that integration should begin at the top, allowing lower levels to follow suit.

According to one manager at the State level, 'Any change in the existing information system at State level without a corresponding change in the organisational structure is a futile exercise.' Managers tend to agree that the integration of several of the programmes and functions at various organisation levels should precede any attempt to integrate or change the existing information systems. Presently, the major problems facing the health department are considered to be the

implementation of the multipurpose workers' scheme (see Appendix I) at lower levels, (PHC, subcentre, etc.) and the continuation of the uni-purpose scheme at District, State and Central levels.

There have been some attempts to streamline the processing of information. Approximately nine months ago, two personal computers were acquired, one for the Secretariat and the other for the Directorate. While the computer for the Secretariat is being used to analyze budgetary allocations for various programmes, the facility at the Directorate has remained largely unused. The reason given for this is that no one in the Directorate has received any training in the use of the computer.

Until recently, the registration of births and deaths was the responsibility of the Panchayat Department, but now the responsibility has been shifted to the Health Department. Given the problems of migration into Assam and the political implications, considerable importance is attached to this work. The system is presently being streamlined with the help of the village health guides (VHGs), but not all VHGs are in position. A total of 19,000 VHGs (11,000 females and 8,000 males) were recruited over time under this scheme. With a recent shift in the Government of India's staffing policy, 8,000 male VHGs were discharged a few months back. These vacant positions are being filled by female VHGs, but the process takes time and has slowed the pace of implementation.

The Assam Health and Family Welfare Department is responsible for making sure that the information received from various units is reliable and that the flow of information is on time. The achievement of targets is equated with programme performance and is considered very important. The monitoring of other inputs like materials, personnel, training, and financial resources is extremely limited. There is general recognition of the immediate need to create an integrated information system and to redesign the existing report formats. However, as mentioned earlier, the State Officers would like the Centre to take the initiative and reorganize the entire system on more integrated lines. They believe that only then will the integrated information system become effective. Currently the information already available within the MIS is not used at any level for proper planning or evaluation.

Programme monitoring consists mainly of routine meetings and supervisory trips to the field, and the Officers do not perceive it as very effective. The feedback system does little more than convey the performance rankings of the Districts in terms of select activities. At present, the State authorities are either unwilling or unable to take any initiatives to introduce changes in a system that they themselves perceive as inadequate. The general feeling is that they would prefer to wait for changes to come from the Centre.

ORGANISATION STRUCTURE

Assam has a small Secretariat with one Secretary, one Joint Secretary, and two Deputy Secretaries. Both the Secretary and Joint Secretary look after the administrative, financial, and policy aspects of Health and Family Welfare Programmes in the State. The Directorate, located one kilometer away from the Secretariat, has three Directors who look after medical education, public health, and family welfare. Because the position of the Director of Family Welfare is vacant, the Director of Public Health is overseeing both family welfare and health services (The present Director of Health and Family Welfare is going to retire in a few months' time).

Working for the Director of Public Health are three Additional Directors-in-Charge of family welfare, special programmes and medical aspects. Two Technical Officers, Deputy Directors for EPI and MCH, one Mass Communication Information Education Officer, one Demographer, and one Senior Research Officer report to the Additional Director (Family Welfare). The Additional Director of Special Programmes has under him a Joint Director of Ophthalmology, a Joint Director of Malaria, a Joint Director of Public Health, a Deputy Director of TB, a Deputy Director of Headquarters and a Deputy Director of Leprosy. To look after the administrative and financial aspects of both the Health and Family Welfare Programmes, there are two Officers who report directly to the Director of Public Health.

In addition to the Programme Officers at the Directorate, there are Joint Directors at the Regional level: Upper Assam, Lower Assam, and Hills. Each of these Joint Directors is in charge of all institutions and programmes in a set of Districts within his Region. This hierarchy functions almost on multipurpose model lines, but there is a general feeling that the Regional Joint Directors lack adequate authority and are therefore ineffective in implementing the programmes.

The operation of the programmes on unipurpose lines creates immense problems of coordination within the Directorate. The respondents felt that each Programme Officer 'overemphasizes' the relative importance of his programme and that this has resulted in 'too large a span of control for each Programme Officer and too many lines of command for District Officers.' To overcome these problems two important decisions were taken: one was to entrust the implementation of all programmes and achievement of targets in two Districts to each Programme Officer, in addition to responsibility for his/her programme in all Districts of the state; the other was to hold a monthly Programme Officers' meeting at the Directorate level. Although the Programme Officers admit that this arrangement has led to an increased familiarisation with the other programmes, they feel that the main result has been to increase their workload.

PROFILE OF RESPONDENTS

All the Officers in position in Family Welfare, Maternal Child Health, Immunization and Malaria units in the Assam Health and Family Welfare Directorate have been interviewed with the help of either an interview

schedule or a checklist. (A list of officers interviewed is given in Appendix II). These interviews revealed that all the technical officers in the Directorate are not only highly qualified but also have many years of experience in the field. Most of them have been in their current positions for more than one year. For example, the Demographer has a Diploma from IIPS Bombay, 16 years of service in his present position, and a total of 27 years of experience within the State health department. The Mass Information Education Officer has a degree in social sciences; he has been in his current position since 1984 and has a total of about 30 years at various levels within the health department.

The Technical Officers are largely concerned with field-level supervision and programme performance, particularly with the achievement of targets. They attend to urgent requests from subordinates for supplies and spend a considerable amount of time on routine administrative functions and on attending meetings at the Directorate to review performance or programme changes. However, there is a feeling that the workload is unevenly distributed -- that some Programme Officers have substantially more work than others. They tend to consider inadequate delegation of authority a major hurdle in the implementation and operation of the programmes.

The Demographer, in addition to field supervision, compiles and processes performance data and provides suggestions for improvement. The Media Information and Education Officer plans activities, provides targets, supervises the work at field level, and supplies media material to the District Media Officer. The Director is the link between Secretariat and Directorate and participates in formulating policy.

REPORTS AND THEIR RELIABILITY

Apart from the expenditure statements, the District Officers-in-Charge submit all other Family Welfare Programme reports to the Demographer. They send three sets of reports to the State Headquarters:

- Family Planning
- MCH and immunization
- IEC activities.

Four reports are submitted each month as part of the Family Planning Programme performance review:

- Medical termination of pregnancy
- Family planning progress report
- Sterilisation and IUCD performance
- Distribution of conventional contraceptives (condoms and pills).

The EPI and MCH Programmes receive the EPI Monthly Surveillance and Vaccination Performance Report, the Universal Immunization Monthly Report and the MCH Statistics Report.

The monthly and quarterly reports on Mass Education and Media Activities form the basis for reporting on information, education and communication activities. These reports are sent to the Mass Information and Education Officer for consolidation, while the reports on Family Planning, MCH, and EPI are collated and processed by the Demographer with the help of statistical assistants.

The emphasis given to the analysis of information from different programmes varies with the importance bestowed on a given programme. For instance, data from the Family Planning Programme is analyzed in greater detail than that from the MCH and EPI Programmes. For Family Planning, three statements are prepared every month. The first statement compares performance by method across the State to performance during the same period in the previous fiscal year. The second statement shows the target achievement figures by method and by District. The third statement compares the month's performance, by method and by District, to performance figures for the same month last year. The main aim of this analysis is to make the District Officers aware of shortfalls in performance (target achievement) and thereby apply pressure on Districts to achieve targets. In contrast, EPI and MCH activities are analyzed less rigorously; the monthly analysis addresses only each District's percentage achievement of annual and proportionate targets.

Target setting is based upon the Districts' performances from the previous year. Because there was no 1981 census, the target setting formula established by the Centre for the States is not considered applicable to Assam. One of the main problems with the present method of target allocation is that the Districts with high performance get higher targets, indicating that little if any evaluation is made of actual performance.

The Districts receive annual targets for Family Planning, EPI, and MCH activities; these are then broken into monthly targets. All Districts are ranked solely on the basis of Family Planning achievement, and there is no ranking for the MCH and EPI activities. Performance data is sent to all Programme Officers and to the Secretariat. This data forms the basis for discussions at the monthly meetings of the Programme Officers at the Directorate level.

The flow of information from the Districts to the Demographer at the Centre is relatively timely. Before the tenth of every month, Districts are expected to send information to the Demographer. The practice is to send provisional figures to the Centre by the tenth and send final figures by the twentieth. The Districts which are less developed (and which usually have a large number of vacant positions) are more often than not responsible for any delays. In cases of delay, special messengers are used to speed up the delivery.

Programme Officers on supervisory trips are expected to conduct reliability checks. Usually the names of acceptors are randomly selected from the records and verification is done by visiting the households. For example, in one such visit, a Programme Officer found that one 80-year-old widow was recorded as a sterilisation acceptor;

two names of acceptors could not be traced in the village; and two persons in a village recorded as sterilisation acceptors were never operated upon.

In this specific case the writer of the trip report mentioned these inaccuracies and requested the Director to ask the District authorities to investigate the matter. However, there are no general guidelines for dealing with over-reporting or misreporting, and similar cases are seldom acted upon. Most of the officers feel that over-reporting of the total number of Family Planning acceptors is common, and although some effort is made to check this trend, they believe such practices cannot be entirely eliminated.

In addition to this supervisory monitoring, the Evaluation Wing of the Director conducts regular surveys. Last year three Districts were covered and four reports were submitted to the Director. Based on the findings of the reports, efforts were made to improve the quality of data. In some cases of over-reporting, enquiries were held but there were few tangible results. Most Officers think that distortion in performance reporting is the result of the involvement of people at different levels and that it is difficult to pinpoint a particular level at which this could be rectified.

While over-reporting is a problem in Family Planning, under-reporting is an issue in MCH activities. Programme Officers believe that the female workers do not attach enough importance to reporting MCH services that have actually been provided. This neglect on part of the female workers is considered the main reason for the poor MCH programme performance figures.

In regard to IEC activities, no targets are set, so no analysis of target achievement can be made. What has been done is to prepare a monthly and quarterly quantitative statement of IEC activities carried out in each District. Random checks are carried out at the PHC level to determine the reliability of reports, which seems spotty. In one instance, it was noticed that posters sent to a PHC had remained unused and undistributed. Lack of effective leadership and continuous conflicts between PHC medical officers were considered the main reasons for this neglect.

In some such cases, concerned employees are reprimanded on the spot, new instructions are issued, and a report of the "incident" is submitted to the Director. However, in many cases no action has been taken, and the respondents perceive this as indicative of the low importance attached to IEC activities. They also consider the usefulness of some of the data collection formats questionable. For example, they feel that the "new" proforma designed by the Centre for monitoring IEC activities is less useful than the old one: although it provides more information, much of the new information is difficult to quantify and the Programme Officers therefore perceive it as irrelevant.

The NMEP Programme collects more information from the Districts than all the other programmes combined: two weekly, 13 monthly, two quarterly, one half-yearly, and five annual reports. These reports cover a wide range of topics, including motor vehicles and drugs

position, programme performance indicators, special reports, and clinic-based information. All the reports from the Districts are sent to the Joint Director (Malaria) who collates and processes the data and sends the reports to the Director, the Secretariat, and the Centre. All information relating to the exact status of malaria in the State is considered very useful, and programme strategies are developed on the basis of this information. There is no ranking of the Districts; performance is measured in terms of percentage of target achievement. Whenever discrepancies are found in the reports sent by the Districts, written explanations are requested. There are no systematic reliability checks except for the supervisory checks conducted primarily at the village level.

The Programme Officers consider the forms supplied by the Director of NMEP and used to collect this information very repetitive and cumbersome. They agree that the forms should be consolidated and simplified immediately. They also consider certain forms unnecessary, with the weekly Sevingram Report cited as an example.

There is no regular reporting on materials and supplies, vehicles, personnel, or training. Whenever a need for Family Planning supplies arises, the District Officers picks up stocks from the Family Planning stores. Although Family Planning stocks are generally plentiful, there have been instances when the State stores were understocked. For example, there was no stock of Nirodh pieces at headquarters from October 30, 1986 to January 1987. These problems have been compounded by the fact that the position of storekeeper has been vacant for a long time. The current state of the stock book is poor, with several columns in the stock register completely blank and only information about the stock issues, remaining stock, and date of issue completed. Stock verification is rarely done and supplies at the State level are based on push strategy rather than pull strategy.

As to other supplies, IEC materials are, in most cases, sent directly to the Districts. Supplies of DDT were considered erratic last year but improved this year. Though there is not a problem with regard to vaccines, the supply of refrigerators is insufficient to maintain a cold chain. There is no information available on vehicles. The respondents have the impression that there are fewer vehicles than required and quite a number of them are not roadworthy.

Personnel information is maintained by the Establishment Section, and there seem to be no "seniority list" problems in regard to promotions. However, there is considerable difficulty in creating new subcentres under the Minimum Needs Programme. Presently Assam has around 3100 subcentres, and targets from the Centre require that another 2000 be created by 1990. Given the present ANM training capacity, only 500 subcentres can be created per year. Even with full-capacity utilization in 22 ANM training schools, the target cannot possibly be achieved before 1992. Since the State has only one training center for male workers, placement of male workers in all subcentres is likely to take several more years.

There are no needs assessments for determining training activities; achievement targets form the basis for establishing training courses. The effectiveness of these training programmes is not known.

Family Planning expenditure statements are submitted quarterly. The respondents stated that receiving statements on time is a major problem, for two reasons: the Medical Officers' lack of understanding of financial procedures and the requirement that PHCs provide information on every single expenditure item. The system of reimbursement for costs functions relatively smoothly for Family Planning which is 100% centrally funded by the GOI. However, there are major problems in reimbursement of malaria programmes which are only 50% funded. The States are expected to spend money first and get reimbursed only after submitting quarterly expenditure statements. Given the resource constraints at the State level and the uncertainty of getting reimbursement, the release of financial resources is slow and funds often arrive at the end of the quarter. This makes it difficult to spend money at the required and appropriate time and results in delay in submission of expenditure statements.

For some of the programmes, telegrams are sent asking for expenditure statements -- not estimates -- for the current month. Each programme and each set of activities within the programme requires expenditure statements on different expenditure heads, increasing the workload and administrative procedures. The Programme Officers see these fiscal arrangements between the States and the Centre as an additional reason for the delays in target and programme implementation.

Outside the normal flow of information, the Centre often calls upon the programme units to provide additional information (this is especially true for the IEC and NMEP units). Experience in the past has shown that even when this additional data is available, it is often difficult to collate because the retrieval system is ineffective. The Programme Officers state that such requests from the Centre often require additional and unnecessary proformas and field collection.

FEEDBACK

The information processed by the Demographer reaches Regional Directors, Programme Officers, the Secretary, the Director, and the Government of India. Usually, the same information is taken up for discussion at the monthly Programme Officers' meeting at the Directorate level. The Programme Officer-in-Charge of the overall performance of two Districts is instructed to look into the matter if one or both of the Districts receive a low performance ranking.

District Officers do not meet at the Directorate level and have not done so 1975-76. They are asked to discuss target achievement figures in the PHC Medical Officers' meeting held at the District level the first week of every month. The Joint Director of NMEP writes to low-performing Districts (based on monthly performance data) and asks for explanations. This is followed up in the monthly District-level meeting. In general, the District Officers are expected to devise their own strategies to improve performance in all programmes.

The Centre also gives feedback to the State, but the respondents do not perceive this as particularly useful. For instance, the Health Department in Assam regularly receives feedback on State-level target

achievement and on the couple protection rate by District. The Programme Officers interviewed felt that visits by the Central Officers to discuss and solve problems would have been more useful.

Feedback is also given in the form of the Central evaluation teams' reports. Although these evaluations highlight some of the most obvious problem areas, they appear to have little impact upon actual performance. At times explanations are called for, particularly in the area of low performance in Family Planning. Usually the Cabinet Minister of Health and Family Welfare writes to the Chief Secretary and Chief Minister, who ultimately turn to the Secretary of Health and Family Welfare for an explanation. The usual explanations in terms of drought and floods are given, and at times, measures are taken to step up performance. The matter ends there.

UTILISATION

Though the Department of Health in Assam participates in a Five Year Plan formulation, a Mid-Plan appraisal, and an Annual Plan preparation, the information available is generally not used for these planning exercises. The role of the State Government is perceived as very limited, since the norms and targets for inputs and outputs are determined by the Centre. The State officials express their helplessness in influencing the planning process. For instance, the Centre does manpower on the basis of certain norms fixed in terms of population and worker ratio. The States are asked to implement the programme which the Centre has established without looking into the training facilities available, effectiveness of training already given, and additional resources required to achieve recruitment targets. The Centre even determines the type of territory to be covered and applies the standards without taking into account the views of State Government officials. As a result, State officials have little respect for the plan that has been imposed from above.

Normally, the State-level Officers receive a lot of pressure to attend to immediate administrative and routine problems. This leaves very little time for either the development of new strategies or the systematic evaluation of programme implementation. The State officials Officers feel that they express their views at the Central meetings in Delhi with little effect.

FUTURE PLANS

Assam has identified nine less developed Districts and set an objective to bring down the CBR in these Districts to 21 by 1997. Accordingly, separate targets are to be set for these Districts and District plans are to be prepared, taking into account the resources available. Since this is an exercise still in its initial stages, it is not clear what these plans will look like.

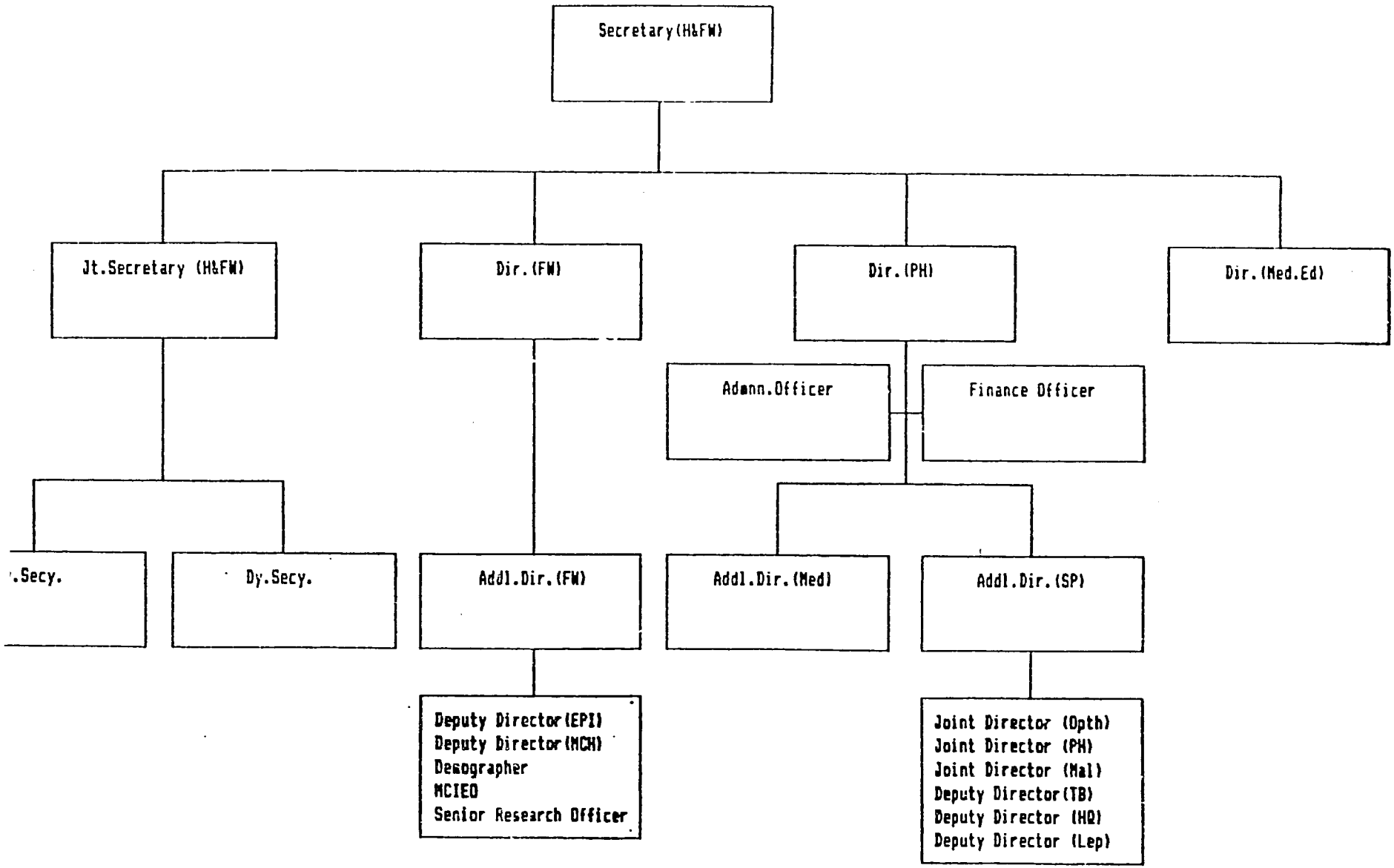
No personnel at any level have been trained in data collection and use. Although several Officers recognize this as a need, there are no immediate plans to provide training. There are no plans to computerise the data at any level, nor to integrate programmes at various levels --

a step that the top management believes should precede computerisation.

From 1972 onwards, no new eligible couples' registers were printed. Recently, approximately three laks of rupees were sanctioned for this purpose: orders have been placed for the purchase of paper and the Family Welfare press will print the registers. Since the shortage of forms and registers is considered a major bottleneck in the flow of information, the supply of registers will ease the situation.

APPENDIX I

ORGANIZATION CHART OF ASSAM MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN ASSAM

1. Secretary (Brief)
2. Joint Secretary
3. Director of Health and Family Welfare
4. Additional Director (Family Welfare)
5. Joint Director (Malaria)
6. Deputy Director (Immunization)
7. Deputy Director (MCH)
8. Demographer
9. Mass Information Education Officer
10. Senior Research Officer
11. Administrative Officer
12. Finance Officer
13. Stores (in charge)

BIHAR

STATISTICS

Area: 173,877 sq km

Number of Districts = 33

Population 1981 census: 69,914,734
Projected Population 1988: 81,156,000

Number of Eligible Couples per 1000 pop. = 182.7

Eligible couples (000's) = 14,413

Birth rate = 37.8

Death rate =15.0

Infant mortality rate = 106

CPR (%) = 18.3

BACKGROUND

The Ministry of Health and Family Welfare in Bihar uses the management information system developed by the Centre in the early sixties, with very few modifications. However, only some of the forms, registers, and reports of the information system are being used to collect information on Family Planning, Immunization, Maternal Child Health, and Malaria Programmes. The Programme Officers perceive the system as a skeletal form of the original system and view its primary purpose as catering to urgent requests for information by the Centre. Inadequate manpower at all levels, insufficient resources, poor communications, and improper delineation of job functions are considered the main reasons why little attention is given to either the operation or the modification of the existing information system. However, some attempts have recently been made in a few selected areas to use computers to improve data processing techniques.

At present, each Programme Officer at the State level determines the achievement targets for his own programme, without reference to the targets of any other programme. Family planning targets, for example, have no relationship to targets for mass media activities, despite the fact that these activities are complementary.

Programme Officers seldom visit the field for supervision, either because vehicles are unavailable or because they haven't enough time. "Most of the work is related to pushing files within the department or attendance at the meetings." Those who do visit the field for three or four days in a month look into the implementation of their own programmes unrelated to that of any other programme.

Computerisation of data began at the State headquarters with acquisition of three PC-XTs a year back. Outside consultants recruited for the job were not given a specific scope of work but were expected to respond on an ad-hoc basis to whatever requirements arose. To date, computerisation has been completed on family planning and immunisation data, monthly targets and achievements, background and placement of newly recruited medical officers, section-wise unanswered questions of legislatures, and quarterly family planning expenditure statements. This computerisation has not, however, reduced the workload, as all this work is also done manually. There is, in other words, a considerable gap between what could be done with the help of computers and what is being attempted.

In an attempt to improve the current situation, the department sent a team of officers to look into the feasibility of implementation changes similar to the new information system operational in Maharashtra. The Central Government was also requested to depute a person from Maharashtra Health and Family Welfare Department to advise on implementation of new system in Bihar. Nothing useful has emerged out of these requests. A plan was drawn to collect information on manpower deployed at various levels, and an external agency developed a proforma to collect the information. The proforma was later circulated to all District Officers but no one in the Directorate knew what happened to the project after that.

These events demonstrate that the Bihar Government has taken steps to identify problems and is able to locate external resources (consultants) to analyse problems and suggest solutions. However, no serious and systematic effort has been made to solve these problems after they have been identified. In fact, in many cases, problems already identified in earlier studies are simply re-identified.

ORGANISATION STRUCTURE

Bihar is one of the States where Directorate and Secretariat are located in the same building, which makes the distinction between these two offices less visible. To begin with, Health and Family Welfare were integrated departments, but a sudden decision was taken four years back to separate them. Then a month back, with the formation of a new Government, it was decided to integrate both the departments again. Separation and integration proceed on a cyclical basis depending on the political leadership, and officers of the departments are hardly consulted before a decision is taken.

At the Secretariat level, the Secretary heads the integrated Family Welfare Department and looks after the Family Welfare Programme, with a Deputy Secretary to assist him. At the Directorate level, a Director-in-Chief looks after both health and family welfare and another Director is responsible solely for health programmes. What the integration has achieved is to have a common secretary and Director-in-Chief for both Health and Family Welfare. In practice, Programme Officers notice little if any difference between the old system and the new integrated system.

Several of the positions at the Directorate are vacant. The Additional Director (Family Welfare) position is vacant and is being covered by the Joint Director (Medical Education). Similarly, the Joint Director (Immunization) position is covered by the Deputy Director (MCH). The position of Deputy Director (Planning) is covered by the Administrative Officer. Out of the total sanctioned strength of 20 evaluation personnel -- two statisticians, one investigator, one senior statistical assistant and one social scientist -- only four are presently in position. Of these four Officers, only three are provided with office space. The situation at the District level seems no better. For instance, out of 39 District Mass Education Officers only 17 are in position. Nearly 21 Deputy District Mass Education Media Officer (Female) positions are vacant.

Many reasons are given for the large number of vacancies at the Directorate level. For example:

> An inadequate personnel information system, leading to problems in the preparation of seniority lists for promotions
>
> The practice of promoting officers at the time of retirement, with retroactive pay raises
>
> A general blanket ban imposed by Bihar Government on recruitment of personnel, so as to limit expenditures
>
> Cumbersome administrative rules and procedures, coupled with political interference, resulting in inordinate delays in decision making
>
> The reservation of certain positions to the Scheduled Castes and Scheduled Tribes and non-availability of suitable candidates from these categories
>
> Reluctance of District Medical Officers to take on less professionally rewarding positions at the Directorate.

Many Officers accept positions in the Directorate just before retirement because it is difficult to settle their retirement benefits after retirement. The fact that most Officers are about to retire in a short time contributes to a pattern of instability in the department. For example, the Director-in-Chief, Director (Health), and Deputy Director (Training) are going to retire in a few months and most others in a year. It is going to take considerable time to fill their positions, and in the interim the positions will either be manned by others on ad-hoc basis or remain vacant. For instance, the position of Chief Malaria Officer was vacant from April 1 to April 25, 1985. From April 22, 1985 to January 1, 1987, four Officers were in charge of this office on an ad-hoc basis. On January 1, 1987, a permanent Officer was appointed, but he is due to retire in December, 1989.

PROFILE OF RESPONDENTS

All the Officers in position in the Family Welfare, Maternal Child Health, Immunization, and Malaria units have been interviewed (see

Appendix II) with the help of an interview schedule or checklist. The interviews show that the Technical Officers have post-graduate degrees in either medical sciences or public health and that most of them have put in more than 25 years of service in the department. However, their experience in their present position is extremely limited; many have been very recently promoted or have less than one year of experience. Continuous and frequent changes in portfolios within the Directorate are also responsible for Officers not having enough experience in their present position. The Demographer and Media Officer both have a post-graduate background and long experience in their present positions. Officers from the Indian Administrative Services and Bihar Public Service Commissions have a social science background and are relatively young. These officers hold transferrable positions, a source of the lack of continuity amongst the personnel in the Ministry of Health in Bihar.

All Technical Officers, including the Media Officer, oversee the technical aspects of their programs. They are responsible for both supervising work in the field and providing technical advice to the Districts. However, there is a difference between what is prescribed and what is actually done: answering questions raised in legislatures looking into administrative requests from below, and attending meetings takes most of their time. Field visits are rare and only made when an urgent need arises. The Demographer is mainly concerned with compiling and processing data received from the Districts; a lack of manpower prevents him from conducting the evaluation studies that are part of his position. Non-technical Officers in both the Directorate and Secretariat who are concerned with financial, administrative, and planning aspects of their programmes find that most of their time also goes for meetings and discussions.

REPORTS AND THEIR RELIABILITY

The Directorate presently receives three monthly reports:

> 'Monthly Return on the Number of Sterilisation and IUCD Service Units and Their Performance' which details the number of sterilisations completed by each unit
>
> 'Monthly Return on Distribution of Conventional Contraceptives' which deals mainly with the number of condoms and oral pill cycles distributed.
>
> 'EPI Monthly Surveillance and Vaccination' which is submitted by the Districts.

These three reports on family planning and EPI are sent directly by the District Officers to the State Demographer. The Demographer collates all information received from the Districts, ranks the Districts in regard to the relevant programme, and supplies copies to all Programme Officers. After the District-level meeting of PHC Medical Officers on the first or second day of every month, the collated reports from Districts are expected to reach State headquarters on the 5th day of the month, but only half of the 33 Districts regularly comply with this schedule. The rest of the District Officers bring the reports with

them on the 8th day of the month -- the day fixed for the District Officers' meeting at State headquarters.

Telephone and telegraphic reminders are regularly sent to District Officers in an effort to speed up the delivery of these reports. According to the State-level Officers, it is difficult to obtain even half the reports due to the lack of manpower at the District level.

The current level of information flow is maintained only by applying considerable pressure from above. All the Officers interviewed stated that more information needs to be collected, including reports on MCH activities which are virtually non-existent. Although the specifications given to State Governments by the Centre require more information, the Health and Family Welfare Department in Bihar makes no effort to comply with these norms.

Family planning and MCH targets, given to the State by the Centre, are distributed to the Districts on the basis of past performance and population at the beginning of fiscal year. In the meetings for target setting, a few adjustments are made in targets for each District. Annual targets for each set of activities are divided into monthly targets against which performance in family planning and MCH are evaluated. In addition, cumulative performance up to the month under review and percentage achievement of annual targets are calculated for each District. Then a list of Districts with below-average and above-average performance is prepared. All the collation and analysis of data from the Districts is done by the Evaluation Wing, first manually and then with the help of the computers. Unfortunately the computers have only been used as a word-processing tool.

The Directorate does not conduct reliability checks of the data supplied from the Districts. Due to vacant positions in the Evaluation Wing, there is no regular evaluation or monitoring of sterilisations or IUD insertions. When the central team carried out the annual evaluation last year, they pointed out cases of over-reporting, but top management in Bihar considers the team's report 'simplistic' and the work done by the team members 'perfunctory.' According to the Bihar Officers, the central team goes to a selected PHC and picks up names of acceptors for verification. If the couple selected from the acceptors' list are not available, the team members write 'acceptor not traceable.' Bihar Officers have their own explanations for such non-traceable cases: that after the procedures many couples go back to their in-laws, and the change of address makes it difficult to trace them. Sometimes, according to the Officers, the couples camouflage their real name and address if they have decided to accept sterilisation without permission from parents or in-laws.

Although the Centre evaluation report has been heavily criticised for its lack of thoroughness, the Bihar Health and Family Welfare Officers have not attempted to estimate the validity of the information that they themselves collect. The general feeling is that over-reporting is on the increase, and there have been a considerable number of public complaints addressed to the Ministry in this regard.

The Officers in the Evaluation Wing in Bihar do not keep in touch with the staff of the Population Research Centre located in Patna University and are unaware of their work. Instead, they have come up with a series of real or hypothetical explanations of programme problems. There is no way presently to determine the accuracy of these explanations.

As mentioned earlier, there is a serious lack of data on MCH performance. The only information available on programme status is through the results of the UNICEF-sponsored immunisation coverage survey. The Officer-in-Charge of immunisation assumes that the reports are highly reliable, as there is no motive to exaggerate the figures (unlike the situation with family planning performance). This data is received from Districts and collated and processed by the Evaluation Wing of the Ministry in the same way as family planning performance information. Districts are ranked on the basis of performance every month. Those Districts achieving more than 80% of their targets are ranked A1; 70-80% as A; 60-70% as B; and below 60% as C.

The Districts do not submit information on deliveries or pre-natal and post-natal services. The information on family planning and immunisation performance is sent to the Centre by twentieth of every month. In case of delay, the District sends a special messenger to Delhi to hand over the information sheets. Additional requests for information are received from the Centre from time to time, particularly on characteristics of family planning acceptors. Special efforts are made to meet such demands, but in such cases delays are common and information remains incomplete.

There are four Health and Family Welfare Training Centres located in Patna, Muzzafarpur, Hazaribagh, and Bhagalpur; these provide mainly in-service training. In addition, each District has an ANM training school for induction training. Information on staffing patterns and numbers of vacant positions in each centre is not readily available. The Directorate has recently developed a questionnaire and is starting to collect information from these training centres. Each HFWTC submits a quarterly training plan to the Ministry for approval. Based on the approved plan, District Officers are asked to depute persons for training and to send to the Directorate a list of those to be trained. Nominations for training programs are based less on job requirements than on personal preference, 'convenience,' availability of staff, with the pressure to achieve the actual training target playing a major role. In fact it is not known who has or has not been trained, and there has been no evaluation of either the quality of training programmes or their impact.

The Information Education and Communication cell in the Ministry supports the service delivery activities of Health and Family Welfare. However, the IEC functions almost as a separate vertical programme. Targets are fixed for a variety of activities like orientation training camps, film shows, song and drama, school programs, exhibitions, mother's clubs, mini-hoarding, wall paintings, and group meetings. Annual targets are broken into monthly targets, and each District submits a monthly report on targets and achievements. Delays in sending this information are quite common, due to either vacant

positions or lack of interest on the part of District Family Welfare Officers.

The information collected from the Districts is collated at State level each month, and quarterly reports are sent to the Media Wing of the Ministry. There is no ranking of the Districts. The Centre does not make any special requests except when parliamentary questions require particular information from the Districts. No impact surveys have been conducted. A few cases of false reporting have been found and explanations called for, but generally the information provided is generally considered reliable and adequate. Mass media materials are sent from the Centre to Districts and PHCs directly, in addition to the materials supplied by the State Media Wing. There is no reporting of materials supplied and used, or on their effectiveness.

There is a separate reporting system for family planning and immunisation supplies which includes expenditure statements. Usually supplies are based on programme targets fixed by the Government of India. Since performance is always below the targets, there have been no stockouts have emerged at the State level. Supplies of Nirodh, oral pills and Cu T in particular are always plentiful. Districts do not report on the stock position but send special requests for needed supplies, which the Administrative Officer is expected to fill. The way the system is operating now, one can assume that there is considerable wastage.

District offices submit Family Welfare quarterly expenditure statements for reimbursement of additional amounts spent that quarter and advance payment for the next quarter. These statements cover the costs of bureau and centres, transport, compensation, other services and supplies, mass media, training, research and statistics, and the village health guide scheme.

There are frequent delays in the submission of expenditure statements. For example, for the quarter ending June 1987, the information was not received from four Districts, and for the remaining Districts, the information received was largely incomplete. Similarly for the quarter ending September 1987, 17 out of 33 Districts had not submitted expenditure statements by the end of the fiscal year and the remaining Districts sent incomplete information.

The main reasons for these extreme delays are cited as the District Officers' unfamiliarity with financial rules and their inability to get information from primary health centres. No corrective measures has been undertaken to streamline the system.

The National Malaria Eradication Programme (NMEP) continues to operate as a vertical programme even after the introduction of the multi-purpose workers scheme at PHC and lower levels. All the information needed to comply with the NMEP system is being collected on a monthly basis. The reports cover case detection, characteristics of positive cases, DDT spraying, stock position of drugs, and numbers of persons treated. These reports are consolidated and sent to the Centre annually. Information is often incomplete, and some columns, (e.g., age distribution of positives) remain blank. Since the GOI finances

the NMEP on a 50% basis, quarterly expenditure statements are submitted for reimbursement. While the programme performance information is usually received on time, obtaining expenditure statements from the PHC level upwards is extremely problematic. According to the State Malaria Officers, the quality of information is questionable and the Modified Operation Program for Malaria Eradication has not been effectively implemented, due to lack of resources, inadequate supply of DDT, and the poor quality of blood smear collection. The Officers often notice false reporting but they believe that nothing can be done to rectify the situation.

In addition to false reporting, there are many other instances where even an effective information system could not fulfill all the needs of the programme. For instance, one Malaria Officer mentioned that DDT supplies usually arrive after the ideal spraying period. Once the supplies arrive, the railway authorities have to be paid freight charges and handling and transportation costs, and the Government takes considerable time advancing these payments. By the time money has been made available for all these activities, the season for DDT spraying is over and house spraying is ineffective. A similar incident is the case of the DDT sprayers who worked for 18 rupees per day in April 1987 and were not paid until March 1988. There are also instances where a significant number of vehicles were either condemned or auctioned off without being replaced. Under such circumstances even reliable reports would fail to achieve programme objectives.

Given these problems, the State Malaria Officers believe that they have a considerable moral conflict when requesting any improvement in the timeliness or reliability of reports, as they are often unable to respond to the requests for programme inputs. This dilemma also results in a lack of motivation for verifying information before they send it to the Centre.

FEEDBACK

Feedback is generally given in the form of discussions in monthly meetings at the Directorate level and written rankings of Districts. These discussions generally focus on the Districts unable to achieve targets, particularly in family planning. Since the information on monthly target achievement is usually late, and since no ranking of Districts is made before the monthly meetings, the discussions more often than not revolve around low-performing Districts in general. District Officers tend to offer such explanations as lack of manpower, inadequate resources, seasonal variations, or epidemics. Few problems of significance are identified and resolved. The same pattern repeats itself every month, making the discussions more or less ritualistic.

Written communication on District performance reaches Districts at the end of each month. In his feedback note, the Special Secretary, Family Welfare, asks the Districts with below-average performance to make special efforts and appeals to the Districts with above-average performance 'to keep up and step up' efforts. The officers think that such feedback has no meaning without attending to the several related problems. Aside from Family Planning, feedback on all other programmes is extremely limited.

In addition to this oral and written feedback, the Programme Officers use their supervisory visits to assess performance and check supplies, requesting explanations for low performance or stockouts. Like the oral and written feedback, these supervisory visits seem to have no positive effect.

The State also receives performance feedback from the Centre, with inter-State comparisons and couple protection rates from the Districts. Most of the Officers at the State level think that the officers of Centre visit the State too infrequently, and that even when they come they do not bother either to solve problems or to discuss outstanding issues.

UTILISATION

Although the planning exercise based on the State Five Year Plan and Annual Plan is carried out regularly, the inputs from the Health and Family Welfare Ministry are extremely limited. The Government of India determines the norms for manpower deployment and infrastructure development. Targets are fixed on the basis of national plan objectives, and financial allocations are made accordingly. As a result, the State has little flexibility in preparing plans to meet its needs. The Centre also does programme planning and sets annual targets for the States. Meeting these targets is seen as the most important achievement. However, States can design implementation strategies at the District level to achieve their targets. In Bihar, targets are distributed to Districts, and pressure is sometimes applied to achieve results. However, no exercise has been undertaken to bring low-performance Districts on par with high-performance Districts, and there is very little effort to solve problems of programme implementation. Everybody seems to be concerned with "somehow" managing the situation. Corrective measures have not been taken to make information more useful, timely, or reliable.

In Bihar, the information needed for decision making at various levels is rarely available; when it is available, there is serious doubt as to its adequacy and reliability. This affects many aspects of the Health and Family Planning Programmes. The lack of information related to personnel, for example (number of persons working, seniority lists, and vacant positions) makes it difficult to plan effective training programmes. Thus training is done to fulfil the targets rather than to develop manpower skills or to bring about attitudinal changes. Expenditure statements on various programs are delayed or remain incomplete. Stock position of various items is considered higher than needed. There are long delays in getting financial sanctions for simple items like freight charges. Information is sketchy on the number of vehicles in running order, the number requiring maintenance, or the number to be condemned.

Program performance data arrives late every month and special efforts have to be made to improve this. However, the limited information that has been collected in regard to performance is not useful for trend analysis or for preparing strategic plans for low-performing Districts.

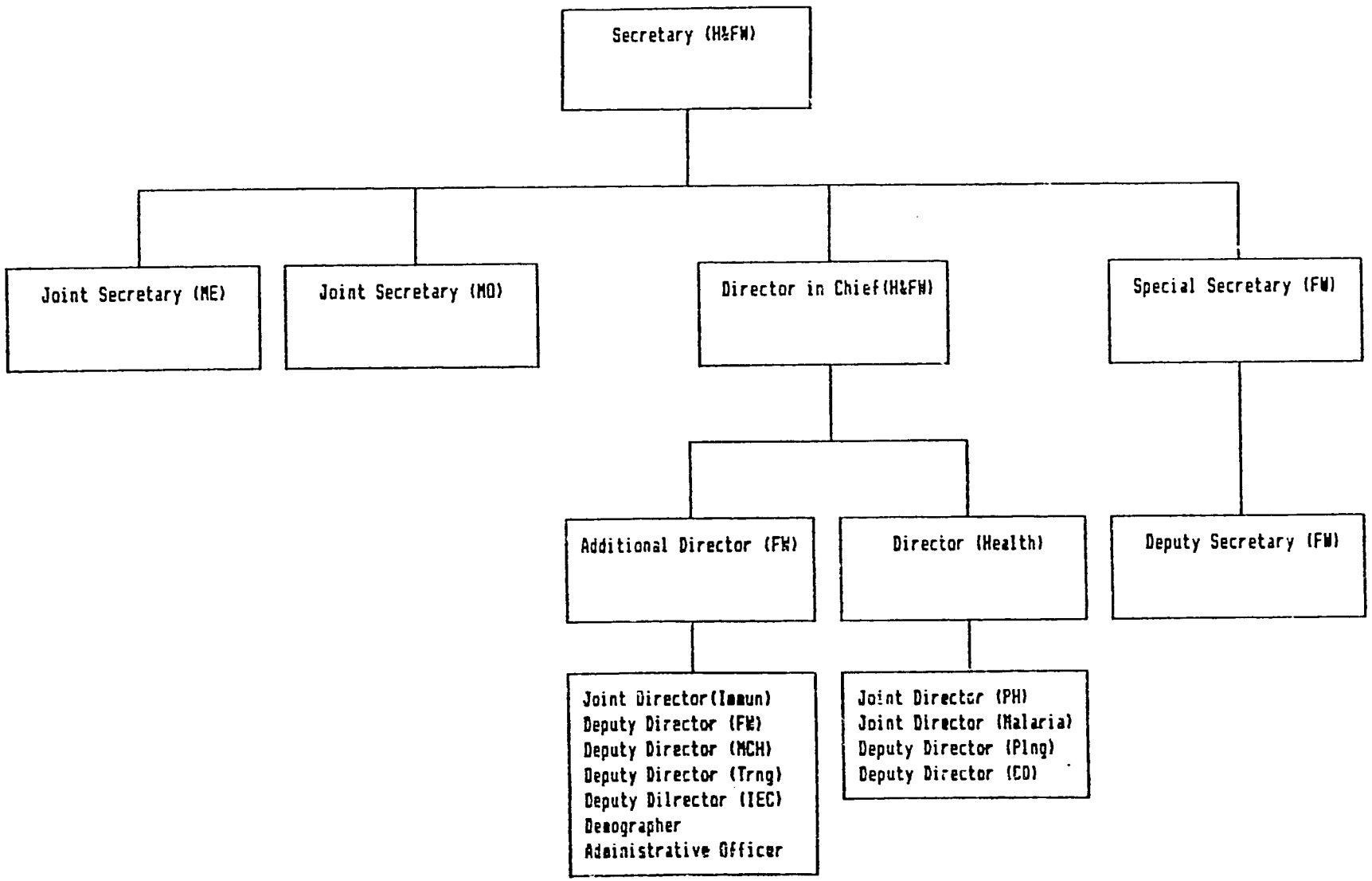
Bihar administrators consider that the information system problems are primarily due to vacant positions at various levels and that unless the positions are filled, nothing worthwhile can be accomplished. It is therefore slightly ironic that most positions at the Directorate level are vacant because of inordinate delay in decision making and due to lack of clarity on the seniority list -- something that could be remedied with a proper personnel information system. The confusion that exists is also conducive to political interference which further complicates the situation. Only strong political and administrative leadership can break this vicious circle and convert ad-hoc management practices into a systematic and streamlined system.

FUTURE PLANS

Bihar has no future plans to change the systems. Only one of their Officers has attended a technical training program in the past two years, with another scheduled to go to Delhi for training. None of them have received any training in management information systems. There are currently no plans train the Statistical Officers in the department to use the computers already available. In fact, the top management thinks that the transfer of skills will not work in Bihar. They are convinced that it is difficult to extract work from Government employees even if they are trained and that lack of efficiency in the Government systems permeates all levels of the organization. Continued and permanent reliance on external agencies is considered more effective than trying to improve the workings of their own MIS, and efforts are now being made to renew the contract with the local consultants to solve some of the worst problems.

APPENDIX I

ORGANIZATION CHART OF BIHAR MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN BIHAR

1. Special Secretary (Family Welfare)
2. Deputy Secretary (Family Welfare)
3. Director-in-Chief (Health & Family Welfare)
4. Director (Health)
5. Joint Director (MCH)
6. Deputy Director (Training)
7. Deputy Director (IEC)
8. Demographer
9. Administrative Officer
10. Computer Consultant
11. Chief Malaria Officer

VACANT POSITIONS

1. Additional Director (Family Welfare)
2. Deputy Director (MCH)
3. Deputy Director (Planning)
4. Deputy Director (Family Welfare)

GUJARAT

STATISTICS

Area: 196,024 sq km

Number of Districts = 19

Population 1981 census : 34,085,799
Projected Population 1988: N/A

Number of Eligible Couples per 1000 pop. = 168.1

Eligible couples (000's) = 6,437

Birth rate = 33.0

Death rate = 10.8

Infant mortality rate = 98

CPR (%) = 38.0

BACKGROUND

The State of Gujarat has been using the management information system developed by the Department of Family Welfare in the sixties. In the early eighties a new integrated system, developed by the Directorate of Health Services, was introduced. Under this system, the Districts were expected to send information directly to the Central Bureau of Health Intelligence, the Director of Health Services, and the Ministry of Health and Family Welfare. It was envisaged that this new MIS would replace the earlier system; however, this has not been the case, largely because the integrated system has not worked satisfactorily.

State officials ascribe the lack of success of the new system to the less than complete implementation: the old system has never been abandoned, so dual reporting has continued, and the reports generated by both systems are still in use. Some Districts submit their reports on an irregular basis, and the reports were often incomplete.

Most of the Officers feel that even with full implementation, the present system would not be adequate. They believe that it should be changed to include information on new programmes and new aspects of the existing programmes. For Malaria, the System has already been modified three times: in 1959, 1977, and 1978.

The Government of India recognizes that such dual reporting system should not be continued because of the heavy time commitment it requires at all levels. Several organisations have reviewed the existing MIS with the intention of introducing one simple system in the country. Gujarat, together with Haryana, Rajasthan, and Maharashtra, is participating in a project that aims to improve and simplify the

MIS. There have been several meetings of the State Directors, Officers dealing with MIS in the States, and Programme Officers of the State and the Centre. This group has developed a format to be tested in one District of each State. Under this proposed system, reports will be generated from the subcentres and flow to PHCs, District headquarters, and State headquarters. The State will consolidate the information and send it to the Central Bureau of Health Intelligence, GOI. Officers at different levels, from the subcentre to the State, will be trained to understand all the components of the system, so they will be able to maintain a high quality of information reporting. The proposed system includes a format for monthly reports on various programmes of Health and Family Welfare. All efforts are being made to keep the information to a minimum so that the total programme can be monitored with a few important indicators. The experimentation period is about one year.

ORGANISATION STRUCTURE

The Department of Medical and Health Services is headed by a senior-level IAS Officer. The Family Welfare Programme is directed by the Commissioner of Family Welfare, who has day-to-day responsibility for this programme and who oversees the Secretary (Public Health) and Under Secretary (Family Welfare). The organisation chart is shown in Appendix I. The Director (Health Services) heads the Directorate; the Family Welfare section is headed by a Joint Director, assisted by a Deputy Director (MCH/UIP), Deputy Director (Rural Health Services), Deputy Director (Training), and Assistant Director (Family Welfare). There are also Joint Directors for Demography and Evaluation and Malaria. The organisational chart of the Directorate is given in Appendix II.

REPORTS AND THEIR RELIABILITY

Many State Officers feel that accuracy in reported performance depends upon the time of year. In April to September, work is carried out in routine fashion and inaccuracy in the figures provided is thought to be insignificant. After September, pressure begins to mount for workers to achieve the targets assigned to them. There is a clear indication that the amount of over-reporting rapidly increases at all levels, starting with the grass-roots worker. The respondents estimate the amount of over-reporting between September and December as approximately 2%. The pressure then increases tremendously between January and March, when States and Districts have to achieve their targets. At the same time there is increased competition for the same acceptors from other Departments like Panchayat, Education, and Revenue. The situation becomes desperate: on the one hand, the officials are pressured to achieve their targets and on the other hand, other Departments involved in the programme claim some of their potential clients. The respondents estimated the over-reporting during this period as approximately 10%: about 5% for IUDs and about 10-15% for oral contraceptives and Nirodh.

It was suggested that one way to reduce these inaccuracies is for Officers to strive for more uniform performance during the whole year instead of the current end-of-the-year rush. The award of prize money should consider such uniformity as one parameter of good performance.

One Officer explained over-reporting slightly differently. According to him there are three types of Districts:

- Those where performance is good and the workers are not be tempted to over-report their figures because they can already achieve their targets.

- Those where performance is very poor and no effort seems to help workers achieve their targets. Workers in this group of Districts do not feel tempted to over-report their performance, as past experience make target achievement very unlikely and unbelievable.

- The 'average' District, where a little more scrutiny of the work would improve reliability in performance reports.

The checks on the accuracy of Family Planning Statistics in Gujarat are being carried out at three levels. The Central Government evaluation teams periodically go to different parts of the States to check the accuracy of the figures. This is a regular exercise which has been responsible for keeping over-reporting under control. The Demographic and Evaluation Cell of the State Government is also expected to carry out random checks, but their work is not been conducted on a regular basis. In addition to these checks, the Regional Director conducts similar checks once in a while.

Although these checks are considered helpful, they are not perceived as either adequate or timely (the findings are often received well after the event). They vary in intensity, with sterilisation and IUD being checked more intensely and oral contraceptives and Nirodh less so. There are no checks on MCH and Immunisation figures, and the respondents felt that this is a lack in the system.

In the case of IEC, information on budget, staff position, orientation training camps, and films shown comes directly to the Chief of the Unit so that he can monitor the programme without delay. Although there are no systematic checks for IEC activities, the Programme Officer has formed impressions about the accuracy of reported information during field visits. It might be assumed that the number of reported activities is correct because it is so easy to cross-check the figures, but the State Officers believe that some aspects of the IEC reporting system are likely to be inaccurately reported. They suggest that the number of participants recorded in IEC activities is sometimes inaccurate, and that those activities carried out by the District are more correctly reported than those carried out by PHC or subcentre workers on their own. For example, group meetings reported in a block are less likely to be accurately reported than the number of exhibitions organised.

The accuracy of Malaria statistics was reported to be very good; the Programme Officer for Malaria did not see any scope for 'cooking' data in this programme. A system has been devised whereby Surveillance Inspectors regularly check the performance of workers in this programme. Similarly, the State and District-level Officers

cross-check not only the numbers reported but the accuracy of the information (for example, the diagnoses that have been made vis-a-vis blood samples taken from the patients.

In an effort to improve the prompt delivery of reports, timeliness is emphasized in State and District-level meetings. Data that have been scrutinised and found to contain inconsistencies are supposed to form the basis of a report that is sent to the Centre. However, these reports are often delayed due, at least in part, to such simple things as the lack of typing facilities.

In general, whatever information is available on the due date is dispatched to the Centre, irrespective of how complete the information is, how many centres have reported or whether the information is provisional or final. Delays in reporting from subcentres, PHCs and Districts are very common. The Malaria Officer, for example, reported delay of 10-15 days in receipt of reports because of the MPW scheme.

There is also a difference in the emphasis given to reports from the different programmes: Family Planning data receive a much higher priority than either MCH/Immunization or Malaria data.

FEEDBACK

All Districts receive information on their relative position in relation to target achievement, as a way of assessing their work. They are also told how far they have to go to further improve their programme. Their problems are reviewed and discussed so that corrective measures can be taken. The first level of feedback is given by the Programme Officers. In the case of Family Welfare, the Joint Director (FW) evaluates performance for sterilisation and IUDs based on three indicators: percentage of targets achieved, comparison of performance with the previous month, and comparison with the same month of the previous year. No feedback is given for oral contraceptive pills or Nirodh.

In the case of immunisations, feedback is given for BCG, DPT, Polio Measles and TT to mothers but not for the distribution of Iron and Folic Acid Tablets and Vitamin A.

At the Secretariat level, feedback is given by the Commissioner and the Joint Director of Family Welfare. The Family Welfare Commissioner gives feedback on the Districts' work through quarterly letters to the District Development Officers and collectors. Districts where performance is poor receive letters indicating their ranking, and Districts where performance is good receive letters of appreciation. The Joint Director (FW) gives written feedback on the quarterly reports and reviews the performance of the District Health Officers in terms of the three indicators named above; he then discusses identified problems with the Officers in monthly meetings and in quarterly letters.

Some respondents stated that programme review and feedback should in fact be the responsibility of the Directorate, and that the Secretariat should only review problems which are hampering the progress of the programme and initiate the necessary actions to remedy them.

The Assistant Director (Mass Media) receives monthly reports on performance and gives written feedback. He also holds quarterly meetings of the District Mass Education and Information Officers where more detailed discussions are held and verbal feedback is given. This feedback tends to concentrate on the shortfalls in target achievement without analysing the root causes of these shortfalls.

In the case of the Malaria Programme, the District Officers receive written feedback only to express unhappiness when their District has not done well.

UTILISATION

In addition to the efforts made to explain MIS to the District-level Officers at monthly meetings and during field visits, circulars are also sent periodically to explain items of information and their utility. Despite all these efforts, it is clear that not all Officers at the State level understand how the MIS can be used to review and strengthen programmes. When the MIS is actually used, the Family Welfare Programme (with special emphasis on target achievement) receives greater emphasis than the other programmes. Even within Family Welfare, Family Planning receives more emphasis than MCH, Immunization, or IEC.

Some Senior Officers expressed the need for more regular, formal training on MIS issues. One Officer felt that a limited set of standard information (required by the national programme) should be determined by the Central Government, thereby reducing the current volume of data.

Programmes are monitored at six levels: the Programme Officers, the Director of Health Services, the Commissioner of Family Welfare and the Chief Secretary, the Minister of Health and Family Welfare, and, ultimately, the Chief Minister. The intensity varies greatly from one level to the other, generally tapering off at the higher levels.

The Programme Officers have primary responsibility for monitoring their programme, and they review the performance statistics. The review carried out by the Director of Health Services is used to apply pressure on the workers to improvement their performance.

At the Secretariat level, the Commissioner of Family Welfare and his staff review the programme and initiate corrective measures. The Minister and Chief Minister review and monitor the programme in the context of the Prime Minister's Twenty Point Programme, (see Appendix III).

Under the Joint Director (FW), the D&E Cell analyses Family Welfare Programme data only and does not help other components of the programme like IEC, Rural Health, etc. IEC programme information does not get analysed; it is reviewed mostly on the basis of overall impressions obtained from the performance figures.

Apart from the performance data, the Programme Officers also review the supply situation, training needs, and vacant positions, but these reviews are rare and only likely to occur when problems arise. The Secretariat holds weekly meetings with the Directorate to work out solutions to problems the programmes are facing. The Chief Secretary convenes meetings of the District Development Officers and Collectors of low-performance Districts to emphasise the need to improve programme performance. (The Secretaries of the Department of Education, Panchayat, Finance, and Social Welfare lend support by participating in these meetings).

The Minister holds meetings between the 18th and 20th of every month to discuss elements of the Health and Family Welfare Programme which pertain to the 20 Point Programme. Decisions are taken in these meetings on current problems and suggested solutions. The Cabinet subcommittee headed by the Chief Minister also monitors the programme. The other members of this sub-committee are the Ministers of Education, Panchayat Revenue, Finance, and Social Welfare. This Committee has so far not functioned effectively.

Monitoring of the Malaria Programme is comparable to that of the Family Welfare Programme. Although the Programme Officer has overall responsibility for monitoring, the Director of Health Services also monitors this programme occasionally. Performance is also measured in the form of target achievement, with comparisons between the last month and the same month of the previous year used as the basis for ranking the Districts.

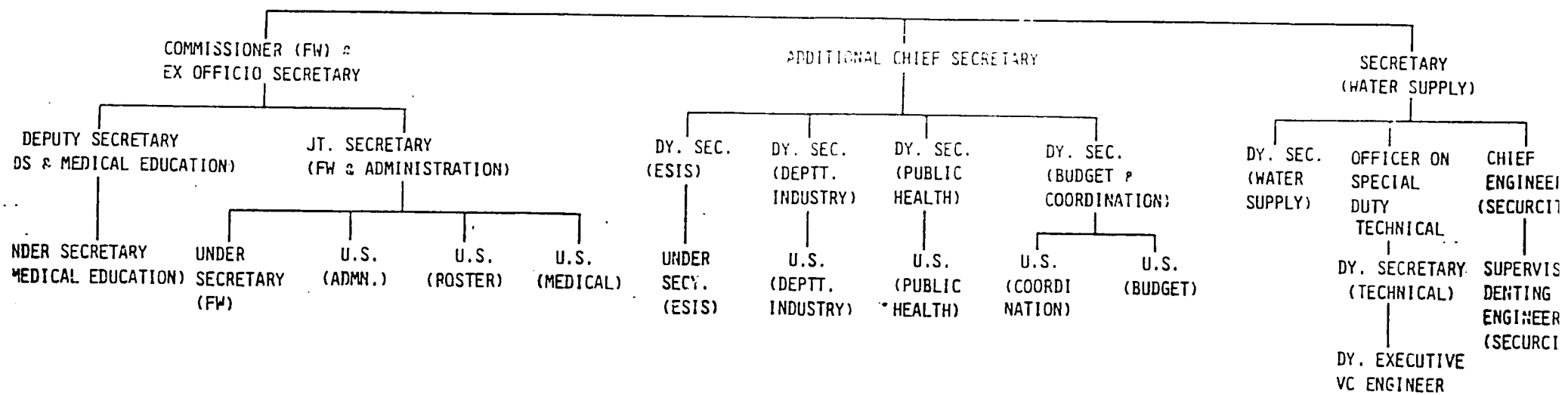
There are two schools of thought among the State Officers about the usefulness of the MIS. The Programme Officers generally agree that the MIS is being used to review performance and not to manage programmes. But even within this limited function, some Officers perceive the MIS as a useful monitoring tool, while others believe that the available information is not used satisfactorily. (A review of the existing reports and returns by the consultants suggested that useful information on various programme components is indeed available but not used). The Programme Officers suggested that the existing MIS should be reviewed to see the what data are available and how that information is being used. It is important to point out similar 'reviews' conducted in the past have not resulted in any noticeable changes or improvements.

The Programme Officers in the Malaria Programme felt that the MIS has all the useful information and that it is helpful in planning logistics, supplies, and personnel management.

GUJARAT

ANNEXURE 1

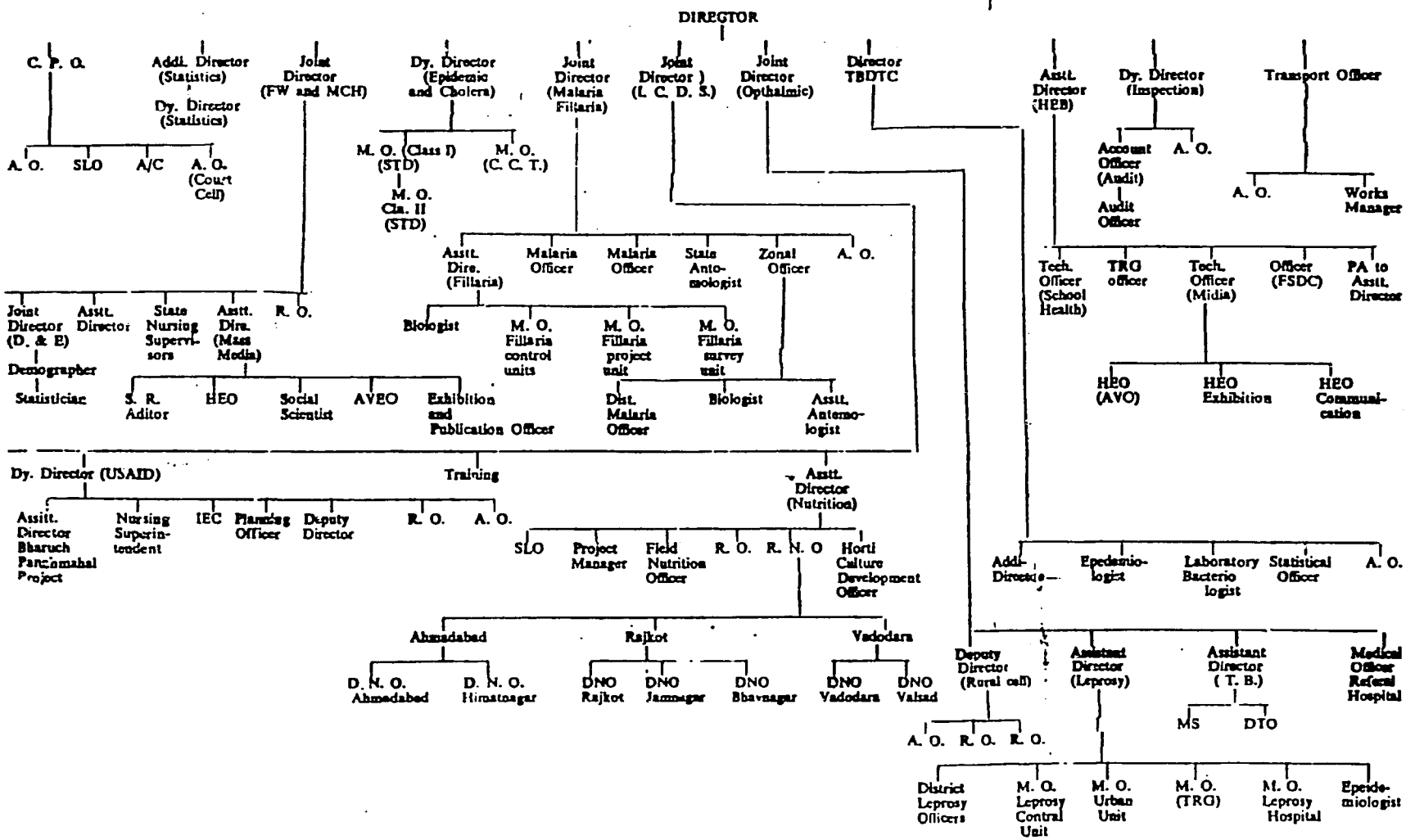
HEALTH AND FAMILY WELFARE DEPARTMENT



GUJARAT

TABLE—131

ORGANISATIONAL CHART OF DIRECTORATE OF HEALTH, MEDICAL SERVICES AND MEDICAL EDUCATION (HEALTH SECTION)



CPO :—Chief Personal Officer
A/c :—Account Officer
Asstt :—Assistant
HEO :—Health Education Officer
CCT :—Cholera Combat Team
USAID :—United State Aid
HEB :—Health Education Bureau
IEC :—Information Education Communication Officer

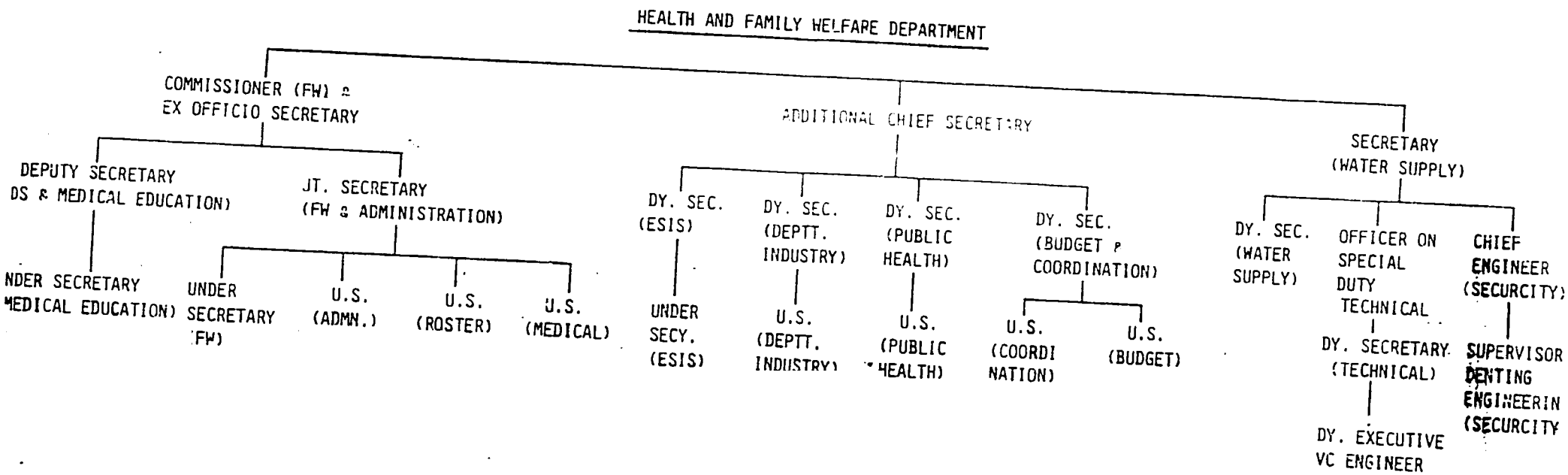
A.O. :—Administrative Officer
ADDI :—Additional
FW :—Family Welfare
AVEO :—Audiovisual Education Officer
M.O. :—Medical Officer
D & E :—Demography and Evalution
DIST :—District
FSDC :—Field and Domonst Centre
MS :—Medical Superintendent

SLO :—State Liaison Officer
S.O. :—Statistical Officer
MCH :—Maternity Child Health
STD :—Sexually Transmitted Diseases Cell
ICDS :—Intigrated Child Development Scheme
R.O. :—Research Officer
TRG :—Training
Tech :—Technical
DTO :—District T. B. Officer

R.N.O. :—Regional Nutrition Officer
D.N O. :—District Nutrition Officer

GUJARAT

APPENDIX I



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN GUJARAT

1. Commissioner (Family Welfare)
2. Joint Secretary (Family Welfare)
3. Deputy Secretary (Personnel and Public Health)
4. Director, Medical and Health Services
5. Joint Director (Family Welfare)
6. Joint Director (Demography and Evaluation
7. Deputy Director (Rural Health Services)
8. Deputy Director (Malaria)
9. Assistant Director (Family Welfare)
10. Assistant Director (Mass Media)
11. Demographer
12. Chief Personnel Officer
13. Accounts Officer

HARYANA

STATISTICS

Area: 44,212 sq km

Number of Districts = 12

Population 1981 census : 12,922,618
Projected Population 1988: 15,513,000

Number of Eligible Couples per 1000 pop. = 164.5

Eligible couples (000's) = 2,463

Birth rate = 35.7

Death rate = 9.1

Infant mortality rate = 85

CPR (%) = 30.6

BACKGROUND

In its collection and use of information, the Department of Health and Family Welfare in Haryana has traditionally followed the path of performance indicators developed by the Government of India for its vertical programmes. The State Government has taken little initiative to organise a systematic, integrated, need-based information system responsive to the requirements of the State Health and Family Welfare Departments.

An effort to create a better system was initiated during the USAID Area Project, mainly oriented towards the Malaria Project because the State Area Project Officer also happened to be the State Malaria Officer. The Malaria Department installed computers and developed computer programmes, but before they could be implemented in an integrated manner with other sections of the Health and Family Welfare Department, the Area Project was terminated and no further development took place.

According to the Senior Officers of the Directorate, there are two key problems in developing and maintaining an effective MIS. The first is that doctors tend to be apathetic towards statistics and fail to understand how information can be used in Public Health and Family Welfare Programmes. The second is the introduction of the multi-purpose health workers' scheme which they feel has increased the variety and amount of information that workers must record and collect, without providing the understanding or time required to maintain so many records and returns. Considering the work they are supposed to do and their educational background, drastic steps must be taken to simplify their contribution to the MIS.

The majority of Officers suggested that the Government of India should decide the maximum number of indicators on which information is required and communicate the same to all the States. Following this, each State should design and process the MIS that best suits its needs. Most of the Officers are in favour of computerisation, provided sufficient funds are made available to the State Government.

ORGANISATION STRUCTURE

The Health Secretary, whose office is in the Central Secretariat, heads the Department of Health and Family Welfare of Haryana. Below him is a Joint Secretary assisted by a Deputy Secretary and Under Secretary to look after the Family Welfare activities. At the Directorate level, the Director of Health Services heads the organisation, assisted by one Additional Director and four Joint Directors. The Additional Director is in charge of Malaria and Vital Statistics, and the four Joint Directors look after one programme each: Family Welfare, Health, Laboratories, and Administration. Ever since the present Additional Director was promoted to this position one and one-half years ago, his substantive position of Joint Director (Malaria) has been vacant. As a result, he looks after both portfolios (see Appendix I).

During the war with Pakistan in 1971, the Health Directorate building was converted into a military hospital and the State Health and Family Welfare Directorate was scattered among several commercial buildings of the city. The political uncertainty related to the transfer of Chandigarh has prevented the construction of a new building. This situation makes it very difficult for Officers to communicate with one another; at times it becomes a very tiresome and time-consuming activity. Other serious constraints on programme implementation are the repeated political reshuffling of the cabinet in the last five years; short-term, piecemeal, and ad-hoc approaches to programme implementation; and frequent changes of the Secretary of Health.

PROFILE OF RESPONDENTS

At the time of this study all the Officers at the Secretariat level were either on tour or leave and thereby unavailable for interviewing. Most of the Officers in position in the Family Welfare, Maternal and Child Health, Immunisation, and Malaria Units at the Directorate level were interviewed (see Appendix II) with the help of an interview schedule and checklist.

All the Technical Officers have post-graduate degrees in either Medical Sciences or Public Health. Most of them have been in service for over 25 years. However, their experience in their present positions ranged from one to three years, except the Mass Media Officer, Demographer, and Entomologist who have held their positions for 16 years, 9 years and 18 years respectively. The positions of the other Senior Officers have been recently filled by promotions and junior positions by transfers.

The Demographic and Evaluation Cell and Vital Statistics Cell are controlled by two executives in the Directorate. The D&E Cell, headed by an Assistant Director, reports to the Joint Director (Family

Welfare); Vital Statistics Cell, headed by the Deputy Director, reports to the Additional Director (Malaria and Vital Statistics). The Mass Media Officer and Accounts Officer of the Family Welfare Department report to the Joint Director (Family Welfare). The Accounts Officer is on deputation from the State Accounts Service and the Joint Director (Administration) from Haryana Civil Services. The latter is in charge of the personnel matters related to recruitments, placements, remuneration, and termination of services.

All Technical Officers not only supervise their offices and oversee field work but also provide technical advice to the Districts.

The Demographic and Evaluation Cell, Vital Statistics Cell, and Media Unit are the nerve centres of Family Welfare Programme Information. They are required to reply to legislature enquiries and transfer information to levels above and below. There is no co-ordination or information sharing between Officers in the Directorate. Middle- and lower-level Officers normally channel information to one another through their respective heads of the section. For instance, the Joint Director (Family Welfare) collects information from the Demographer and passes it to the State IUD Officer, rather then their transmitting it directly between them. Professional rivalry between clinicians and non-clinicians has created communication barriers within the Department. People have a tendency to hold back information to enhance their importance.

The State IUD Officer revealed that she had little role to play in the entire Family Welfare services structure. Both she and the Assistant Director (Family Welfare) are required to conduct field visits for purposes of investigation and technical advice but are hardly consulted or used to conduct field-based training. They are also not sure of their continuance in their positions because they could be transferred to the Districts as PHC Medical Officers at any time. For this reason they are hesitant to come forward with frank opinions.

REPORTS AND THEIR RELIABILITY

The Demographic and Evaluation Cell receives monthly information from the Districts on numbers of sterilisations conducted, IUDs inserted, and conventional contraceptive and oral pill cycles distributed. The D&E Cell also receives the reports of sterilisation by methods and motivation by different departments; the monthly report of the Family Planning Association of India, Haryana Branch; and an annual statement of eligible couples in each District. The Demographer is in charge of tracking the supply of conventional contraceptives, copper-T, and oral pill cycles and maintains a regular account of the contraceptive devices supplied to the Districts.

The D&E Cell compiles and processes all the information received through the usual GOI reporting system and submits the results to the Joint Director (Family Welfare); he, in turn, transmits them to the Health Secretary with a report on the progress achieved for the month. The State Government sends the provisional progress report to the Government of India by the 5th of every month and the regular report by the 20th. Since these reports are brought from Districts by special

courier service, there is rarely any delay. If, on occasion, one or two Districts are late submitting their reports, the Medical and Health Officer of the concerned District is required to explain the delay at the State-level monthly meeting. This requirement acts as pressure on the District Officers to get their reports in on time.

To verify the reliability of the data received from the Districts, the D&E Cell conducts sample surveys, with specific emphasis on sterilisation. This is done regularly except from January to March, the peak months of sterilisation performance. A compiled list of MTPs conducted is sent to the Government of India on a regular basis. The Cell also receives a monthly report from the Districts on vaccination performance and surveillance under the EPI. This report also covers prophylaxis against nutritional anaemia and night blindness. According to the Joint Director (Family Welfare), there are hardly any distortions of sterilisation performance figures, but he feels there could be some discrepancies in reports of the distribution of conventional contraceptives and oral pill cycles. However, some of the Officers in the Directorate feel that there is a high percentage of distortion in copper-T performance figures.

Each District submits a report of IEC activities (by special courier) by the 4th of the month. These reports are compiled at the State level and a quarterly report is sent to the Media Wing of the Ministry. The number of orientation camps organised is verified at State level meetings with other inter-sectoral departments (Education, Revenue, etc.) As the District offices of these departments are also required to send reports on their activities to their respective Directorates, it is easy to verify whether or not their functionaries at the grass roots level attended any orientation camps. However, there is no attempt to verify posters and hoardings. According to the State Mass Media Officer, the orientation camps are usually organised in a block prior to sterilisation camps, so the reports of numbers of sterilisation camps are used to evaluate the impact of the orientation camps.

The State Mass Media Officer opined that the success of Family Welfare Services was largely dependent on two factors: motivation of the community and quality of post-operative services. According to him, the entire Mass Media Organisation of the Health Department is frustrated by the lack of promotional opportunities. Under such circumstances he considers it impossible for mass media people to maintain their initiative. Further, the doctors take hardly any interest in providing follow-up services to the sterilisation and copper-T acceptors. As a result, the mass media people find it difficult at times to convince the community. The present MIS does not provide any opportunity for reporting these bottlenecks encountered in the field.

The Accounts Officer is the drawing and disbursing Officer of the Family Welfare Department and supervises the administration of all department accounts. He inspects the accounts of the State and Districts; audits grant-in-aid claims of central assistance; enquires into accounts matters, construction work and all schemes connected with Family Welfare; inspects accounts of voluntary organisations connected

with Family Welfare work; and prepares budgets for plan and non-plan expenditures and plan infrastructure development.

The Accounts Officer receives monthly expenditure reports, quarterly miscellaneous purpose accounts, the annual list of excess, and the annual budget from all the Districts. There are often delays in receiving the first two reports due to compilation problems. Although these delays in turn delay the annual report to the Ministry, the Ministry does not make any ad-hoc requests for information on expenditures. The monthly expenditure statements are reconciled with Treasury records.

Apart from the reporting and recording system, the Senior Officers of the Directorate visit the Districts every month and chair monthly meetings with the District Officers and Medical Officer-in-Charge of PHCs. These meetings are used to monitor the performance of PHCs, the staff in position in PHCs and sub-centres, drug requirements, equipment in working condition, shortages in supplies, transport, additional POL requirements, and financial position.

At the State level, monthly meetings of the Chief Medical and Health Officers are held under the chairmanship of the Director or, sometimes, the Health Secretary, Chief Secretary, or Health Minister. In these State-level meetings, the problems cited at the District meetings are discussed and the remedial steps are identified.

According to the Director of Health Services, there is adequate information at the Directorate level related to performance, expenditures, personnel, equipment, transport, supplies, and construction of buildings. This information is gathered partly through the usual reporting and recording system, partly through monthly meetings, and partly through occasional enquiries made by the State to the District which, in turn, gathers the date from the PHCs.

The NMEP Programme has a very systematic and detailed action plan up to the PHC level. The Malaria Department was the only department of the Health Directorate to develop computer programmes on their own under the USAID Area Project. The staff of the Malaria Department were trained in computer programming, and on the reporting and recording needs of NMEP and used this training to develop the computer programmes. The interpersonal relationships within the Department are cordial and the activities are highly co-ordinated with one another. An abstract of the annual report reflects their effective handling of MIS.

Since the introduction of MPO during 1977, malaria incidence is showing a steady decline, with the 1987 incidence 9.1% below that of 1986. Regular fortnightly household surveillance is being carried out throughout the State. In 1986, 25,92,518 blood slides of fever cases were collected (ABER being 16.6%) and promptly examined in 209 malaria clinics. Regular spray operations were also carried out as scheduled. Three rounds of BHC were given in 45 blocks, three rounds of malathion spray in 41 blocks, and two rounds of DDT in one block of District Kurukshetra.

Also in 1986, two District Malaria Officers were trained in malariology at NICD, Delhi. In the same year, 8967 drug distribution centres were established, and 8032 fever treatment depots were opened with the help of community health guides. But with the changes in policy to involve only female health guides, the number of fever treatment depots was drastically reduced to 1007 by December, 1986.

The Report System under the NMEP was designed by the GOI and underwent change in 1977 with the introduction of the Modified Plan Operation. Till recently 29 returns were sent from District to State, but presently 10 of these returns have been eliminated. The State sends 13 returns to the Director of NMEP, Government of India.

FEEDBACK

At the beginning of the fiscal year, after receiving the targets from the Government of India, the State Government allots the Districts targets for different contraceptive methods, immunisation, prophylaxis for nutritional anaemia and night blindness, antenatal and postnatal visits, and dai training. The District targets are based on population size and past performance and are kept a little above the state target. Each set of targets is then monitored on a monthly basis with percentage cumulative achievement. The Districts are ranked by only five performance indicators: sterilisations conducted, copper-Ts inserted, conventional contraceptives distributed, oral pill cycles distributed, and immunisations done. For NMEP, the Districts are ranked on the basis of reduction of malaria incidence reported, reduction of P.F. cases reported, and blood slides collected and examined.

The Officers of the Family Welfare and Malaria Departments stated that monthly rankings develop competition for improvement. Supervision further strengthens this competitive spirit.

The Accounts Officer gives feedback on the budgets sanctioned, discrepancies in expenditure patterns, and all other correspondence related to the field inspection report of the Auditor General Office.

Monitoring is normally done through supervisory visits and performance reports. At times public complaints also provide information on programme implementation.

UTILISATION

The present MIS is largely meant to fulfill GOI requirements. The information is based on performance figures with no further analysis. The State Government uses a few performance indicators for monitoring Family Welfare, MCH, Immunization and NMEP programmes, reviewing performance at the monthly meetings to identify shortcomings and initiating steps to rectify problems. The Districts report on the manpower position to the Directorate at unpredictable intervals; despite the irregularity of these reports, the Directorate considers this information very useful. Information on equipment and transport facilities is used in preparing monthly action plans.

The present reporting and recording system is of no help to programme planning. In the preparation of the Five Year Plan, Mid Plan Appraisal and Annual Plan, the role of the department is very limited. Norms and targets are fixed by the Centre with little flexibility for area-specific approaches.

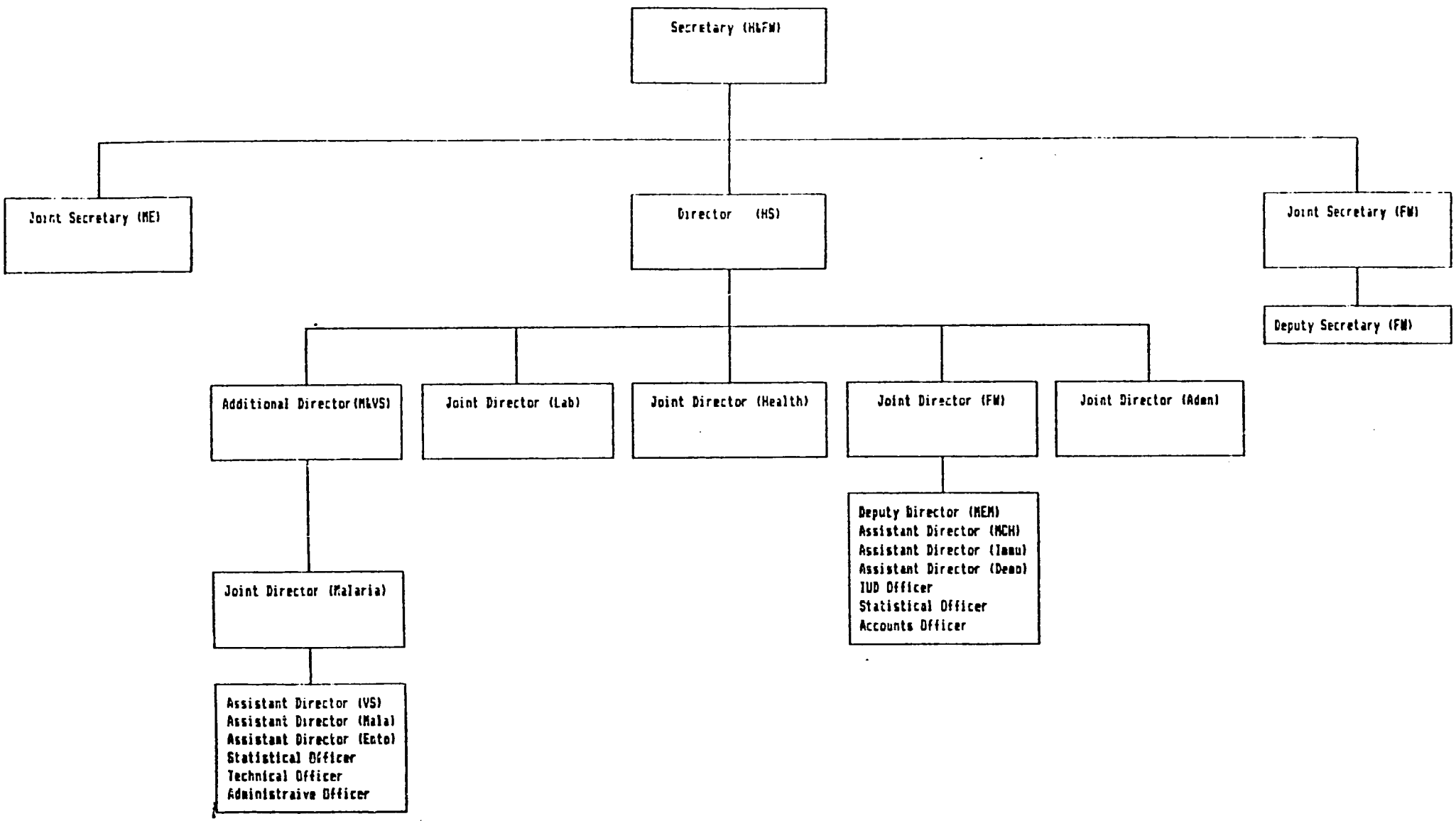
The Senior Officers are so preoccupied with supervisory tours and routine administrative problems like transfers, monitoring sterilisation targets, and organising sterilisation camps that they hardly get any time to plan. The Malaria Department, however, analyses the data and identifies thrust areas for controlling the disease through either extra manpower and insecticides or more effective supervision of spraying.

FUTURE PLANS

Recently the State of Haryana, in collaboration with the States of Rajasthan, Gujarat and Maharashtra, has engaged in an exercise to rationalise the Information System for ten programmes. Consultancy for this project is being provided by an external agency and funds by the World Health Organisation. It appears that this exercise is directed purely towards fulfilling the Government of India's information requirements and concentrates only on report formats. The information does not include such input indicators as population characteristics, personnel, logistics and supply, financial management, and IEC activities. Even the programme performance indictors are dependent on gross figures without any analysis. The State plans to use computers for data processing and analysis, but it is likely that lack of funds and expertise will inhibit this effort.

APPENDIX I

ORGANIZATION CHART OF HARYANA MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN HARYANA

1. Director of Health Services
2. Additional Director (Malaria & Vital Statistics)
3. Joint. Director (Family Welfare)
4. Deputy Director (MME)
5. Assistant Director (Demography)
6. Assistant Director (MCH)
7. Assistant IUD Officer
8. Assistant Unit Officer (Immunization)
9. Assistant Director (Malaria)
10. Assistant Director (Entomology)
11. Accounts Officer (Family Welfare)
12. Officer Superintendent (Administration.)

VACANT POSITIONS/NOT AVAILABLE

1. Secretary (Health and Family Welfare)
2. Joint Secretary (Family Welfare)
3. Deputy Secretary (Family Welfare)
4. Under Secretary (Family Welfare)
5. Joint Director (Malaria)
6. Assistant Director (Immunisation)
7. Joint Director (Administration)

HIMACHAL PRADESH

STATISTICS

Area: 55,673 sq km

Number of Districts = 10

Population 1981 census : 4,280,818
Projected Population 1988: 4,866,000

Number of Eligible Couples per 1000 pop. = 167.5

Eligible couples (000's) = 797

Birth rate = 30.2

Death rate = 10.5

Infant mortality rate = 84

CPR (%) = 33.5

BACKGROUND

Himachal Pradesh is a small, sparsely populated State: 55,673 sq. km. and 77 persons per sq. km. More than one-third of the total area, spread over two Districts, is totally snowbound and not easily accessible; only about 2.14% of the State's population live in these Districts. This background should be taken into consideration in reviewing the Management Information System for Himachal Pradesh.

Presently the State is following the GOI performance reporting requirements for Family Planning, 20-Point Programme, Immunisation, and Malaria. Modifications are incorporated from time to time to meet the needs of the Centre, but no attempts are made to modify the system to suit State needs.

The State-level Officers generally believe that the scope of the MIS is limited to reporting and recording of achievement against given targets given. None of the respondents proposed that data on manpower, logistics, transport, and finance should be an integral component of the MIS, but they do appreciate the concept of a comprehensive flow-in and flow-out data bank and its appropriate usage. They have been reluctant to move forward in developing such a mechanism because they lack the necessary expertise, and they have a positive attitude towards the possibility of working with a consultant to develop a new MIS.

All Officers are in favour of computerisation but are not sure that computers would be used adequately in order to be cost-effective. Time and again questions on financial resources, trained manpower, and installation sites have been discussed and it has been decided to postpone the introduction of a computer-based MIS.

ORGANISATION STRUCTURE

The Minister of State is assisted by the Secretary (Health and Family Welfare) one Deputy Secretary and one Under Secretary at the Government level. The Directorate is headed by the Director of Health Services. The State has a separate Director for Medical Education. The Director (HS) is assisted by four Deputy Directors, one each for Family Welfare, Public Health, Administration, and Planning and Budgeting. Each Deputy Director is responsible for monitoring all programmes for a group of Districts.

The Deputy Director (Family Welfare) supervises one Assistant Director for EPI & MCH, one for Family Welfare, and one for the Demography and Research (D&R) Cell. In addition, there is a post for a State Evaluation and Investigation Officer (SEIO). Presently, the Assistant Director (Demography and Research) is overseeing Evaluation and Investigation, and the post of Assistant Director (Family Welfare) is vacant. The Assistant Director (Malaria) works independently for NMEP and reports to the Deputy Director (Administration). Six other Assistant Directors look after Dentistry, Primary Health Care, Statistics, T.B., Leprosy, AIDS and STD, and Nursing. (See Appendix I).

Simla, a hill-station capital, has a number of small building complexes, and the Directorate Officers are scattered among four different buildings. One has to climb up or walk down the hills to go from one health office to another. The Deputy Directors for Family Welfare and Public Health, along with the Assistant Directors for EPI & MCH, Family Welfare, and D&R, work in a building called Govind Niwas -- popularly known as the project office, as the building was rented during Phase I of the Area Project. The Assistant Director (Malaria) is in separate premises near Repan Hospital. The Director (HS), along with the remaining two Deputy Directors, sits in Kennedy House. The Regional Health and Family Welfare Training Centre is located outside Simla at Parimahal in Kesumpti.

Formal interaction among Officers in the State is not frequent. Promotions to Deputy Director positions come from two streams: public health and clinical. In addition to geographic location, the differences between the clinical and non-clinical background of Officers is a major constraint against effective coordination.

Historically, Himachal Pradesh was a part of Punjab. When it became a State, all the existing Officers were asked to choose between HP and Punjab services. Quite a few Officers from the Punjab cadre opted for HP services and, by virtue of seniority, got senior positions. This reduced the chances of promotion for HP services Officers and resulted in considerable frustration among the latter. Many Officers cite this as another factor contributing to infrequent interaction among Officers at the State level.

PROFILE OF RESPONDENTS

Officers at both the Directorate level and the Secretariat level were interviewed in detail. (See Appendix II.) The interview was a discussion session with the checklist and interview schedule used to

maintain the sequence of discussion. Almost all the Officers at the Directorate level had put in more than 20 years service in the Department. These Officers have risen from the post of BMO to their present positions, carrying with them vast amount of experience. In addition, they are highly qualified either in one of the specialities of medicine or in public health.

Most of the Deputy Directors are new. The Assistant Director (MCH/EPI) and Assistant Director (Malaria) have six years and two years experience respectively in their present positions. The Assistant Director (D&P) with a a post-graduate degree in Statistics and a diploma in Demography, is a highly experienced senior Officer. He has been in his present position for more than eight years in HP and previously served for eight years Haryana.

The Health Secretary is presently overseeing the Social Welfare Department as well. He took over as Health Secretary just three months prior to this study. The State Mass Information and Education Officer was on long leave and unavailable for the interview. Therefore, the team could not assess the reporting mechanism of this section of the Directorate.

The Technical Programme Officers -- Deputy Director (FW), Assistant Director (MCH & EPI), and Assistant Director (Malaria) -- are by and large engaged in overall monitoring and supervision, procurement and distribution of supplies, day-to-day office work, technical support in plan formulation, and on-the-job guidance. In addition, they pay special attention to public complaints, especially from family planning and immunisation acceptors.

Officers engaged in overall State planning, general administration, and preparation of budgets are also engaged in developing plans for the creation of new institutions, manpower, training programmes (basic and post-basic), and procurement and supply of equipment and kits. They also supervise and monitor the performance of a group of Districts for the 20-Point Programme, Family Planning, and Immunisation.

The Districts submit to the Assistant Director (D&R) monthly reports on the 20-Point Programme, Family Welfare, MCH, and Immunisation. The Assistant Director compiles and analyses the information and transmits the analytical reports to the Health Secretary and Director. In addition, he carries out sample verification, conducts research studies, and supervises register maintenance in the field.

REPORTS AND THEIR RELIABILITY

As stated earlier, the Deputy Director (FW) oversees EPI & MCH, Family Welfare, the Demography and Research Cell, and Evaluation and Investigation. The monthly reports for sterilisations conducted, IUDs inserted, Nirodhs and oral pill cycles distributed, and MTPs done are sent to the Demography and Research Cell. The D&R Cell consolidates and analyses these reports and sends them to the Director of Health Services, the Secretary of Health and Family Welfare, and the Government of India.

The reports are sent to the D&R Cell first by telephone and then by post. The District CMHOs are also required to send a report of sterilisation performance to District Deputy Commissioners who transmit them by phone to the Health Secretary. The compilers of the D&R Cell stated that there are often variations between the phone report and the written report. Variations were also observed in the report sent to the D&R cell and that received through the District Deputy Commissioner.

The Assistant Director (MCH & EPI) receives the reports associated with the EPI & UIP: surveillance of diseases, vaccination performance for mothers and children up to 16 years, and prophylaxis against nutritional anaemia and night blindness. In addition, the CMHOs of UIP Districts are required to send a separate monthly report on immunisation coverage against targets, in a format developed to suit the needs of the State DPI Officer. This report also provides data on vaccine supply, condition of refrigerators and freezers, and reactions due to immunization

The Assistant Director (Family Welfare) receives a quarterly report on mass media activities, including data on manpower positions at both District and block levels, AV availability and mobility of vans, stock position and working condition of equipment, and MEM activities. These reports are sent to the State Mass Media Officer.

The reports received by respective sections of the state Family Welfare Office are compiled, but the Districts are ranked only on the basis of sterilisations conducted and immunisations done. The EPI/MCH Programme report assesses the target achievements of UIP vs. non-UIP Districts. This UIP/non-UIP bifurcation helps the State Programme Officer to judge the impact of extensive programme interventions. At present a year-to-year comparison is not possible, as the UIP Programme was launched in phased manner and is running only in a few Districts. However, an annual analysis has been done at the State level. In addition to the monthly reports, during the last three months of the fiscal year, the Deputy Commissioner of each District reports weekly on sterilisation to the Health Secretary, by phone or telegraph.

The key link between the State and the District for the Malaria Programme is the Assistant Director (Malaria). He compiles and analyses all the District reports and transmits the results to the Deputy Director (Administration) and the Ministry of Health and Family Welfare, Government of India. To maintain timely reporting from the Districts to the State Headquarters a fixed time schedule has been established: reports from the periphery in a block are collected until the 26th of each month; the compiled report is sent to District Headquarters by the 28th of that month and to State Headquarters by the 30th, through a special messenger. By and large this schedule is maintained.

Reports on sterilisation cases arrive regularly and generally on time from 10 out of 12 Districts, the exception being Kinnaur and Lous-Spiti. When there are delays, the respondents attribute them to bad weather, the absence of concerned staff at the District level, preoccupation with other work, or apathy of the CMO towards the reporting system.

When asked about the efforts made to avoid delays, the Officers conveyed a feeling of helplessness, stating that very little could be done to motivate those who do not submit information on time. They commented that the CMOs' involvement in clinical work leaves very little time for them to attend to the details of programmes. Sometimes the District Statistical Assistant and Computer are assigned the routine office work because of shortage of clerical staff.

The State Headquarters tries to be regular and punctual in reporting to the Centre, submitting provisional information for the non-reporting Districts. On receiving the final report from the Districts, the State adjusts the report of the subsequent month. This procedure has often been followed in the cases of Kinnaur and Lous-Spiti.

The State Officers were disturbed about the frequent telegraphic messages they get from the Government of India, enquiring about FP performance. This usually occurs after the State has already furnished the monthly report. When State Officers discuss this matter with appropriate GOI representatives, they are told to overlook these messages, as telegraphic messages are routinely sent to all States without checking the records.

'Reliability of reports is unquestionable,' say most of the State Officers. However, some Officers do feel that there is occasional distortion of figures in regard to conventional contraceptive and oral pill users. Such distortion can occur at any level: a worker who wants to show good performance and earn more incentive/prize money may report false figures, or a BMO may distort the figures for the same reason at the PHC level. At the District level the distortion may be a way to get the prize money offered to Districts or to get preferential treatment for transfers. Distortions in the total number of cases communicated to the State are attributed to the dual reporting system from Districts to State. The reliability of reports transmitted by telephone or telegram depends on both the calling and receiving person, as well as on the condition of the telephone system.

Reported cases are not cross-checked regularly because Demographic and Research Cell personnel are often given other jobs that make them unavailable for the monitoring and evaluation that should be among their key responsibilities. There was an earlier practice of random cross-checking of sterilisation cases by the Programme Officers and members of the D&R Cell, but this has been abandoned. At present, only the Government of India team carries out such checks. No false cases were identified among sterilisation acceptors reported during these checks.

There is no cross-checking of the reports received on immunisation performance. Coverage evaluation surveys conducted for some Districts in different years do suggest a gap between reported achievement and actual coverage. The State EPI Officer feels that the changes now incorporated in the reporting format (immunisation achievement broken up by age) will narrow the gap between the actual and reported coverage. But in general, there is no effective mechanism for cross-checking the correct enumeration of beneficiaries at the grass-roots level, especially in more remote areas.

Under the NMEP Programme, the Districts submit reports to the Assistant Director (Malaria). These reports cover the number of slides collected and examined, curative treatment given, rounds of spray, stock position, and transport. The District reports are collected and analysed at the State level and sent to the State Directorate and the Ministry of Health and Family Welfare, GOI. They are scrutinised for completeness, performance, time lag in collection and laboratory examination, gap between positive cases and radical treatment administered, and consumption of insecticide at the grass-roots level. Positive slides are randomly cross-checked by re-examination at the State level, and house-to-house verifications conducted by supervisors during field visits.

In spite of the MPW scheme, the State Malaria Officers are happy about the loyalty demonstrated by the field staff towards the Malaria Programme. However, they expressed their concern with the 'step-motherly' treatment given to the CMOs. Presently, there are no District Malaria Officers, so the CMOs are made responsible for the programme. The Assistant Malaria Officer at the District, a non-medical person, receives very little support from the CMO. The delays in receiving reports at the State level are primarily due to the low priority given to the programme by the CMOs. This, in turn, makes it difficult for the State Directorate to send the reports to the Centre on time.

There is no systematic or regular in-and-out flow of information on manpower, logistics and supplies, or budget from the District to the State. Planning for manpower needs, creation of new institutions, and budget allocation at the State level is largely ad-hoc and is based on the targets set by the Government of India for a particular year.

A prospective manpower planning exercise for 1990 and thereafter is the major concern of senior executives. Presently, training is based on ad-hoc policy; the number of training programmes, types of courses, persons to be trained, training sites, and types of trainers are based on the guidelines received from the Government of India. Information on the training status of health personnel in the state is not available: the only training information the State receives and transmits is the number of persons trained in various programmes and the supply of kits to workers and volunteers. There is no regularity in sending even these meagre reports.

The top management feels an urgent need to develop a system to help the senior executives design and implement a placement and promotion policy. A mechanism to provide continuous training to health personnel at all levels is being worked out.

Financial planning for the annual budget is based on the expenditure statements for the last eight months, under both plan and non-plan heads. The State works out a consolidated budget including the new schemes.

Ad-hoc demands for information from the Centre are not too frequent, except for occasional parliamentary questions, and generating data for these few ad-hoc requests do not disturb routine activity. The major problem, according to the State-level Officers, is not ad-hoc demand, but frequent changes in the contents of the reporting format required by the Government of India. In view of inadequate resources for printing and limited supplies of stationery, it is difficult to furnish the required data to the Centre. Large numbers of columns remain blank for quite a long time after the introduction of a new format. An example of this problem is well seen in UIP reporting against EPI reporting, where the peripheral staff does not yet have the knowledge and skill to collect and report the added information. Similarly, in NMEP, the Centre has recently demanded data on malaria performance according to the section of a block. Such information is not available at either the State or District level, and to generate it and transmit it quickly is a herculean task.

FEEDBACK

The Government of India fixes the targets for the State which divides this target amongst its Districts on the basis of population size and past performance. The targets are fixed annually for sterilisation, IUD insertion, conventional contraceptive and oral pill distribution, immunisation, prophylaxes for nutritional anaemia and night blindness, ante-natal and post-natal visits, and dai training. There are no mid-course target revisions.

The reports received by State Headquarter on Family Welfare, MCH and Immunisation, and Malaria are consolidated and transmitted to the State Secretariat and the Ministry of Health and Family Welfare, GOI. A data sheet on performance by District is prepared, and the Districts are ranked on the basis of achievements against the targets. The reports are discussed in a joint meeting of the Health Secretary and the Health Director with the Programme Officers once every month during the last 6 months of the year. The reasons for low performance of Districts are discussed in these meetings, and follow-up action is suggested to the respective Programme Officers and Deputy Directors of the Zone. District CMOs do not attend these meetings. They are informed of the decisions either verbally during supervisory visits of State Officers or through letters which make special mention of any fluctuation or low performance. To draw the attention of the District CMOs, the performance data of the District is underlined.

State-level CMO meetings are held only twice a year. These are general review meetings and are not intended to deal specifically with any programme. However, the Family Planning Programme, and especially sterilisation achievement, takes the major share of the discussions.

The State Officers do receive feedback on the reports transmitted to the Centre. Again, the feedback is either given during meetings of the senior executives with the Ministry at Delhi or, rarely, through letters. State officials defend their case with qualitative information in these meetings.

UTILISATION

Most of the Programme Officers feel that the usefulness of the present recording and reporting system is limited to programme monitoring. The present system does not fulfill the need for planning on manpower, materials, and funding at the State level. The Officers see the process as the Centre preparing a scheme, fixing targets and plans for the manpower requirement and development, and allocating the budget. The Officers do not feel it is important for them to use data to plan because the Centre does not set a good example.

The routine planning exercise in terms of the state's Five Year Plan and Annual Plan is carried out as a ritual, but it is based only on the resources and targets established by the GOI. The State is totally dependent on the Centre, even down to the scheduling of field visits of D&R personnel and the topics of research studies. At the State level sporadic and ad-hoc corrective measures dominate the thinking of decision makers, rather than solutions to underlying, persistent problems.

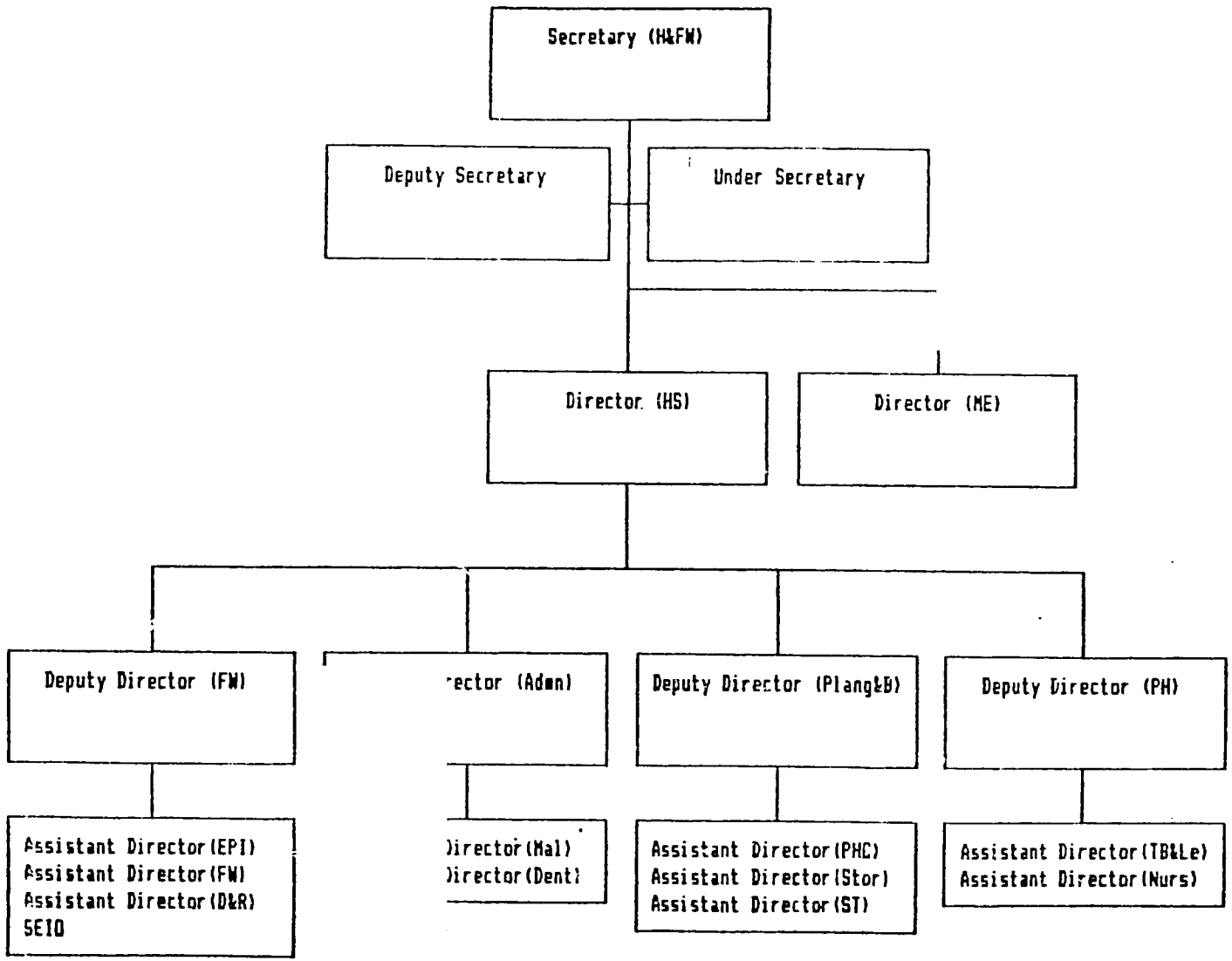
FUTURE PLANS

Both the Secretary and the Health Director are keen to develop a data bank in the areas of manpower planning, creation of new institutions, and budget allocation. This step is considered useful in developing a sound case for better resource allocation for the State to present to the Government of India. They also propose to develop a mechanism to update information on postings of Medical Officers and para-medical staff, so that information on any changes in placement would be available within a week. Similarly, information on progress in construction of health institutions would be made available every three months and used in regular discussions with the PWD authorities.

At present, the State is thinking of developing a comprehensive management information system with the help of a consultant. The new system will be developed to meet the needs of both the State and the Centre and is expected to speed up collection, compilation, and retrieval. However, resistance to change is likely to be high. Programme Officers feel that if change has to be introduced in any programme, the initiative should come from the Centre. They would prefer to use the system the GOI desires rather than to develop a new system on their own. These differences are likely to continue in the absence of any mechanism to discuss and iron out divergent viewpoints and arrive at consensus.

APPENDIX I

ORGANIZATION CHART OF HP MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN HIMACHAL PRADESH

1. Secretary of Health and Social Welfare
2. Director (Health Services)
3. Deputy Director of Family Welfare (State Family Welfare Officer)
4. Deputy Director (Public Health)
5. Deputy Director (Administration)
6. Deputy Director (Planning)
7. Principal, HFWTC
8. Assistant Director (MCH & EPI)
9. Assistant Director (D&P and SEIO)
10. Assistant Director (Malaria)

JAMMU AND KASHMIR

STATISTICS

Area: 101,387 sq km

Number of Districts = 14

Population 1981 census : 5,987,389
Projected Population 1988: 6,995,000

Number of Eligible Couples per 1000 pop. = 158.1

Eligible couples (000's) = 1,076

Birth rate = 33.6

Death rate = 9.8

Infant mortality rate = 85

CPR (%) = 17.6

BACKGROUND

The Health and Family Welfare Department of Jammu and Kashmir has carried out a few experiments to develop a workable information system. The first of these was conducted by the State Government in the early seventies. The then Director, realising the importance of comprehensive health care, developed a complete recording and reporting system of preventive, promotive, and curative services. Monthly reports called R-1, R-2 and R-3 provide information on three components of comprehensive health care. Report R-4 is a quarterly report which provides details of the establishment. Printed forms in four different colours for easy identification are supplied in a bound booklet. Considerable effort has gone into making this reporting system workable, but poor motivation of medical professionals towards recording and reporting has kept the innovation from reaching the desired level.

The present reporting system followed in the State has one more unique feature: the State Office receives only a four-page form from each District every month. The present system has eliminated some of the duplications of the old Centre system but has not added anything new in the way of household or eligible couple registers.

The information needed by various sections at the Central Ministry of Health and Family Welfare is included in this form. There has been a recent attempt to procure a computer and to computerise information. The top management is keen to use modern technology for data processing, analysis, storing, and quick retrieval. Presently, however, the State is not in a position to adopt this system because of

inadequate resources and the low priority accorded to the health sector in the overall State budget. Efforts are underway to obtain external funding to purchase hardware and software packages suitable to the State needs. Senior executives are looking forward to working with agencies which could help develop the expertise to computerise the present management information system.

ORGANISATION STRUCTURE

The Jammu and Kashmir Department of Medical and Health Services is unique in the fact that it is divided into Jammu Division and Kashmir Division. Each division has a separate Medical and Health Directorate with complete administrative and functional control over the health system of the Districts in that division. The state Malaria Office is active only in Jammu Division, as malaria is not prevalent in Kashmir Division. (See Appendix I.)

Another unique feature of the State is that there is a separate Directorate for the Family Welfare Programme which is responsible for implementing all the activities for this programmes in the State. Except for disbursing salaries to personnel in the District Family Welfare Bureau and to the paramedical staff recruited under Family Welfare at the block level, the Directorate has no other administrative or functional control. This is perceived as a major handicap in implementation of the programme.

Each Directorate of a division is headed by a Director of Health Services. The Director is supported by two Deputy Directors -- one to provide staff support and another to look after technical aspects of the programme. In addition, there are five Assistant Directors -- one each for Medical Education, Health Guide Scheme, Planning, Leprosy and Tuberculosis, and Family Welfare and MCH. In addition, the Jammu Division has a State Malaria Officer (Deputy Director rank) assisted by an Entomologist and Insect Collector.

The Directorate of Family Planning, MCH and Immunization (State Family Welfare Bureau) is headed by the Director (Family Welfare). The Director is supported by an Administrative Officer, an Assistant Accounts Officer, a Demographer, and a Mass Media Officer. In addition, he supervises the activities of the Regional Health and Family Welfare Training Centre and the State Health Transport Officer in the State Motor Garage. Lately a new post of State UIP Officer has been created under this Directorate. The State also has a separate Directorate for the Indian System of Medicine and Drug Control.

At the State Secretariat, the Department of Medical and Health Services is headed by a Secretary (Medical and Health) He is supported by two Additional Secretaries, one for Medical Education and the other for Health and Family Welfare; each of these has an Under Secretary as well.

The Directorate of Health Services for Kashmir Division and the Directorate of Family Welfare, MCH and Immunization are both located in the same building complex. The RFPTC, Srinagar, is located at the

outskirts of the city near Srinagar Airport. Interaction between these two Directorates is very limited in spite of the easy accessibility. One could easily make out this lack of contact while observing the functioning of the two offices.

The structure of the Directorate is more or less the unipurpose type. Each Officer is responsible for a specific programme and set of job responsibilities. All Officers report directly to the Divisional Director. The Assistant Director (FW/MCH) has no relationship with the Directorate (Family Welfare); he reports only to the Director (HS) of the division.

The Director (Family Welfare) has direct control over the State-level Officers in his Directorate and the Principal of RFPTC. He has no control over any other health functionary in the State. The only kind of administrative action he can take is to ask his Administrative Officer to restrict or stop financial support to a person who is not performing appropriately. Authority for recruitment, placement, award/punishment etc. is vested with the Divisional Director. The Director (FW) is not even the drawing/dispersing Officer in the State.

In the Directorate of Family Welfare all five heads of cells are from non-medical backgrounds. Except for the State Demographer, all the other Officers are on deputation from other departments of the State and have a short life in this office. This seems to be a major problem because the Officers do not get enough time to understand the system before moving on. Any attempt to modify or streamline an Officer's work cannot last long as he/she is not available to follow up. The non-medical status of Officers in the Divisional Directorate and State Family Welfare Bureau is considered another major constraint on the effectiveness of the Department.

PROFILE OF RESPONDENTS

Looking at the organisation structure of the health department of Jammu and Kashmir, the research team decided to interview the key functionaries at the Secretariat, Divisional Directorate, and Directorate of Family Welfare. The Officers in the State Malaria Office were interviewed only in Jammu Division. This decision was taken on the advice of the senior executives at the State level, who said that the job functions and the system of reporting and recording were identical in both divisions. The State Malaria Officer was not available for discussion, as she had gone out to the field on supervisory visits. (The list of Officers interviewed is given in Appendix II.) The interviews were conducted with the help of a checklist and interview schedule. At the Secretariat, the discussion with the Health Secretary and Under Secretary was held in a joint session. Both had joined the Department only 2-3 months earlier, but their experience as District Commissioners came in handy in detailing the key constraints in MIS in the State. Because of conflicting preoccupations of the Additional Secretary, the team could spend very little time with him.

At the Directorate of Health Services (Kashmir Division), all the Officers interviewed were quite senior, with 15 or more years of service in the health system. The Director had held his position for

about 8 months, and all the other Officers had been in their posts for more than one year. All these Officers were from a medical background, with higher degrees in special branches of medicine and surgery. No Officer had any special training in public health administration.

The Director (Family Welfare, MCH and Immunization) and two other Officers -- a State UIP Officer and a lecturer-cum-demonstrator at RFPTC Srinagar -- possess medical degrees. The Director was posted 8 months ago. Except for the State Demographer, all the Officers in this Directorate were quite new. The Mass Media and Education Officer, although he has long experience in the health sector, is constantly shifting from this Directorate to the parent Department, thereby reducing his attachment to the health system. The Administrative Officer belongs to the Kashmir Administrative Services. She expects her transfer in another two months. The Principal RHFWTC, Srinagar, has been working for more than two years and has attended several training of trainers programmes.

All the Technical Officers look after the technical aspects of their programmes, monitoring and supervising the work in the field and providing technical advice. The Director of Health Services and the Administrative Officer have drawing/dispersing power in the two Directorates (Health and Family Welfare). All the key functionaries have field duties. The Director (FW) is almost always on field visits, making about 20 tours to various parts of the State every month. The demographer is concerned with compilation, processing of data, evaluation studies, and field-level reliability checks. At the State level, the senior executives are responsible for policy formulation and programme planning and monitoring.

REPORTS AND THEIR RELIABILITY

The performance reports on the Family Welfare, MCH and Immunization programme are posted by the Districts to the Directorate, as is information pertaining to manpower, logistics and supplies, transport, drugs, vaccines, and budget when required. The reports on performance of the All India Hospital Post Partum Programme are sent directly to the Centre from the respective Units. The reports for the National Malaria Eradication Programme are sent to the State Malaria Office from the malaria-affected Districts of the State.

The State Family Welfare Bureau (SFWB) receives one monthly return from each District of the Jammu and Kashmir regions. The Deputy Chief Medical Officer (FW), often called the District Family Welfare Officer, is responsible to send this report to the state. Deputy CMHO (FW) consolidates all the returns from health institutions in the District into a four-page Performance Report on Family Welfare Programme and MCH Activities, which he forwards to the Director (SFWB) and Director (HS) of respective divisions.

Section A of the Performance Report details the performance of sterilisation operations and IUD insertions, with acceptors classified according to rural and urban sector and sex. The number of acceptors for the month is given, along with the cumulative performance since

April. In addition, the report further breaks down female sterilisation acceptors according to the techniques used (abdominal tubectomy, minilap, and laparoscopic.)

Section B deals with the distribution of Nirodh, broken down according to rural and urban sectors, regular and casual users, and distribution of Nirodh pieces to vasectomised persons or as samples. As with sterilisation, the number of acceptors for the current month and the cumulative total are given.

Section C deals with oral pill distribution. This section enumerates old cases (the number of women continuing on oral pills from the previous month) and new cases (the number of women put on oral pills during the current month). Section D profiles female acceptors of sterilisation and IUD during the current month, by age group, number of living children, religion, and educational status.

Section E provides half-yearly information on eligible couples, as of the 1st of October and April. The eligible couples are classified according to rural/urban sectors and number of living children.

Section F deals with MCH and Immunization activities. The first part of the section details the performance of the Immunization Programme, according to the type and dose given during the current month and the cumulative performance of the District since April. The second part of the section gives information on iron & folic acid beneficiaries, and the third part on vitamin A beneficiaries, noting to the dose each has taken.

Section G provides data related to the stock position of IUDs, condoms, oral pills, vaccines, iron and folic acid tablets, and vitamin A solution. The balance for the current month is shown here.

The District receives the monthly report from the block in the same format, so compilation at the District level is quite simple. There is a fixed time schedule for collection, compilation, and transmission, from the periphery to the Centre. On the 5th day of every month the District office receives the returns from the block and other institutions. Then the Districts compile and consolidate the information and prepare one District report which is transmitted to the State by the 10th of every month. The State office, after processing and consolidating, despatches the report to reach the Ministry of Health and Family Welfare in New Delhi by the 20th.

Although this schedule is followed to a large extent, there are a few occasions when delays and irregularities occur. These usually take place in six Districts which, because of their smaller population, do not have a District Family Planning Bureau, and have to rely on mini-bureaus. Other reasons cited for these delays are the large number of vacancies at the block level in these six Districts, utilisation of staff responsible for report preparation for various other activities, difficult geographical conditions, and lack of means of communication in remote areas.

In order to maintain the date for reporting to the Centre, the State turns to the submission of provisional data. Figures are changed when the State receives subsequent reports from the Districts. Since the SFWB was made independent, the report flow has improved. Strict action, like withholding the salary of the responsible person, has been effective in reducing delays.

The Officers reported that the information furnished to the state is generally reliable. Rarely, one may find some distortion, usually attributable to a particular worker at subcentre or block level. The rewards and punishments attached to Family Welfare performance tempts an individual to do false reporting.

The Evaluation Team from the State headquarters periodically cross-checks the accuracy of reports. In addition, the Director (FW) uses his supervisory visits to the Districts and blocks to cross-check the performance reports submitted. Every month random cross-checking on sterilisation cases is done in one or two blocks.

The limitation of this cross-checking is that it addresses only quantitative information. Very little information is available on the quality of services provided. However, sample verification conducted once or twice every year among more than 7% of sterilisation cases and 14% of IUD acceptors gives more qualitative information, including the level of rapport of the medical professionals and paraprofessionals with the community, quality of follow-up services, maintenance of records and reports, and geo-socio-economic barriers to better acceptability The last sample verification report showed no false reporting.

Coverage evaluation surveys for the Immunization Programme do show some gaps between the actual and the reported coverage in some Districts. The Officers are aware of the deficiencies in Immunization performance reporting and are working to reduce this disparity.

In addition to the above report, the SFWB has also started receiving a monthly report on Medical Termination of Pregnancy for the past three months. There is also a quarterly report on MCH performance which is not submitted regularly. The respondents were not concerned with the irregularity. They consider this report an unnecessary duplication of the monthly reports, which the State office uses to determine quarterly trends.

The Demographer receives these reports and, with the help of his assistants, consolidates, processes, and analyses the progress, and then prepares a State report which is sent to the Centre with a copy to the Secretary and the Divisional Director. In addition, he prepares a Monthly Bulletin showing District ranking and sends it to each District.

In the area of Mass Education and Media Activities, the SFWB receives one report every month. The report covers entertainment media, publicity, inter-personnel communication, competitions organised, and the support received from the media (Radio, TV, the press etc.) It

also provides information on any survey, service camp, or special drive undertaken during the reporting month. The report contains the performance data for the current month and the cumulative data.

There has been a feeling that the State MEM Cell cannot always maintain the schedule of reporting, as illustrated in the frequent delays in reporting performance of Family Welfare & MCH activities. These delays are attributed to vacancies and inadequate belief in the utility of the MEM report. However, with the new status given to SFWB, there has been an improvement, and for the last year the State has promptly furnished the quarterly MEM report to the Centre. The MEM Cell has succeeded in maintaining this through regular follow-up and supervision down the line, with Senior Officers constantly pursuing the District CMOs on MEM reporting. The State was proud to receive an expression of appreciation from the Centre for these improvements.

The State Malaria Office, Jammu, receives a large number of the monthly reports prescribed by the Centre: a Monthly Malaria Report (MF-5 and 6), the Malaria Clinic Report, the Insecticide Spraying and Round Completion Report with stock position of insecticides, reports on Deaths due to Malaria, on DDT and FTD, on Cases and Death due to Japanese Encephalitis, on Kalazar fever, and on DDT supplies and stock position. The Districts also submit entomological and susceptibility test reports.

The State Office compiles these reports and sends the compilation to the Ministry of Health and Family Welfare, Government of India, which ranks the Districts according to the endemicity of malaria. Although there are no fixed schedules, the reports to the Centre are usually submitted regularly. Any delays are attributed to poor support from some District CMOs. The State Malaria Office also prepares an annual report which it sends to the Districts. Our respondents considered the information in all these reports reliable.

There is no regular flow of information on manpower, logistics, equipment, and financial resources from the Districts. The State demands such information only when the need arises. But, with the joining of the present team of persons at the Secretariat level and the independent status of the SFWB, there is a sense that this information is needed on a regular basis. A circular has already been sent requesting all the Districts to furnish data on the status of medical and para-medical staff working under the Family Planning Programme in each District. The SFWB is developing a brief personnel history of each individual, giving the date of appointment, duration of the present posting, pay scale, and the last pay drawn on April 1, 1988. An attempt is also underway to determine the total strength of workers drawing salary under this programme and the present place of posting of each worker. These efforts reflect the feeling of the Officers that many Family Welfare posts in the Districts are filled by persons other than Family Welfare workers, or that some Family Welfare workers are engaged in other work.

The Family Welfare Programme information coming from different Districts to the DTE cell are tabulated without computers. Rankings

are developed on sterilisation and immunisation performance. Of late, emphasis is also given to copper-T insertion, since there seems to be an increasing acceptability of this method amongst the females of the State.

Occasionally meetings are held at the State level, headed by the Director of Health Services of both Kashmir and Jammu regions and attended by the District DMHOs. These meetings usually include a discussion of past performance and the working out of possible solutions to problems. There is no specific frequency for these meetings.

The State Officers very rarely receive ad-hoc requests from the Centre, since their comprehensive reporting proforma usually fulfills all needs for information. The recent changes made in the reporting format for the UIP Programme did create some initial problems, but the present reporting format is now being modified to suit the needs of the UIP Programme and is ready for distribution to the Districts. The State-level Officers do not hesitate to accept any changes required by the Centre.

FEEDBACK

The targets are set by the GOI at the beginning of the year, and the State, in turn, allocates them to the 14 Districts, according to population, past performance ,and accessibility during the year. There are no mid-course changes. Efforts are made to identify such bottlenecks as shortage of staff, transport, supplies, etc.

The D&E Cell of the SFWB prepares a monthly bulletin which provides feedback to the Districts; it is sent out within a month of receiving the District reports. The bulletin points out the high- and low-performing Districts according to the percentage of achievement against targets in sterilisation, IUD insertion, CC use, and OP use, along with achievements in MCH activities.

The bulletin also annexes one statement for each of the FW and MCH activities. These statements show each District's achievements for the current month against the allotted targets and the corresponding achievement during the previous year. In addition, the statements report any proportional increases or decreases in achievement against targets for two years.

In addition to the bulletin, the usual feedback is verbal and is given during the regular field visits made by the Officers from the State. Unfortunately, deficiencies identified during the field visit or through the evaluation may or may not be rectified because of the present organisational set-up. Under this arrangement, the State Family Welfare Officer feels handicapped in getting work done through the division. Programme performance is largely dependent on the motivation and commitment of the CMOs who are under the administrative and functional control of the Directors of Health Services of respective divisions. Similarly, the single-line administration in the State hinders the State Health Officers in effectively implementing

their programmes. The total functional control of the District is with the District Development Commissioner. His or her priorities and motivation towards Family Planning, MCH and Immunization programmes make all the difference in overcoming the bottlenecks in the Districts.

UTILISATION

The present organisation set-up restricts the use of reports to programme monitoring, allowing for very limited use of the reports for planning and implementation. The data sheet generated with the help of District performance figures suggests areas for improvement. The Officers at SFWB do use this information to prepare and present their case to the Director (Health Services) and the District Commissioner. It is, however, for the Director and the Commissioner to take the necessary steps for improvement.

Unfortunately, the data sheet does not find any place in the planning process or implementation of the programme in the division. Instead, the State plan is based on plans prepared by the individual Districts. The District plans detail the GOI requirements for health institutions, along with requirements for manpower, logistics, and equipment for the following years. The plans are expected to conform to the allotted funds for each District, based on expenditure statements of the last eight months. Hence one finds no relationship between performance and inputs. The District Development Board is responsible for the locational planning best suited to the District.

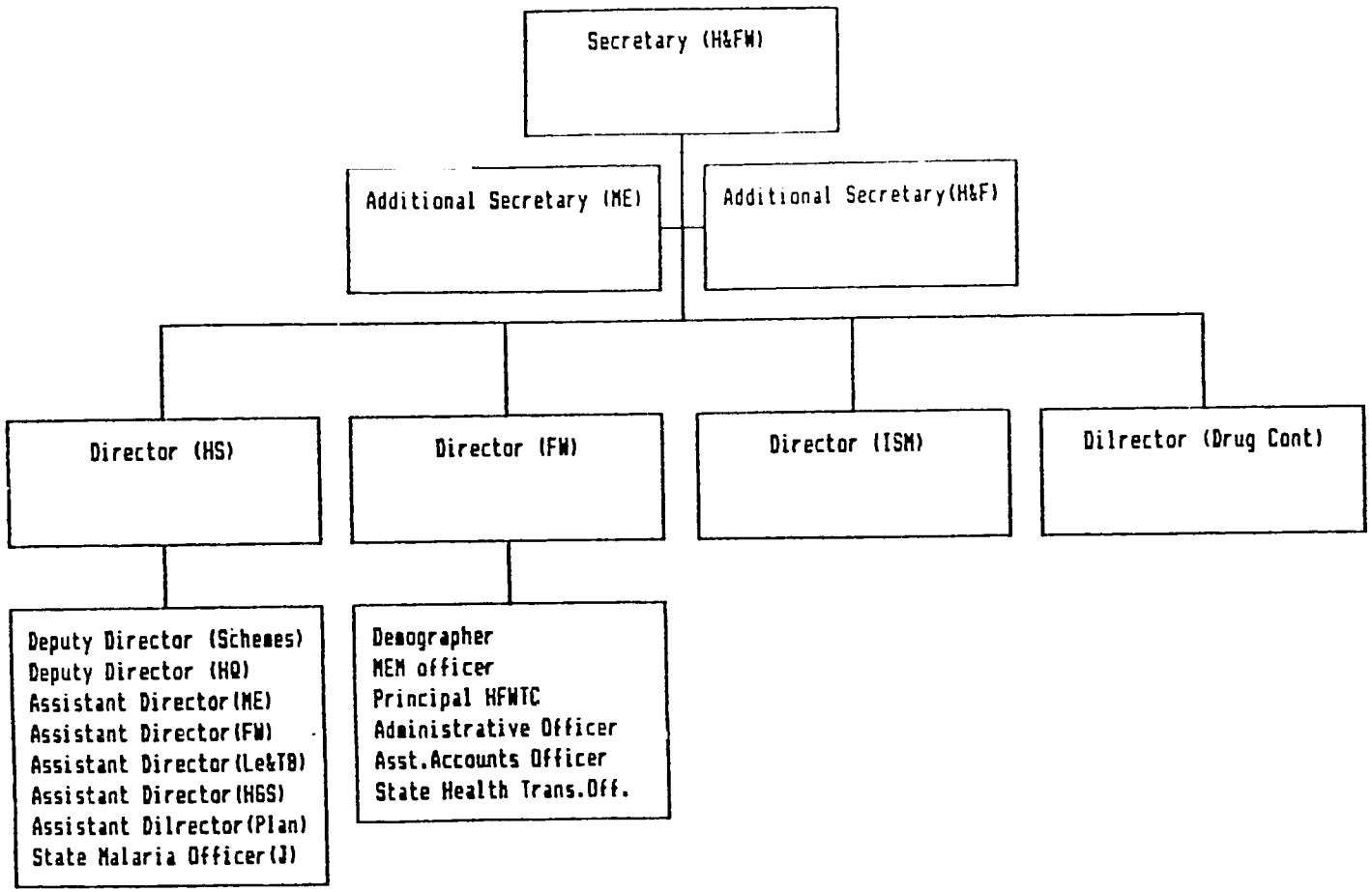
Further, the respondents observed that there is a lack of information necessary for decision making, manpower planning, or material planning. For example, seniority lists, vacant positions, and training status of health personnel are not readily available. Training seems to be done to fulfill the targets. No one at the State level has any information on manpower development.

FUTURE PLANS

The State Government is keen on developing a data bank, especially on manpower. The respondencs felt that individual personnel data sheets should be developed to support future recruitment, development, placement, and promotion; similar efforts will be required to develop an effective continuing education programme for updating the skills of medical professionals. The Senior-level Officers plan to develop a system that will help them prepare for demanding more resources from both the State and the Centre. The system so developed should provide information on location, quality, and usefulness of equipment, etc. The senior executives wish to develop this system with the help of a computer so as to minimise the workload on the present office staff and to get the information quickly.

APPENDIX I

ORGANIZATION CHART OF JK MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN JAMMU AND KASHMIR

1. Secretary (Medical and Health)
2. Additional Secretary (Family Welfare)
3. Under Secretary (Family Welfare)
4. Director (Health Services, Kashmir Division)
5. Director (Family Welfare, MCH and Immunization)
6. Deputy Director (Headquarters)
7. Deputy Director (Schemes)
8. Assistant Director (Planning)
9. Assistant Director (FW & MCH)
10. State Demographer
11. State Mass Media and Education Officer
12. Administrative Officer
13. Principal, THFWPTC Srinagar & his faculty members
14. State Entomologist (Jammu)

KARNATAKA

STATISTICS

Area: 191,791 sq km

Number of Districts = 19

Population 1981 census : 37,135,714
Projected Population 1988: 42,970,000

Number of Eligible Coupies per 1000 pop. = 163.5

Eligible couples (000's) = 6,835

Birth rate = 29.6

Death rate = 8.8

Infant mortality rate = 69

CPR (%) = 33.2

Karnataka State is one of the highest ranking States in terms of the achievement of Family Welfare targets. The implementation of Health and Family Welfare Programmes over the last three decades has brought down the crude birth rate to 29 per thousand population. The infant mortality rate stands at 69 and the couple protection rate at 33%. The State secured the second prize in the Family Welfare Programme in 1984-85 and 1985-86. Interviews with the Senior Officers in the Department of Health and Family Welfare revealed a strong sense of pride in the achievements that have been made in the health sector.

ORGANISATION STRUCTURE

The Health and Family Welfare Programme is implemented by the State Department, a comparatively small organisation. At the Secretariat, the Secretary is supported by one Additional Secretary for the programmes. The Directorate of Health and Family Welfare coordinates the MCH, Family Welfare, Immunisation, and Malaria programmes. The Director of Health and Family Welfare has two Additional Directors, one coordinating the India Population Project and the other in charge of the MCH, Immunisation, and Malaria programmes. The Programme Officers hold the rank of Joint or Deputy Directors.

REPORTS AND THEIR RELIABILITY

The Department has been following the MIS introduced by the Government of India for reporting programme performance. There are several monthly programme reports: EPI, UPI, and MCH; the Karnataka Development

Programme (20-Point Programme); and the Malaria Eradication Programme, which also uses weekly reports. Besides these performance reports there are financial statements which are used to review financial targets and expenditures. All these reports are compiled by the State Demographer's section for State-level monthly review meetings and for reporting to the Government of India.

Programme Officers conduct random checks on the accuracy of information provided by the Districts. The reliability of information is said to be quite high in all the reports: the Project Coordinator of IPP estimates the accuracy at 85 to 90%. Through random checks, the EPI Programme Officer can find out whether or not the correct antigen was administered and the prescribed interval maintained between primary and booster shots, and whether immunisation cards have been issued in the villages. (These cards have recently been amended to include data on vaccination.) Random checks have also been conducted on the Malaria Programme to reduce misreporting and improve the quality of the programme.

The checking system has revealed some instances of incorrect information, particularly in the Post-Partum and Immunisation Programmes. In the latter, there have been several instances where booster DPT injections have been inappropriately included in the data, to increase coverage statistics and try to show that the targets have been achieved. This distortion of data illustrates the general feeling of the Programme Officers that the main reason for the distortion of information is to achieve or even surpass programme targets. This is most true for Family Planning and, within Family Planning, for the distribution of contraceptives, oral pills, and Nirodh, and for sterilisations carried out.

The Programme Officers discuss the need for reliable programme data and information during their quarterly State-level review meetings with the District Officers. Sometimes the Programme Officers also participate in the District-level monthly meetings where such issues are also discussed. For the most part, the Health Officers feel that the information that is available is adequate for their needs. However, for the Immunisation Programme, the concerned Officers believe that the inclusion of disease surveillance would make monitoring more effective.

The information from the District Health Officers and District Family Welfare Officer generally reaches State Headquarters on time, although until recently there were delays due to difficulties with the postal services. To resolve this problem, an arrangement has been worked out with the Road Transport Corporation whereby the staff of DMO/DMFWO drop the reports in a box fixed to the buses travelling to Bangalore. This ensures prompt delivery to the Directorate. Reports to the Government of India are now sent by registered post to ensure that they reach Delhi, something that was not always the case in the past.

Data tabulation for the Immunisation and MCH Programmes currently is not completed until three weeks after the reports have been received, primarily because of the lack of trained staff. This delay contributes to the State's difficulty in adhering to the time schedule for reporting prescribed by the Government of India.

Over and above the regular reports required by the GOI there are periodic requests from the Centre to provide special information. For instance, the State submits monthly post-partum progress reports. At one point, the Centre requested additional information on the sex determination test data. Special efforts were made to collect the information only to find that no post-partum centre in the state carries out such tests.

In the event of an outbreak of malaria, requests for additional information from the Centre tend to multiply. In one instance, the Centre wanted to assess drug resistance in the areas where the outbreak of malaria was reported, and the State had to deploy a technical staff to visit the areas and collect the data.

In some cases there is no need for special efforts to answer the questions from the Centre, since the required information is available at the Directorate. Some examples include requests for data on vaccine stock position, addresses of Officers, the Districts for UIP, location of PHCs, and expenditure statements.

FEEDBACK

Programme Officers are expected to send feedback to the Districts, based on the information they have submitted, on the observations made during field trips, and on the entries made in diaries. The MCH and Immunisation Programme Officer has evolved a format for giving the feedback is sent to the District Officers. The results of sending such feedback have been encouraging. In an intensive outreach effort for one quarter, performance was poor in three Districts. After receiving the feedback report with specific suggestions, these Districts improved during the following quarter. Sometimes, however, feedback reports are resisted by the District Officers who view as fault finding and not as a tool for improving one's performance.

The Department has involved the medical colleges in the State to undertake concurrent evaluation of some activities at the District level. The college professors in the related disciplines conduct special surveys on activities like immunisation and send their reports to the Directorate. These reports from independent outside agencies provide valuable information to the Directorate that can be used for taking corrective measures. But the District Officers have some reservations about this system: if the medical colleges' findings are not in tune with the Medical Officers' view, they tend to oppose the idea of involving external agencies to conduct evaluations.

All programmes rank the Districts on the basis of achievement of physical targets, except for Malaria Control where the Officer believes that there is no need to rank the Districts. In the MCH and Immunisation Programmes, the Districts are ranked on achievement of each target and weights are assigned to the scores to arrive at the performance indicator scores. This exercise is carried out once a year. Should a District repeatedly get a low ranking the Programme Officer is expected to send feedback, visit the District, discuss the problems, and arrive at solutions. This practice has led to considerable improvement in MCH and Immunisation Programme performance.

There are many reasons given for poor performance and consequent low ranking. The most common are poor infrastructural facilities like PHCs and subcentres, inadequate staff and supplies, and lack of motivation among the staff. Additional prerequisites for good performance are the attitude of the people, their literacy, and their awareness on the benefits from family welfare.

The Officers have opportunities for training in management and technical subjects within their State. The Indian Institute of Management, Bangalore, and the Administrative Training Institute, Mysore, are the two training centres in Karnataka to which State Government Officers are deputed for training. Two of the respondents who had been trained during the last two years had studied MIS design, operation, review, and revisions. The Directorate has conducted workshops on micro-level planning for health schemes in a cluster of villages. These workshops also address the role of MIS in effective health service delivery.

UTILISATION

The reporting system is at present used to review progress, rank the Districts according to performance, report to the State and Centre, and inform the State Government when action should be taken against Officers who achieve less than 50% of their targets. The system is not viewed as a tool for taking decisions on how to improve their performance.

The respondents unanimously agree that there is a need to change the present system to make it more useful for planning, monitoring, and decision making. In the design of the MIS, technically qualified people should be involved along with the experts in management. The Programme Officer-in-Charge of Immunisation and MCH feels that the data available at present do not cover technical aspects. For instance, reports on the use of vaccines should also include information on type, suitability, date of manufacture, expiry dates, etc. Without such data the progress reports may show excellent achievement of targets but hide more than they reveal.

The personnel information system does not provide sufficient information to plan training for doctors and other health personnel. Decisions on whom to nominate for training are more often ad-hoc than related to real needs.

FUTURE PLANS

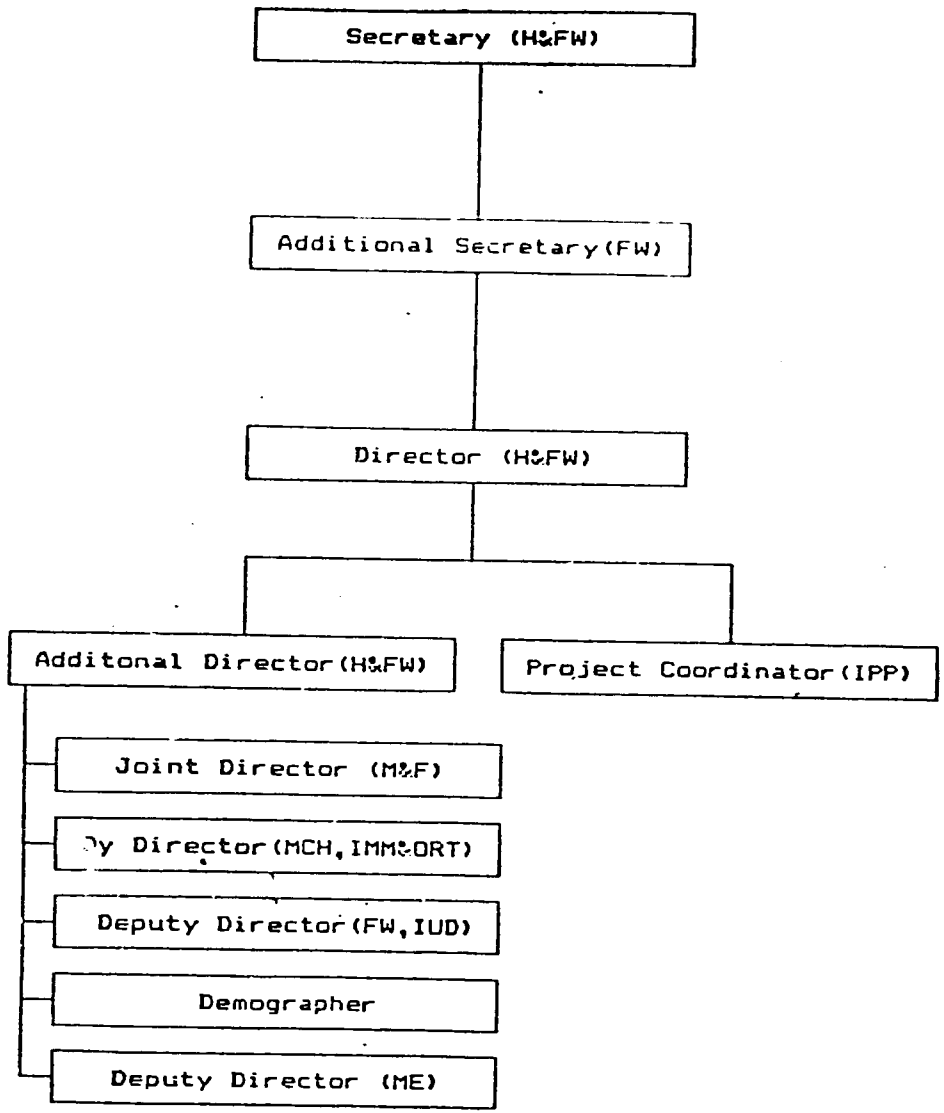
Senior Officers in the Directorate agree on the need to introduce changes. The Demographer has initiated changes in the reporting formats and to wants to computerise the system (at least at the State level) to facilitate the storage and retrieval of information. He feels that a revised system would reduce the workload of the field workers and help to avoid duplicate reporting.

The Population Centre, Bangalore, has been associated with the design of new systems and procedures which the Directorate plans to introduce as soon as they receive the Population Centre's final report. The

Directorate also plans to conduct village-level household surveys to create a data base with information on every household. Each household will be assigned a code number and the information collected will be computerised using a personal computer at the District level. The National Information Centre's (NIC) computers are used to carry out tabulate and process data and to generate reports. It is expected that the system will be useful for formulating micro-level as well as District-level plans for health programmes. Though the proposal at the outset appears interesting and useful, the task of creating the data base looks formidable. More than that, if the information is not periodically updated, the system will not serve the purpose for which it is being developed.

APPENDIX I

ORGANIZATION CHART OF KARNATAKA MOHFW
SECRETARIAT AND DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN KARNATAKA

1. Secretary
2. Additional Director
3. Project Coordinator, India Population Project
4. Joint Director (Malaria Control)
5. Deputy Director (Family Welfare, IUD & PPP)
6. Deputy Director (MCH, Immunisation & ORT)
7. Demographer

KERALA

STATISTICS

Area: 38,863 sq km

Number of Districts = 14

Population 1981 census : 25,453,680
Projected Population 1988: 28,782,000

Number of Eligible Couples per 1000 pop. = 146.0

Eligible couples (000's) = 4,126

Crude Birth rate = 23.3

Crude Death rate = 6.5

Infant mortality rate = 31

CPR (%) = 39.0

BACKGROUND

Until 1984, the Department of Health and Family Welfare in Kerala State followed the systems and procedures developed by the Ministry of Health in the Government of India. During the early eighties, Senior Officers in the Directorate felt the need to simplify the procedures for recording and reporting health information. Although the GOI reporting forms had been revised to make reporting easier, but most informed users felt that the old system still collected more information than was actually used for programme planning or monitoring. The need for simplification was partly satisfied by the introduction of the India Population Project III (IPP III) in 1984, under the Research, Monitoring, and Evaluation component introduced to monitor Health and Family Welfare. The project was designed to use computers to assist in the management of the massive volume of data within the information system.

In order to reduce the volume of data, each Programme Officer was asked to list information needs for programme management at his level. However, the total volume of data listed was still considerable, and the IPP requested a consultant from a management institution to help the project reduce the number of indicators and design suitable report formats. The consultant, along with the IPP coordinator, organised a series of meetings, followed by a workshop in which the formats, systems, and procedures were finalised. In addition to these consultancy services, a computer software package was developed for

entering and analysing data and preparing periodic reports. The IPP acquired two personal computers and a PC-XT with a printer to computerise the MIS. The PHC Officers were trained to furnish the information in the newly designed formats.

Presently the old GOI system and the computerised management information system are used in parallel. The Programme Officers stated that the main reason for the continued use of the old system is that they are more familiar with it and find it practical to submit information in the standard format required by the Government of India. Under the parallel system, the computerised reports are used as feedback to the Districts, subcentres, Directorate, and State Government.

Although IPP is confined to only four Districts -- Wynad, Palghat, Idukky, and Malappuram -- the computerised MIS has been implemented in all 14 Districts of the State. The reports are received from PHCs on the 10th of every month, processed by the 16th, and the results sent by the 20th as feedback to the concerned Programme Officer and to the Districts. The information collected by the PHCs consists of as many as seven variables for each of the following 11 factors: malaria, TB, leprosy, diarrhoeal diseases, prevention of blindness, anaemia, deaths, immunisations, mother care, family welfare, and facilities. The PHC information is forwarded to the District Medical Officer who compiles two sets of reports with graphic illustrations, one by PHC and one by District. The District summary reports are sent to Directors and Programme Officers. It is expected that after March 31, 1989, the end of the Project, the system will be taken over by the Programme Officers in the Directorate.

PROFILE OF THE RESPONDENTS

Of the respondents interviewed, four have undergone training in Health Management which included MIS. The coordinator of IPP participated in a course at a management institute where the principles of MIS were discussed. This exposure has motivated him to attempt the development of a more effective MIS for the programmes.

There are opportunities for Officers to undergo training in Health Programme Management at the Institute of Management in Government, a training and research institution run by the Government of Kerala. Some of the Programme Officers have made an effort to expose the District and PHC Medical Officers to the concepts of MIS, emphasising report preparation and the processing of information.

The research and case studies carried out by the Institute of Management in Government are ploughed back into their training courses. A recent study on MIS, for example, examined the flow of information from the village level to the State, identifying how information is stored, retrieved, and used for planning and monitoring. The study also revealed where the flow of information suddenly stopped and was not available for planning decisions at higher levels. (The study has not been published and is available only in Miami.)

ORGANISATION STRUCTURE

The implementation, supervision, and coordination of the Health and Family Welfare programme rests with the Directorate of Health Services. A major change was brought about in 1983-84 when the Directorate was split into two separate posts: the Directorate of Medical and Public Health and the Directorate of India Population Project and Family Welfare. The two Directors are supported by Additional Directors of various programmes and Deputy/Assistant Directors, as seen in the organisational chart presented in Appendix I.

There is a separate section in the Directorate for training. This is looked after by an Assistant Director who reports to the Additional Director for Planning.

REPORTS AND THEIR RELIABILITY

When reports from the Districts do not arrive on time, telegrams and telephone calls are made requesting the information. Of the 14 Districts, two are generally unable to adhere to the time schedule. They are in outlying areas where the postal communication are poor. (Another reason given by the State Officers for delays is the shortage of manpower.)

Discrepancies or inconsistent values in the data are usually discovered when the District reports are reviewed at the State level. Inspections are also carried out by supervisory administrators.

In the past, each PHC Medical Officer was required to send reports directly to the State-level Programme Officers. Because these reports were often delayed and sometimes lost, it was decided that the reports should flow through the District Medical Officers. This form of decentralized consolidation has made it possible for majority of the reports to reach the State on time.

The information furnished in the two systems (computerised MIS and GOI MIS) are perceived by the Programme Officers to be largely adequate for their needs, with the exception of some major gaps. One is the drugs and supplies inventory information system, which has yet to be established. It is a formidable task, since only 25% of the drugs and medicines are supplied by the State-level stores and the remaining items purchased by the DMOs from authorised dealers, making it difficult to keep track of the purchases. Despite these obstacles, the IPP coordinator plans to introduce this reporting system in the near future.

The system for personnel information is also perceived as inadequate by the Programme Officers. There are 39,400 persons employed by the department in the entire State and there is proposal to create a computerised District/Institution-wise personnel data base. The current MIS does not include detailed reports on the personnel and manpower availability. When a PHC doctor goes on a long leave, substitutes are seldom provided because his/her absence does not come to the notice of the State-level administrators. The information system would also be useful in deciding promotions, transfers and

deputing of doctors for training programmes. An attempt to create a similar personnel system three years ago was dropped, as there was no consensus amongst the senior State-level Officers on the feasibility of using a computer to store and process personnel information.

Detailed information is collected at the PHC level on sanctioned positions and vacancies for each category. This is reported in each District and summarized by District for each IPP Centre. Higher Officers are deployed by the Secretariat on the recommendation of the Directorate, which is also responsible for lower-level staff. The Secretariat is responsible for the creation of new posts. Seniority lists and information on promotions and the performance of individual workers are all maintained by the Directorate or Secretariat depending on the level of the employee.

Every Officer interviewed felt that the information received from the Districts and lower levels is 'highly' reliable; they estimate the level of distortion at approximately 5%. The Programme Officers carry out random checks, and the District Medical Officers also check the information before forwarding the reports to the Directorate. The State Officers believe that some of the distortions in the past were due to problems of interpreting the variables to be measured. This has, to a large extent, been resolved by improving definitions and ensuring that they are understood by the reporting staff.

The respondents indicated that there is some distortion of information on the achievements of target. For example,

> 'For the distribution of oral pills or condoms the targets are handed over to the grass-root level workers and when their achievements are below targets they tend to cook up the figures so that their superior Officers would not reprimand them.'

Every respondent mentioned that he/she always talks about the need for reliable data in review meetings and on field visits with District Officers. They also discuss the importance of the timely arrival of information which is essential to make the best use of both time and resources.

Ad-hoc requests from the Centre for additional data are not very common. When these requests are made (usually during an epidemic) they can often be answered by the State-level Programme Officers who retrieve the information from their records and only occasionally have to request data from the affected Districts.

FEEDBACK

The Programme Officers give regular feedback to the Districts through the consolidated and analysed cumulative reports. These reports provided a comparative picture. The rankings of the Districts, calculated from target achievement ratios for each programme, are monitored by the Programme Officers. The low rankers are sent an official letter asking them to identify reasons for the shortfall and take remedial measures to improve performance. The high rankers are commended and encouraged to continue the good performance.

For mass media feedback, an annual conference of all District Officers is held in June to review past performance and plan for the coming year. Each District puts forward its own plan for the next year, with accompanying justification, and these plans are consolidated for the State.

UTILISATION

The Programme Officers perceive the current computerised MIS as useful in some but not all aspects of planning, monitoring, personnel management, and resource allocation. However, the Secretary to the Government has a different view. Since the targets are set by the Centre, the State Government Health Departments 'do not have the freedom to plan.' Whatever planning is done is limited to locating PHCs, and the State Departments do not even have jurisdiction over the determination of the number of such units.

The Project Officers use the existing MIS to evaluate performance and target achievement; to make decisions on supplies, equipment and manpower; and to consolidate and submit this information to the Government of India. The Secretarial Officers use the MIS for State-level compilation, review meetings, planning and budgeting, and personnel deployment.

The cold chain report sent by the Districts to the Programme Officer carries information on equipment. Independently, the IPP Centre collects information on refrigerators and vehicles from each PHC and submits its own cold chain report, by District and by PHC.

The stock report is collected by the Programme Officer from each District. This provides the opening balance, receipts, issues, and closing balance for iron and folic acid (large and small dosage) and vitamin A.

Targets are fixed for the following indicators: Sterilization, IUD insertion, Nirodh distribution, oral pill distribution, equivalent sterilization, TT, DPT, Polio, BCG, measles, DT, typhoid prophylaxis, prophylaxis against nutritional anaemia and blindness in women, and vitamin A distribution.

The GOI targets for the State malaria surveillance are apportioned to the Districts by predetermined formulae based on population size and certain rates. Rankings are worked out for the percentage of achievement of specific targets and are made available to all workers. Low rankers are reprimanded, asked to explain their performance, and given suggestions for improvement, while high rankers are commended for their work.

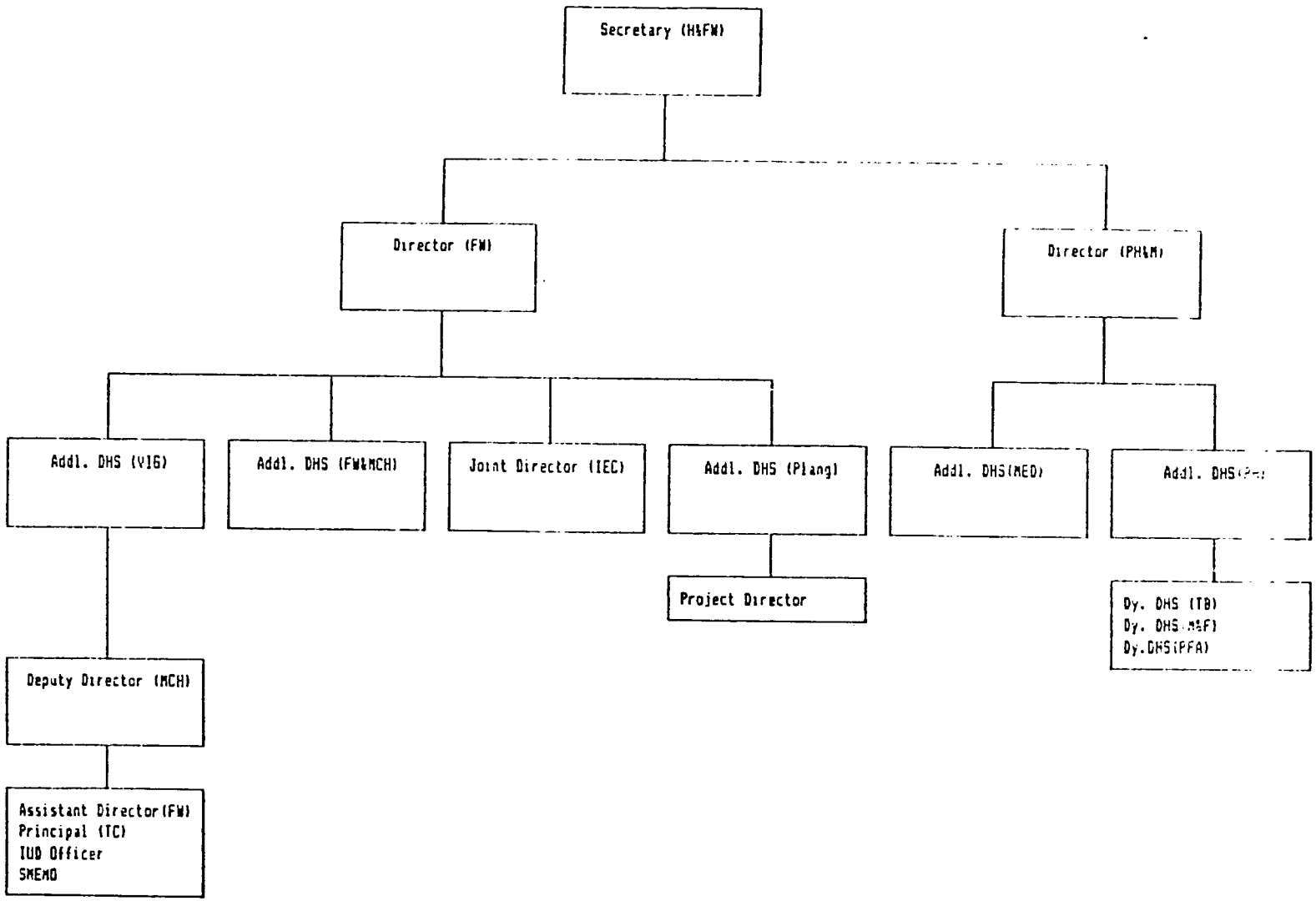
There are monthly IEC review meetings, and at the annual conference Districts submit their targets for the coming year. In this case, a form of bottom-up approach is used: targets are set and plans made on the basis of the information the Districts themselves generate.

FUTURE PLANS

Almost everyone interviewed felt that the existing MIS requires a thorough review and improvements, but not many could offer any constructive suggestions as to the way it could be improved. The Secretary and Coordinator of IPP seem to have some ideas for improvement, though these were not identified in clear terms during the interviews. As mentioned earlier, the IPP coordinator plans to introduce a reporting system for drug and supplies inventories; there is a proposal to create a personnel information data base to improve the personnel planning capabilities of the State; and the Secretary has stated that he would like to have more information on buildings and maintenance.

APPENDIX I

ORGANIZATION CHART OF KERALA MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE DIRECTORATE AND SECRETARIAT IN KERALA

1. Secretary
2. Joint Secretary (India Population Project & Planning)
3. Joint Secretary (Family Welfare)
4. Director (India Population Project and Family Welfare)
5. Director (Medical and Public Health)
6. Additional Director (Training and Planning)
7. Deputy Director (MCH and EPI)
8. Deputy Director (Malaria)
9. Project Coordinator (India Population Project)
10. Assistant Director (Family Welfare)
11. Demographer
12. Mass Education Officer

MADHYA PRADESH

STATISTICS

Area: 443,446 sq km

Number of Districts = 45

Population 1981 census : 52,178,844
Projected Population 1988: 60,626,000

Number of Eligible Couples per 1000 pop. = 177.8

Eligible couples (000's) = 10,472

Birth rate = 39.4

Death rate = 14.2

Infant mortality rate = 122

CPR (%) = 27.6

BACKGROUND

The MIS developed during the sixties is still in use in Madhya Pradesh. When it was introduced, the GOI prepared and circulated to the States a manual for Family Welfare Records. The forms and registers prescribed in the manual are still in use. The Integrated Management Information System developed by the Central Bureau of Health Intelligence in 1981 is used by only 20 of the 45 Districts. Recently the EPI and Malaria reports format has been modified by the Government of India and has been adopted by the State.

ORGANISATION STRUCTURE

The Department is headed by the Principal Secretary (Health), who is a senior IAS Officer. He is assisted by a Secretary and two Deputy Secretaries. There is one Under Secretary and a section which deals with all matters related to Health and Family Welfare. (See Appendix I.)

The Directorate is headed by two Directors, one for Public Health and Family Welfare and the other for Medical Services. The next levels consist of Joint Directors, Deputy Directors, and then Assistant Directors. There is a State Mass Education and Media Officer and a Demographer responsible for the D&E Cell, The Joint Director for Family Welfare also looks after the 20-Point Programme and is assisted by three Deputy Directors of Health Services for the National Programmes of Family Welfare, Leprosy and TB. A Joint Director is responsible for the Malaria Programme, and an Assistant Surgeon for the EPI and Public Health Programmes.

Madhya Pradesh is divided into 12 Divisions. Each Division encompasses several Districts and is headed by a Joint Director of Health Services.

REPORTS AND THEIR RELIABILITY

Most reports are submitted quarterly, except for a few essential reports which are on a monthly basis. Though the number of reports is limited in the State, the respondents considered it important to review them to explore possibility of reducing their content and changing their periodicity. For instance, in the case of the monthly returns for IUD insertion, separate performance reports are prepared by the units operated by the State organisations, local bodies, and voluntary organisations.

Performance reports and Family Planning data are received from the Family Welfare planning centres, mobile units, State units, camps, private medical practitioners, and other institutions. These reports permit the monitoring of performance for the various types of units.

The EPI monthly report provides figures on: births and deaths in various areas as part of overall surveillance; vaccinations administered, including TT to mothers, DPT, polio, measles, BCG, DT, and typhoid; and vitamin A prophylaxis against blindness among children.

Though the reports mentioned above are those which the State regularly collects and uses, there is a tendency for Programme Officers at the Centre to request their own programme reports. Although the State can usually fill these requests from existing reports without additional data collection, several Programme Officers felt that the Centre should coordinate the requests. The legislative Assembly sometimes requests information by Districts or PHCs, and often for a different time period than the one provided by the normal reporting system. This information has to be collected from the Districts and PHCs, as it is not available at the State level.

All reports are delivered to the D&E Cell of the Directorate where they are consolidated, compiled and analysed. The D&E Cell analyses the reports related to Family Planning and sends the EPI and Mass Media reports to their respective sections for further analysis. Although EPI and Mass Media Programme Officers read these reports and use them to some extent to monitor the programmes, they are unable to analyse the information in depth because of the lack of staff. The general feeling is that Family Planning Programme statistics are used for monitoring to a much greater degree than either EPI or Mass Media data.

Performance reports receive more emphasis than any other type of report and are also received more regularly. Reports on vacant positions are reviewed at the District level, and occasionally at the Secretariat level, and steps are taken to fill the vacancies. Training seems to be the most neglected reporting area.

Although some checks are carried out during field visits, there is no internal system to check the reliability of the reports, and the State relies on the investigations conducted by the Evaluation Team of the Central Government. The State Officers felt that the Divisional Joint Directors and D&E Cell of the State should be involved in checking the validity and reliability of the reports. This is not being done at the

present time because of the lack of support staff. There is a perceived need for regular verification to identify those who over-report. The respondents felt that this would not only reduce the tendency to over-report but also improve the performance of the workers (rather than trying to please the State Officers by exaggerating the figures).

To conduct regular reliability checks, additional staff are required at the State level, with an organizational structure similar to that found at the Central level. It was suggested that these teams should be headed by a senior-level Officer who can command respect from CMOs whose work they are verifying. There is also a need to provide transportation to the team members.

As regards Family Planning reports, the State Officers had the impression that sterilisation figures are over-reported by 10%, IUDs by 30%, and the pill and Nirodh by as much as 50%. Distortion takes place at all levels -- subcentres, PHCs, and urban centres. It was also pointed out that the accuracy of reports on IUDs, oral contraceptive pills, and Nirodh is improving because of the verification conducted by the Central Government team. In regard to figures on EPI and educational activities, little was said except that they seem 'reasonable.' The respondents' uncertainty about the accuracy of these figures stems from the fact that this information is not used for programme monitoring by the higher-level Officers.

The accuracy of malaria reports is thought to be very high. The Officers attributed this to the effort that is made to verify the collected information.

The State telegraphs figures to the Centre on the due date, but more often than not, several Districts are not covered. Approximately 25% of the monthly and 50% of the annual reports are delayed (five to ten days delay is quite normal). One of the reasons given for these delays was that when the District-level Statistical Assistants are absent, the responsibility for Family Planning Programme reports is not given to anybody else. Delays are also experienced in March when total annual figures are to be sent.

The delays in submitting EPI and IEC reports is attributed to the fact that senior-level Officers in the State do not use them for monitoring the programmes. This is in contrast to the malaria reports which are usually received in time.

FEEDBACK

The State has developed a feedback system which concentrates on Family Planning Programme performance. The D&E Cell analyses monthly reports District, and the Districts are ranked on the basis of two indicators: the percentage achievement of targets by various methods and comparison of performance to the same period of the previous year. Districts are ranked A, B, C, or D; A = 100% target achievement, B = 75-100%, C = 50-75% and D = 25-50%. Quarterly reports are analysed on the same basis.

Once the D&E Cell has analysed the data, they give the results to the Director and Secretary, who review them in terms of percentage of targets achieved and District rankings. Letters are written to the CMHOs of poorly performing Districts and to the Joint Director of the Division, asking them to improve performance. The Health Secretary contacts the Collector (the administrative head of a District) and the Commissioner, urging improvement of performance. The Chief Secretary also reviews the performance figures and rankings. The Health Minister contacts the local Minister in charge of the District to emphasise the importance of this programme. And the Officers of the Directorate make personal visits to discuss problems and propose solutions. The monthly meetings are also used for discussion on performance, though there is no attempt to use these meetings systematically to review the programme and provide meaningful feedback.

Districts which have shown good performance receive letters of appreciation from the CMHO and the Collector and get awards for good work. The Chief Secretary also writes positive confidential reviews of the Collectors in these Districts. The strategies adopted by these Districts are discussed in the monthly meeting so that others can learn from them. In this way, the successful Districts are rewarded, and an attempt is made to introduce 'healthy competition' in the other Districts.

One of the Officers said that the feedback and the meetings have become more ritualistic and less effective, largely due to the inability of the supervisory staff to remove poor or non-performing staff. This lack of authority is blamed on political interference whenever an attempt is made to remove a poorly performing employee. The Chief Secretary also discusses Family Planning Programme performance and reprimands the Commissioners for poor performance in their Districts.

The respondents pointed out that feedback is based on only performance figures and rankings, which do not provide enough in-depth information to be truly helpful in improving performance. They stated that the MIS should take into account the problems of different Districts, so that appropriate action can be taken to solve the problems. This would be genuine feedback, rather than superficial ranking of the Districts.

There is no regular feedback on MCH, EPI, and IEC activities. The Programme Officers -- not the Director or Secretary -- form their own impressions and give their feedback on the basis of the figures which have not been fully analysed. The Malaria Officer, however, stated that he provides feedback to the Districts by giving suggestions on how to improve the work.

UTILISATION

The MIS is taken very casually. It is seen simply as a source of data on family planning acceptors, used to determine the percentage of achievement of targets set by the Centre/State Government. The figures are used to pressure the District-level Officers to achieve the targets, without in any way considering the problems and doing something to reduce them. The reports are simply signed and forwarded

from one level to the next without any attention to their use in improving programme planning or implementation. One gets the impression that if only the number of family planning acceptors were available, no further information on programme indicators would be needed. It appears that only the Demographer of the D&E Cell knows the various performance indicators which exist and the types of information which are available on them. Even for family planning performance, information is available in all sorts of shapes and forms and it took time for the Programme Officers to say which was being used currently for their programme. This situation persists in spite of the fact that every Officer expressed the need for a Management information system which serves as the 'eyes and ears' of the programme.

As mentioned earlier, the method of monitoring Family Planning Programme performance is different from that of EPI, UIP, MCH, and IEC activities: Family Planning data are analysed at the highest level by the D&E Cell, but the analysis of data for the other programmes is left to the concerned Officers, without any recognition that they have no staff for this purpose. What monitoring there is for EPI, UIP, MCH, and IEC is done on an ad-hoc basis. The EPI Programme Officer generally monitors supplies rather than services. Only rarely do these programmes come to the attention of the Director or Secretary. The respondents summed up the situation by saying that there is essentially no monitoring of these programmes.

The Joint Director's Division can play an important part in monitoring programmes in large States, but in Madhya Pradesh this involvement is minimal. The Joint Director operates a one-man office, with no support staff to analyse data for him. His method of monitoring is monthly meetings to which District Officers bring their performance figures and discuss the various problems they are facing. The respondents commented that this is not monitoring, it is only ritualistic. They stated the need to involve this office on a systematic basis.

The Director of Health Services was very emphatic that monitoring means solving the problems of Districts rather than simply hammering away at performance. He spoke of the importance of designing a monitoring system that will engender real discussion of these problems rather than the current superficial process.

In summary, although the Officers described the MIS as useful for monitoring the progress of the Family Planning Programme, the interviews did not bear out this assessment. All comments suggested that the system is useful only for knowing the percentage of targets achieved vis-a-vis the goals set by the Central Government. Feedback from this information system is not useful in analysing problems and proposing solutions that will strengthen the programme. There is only indirect information for planning and no information for implementation, and the scope of the MIS should be expanded to include this information.

The EPI Programme Officer felt that enough information is available to plan the supply of vaccines; the Malaria Programme Officer claimed that the information is useful to him for planning, implementing, and evaluating the programme. The IEC component has nothing in it to help improve the programme.

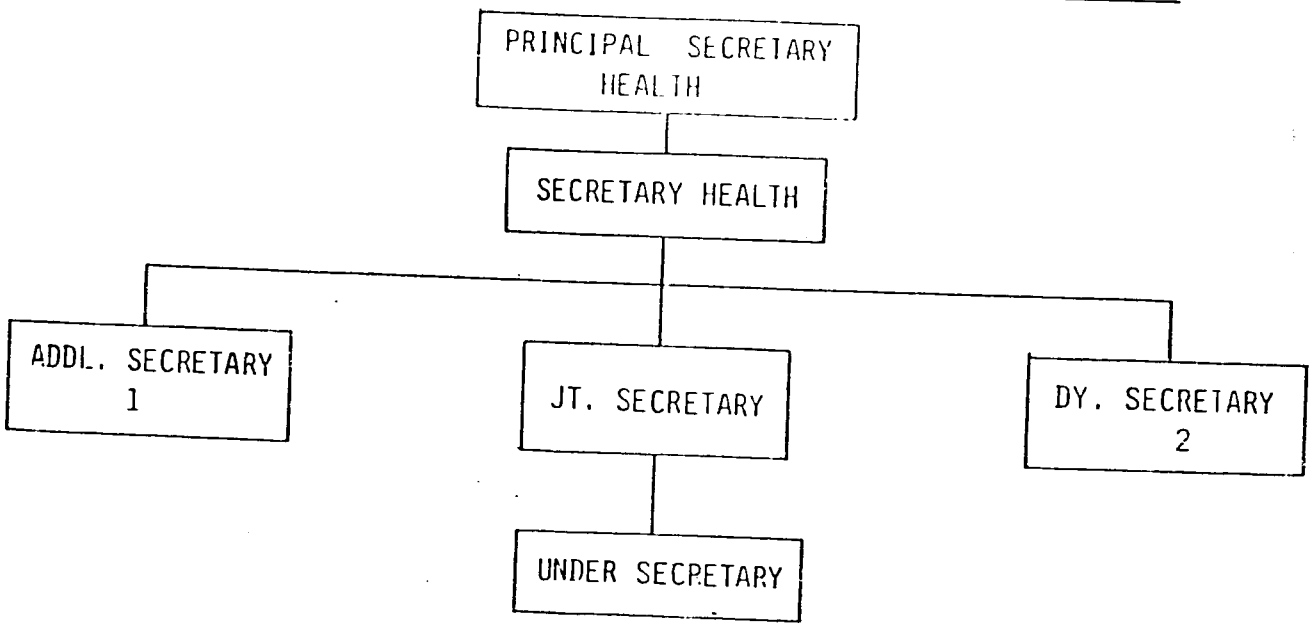
One officer reported that the collection, compilation and analysis of data takes too much time, particularly when the part used is only a very small fraction of the total. He expressed the need to reconsider the MIS and decide on the minimum information which should be collected under a revised system. The officers suggested that they cannot use the information they receive to strengthen their programmes because it is only part of what is required, and they have not been adequately trained to use even what there is.

Regarding the EPI, UIP, MCH and IEC, information was generally considered adequate. This assessment is likely due to the fact that these programmes are not optimally monitored.

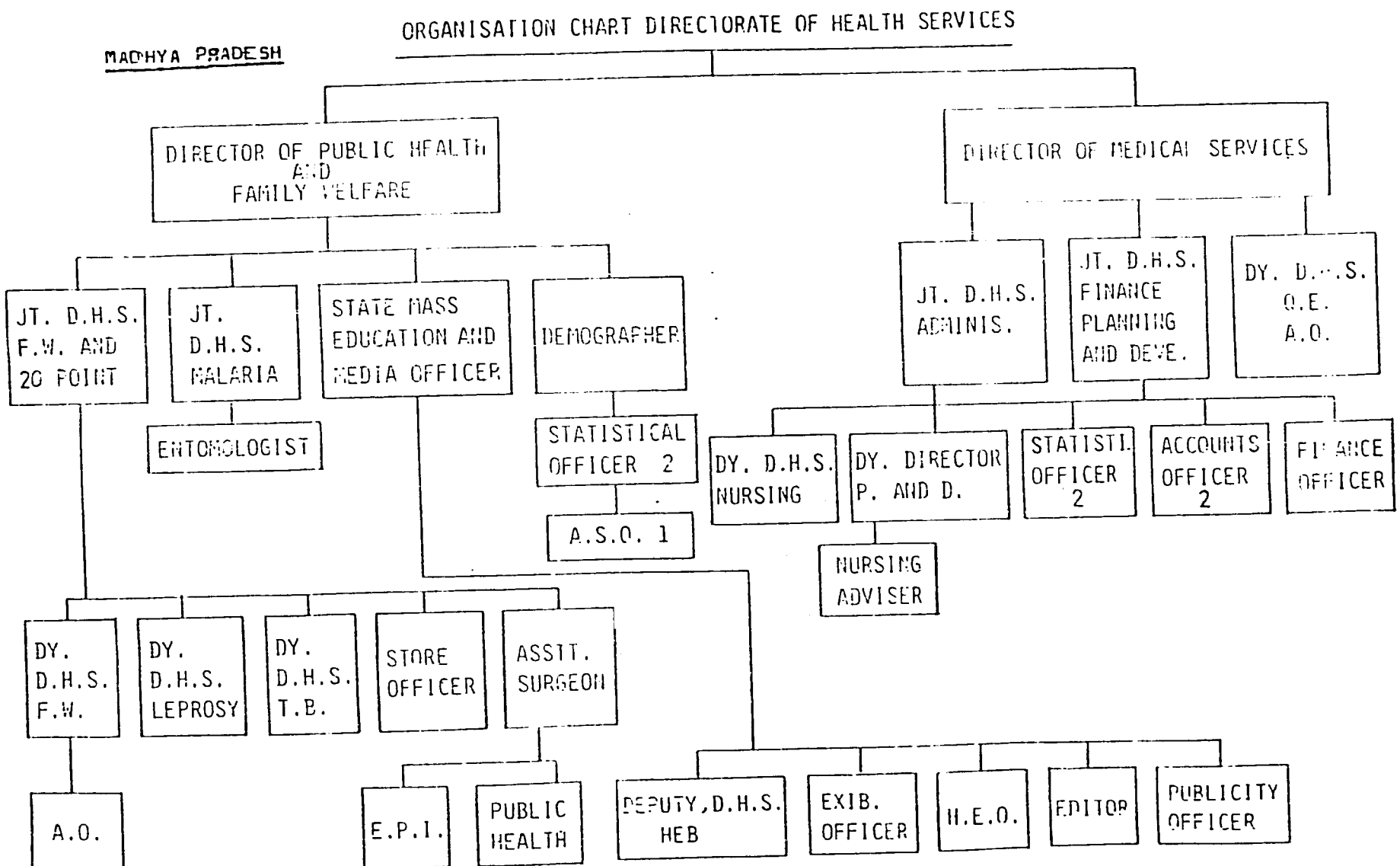
MADHYA PRADESH

ANNEXURE I (-)

ORGANISATION CHART SECRETARIAT PUBLIC HEALTH AND F.W. DEPTT.



APPENDIX I


ORGANISATION CHART DIRECTORATE OF HEALTH SERVICES
MADHYA PRADESH
DIRECTOR OF PUBLIC HEALTH AND FAMILY WELFARE
DIRECTOR OF MEDICAL SERVICES
JT. D.H.S. F.W. AND 20 POINT
JT. D.H.S. MALARIA
STATE MASS EDUCATION AND MEDIA OFFICER
DEMOGRAPHER
ENTOMOLOGIST
STATISTICAL OFFICER 2
A.S.O. 1
JT. D.H.S. ADMINIS.
JT. D.H.S. FINANCE PLANNING AND DEVE.
DY. D.H.S. O.E. A.O.
DY. D.H.S. NURSING
DY. DIRECTOR P. AND D.
STATISTI. OFFICER 2
ACCOUNTS OFFICER 2
FINANCE OFFICER
NURSING ADVISER
DY. D.H.S. F.W.
DY. D.H.S. LEPROSY
DY. D.H.S. T.B.
STORE OFFICER
ASSIT. SURGEON
A.O.
E.P.I.
PUBLIC HEALTH
DEPUTY, D.H.S. HEB
EXIB. OFFICER
H.E.O.
EDITOR
PUBLICITY OFFICER

APPENDIX II

LIST OF PERSONNEL INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN MADHYA PRADESH

1. Secretary (Medical and Health Services)
2. Joint Secretary
3. Director (Public Health & Family Welfare)
4. Joint Director (Family Welfare, MCH, Immunisation, Public Health, 20-Point Programme)
5. EPI Officer
6. Demographer, D&E Cell
7. Joint Director (Division of Bhopal)
8. Health Education Officer, SFWB
9. Joint Director (Malaria)

MAHARASHTRA

STATISTICS

Area: 307,690 sq km

Number of Districts = 30

Population 1981 census : 62,784,171
Projected Population 1988: 72,091,000

Number of Eligible Couples per 1000 pop. = 172.8

Eligible couples (000's) = 12,003

Birth rate = 29.0

Death rate = 8.4

Infant mortality rate = 68

CPR (%) = 42.2

BACKGROUND

In 1981, Maharashtra developed its own management information system for the Family Welfare Programme. This integrated MIS was developed with the intent of rectifying the weaker elements and problems of the old system and thereby increasing the acceptance of the system amongst the users. With this goal in mind, special attention was given to such factors as periodicity, the timing of the reports, a sound feedback system, and training of personnel at all levels. The MIS is periodically reviewed and modify to meet the needs of the programme. Some Districts are also using the integrated MIS and sending their reports to the Centre.

State-level Officers further modified the system in 1987, making changes in the choice of indicators, weightage for ranking overall performance, reporting formats, feedback, and training of the Programme Officers. Although there was some initial resistance to these modifications, the concerned Officers have now accepted the changes. They have come to realise the utility of the system and have been using it to improve programme performance. Some of the Officers have even demanded extra staff to increase utilisation, since the system is quite elaborate and requires a good deal of compilation and analysis.

The regard for the MIS at the State level is all the more apparent when one realises that responsibility for the MIS rests with a fairly senior Officer in the Director's office. This person gets reports from all the Programme Officers, scrutinises them, and prepares his observations for discussion in the monthly meetings. He is also responsible for follow-up actions on the MIS-based decisions taken in the review meetings.

The MIS is also being used to review and monitor programmes at three levels: by the Programme Officers, the Director of Health Services, and the Secretary of Public Health. Recently, Maharashtra has been experimenting with two management information systems, one in collaboration with ESCAP and the other with the Government of India and WHO.

ORGANISATION STRUCTURE

The Department is headed by two Secretaries who are senior IAS Officers. One looks after Public Health and the other Medical Education and Drugs. The Public Health Secretary is assisted by a Joint Secretary and four Deputy Secretaries responsible for Family Welfare, Establishment, Planning, and General Administration.

The Director of Health Services, located in Bombay, heads the Directorate. The Additional Director in charge of Family Welfare, MCH, and School Health Programmes is located in Pune. The Family Welfare Programme also has a Joint Director, as do all the other programmes. The next levels are comprised of Deputy Directors and Assistant Directors. In the Family Welfare Programme, there is a Demographer responsible for the Demographic and Evaluation (D&E) Cell. (See Appendix I.)

The State of Maharashtra is divided into eight Regions or Circles, each consisting of a few Districts. Each Region is headed by a Deputy Director (Health Services) and includes some Assistant Directors and other technical and non-technical staff.

REPORTS AND THEIR RELIABILITY

All the data related to indicators at the District level are submitted to the Programme Officers who scrutinise, compile, analyse, and review them and prepare a feedback report. They are expected to use the information they receive on training, vacancies, promotion, expenditures, and supplies for necessary action. They then send their compiled report (the 'MIS package') to the Director of Health Services.

An MIS package sent by Programme Officers to the Director includes:

- Programme efficiency graphs showing progress for different indicators in different months of the current year and comparing figures for three successive years .

- Overview note

- Suggestions made by the Programme Officers and actions to be taken during the month.

- Assistance required from the Secretary (for all cases which have been referred to the Secretariat)

- Assistance required from the Director (for all cases which have been referred to the Directorate)

- Programme Officers' review note

- Progress made/actions taken since the last meeting (minuted decisions)

- Defaulters list (those who did not send data)

- District/Circle/Corporation/Revenue Division-wise ranking statement of performance for individual indicators and overall performance

- Rural/urban performance

- Monthly progress report -- targets, achievements up to the current month, per cent targets achieved, and ranks.

After the monthly review at the Directorate level, the Director sends the following reports to the Secretariat:

- MIS package

- Minuted decisions of the review undertaken by the Director

- Copy of the report to be sent to the Evaluation and Intelligence Division, GOI, on performance of the State

- Assistance required from the Secretariat (all pending cases).

It is clear that the Family Welfare Programme receives a very intensive review. There are 29 indicators, 7 for family planning and 22 for MCH, and the amount of analysis and dissemination is voluminous. The respondents stated that the degree to which this analysis is used and its benefits are not consistent with the work put into this task. They believe that there is a strong need to make these reporting systems simpler.

In addition to these routine reports which are generated from the MIS, the Center sometimes requests ad-hoc reports, particularly to answer queries raised by the legislature about specific programmes. When epidemics occur, such requests become more frequent. Fortunately, there are very few such requests, and the information is usually easy to glean from the extensive information available in MIS.

Another feature of the reporting system in Maharashtra is that there are no consistent proformas: every District Health Officer sends the required information on indicators in his own format. Even the order of indicators differs from report to report, making compilation quite difficult.

The State Officers feel that the figures on family planning acceptors are reasonably accurate except for possible duplication in three circumstances:

- Acceptors belonging to Railways, Defence and Public Sector organisations may get counted twice, once in the reports received by the Programme Officers and once in the separate report sent by these organisations.

- Achievements for the months of April and May might be added to the previous year's performance to show higher achievements and may also be shown as achievements of the new year

- Acceptors from outside the area who receive service in the area may be shown in the reports from both the areas.

These duplications will not show up in the verifications which are currently being done for the quality of data. Overall, however, the senior State Officers felt that reliability of the information on sterilisation is very good and that on IUDs is fairly good (only about 5% over-reporting). The reliability of figures on Nirodh and oral contraceptive pills is uncertain.

The State has an in-built system for verifying the data on the number of acceptors. The Central Evaluation Teams regularly conduct verification in all the States, including Maharashtra. The Regional Directors of the Central Government are also expected to conduct some checks of the data but the respondents did not know the extent of their actual activities. The D&E Cell of the State also verifies data for one District every month; the respondents stated that this system is working. Sometimes Programme Officers verify the data on acceptors during their field visits.

Maharashtra State has also developed its own Inspection Verification System under which Officers at all levels spend one day a month checking the accuracy of data. For example, the Medical Officers of the PHCs check 1500 villages every month, totaling 18,000 a year. District-level Officers and Deputy Directors of the Circles verify the work of the PHC Officers in alternate months. The Inspection Verification system also checks the accuracy of one different MCH indicator every month. This system is reported to be very effective because workers are aware of the possibility that random checking will hit them, a strong motivation to be alert in their work and up to date in their reporting.

In the EPI/UIP Programme, the team from the office of the Programme Officer goes to the field with clear instructions to verify the cold chain, programme and individual performance, stocks of vaccines, immunisations, and potency of vaccines. The Circle Deputy Director also takes samples of vaccines once every six months from each PHC, to check potency. However, the Programme Officers question the usefulness of these random potency checks because the results are received after almost a month by which time the particular batch is likely to have been used up.

The Programme Officers feel that the EPI/UIP reports are relatively accurate. The distortions that have been discovered have often been due to clumping together different age groups who have received vaccinations to show a greater than actual number of recipients.

In the case of the Malaria Programme, the Programme Officer feels that the data get distorted during consolidation stage, in order to show that targets have been achieved. The Programme Officer has developed a system to verify accuracy of data on malaria. Under this system, the District Malaria Officer verifies the work of five workers every month for all indicators of malaria. The Officer at the Taluka level (immediately below the level of District Officer) verifies three workers every month, and the Divisional-level Additional Director of Health Services verifies the work of five workers a month, totalling 13 workers every month.

Following are some of the comments of the Officers interviewed on this topic:

> 'Only a few individuals bring unreliability in the data, most of the workers report their work correctly.'
>
> 'Commitment to reliable data by senior Officers will ensure better data. The junior programme workers/Officers would not exaggerate the figures if they knew that the senior-level Officers would take such acts seriously.'
>
> 'Regularity in sample check/verification improves the quality of data. It would be desirable that the number of agencies and frequencies of such checks should increase. The distortion in figures should lead to some definite deterring penalty.'

The Central Government receives the preliminary figures from the Districts by telegram on the 10th of every month, and the final figures are sent by the 15th. The Central Government (GOI) has always insisted on an earlier delivery date, but the State is unable to meet these demands because of problems with logistics.

Only 5 to 10% of the monthly and quarterly malaria reports are delayed. The annual report is generally delayed because it has to provide consolidated data for all the Districts and the time allocated for such consolidation is inadequate.

FEEDBACK

The feedback to Districts on their performance is mainly given by the Programme Officers, partly by the Directorate, and sometimes by the Secretariat. The data received from the Districts are analysed by the Programme Officers and the small statistical cells attached to each programme. The D&E Cell is responsible mainly for the analysis of Family Planning data, but, as mentioned earlier, a statistician from this Unit has been posted to the EPI section to analyse MCH data.

Based on these analyses, the Programme Officers review their programmes and prepare written comments which rank the Districts in terms of targets achieved, and give guidelines and operational directions to the programme. These comments and reviews serve two purposes: they help to give feedback to the District Officers, and they form the basis for

the contents of the MIS package which is sent to the Directorate. The Director and Deputy Directors discuss each aspect of the package and propose solutions to the problems, taking minuted decisions which are incorporated into a report that is sent to the District-level staff.

The Secretariat also reviews the MIS package, concentrating on certain aspects. They send their feedback to the Directorate and sometimes, in the case of poor performance, write directly to the District Health Officer.

Monthly meetings are held with the Deputy Directors of the Circle where problems are discussed, corrective measures proposed, and technical decisions taken. The Deputy Directors then hold meetings with their District Officers in which they provide feedback from the Directorate. The Directorate and the Secretariat are informed of what actions they need to take to rectify the problems that have been discussed during these meetings. The Programme Officers also hold quarterly review meetings with the District-level staff, providing feedback primarily on on programme and individual performance.

All the Districts receive feedback showing them their relative position in terms of programme performance; they also receive guidelines and tactical suggestions on how to improve their performance. Poorly performing Districts are scrutinised more closely in the monthly and quarterly meetings. They receive warning D.O. letters from the Programme Officers, Joint Directors, Additional Director, and Director, and even from the Secretary of Public Health to emphasise the need for action to improve the programme. Some personal visits are made to discuss problems and find solutions around the table. Close follow-up of such Districts has reportedly been useful in improving performance.

Districts that perform well are congratulated and asked to share their experiences and strategies in meetings so that others can benefit from them. Such Districts receive awards in Family Planning performance provided they also achieve a certain minimum level of performance in MCH, EPI, and UIP Programmes.

When asked about the effectiveness of the feedback system, the Officers pointed out that all the District and Circle-level Officers have started taking it routinely because they face the same review process each month They felt it would be more desirable to have a monthly review of absolutely critical aspects and review the remaining aspects only quarterly.

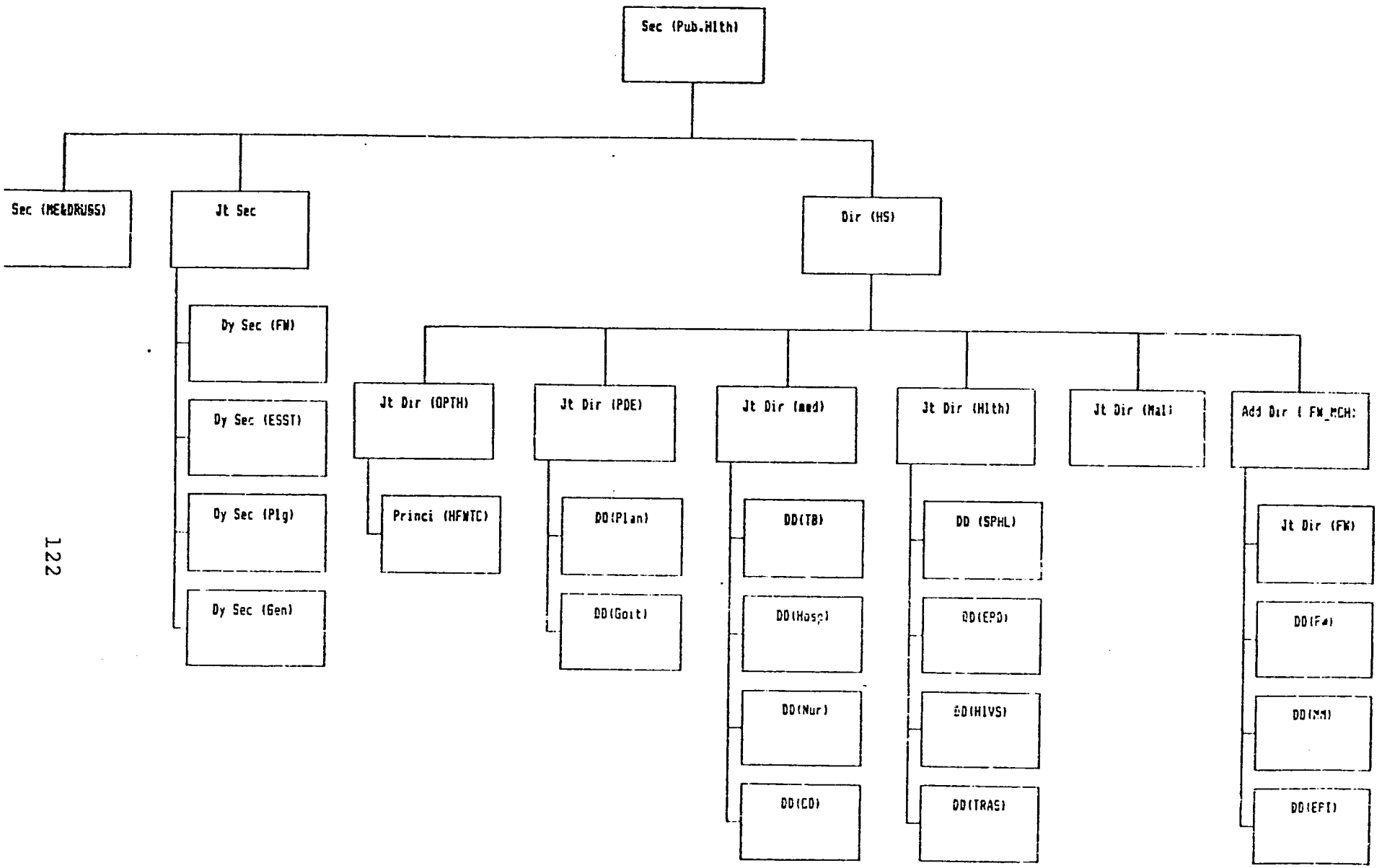
UTILISATION

The respondents expressed a wide range of opinions about the utilisation and usefulness of the MIS. While some Officers thought that the present MIS is essential for the programmes to run successfully, others felt it is unnecessary to collect such a voluminous and elaborate set of data and that only a limited set of indicators is needed to achieve the same results. Lower-level Officers (District and block level) reportedly value the MIS markedly less than Officers at higher levels. Although the State makes an effort to improve the field staffs' appreciation and use of the information

provided by the MIS, the respondents did not consider this enough. They suggested that systematic training at all levels should be given to all those who collect, compile, and use MIS information.

The State-level Officers themselves review the MIS periodically to assess whether it is meeting their needs and to consider potential modifications. The respondents at the Secretariat level stated that the current MIS is not adequate to satisfy all programme monitoring needs; Officers at the Directorate level find it inadequate for strategic planning. Although the respondents considered it quite useful for logistical planning and personnel management, it is only partly useful for strengthening training or IEC activities. There is general agreement that the effort put into the MIS has been much greater than its utilisation and results. In other words, though the MIS in Maharashtra was a moderately well conceived system, it is generally perceived as too elaborate, and the Officers will require a substantial amount of training to enable them to use it to strengthen programmes.

ORGANIZATION CHART MAHARASHTRA
Secretariat & Directorate



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN MAHARASHTRA

1. Deputy Secretary (Family Welfare)
2. Deputy Secretary (Planning)
3. Deputy Secretary (Establishment)
4. Additional Director (Family Welfare)
5. Joint Director (Family Welfare)
6. Deputy Director (MCH)
7. Deputy Director (EPI)
8. Demographer (D&E Cell)
9. Joint Director (Malaria)
10. Assistant Director (HQ) responsible for MIS
11. Assistant Director (FW) responsible for MIS

ORISSA

STATISTICS

Area: 155,707 sq km

Number of Districts = 13

Population 1981 census : 26,370,271
Projected Population 1988: 29,892,000

Number of Eligible Couples per 1000 pop. = 165.7

Eligible couples (000's) = 4,836

Birth rate = 30.7

Death rate = 14.0

Infant mortality rate = 132

CPR (%) = 30.6

BACKGROUND

Orissa is one of the States where no changes have been introduced in the management information system. Reporting formats for all the programmes in the State are supplied by the Centre. In most cases printed proformas are not available, and it is estimated to cost around 4 crores of rupees to supply the necessary registers and proformas to all categories of personnel. Given the paucity of financial resources at the State level, it is extremely difficult to mobilise funds for this activity. To overcome this constraint and streamline the system, there are several plans in the pipeline, some initiated by the Department and others externally generated. One of the plans under consideration is to create at State Headquarters a data bank encompassing categories of personnel, buildings, equipment, vehicles, and other resources -- the type of information considered necessary to do resource planning and provide inputs. A one-time census is envisaged, with a provision for updating information regularly. To carry out this work, Orissa Government has been asked to sanction two new positions; work is expected to start once the positions are sanctioned and the persons are recruited. The other possibility the Department is exploring is to include MIS as a major component of the Area Development Project to be assisted by the ODA.

The National Informatics Centre, as part of its National Information Network Project, plans to provide computer terminals to the Health and Family Welfare Department; this facility in course of time would be extended to the Districts. At the beginning of this effort, the NIC personnel will man the computer unit and train selected individuals in the department. The main objective of this project, however, is to introduce the technology, and there is unlikely to be any change in the information system except for the creation of a facility for speedy processing of data.

ORGANISATION STRUCTURE

Major structural changes in the Health and Family Welfare Department have been made recently, based on the recommendations of management consultants. The thrust of these changes is to introduce a multi-purpose scheme at various levels and to clearly delineate staff and line functions. New positions have been created, and the job functions of some of the existing positions have changed substantially.

At the Secretariat level, one Secretary oversees both Health and Family Welfare, with one Additional Secretary and a medical professional mainly to provide technical advice. At the Directorate level, there are three Directors, one for Public Health, one for Family Welfare, and the third for Medical Education. The Joint Director (Malaria), Joint Director (Leprosy and TB), Joint Director (Ophthalmology), Joint Director (Public Health), and Joint Director (Medical) report directly to the Director of Public Health Services. As part of the Family Welfare Unit, there are two Joint Directors, one for Family Welfare and the other for Rural Health. The Deputy Director (MCH) and Deputy Director (IUD/Training) report to the Joint Director (Rural Health), while the Deputy Director (Media), Assistant Director (Demography), Assistant Director (Statistics), Assistant Director (Sociology), and Deputy Director (Transport) report to the Joint Director (Family Welfare). The position of Deputy Director (Evaluation) has been vacant for the past several years, and the tasks for this position are being handled by the most senior Assistant Director. In addition, there are other positions like Administrative Officer, Financial Adviser, and Establishment Officer drawn from either Orissa Administrative Service or Orissa Financial Service. Under the Area Development Project, Orissa has created a separate centre, with adequate facilities, for media activities. Several of the new positions that go along with the new centre have not been filled. As a result, the resources available in the centre are put to less than optimum use.

As part of the new organisational set-up, three positions of Regional Directors, at the level of Joint Director, have been created. Though all the three positions have been filled, the job functions have not been clearly specified and adequate resources are not provided. All three Regional Directors are going to retire in a few months. As a result, the new positions are viewed more as promotional avenues for senior medical professionals than as an intermediate layer to supervise the work of a group of Districts in implementing the multi-purpose scheme.

PROFILE OF RESPONDENTS

All the Officers at the Secretariat and Directorate level were interviewed. Information collected with the help of the interview schedule or checklist was supplemented with data from secondary sources. All Technical Officers have put in more than 25 years; they all possess post-graduate qualifications in either Public Health or one of the specialised branches of Medicine.

The Technical Officers are largely concerned with programme performance monitoring, supervision, supplies, and technical advice. Though they are supposed to make field visits to the Districts, not many find time

to do so. Most of their time is spent on office work and at meetings at the State level.

The Demographic Section prepares targets, conducts evaluations and special studies, analyses the data, and supplies regular reports to all Technical Officers. The officiating Deputy Director has a diploma in Demography from a foreign university and has more than 20 years of experience in the same department. Health services statistics, including vital statistics, are collected by the Health Intelligence Bureau which works as a separate wing headed by the Deputy Director (Statistics). There are considerable overlaps in the data collected between the Family Welfare and Health statistical units.

The Mass Media Unit plans media activities, prepares targets, produces media material, prints the material, and monitors performance. As mentioned above, though a considerable amount was spent on the building and equipment to create an integrated media unit, the lack of technical persons to handle the equipment is considered a major constraint.

REPORTS AND THEIR RELIABILITY

Reports on the Family Planning, Maternal and Child Health, and Immunisation Programmes are sent from the Districts directly to the Deputy Director (Evaluation). At the District level, the reports are compiled by a statistical investigator and computor. All these reports reach the State before the 9th of every month; they are then consolidated by the Evaluation Wing with the help of four statistical assistants . The consolidated and processed information is sent to the Centre and to all Technical Officers at the State level.

To ensure timely arrivals of returns from the Districts, the department has installed a system of courier service under which a special messenger delivers all the information the first week of every month. In case of delays, special reminders are sent, repeatedly if necessary. In some cases, the matter is referred to the Director and Secretary to take appropriate action, or is taken up in the meetings. All this is done to hammer home the point that the reports should reach the Deputy Director (Evaluation) on time.

In the case of Family Planning Programme performance, the monthly reports sent to the State from the Districts include institution-wise sterilisations performed, IUD insertions done, conventional contraceptives distributed to regular users, and condoms given to vasectomy acceptors. These reports also provide an account of community education activities like film shows, group meetings, and orientation training camps. There is a separate monthly report on oral contraceptives which provides information on the number of urban and rural centres distributing the pill and the numbers of cycles distributed. Another report covers medical termination of pregnancy cases.

While all these programme-based service statistics meet the requirements of the Centre, the State obtains information on performance by PHCs. For the Immunisation Programme, there are separate formats for UIP and EPI Districts. Reports on institutional and domiciliary-based MCH services are submitted twice a year.

The reports are consolidated and District-ranked at the State level. The rankings are based on targets set by the Centre for each activity. Annual targets received from the Centre are proportionately distributed to Districts on the basis of estimated district population; monthly and quarterly targets are calculated with a formula. For instance, the formula followed for Immunisation activities is 15% coverage in the second quarter, 30% coverage in the third quarter, and the remaining 35% in the last quarter. All Districts are advised of the precautions to be taken for successful fulfillment of targets. Programmes are monitored by reviewing proportionate target achievement each month and comparing achievement to the total target.

Information reported from the Districts is verified by a team of three persons using interview schedules supplied by the Centre. Every month the information from one District is reviewed. Summary findings are given separately for sterilisation acceptors, IUD acceptors, oral pill users, and conventional contraceptive users. Then a consolidated statement is prepared for all the Family Planning methods together.

In regard to immunisation, Universal Immunisation Programme information is also sent to State. Sometimes discrepancies are found between the information sent to the GOI and the GOO. For example, in one month the GOI was informed that 19 refrigerators were out of order while the GOO was informed of only two cases. In such instances, verification is done and figures clarified by the concerned District authorities. Once in two months, polio vaccine samples are picked up from selected PHCs, and District and Regional centres and sent for testing at NICD, Delhi. In four out of five cases the potency levels are found to be satisfactory. For reasons not clear, the samples are not taken from subcentre and village levels.

There is no mechanism available to check the immunisation performance figures except supervisory visits. Since field visits by supervisors are not too frequent, and since there is no checklist available for supervisors, it is difficult to say how effective such verification is. Occasionally special studies are conducted to assess the attitudes of opinion leaders, the role of community health volunteers, the characteristics of Nirodh acceptors, and the causes of non-acceptance of Family Planning methods. Similar work is being done by the Population Research Centre located in University Campus, but there is no interaction between the Ministry and PRC personnel.

Orissa is one of the states where the Health Education Unit is integrated with the Family Planning Mass Media Unit. The Mass Media Unit receives monthly reports from the Districts and transmits them to the Evaluation Wing. It also receives quarterly reports based on proformas supplied by the Centre, but at the time of this study, several Districts had not submitted their last quarterly reports and telegrams had to be sent to try to obtain them. Mass media targets are distributed equally to Districts, based on the State targets received from the Centre, but the Districts are not ranked. The respondents did not consider the formats supplied by the Centre useful for verifying performance figures or checking their reliability.

Within the NMEP, all formats given by the Centre are being followed. There are monthly, seasonal, and consolidated annual reports. Entomological teams conduct epidemiological surveys in endemic areas, and the statistician attached to the programme consolidates the data and prepares the reports. The same formats are used to send the information directly to the centre. There is also a special report based on the role of voluntary agencies in remote areas. Getting information on time from the Districts is a problem; the respondents attributed this to the low priority given to the Malaria Programme after the introduction of the MPW scheme. There is no ranking of Districts.

In-service training is mainly provided by the Health and Family Welfare Centres. The Joint Director approves annual training plans and sends letters to nominate the candidates for training programmes which are largely based on targets rather than on need. A crucial problem is the reluctance on the part of PHC officers to attend training programmes, mainly because they cannot obtain funds for travel and daily allowance. Suggestions have been made to include these two expenditure items on the training budgets, but no such measures have been taken by the Centre. There are 17 ANM training centres, and 40 candidates are admitted in each centre for a one-and-a-half-year program. Male workers recruited go through one year of induction training at two Health and Family Welfare training centres and one rural health centre. There are no mechanisms to assess the effectiveness of training courses; the only information collected is the number admitted and successfully completing the course at the HFWTCs; this information is sent to the Training Division in Delhi.

Supplies for the Family Planning Programme are determined by annual targets set in the beginning of the year. Based on the target figures, requirements are worked out and requisitions are sent to the Government of India. The State supplies these items to Districts without indenting. The respondents believe that inadequate storage space is the main reason for not maintaining inventory at the State level or making supplies available on the basis of demand. Districts also do not report on stock position and perhaps follow the same procedure adopted by the State.

In regard to the Immunisation Programme, UIP Districts receive supplies directly from the Centre, while EPI Districts are given vaccines by the State. The stock position of vaccines at the State level is not known. Though there is no problem with insecticide supplies, the freight charges are not sanctioned on time, and the resulting delays sometimes lead to date expiry problems. Previously, supplies used to come with prepaid freight charges, but this practice was discontinued last year. Similarly medicines often arrive late, even when they have been requisitioned on time. For all programmes in Orissa, the information systems in regard to supplies are more or less non-existent, and most decisions are taken on an ad-hoc basis.

Family Planning Programme expenditure statements must be submitted monthly by Districts to the State and quarterly by the State to the Centre. Separate quarterly statements are required for the Malaria, Mass Media, and Immunisation Programmes. District expenditure

statements are sent directly to the Chief Accounts Officer, but there are often considerable delays, attributed to inadequate manpower at the District level coupled with lack of awareness among Medical Officers about financial procedures. The Malaria Unit faces similar problems in regard to expenditure statements, in addition to special problems of its own: insufficient allocation of funds and delays in sanctioning the required amount. The financial norms set for certain categories of workers, like daily wage earners during spraying season, were based on calculations made a few years back. At present, the minimum daily wage is higher than the rates used, so it is difficult to attract good workers and the programme suffers even if money is made available in time. In the Mass Media Unit, a major problem is that funds are not released on time. For instance, during the last fiscal year, only one-fourth of the total amount was sanctioned in the first six months, and one-third was released only two days before the close of the year. Given these problems, it is difficult to determine the reliability of expenditure reports.

In addition to the regular flow of information, special information is collected from time to time to prepare or monitor planned schemes like the Minimum Needs Programme, or to develop project reports. The Planning and Development Section in the Directorate looks after these activities. An elaborate schedule has been prepared by this section to collect information on personnel, buildings, equipment, vehicles, and facilities from all institutions in the State. However, delayed or incomplete responses are common, and the data remain unprocessed and ultimately unused.

Reports from other departments also do not come in time. For instance, the PWD is expected to send information on buildings constructed under the Minimum Needs Program. After several reminders, the information that is finally provided by the PWD generally does not tally with the information collected by the Health and Family Welfare Ministry. This leads to several inter-departmental meetings which, in many cases, remain inconclusive.

The Central Health Intelligence Bureau has introduced an integrated Health and Family Welfare information system at the District level. Although the Bureau was instrumental in introducing the system at the State level, no one from the State was involved in the design of the system or contacted after the system was introduced. The new system is in place alongside the old system. The Districts are expected to send the reports directly to the Centre and also provide a copy to the State. In most cases, forms are not filled in properly. Most Officers in the State have never looked at the new system.

Special requests for information come from the Centre from time to time for various purposes: presentation of particular information by Officers at meetings in Delhi, consolidated statements based on monthly reports, information to be kept ready for visiting dignitaries, discrepancies in figures reported or questions raised in Parliament. All these requests require special efforts.

FEEDBACK

Feedback reports on Family Planning Program performance reach the Districts on the 10th of every month. Unlike most other States, the Family Welfare Director in Orissa writes back to Districts as well as PHCs about their performance. At the District level, there are monthly meetings headed by the District Collector. He reviews the performance of different institutions and coordinates the activities with other departments.

Feedback from State Headquarters is expected to introduce a competitive spirit among PHCs and Districts. There are no regular meetings of District-level Officers, and supervisory visits are not common. The Regional Directors have no facilities (offices, support staff, etc.); nor have they been delegated any authority. Given this situation, dependence on additional inputs is very high, and there is little motivation for the development of new service delivery strategies. For instance, Family Planning performance is expected to have gone up with the recent introduction of a new incentive scheme. Under this scheme, all acceptors of sterilisation are given lottery tickets, six of them get prizes every year, and each ticket can be used for three years. Additional weightage is given to persons drawn from the Schedule Tribes and other economically backward groups. While this addresses one side of the picture, the other side is incentives to workers who achieve more than 80% of the targets in regard to Family Planning, MCH, and Immunisation There are also disincentives for workers, like withholding increments and, of course, disciplinary proceedings. None of these measures has anything to do with information systems, except to provide information on the level of performance of individuals and institutions.

For the Malaria Programme, feedback is given in quarterly meetings held by the Joint Director (Malaria). Some of the Officers also attend District-level meetings and use that occasion to provide feedback.

The Centre provides feedback in the form of statements of comparative target and achievement figures of various States. The respondents consider these comparisons useful for ascertaining one's own position and comparing the results with others. Feedback also comes in the form of meetings held at Delhi for Programme Officers; in these meetings, various performance aspects are discussed and suggestions once given are repeated several times. There are no efforts made to develop new strategies Some respondents mentioned that there is no certainty about the timing of these meetings; they are held frequently sometimes and rarely at other times. In general the feedback from the Centre is not considered very useful in helping to improve performance.

UTILISATION

Information collected from various sources is presently used mainly to meet the demands of the Centre or to instruct Districts and PHCs on how to improve performance. Available information is not being used for planning purposes. In the words of the Director of Family Welfare, 'There is no scope for planning at State level. We are given targets and resources by the Centre. All we have to do is to achieve results and inform the Centre about programme performance.' The Public Health Director thinks that the data available at present are inadequate,

except in the case of NMEP. So steps have been taken to have a close look at NMEP in the State and to draw up plans to achieve programme objectives.

Most plans for resource allocation and strategies for service delivery are based on ad-hoc decisions, rather than on the appropriate use of existing information. Many Programme Officers are of the opinion that the overemphasis on quantitative aspects is responsible for the under-utilisation of data. They suggest that there should be more attention paid to on such factors as quality of services, complication rates, and failures and deaths in sterilisation cases. Others think that personnel at various levels must be trained in how to use data; they believe that the current collection of an enormous amount of information without much emphasis on program direction is responsible for inadequate utilisation.

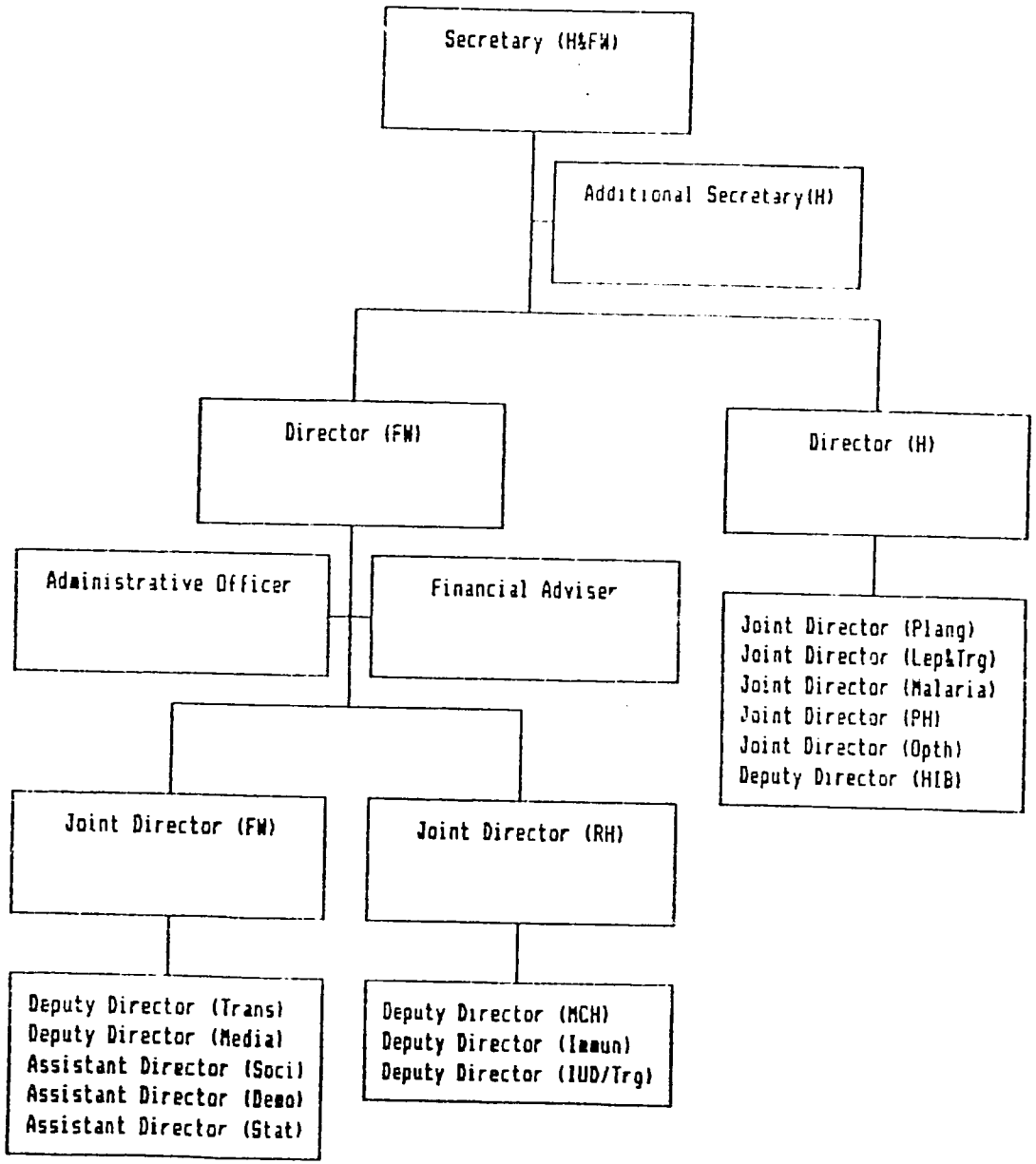
In summary, Orissa has not changed the information system for a long time, and there is considerable duplication of effort. The only information that comes on time to the State from the Districts is that of Family Welfare Programme performance. Adequate steps are taken to check reliability of Family Planning data, and findings of special studies are sometimes explicitly used. Meetings, discussions, correspondence, feedback reports, and introduction of new programme elements like incentive schemes give credibility to the importance of quantified target achievement figures in regard to sterilisations. Programs like NMEP receive brief mention at the ends of meetings. The flow of information on expenditures is a complex problem: the budget is based on separate budget line items for each programme, and accounting is done separately for each programme from subcentre to State. Information systems in regard to training and distribution aspects are more or less non-existent. Attempts have been made to collect information on infrastructure and personnel, but nothing concrete has emerged so far. Whatever information is available remains under-utilised, and feedback is routinised.

FUTURE PLANS

Most of the Officers expressed the desire for simple, easy-to-operate systems and for training workers at various levels to collect and use data. There are plans to create a data bank based on a manual system at the State level. Almost all the Medical Officers have undergone training and have addressed MIS as part of the content of their training programmes. However, none would like to take the initiative to revise the system without adequate financial backup and manpower resources. So the present system is likely to remain as it is for a few more years to come.

APPENDIX I

ORGANIZATION CHART OF ORISSA MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN ORISSA

1. Secretary
2. Director (Family Welfare)
3. Director (Public Health)
4. Joint Director (Planning and Development)
5. Joint Director (Malaria)
6. Assistant Director (HIB)
7. Joint Director (Family Welfare)
8. Joint Director (Rural Health)
9. Assistant Director (Demography)
10. Assistant Director (Statistics)
11. Assistant Director (Sociology)
12. Deputy Director (Media)
13. Deputy Director (IUD/Training)
14. Administrative Officer
15. Financial Adviser
16. Stores Officer

RAJASTHAN

STATISTICS

Area: 342,239 sq km

Number of districts = 27

Population 1981 census : 34,261,862
Projected Population 1988: 41,293,000

Number of Eligible Couples per 1000 pop. = 176.2

Eligible couples (000's) = 7,002

Birth rate = 39.7

Death rate =13.2

Infant mortality rate = 108

CPR (%) = 21.3

BACKGROUND

Though some Districts are submitting the forms developed for the integrated MIS by the Central Bureau of Health Intelligence, the State is essentially following the earlier vertical MIS system. This system is the same as the one developed by the Central Government in the sixties with a few modifications by the State, including such new items as doctor' performance, motivational work by paramedical staff, camp-wise performance, and the collection of monthly performance figures at the end of the year for confirmation. During intensive drives, daily performance figures are phoned or sent by telegraph. These reports are mainly related to Family Planning performance and the equipment and supplies related to that performance. The Secretariat section of the Department collects and monitors additional information on programme personnel. The State has generally found this modified system satisfactory.

In 1977, the State appointed a committee to review the MIS and suggest modifications if necessary. Though the Committee did make some recommendations, nothing much happened to its report. (No copy of the report was available at the time of this study.)

ORGANISATION STRUCTURE

The Department is headed by the Secretary, who is a senior IAS officer. He is assisted by another IAS officer with the status of Special Secretary. A Deputy Secretary assists these senior Officers in overseeing the Family Welfare Programme. In addition, the Project Director of the UNFPA Area Project is also available for Family Welfare Programme activities because this is a slack period for the project.

Two Directors, one for Medical and Health Services and the other for Family Welfare, head the Directorate, with the senior of them in charge of the Department. The next level consists of four Additional Directors, for Rural Health Services and Malaria, Family Welfare, Gazetted Officers, and Non-Gazetted Officers. Under the Additional Director for Family Welfare are a Deputy Director and two Assistant Directors, one for Family Planning and the other for EPI. Besides the Technical Officers, like the Mass Media Officer, a full cell of Demography and Evaluation under a Demographer is also available to assist the Director of Family Welfare. The Additional Director (Rural Health Services and Malaria) has one Assistant Director for Malaria work and one Assistant Director for Vital Statistics. (See Appendix I.)

The State is divided into four Regions, each covering several Districts. The Regions are headed by Deputy Directors, each of whom has one position of Assistant Director (Malaria) and a Chief Medical and Health Officer for each District in the Region.

REPORTS AND THEIR RELIABILITY

There are four types of reports: one for Family Welfare Programme performance, one for educational activities, one which the Secretariat developed for effective monitoring of programme components at their own level, and one for sample checks of the performance statistics. In Family Planning there is only one daily report to be sent during the periods of intensive drives; the rest of the reports are submitted monthly, quarterly, or annually.

A quick consideration of these reports suggests the following:

- There is a good deal of duplication in the reports
- There is scope for synthesising these reports so that their number can be reduced
- There is need to reconsider whether the frequency of some of the reports could be reduced.

For instance, there is a monthly report on the distribution of contraceptives and another on the distribution of Nirodh, duplicates part of the former. And three post-partum reports could be synthesised into one comprehensive report. Any efforts at consolidation or reduction would require careful consideration of the content of each report.

Although the State adheres to the reports prescribed by the Central Government, the State Secretariat has added a set which District authorities send to the State for its own monitoring purposes. Some respondents said that these are the only reports which are being used.

Ad-hoc reports are rarely requested; the occasional request is usually to answer parliamentary questions. The information necessary for these ad-hoc reports can usually be obtained from the regular reports submitted to the State without having to collect new data from the field.

The filled-in proformas are received by the D&E Cell of the Directorate. The information on Mass Education and Media activities is sent to the Mass Media Section and that on EPI to the EPI Section; Family Planning reports remain with the D&E Cell where they are scrutinised, compiled, and analysed for the purpose of monitoring. This arrangement suggests the relative importance of the different Family Welfare programmes: the Family Planning Programme is monitored, while monitoring of the other programmes receives only lip service.

Four systems have been designed to check the accuracy of data reported in the MIS. At the lowest level, the District-level Assistant is expected to carry out a 2% sample check of performance in the rural areas and a 10% check in the urban areas. The D&E Cell is supposed to send their team out to conduct random checks, a practice introduced in 1986-87. At the Central level, the Regional Director of the Government of India has responsibility for such checks. And finally, an evaluation team from the Ministry of Health and Family Welfare (E&I Division) regularly visits to conduct sample checks of the data. Thus, at least in principle, a system of verification of sample data has been developed; in reality, however, no part of the system works except that of the Central evaluation team which does go to the field, collect data for verification, and give feedback on the quality of data to the State and Central Government. Because the other components of the system are not thoroughly implemented, nobody knows the reliability of data except through the work of the Central evaluation team.

Despite this situation, the State-level Officers were generally positive about the reliability of the data from the Districts and felt that quality was, by and large, satisfactory. They reported that figures on sterilisation and immunisation are mostly correct, although they did express some concern about the fact that there is no way to check the accuracy of the figures on distribution of Nirodh, oral contraceptives, and iron and folic acid tablets. They suggested that these figures might be exaggerated, although they believed that the reliability of these figures is greater for the PHCs and higher-level service units with a ladydoctor than for the subcentres with only a health worker. The Director of Health Services went to the extent of saying that it is not possible for doctors at PHCs or at the District level to exaggerate figures because the Officers are able to detect such over-reporting by their experience and have their own methods of penalising the erring staff. He felt that the penalty or fear of penalty is enough of a deterrent to over-reporting performance.

The respondents stated that all Family Planning reports are generally received on time, except in adverse situations. Most Family Planning figures are submitted by telephone or telegram, which helps ensure their timeliness. Other programme reports are sent by post and thus are sometimes received late. The State Government has fixed dates by which they expect the reports from the Districts. The subcentre report is expected to reach the PHC by the first of every month; there it is compiled and sent to the District by the third of the month. The CMHO then compiles these figures and sends the results to the State. If the State does not receive them by the appointed day, the data cannot be

included in the despatch for that month to the Central Government and must be added to the report for the next month. Timeliness is repeatedly emphasised during monthly meetings.

FEEDBACK

The State has developed a feedback system, but it pertains mostly to Family Planning Programme performance. Family Planning information is analysed by the D&E Cell which is not responsible for analysing MCH or Mass Media reports. The analysis of Family Planning information is based on on performance figures for each method, using percentage achievement of targets and performance compared to the previous month as indicators. During intensive drives, Districts are given daily feedback on their rank in relation to other Districts and told what more they have to achieve. At other times, such feedback is given as the percentage of targets achieved. (By contrast, feedback on MCH services is only given 'once in a while.' The information provided is not used adequately by the senior Officers: only the Officer in charge of EPI looks at it and provides occasional feedback to the field.)

Family Planning feedback is given by telephone, telegraph, personal letters, and through meetings and personal visits. It is provided to the Chief Medical and Health Officer (CHMOO) and many times to the District Collectors also, so that the Collector can push the CMHO for better performance. This is particularly true in Districts where performance has been poor. The Collectors are informed of the performance of their Districts by the Health Secretary and periodically by the Chief Secretary who gives high priority to this programme and discusses it in his meetings with Collectors.

The Collectors of poorly performing Districts are asked to give a strong push to the programme. Phone calls are made to convey appreciation to CMHOs where performance was good and unhappiness to those with poor performance. Good districts are also sent letters of appreciation and the ones with bad performance get 'stinkers' urging them to put in more work. In monthly meetings of CMHOs, the discussion centres around performance and on the types of efforts which might be required to improve it. The districts which perform poorly month after month receive personal visits, along with repeated letters to CMHOs and Collectors. Even the politicians of those areas are approached. Several award schemes have been developed to serve as incentives and create 'healthy competition' among Districts, PHCs, and the staff concerned with the programme.

UTILISATION

The basic understanding and perception about the MIS is that it is a system for programme evaluation, intended to help identify the weak components of the programme so that appropriate measures can be taken to strengthen them. In practice, the respondents agree that it is used to pressure the Districts which have not achieved their allocated percentages of the targets. It does not provide information that can help improve programme planning or implementation; it does not, for example, help reveal the reasons for under-achievement, except for obvious factors like supply or manpower. Efforts to improve

performance are based on the reasoning 'if others can do better then why not you?' The emphasis on monitoring performance is implicit in the fact that information is collected almost daily and feedback is given only on relative achievement and what remains to be achieved. Only once a while are programme-related problems discussed. The MIS is considered useful only by the State-level Officers whose programmes are monitored by the Central Government, or by Divisional and District-level officers who are closely monitored by the State. Left to themselves, they probably would not have thought the MIS useful.

The monitoring is done both at the Directorate and the Secretariat level. The Secretariat gets most of its information on the programme from the Directorate and some directly from the District-level staff. The major emphasis at the Secretariat level is on monitoring performance and personnel; such other aspects as IEC, funds, training, and supplies are monitored by the Directorate. A sort of control room has been set up at the Secretariat which maintains constant contact with the Directorate and Districts. They receive the required information daily by telephone and monthly on the proformas.

There are regular meetings with the Divisional Deputy Directors and the staff of the Directorate to discuss the progress of the programme and the various actions needed at their level. The Health Secretary also keeps in touch with the Collectors, particularly in those Districts where performance has not been satisfactory. The Chief Secretary coordinates progress of this programme with the 20-Point Programme and emphasises the Family Welfare Programme in his meetings with the Collectors.

The Directorate has major responsibility for monitoring the programme and supplying information to the Central Government on the prescribed forms. Although they monitor all aspects of the programme, including personnel, training, funds, IEC, and supplies, their major emphasis remains on monitoring performance almost daily, particularly during intensive drives. As stated earlier, MCH performance does not get similar attention, though the Directorate feels that this programme should also be closely monitored. Similarly, IEC does not get the attention it needs. Both these programmes are casually discussed in the monthly meetings. Only in extreme cases, where programme activities are markedly inadequate, are monitoring visits made.

The respondents felt that the present MIS is useful in monitoring the quantifiable aspects of Family Planning Programme performance, while the quality of the programme and such aspects as personnel, training, IEC, supplies, and funds remain largely unmonitored. Information on supplies is received periodically, but it should be conveyed more rapidly by phone, and the State Officers should use it to take take immediate action. As to personnel, besides showing vacant positions, the MIS should provide all information necessary to keep up staff morale. (The Rajasthan Secretariat has developed its own format to get more details on personnel issues.)

No information is collected on training, which is a very important mode of strengthening the quality of work, motivating personnel, and increasing programme output. One gets the impression that programme

workers are not fully involved in the programme, that they carry out their work because of pressure from top rather then their own commitment. Given the importance of training in fostering commitment and improving skills, monitoring of training activities should be built into the MIS.

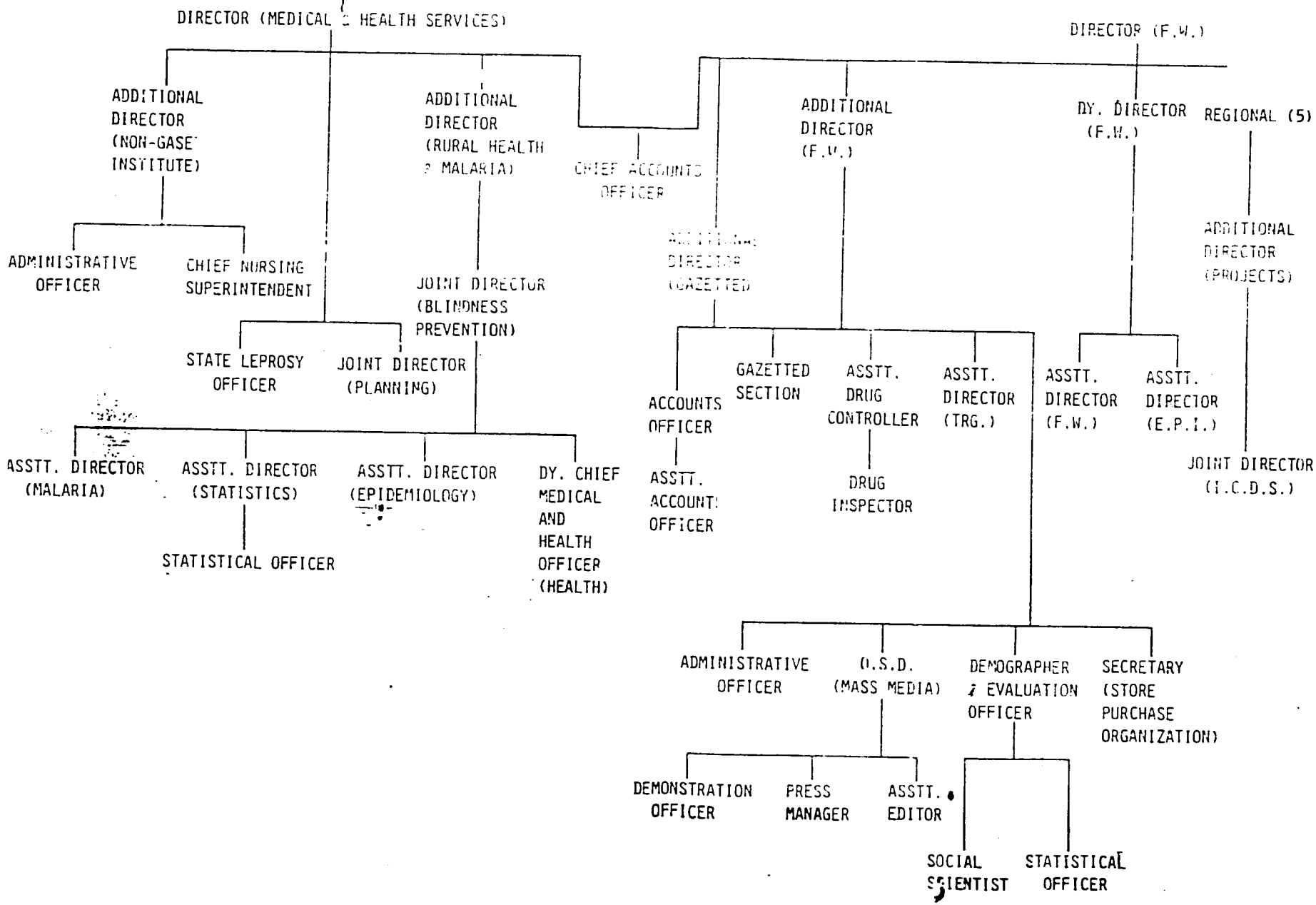
IEC is also monitored less than adequately. The concerned Officer receives the reports and sends instructions to the field, but he is too junior to get an effective response to his instructions. The respondents felt the need to review the adequacy of IEC information and to consider monitoring it at the highest level. They also proposed that a system be evolved to verify the accuracy of IEC reports because of a widespread impression of over-reporting.

In general, there is a need to identify the minimum information required to strengthen planning and implementation and include that information in the MIS. There is also a need to acquire information on the follow-up of Family Planning acceptors so that this aspect can be adequately monitored.

APPENDIX

RAJASTHAN

DIRECTORATE OF ICAL, HEALTH AND FAMILY WELFARE SERVICES - OR ISATIONAL STRUCTURE



TAMIL NADU

STATISTICS

Area: 130,058 sq km

Number of districts = 16

Population 1981 census : 48,408,077
Projected Population 1988: 54,178,000

Number of Eligible Couples per 1000 pop. = 169.0

Eligible couples (000's) = 8,985

Birth rate = 24.7

Death rate = 9.5

Infant mortality rate = 81

CPR (%) = 39.5

BACKGROUND

Tamil Nadu has consistently been one of the top ranking States in performance of Health and Family Welfare programmes receiving the National award among 'B' group States for the past three years. The State uses the management information system introduced by the Government of India, without any major deviation. The system serves the purpose of reporting to the GOI, as well as facilitating monitoring and control functions at the State and District levels.

ORGANISATION STRUCTURE

The Health and Family Welfare programmes in Tamil Nadu are administered at the State level by the Commissioner and Secretary to the Government. The organisational structure at the Secretariat level consists of the Commissioner and Secretary along with three Deputy Secretaries. Tamil Nadu may be the State with the highest number of Directorates for Health and Family Welfare activities. There are seven Directors at the State level in charge of the following areas:

- Family Welfare
- Primary Health Centres
- Public Health and Preventive Medicine
- Medical Services and Family Welfare
- Medical Education
- Indian Medicine
- State Health Transport.

The State Drug Controller, in the rank of a Director, is responsible for regulatory functions.

Below the Directors there are Additional Directors, Joint Directors, and Deputy Directors for each programme. The District-level operations are administered by District Health Officers.

The Programme Officer for Malaria Control is an Additional Director, and the Programme Officer for Immunisation is the Joint Director (Public Health and Preventive Medicine). MCH activities are distributed among several Programme Officers: Family Welfare activities are under two Directorates -- the Directorate of Medical Services and Family Welfare and the Directorate of Family Welfare. Media, Communication, and Publicity, etc., are under the Directorate of Family Welfare. (See Appendix I for the organisation chart and Appendix II for the list of officers interviewed.)

REPORTS AND THEIR RELIABILITY

The following reports are submitted by the District Health Officers to the State-level Directorates:

- Technical Reports
- Staff Position Reports
- Expenditure Statements
- Universal Immunisation Programme Reports
- Expanded Immunisation Programme Reports
- MCH Reports
- Hill Area Development Programme Reports
- Integrated Tribal Development Programme Reports
- Family Welfare Camps Reports
- Outdoor Publicity Reports
- Mass Media Statements
- Training Courses Reports.

The Programme Officers compile these reports and statements, prepare district-wise reports, and send the consolidated statements to the State Secretariat. The Programme Officers also are supposed to use the monthly information on stock position of contraceptives, vaccines, and other supply items to arrange for replenishment of stocks and to divert resources from places where there is excess stock to the centres where there is a shortage. However, in practice, the decisions to transfer stocks are not generally based on systematic use of the information.

The expenditure statements received monthly and quarterly are used by the Programme Officers and the Secretariat to monitor the expenditure of allocated funds. These reports are useful in reporting to the Government of India for the centrally sponsored programmes and the State Government. The expenditure statements are expected to reach the Directorates on the tenth working day of each month, and to date there has been no delay in their arrival.

The monthly and quarterly staff position reports furnish information on the number of sanctioned post in each category and the number of positions filled and vacant. These reports are useful in filling the vacancies and ensuring sufficient manpower to implement the programmes. However, one wonders whether this information is all put to proper use when, for example, the post of the State Demographer in the Directorate of Family Welfare has been vacant for quite some time. The seniority lists of the District Medical Officers and other senior doctors are maintained by the Administration Wing in the Secretariat. This information is used for promotion, transfers, etc.

The personnel performance reports in the employees' personal files are updated every year after receiving the annual confidential reports from the Officers supervising their work. These are handled by the administrative sections in the Directorates.

The periodical reports from the Districts used to be sent by post, but there were many cases of postal delays and sometimes of lost reports in transit. Recently, the Department has introduced a different practice to ensure that the reports reach the Directorates on time: one of the staff members of the Department from the District has to personally carry the reports to Madras and hand them over to the various Directorates. This arrangement, according to an Additional Director in the Directorate of Family Welfare, not only ensures timely arrival of reports but also gives the Programme Officers an opportunity to check the reports in the presence of the District representative before sending them to the Secretariat.

These visits to the State Headquarters every month by 19 District staff members involve expenditure, but, as one of the Assistants in the Demographer's office put it, 'This may be much less than the expenditure the Directorate used to incur on trunk calls -- mostly lightning calls -- to remind the District Medical Officers about the non-arrival of their reports in time.'

The eligible couple Register is an extremely useful document for systematic planning and setting of targets for the Family Welfare Programme. The vital information about the eligible couples falling within the jurisdiction of field-level staff can be used in directing efforts to the target couples. However, the maintenance of the Eligible Couple Register has not been satisfactory. If the register is to be updated once a year, the information must be transferred to new registers each year, which would put a heavy workload on the field staff. Therefore, the Directorate of Family Welfare has designed a new format by which some registers can be used for five years. On each page, information about six couples can be recorded. This format is also used to record the activities initiated (like advising the couple

to go in for sterilisation/IVC/CC/OP), along with the couple's response, any complications that arise, etc. To create the data base for the register the Directorate has just commenced household surveys throughout the State, expected to be completed within the next four months. What is more formidable is sustaining the system by recording the information regularly without delay and updating the register once a year.

The Programme Officers invariably placed the degree of reliability at 90%. At times, arithmetical culations create errors, and on verification these are corrected before reports are finalised. According to the Additional Director of Mass Media in the Directorate of Family Welfare, the staff available at the District level and Primary Health Centres are not sufficient to meet the workload of data tabulation. Therefore, the staff work under time constraints causing errors in the figures reported.

One of the Programme Officers attributed the low level of reliability that one sometimes encounters to the target-oriented approach. For instance, the targets set by the Government of India for the State under sterilisation, IUD, oral pill cycles, distribution of condoms, etc., are apportioned to the Districts on the basis of population and then passed on to the lower levels. For the review of performance in each District, the percentages of targets achieved are computed and the Districts ranked. The personnel at the lower levels who are actually engaged in implementation are afraid of being pulled up their superior Officers if they do not achieve the targets given to them. Therefore, some of them, particularly during the last quarter of the year, tend to 'fabricated' higher figures to show achievement of their assigned targets.

Another source of distortion can occur during the consolidation of reports at the Primary Health Centres and District level, since the responsible staff have not been well trained to do this job. This is particularly true for reports on the number of persons attending mass media or publicity camps, which are consolidated from crude estimated figures. The Programme Officers do appreciate such constraints and accept the limitations of the information.

The reports from the State to the Government of India are, by and large, sent on time, although they are very occasionally delayed by a week or two due to staff going on leave. When the reports from Districts do not arrive on time or are found defective, this too can cause a delay in reporting to the Centre. But in general, the Officers interviewed do not consider this a major problem.

The information provided in the reports is deemed sufficient to meet the requirements of monitoring and review at the State level as well as reporting to the Centre. There have been occasions when the Government of India has made ad-hoc requests for information on, among other topics, the incidence of malaria, Japanese encephalitis, Guinea worm, and parasites. Though the Programme Officer claims that the data base is very good, retrieval of such figures is not easy and may require the Officer to collect the data from the Districts. The requests for the District profiles, population, birth rate, number of PHCs, etc., are usually handled without any special effort, using the information available at the State level.

FEEDBACK

The State Directorates provide feedback to the Districts in the form of instructions for taking corrective measures to achieve the targets and address shortcomings noticed in the District's performance, although not all the Programme Officers regularly provide the feedback. When it is given, feedback from State Headquarters has sometimes resulted in improved performance. For instance, the spraying carried out in Ramnad and Tirunelveli Districts was found to be inadequate during a State-level review meeting. Feedback helped the District Health Officers to recognise the inadequacy of the coverage in their Districts. Similarly, blood samples tested at the state laboratory revealed errors in the results; when these errors were brought to the notice of the District authorities through feedback, efforts were initiated to avoid such errors in the future.

Besides providing feedback, the Programme Officers rank the Districts and inform the District Medical Officers of their rankings. The ranks are determined on the basis of the targets achieved in each activity. The Officers interviewed stated that special efforts are made to improve the performance of low-ranking districts, but most of these efforts are limited to sending instructions and official memos; one of the Officers admitted that such efforts do not always yield results.

The factors contributing to high rankings and very good performance are mostly behavioural: effective leadership style, particularly among the District Medical Officers, devotion and commitment of the workers, and motivation to perform better are some of the factors listed by the respondents.

Most of the respondents have participated in various in-service training courses in some of which they were exposed to the principles of MIS, with application to programme implementation, monitoring and evaluation, and designing and operating information systems. But, according to a respondent, such brief exposures are not adequate to make a trainee competent to design and operate a management information system.

UTILISATION

The respondents unanimously said that the management information system is useful for planning, materials resource allocation, personnel management, and funds planning. They did point out that it has not been used much for the IEC component of the programme, and that IEC should find its place in the system. There was general agreement that the current management information system should be reviewed and changed to improve its effectiveness.

Some of the Officers want a counterfoil system in the proformas used for reporting, so that there would be less chance of reports getting lost and disappearing completely. One respondent suggested bunching reports received at the State level and, after sorting them out, sending them to the concerned unit. For this scheme, there should be unified reporting and flow below the State level. As one Officer put it, a 'health intelligence system' should be evolved to facilitate monitoring and review at the State level.

Very little data analysis and interpretation is at present possible in the Directorate of Public Health and Preventive Medicine because of a lack of THE required expertise. The statisticians are all posted in the Statistical Assistant Director's office and are unable to serve the needs of all the units. The respondents consider it necessary to post statisticians in each unit, but there is not enough trained staff available to take up these posts, even in the statistical unit. When someone gets transferred or retires, substitutes are not provided immediately. For example, the State Demographer's post in the Directorate of Family Welfare has not been filled for quite some time and a statistician has been asked to officiate. Because of such delays in posting, the key personnel are not motivated enough to give their best to the department.

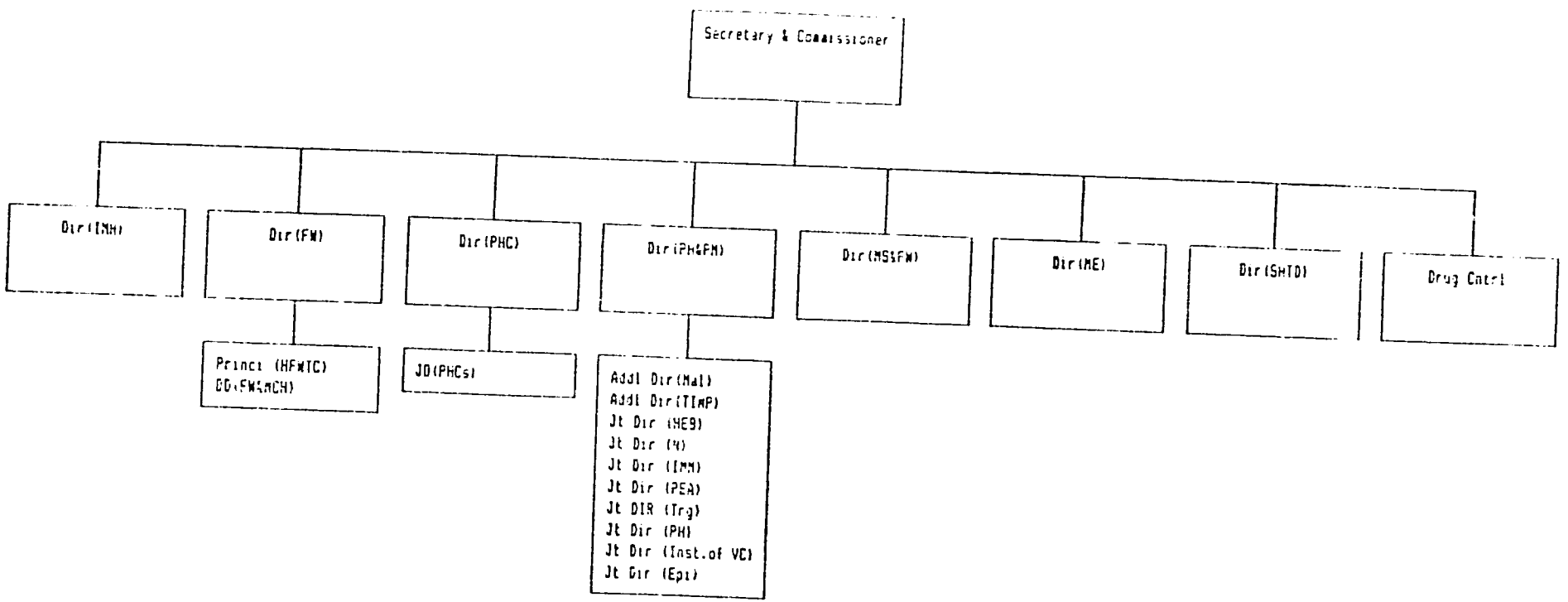
FUTURE PLANS

There is no definite plan in the Directorate to improve or strengthen the management information system currently in use. In the Secretariat, there is a plan to computerise all the health information and statistics received from the Districts. This is at least in part the result of difficulties the present Health Secretary has encountered in getting the latest reports on certain activities, because the information has had to be collected from the Directorate or the Districts. With a view to streamlining the data retrieval, there is a proposal to install a mini-computer in the Secretariat to store the information. The funds for the computer are to be obtained as part of the Area Programmes supported by the Government of India, and the installation is awaiting GOI approval.

On the whole there is considerable need and scope to improve and strengthen the information system in Tamil Nadu. In this direction, the first step should be to simplify the formats to accommodate the information and data most important and useful for monitoring. The second step would be to computerise the information system. Undoubtedly, management will be more effective and efficient with a stronger management information system for the programmes.

APPENDIX I

ORGANIZATION CHART OF IN MOHFW
Secretariat and Directorate



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN TAMIL NADU

1. Secretary and Commissioner
2. Deputy Secretary (Family Welfare)
3. Deputy Secretary (Health, Immunisation & MCH)
4. Deputy Secretary (Programmes)
5. Director, Public Health and Preventive Medicine
6. Additional Director (Public Health and Preventive Medicine)
7. Additional Director (Mass Media in Family Welfare)
8. Joint Director (Public Health and Preventive Medicine)
9. Assistant Director (Statistics)
10. Project Officer (Family Welfare)
11. Demographer-in-Charge

UTTAR PRADESH

STATISTICS

Area: 294,411 sq km

Number of Districts = 56

Population 1981 census : 110,862,013
Projected Population 1988: 128,241,000

Number of Eligible Couples per 1000 pop. = 174.3

Eligible couples (000's) = 21,571

Birth rate = 37.6

Death rate = 15.8

Infant mortality rate = 142

CPR (%) = 15.3

BACKGROUND

Uttar Pradesh is the largest State in the country and has diverse socio-economic and political conditions which pose a formidable challenge for the administration. The Health and Family Welfare services are comparatively far below the levels of other States in the country. The State has created 12 Divisions to control its 57 Districts, headed by Divisional Directors with the rank of Additional Director, but the entire management information system is centrally controlled, thereby relegating the Divisional Directors to merely titular positions vis-a-vis the use of information for programme management. During the World Bank-assisted area project known as the India Population Project, efforts were made to develop an integrated MIS as a tool for management in Health and Family Welfare service delivery. The Population Centre which was started as part of this project was given the responsibility for organising an integrated MIS for Uttar Pradesh, using one of the management institutions was involved as a consultative agency to develop the system and computerise data

Under IPP, the card system for maintenance of household records was introduced in 13 primary health centres. This approach did not succeed because beneficiaries tended to lose the cards and workers had little motivation to maintain the cards at the household level. The project then introduced rationalised registers and reporting formats which reduced the number of registers and returns to be maintained by workers at all levels. Input, output, and activity indicators were developed. Initially, these data were sent to the computer centre at the management institution, and later to computer facilities that had been installed at the Population Center. Computers were used to collate and analyse the data, to identify bottlenecks in inputs and/or activities.

During the more than seven years since then, the system has not been introduced, partly due to administrative lacunae and absence of strong leadership at the Population Centre, and also due to the apathy of the Health and Family Welfare Directorates towards modernising the management information system. Recently the State has received some funds to print stationery, purchase computers, and introduce the new MIS. The Population Centre is at present taking necessary action to launch the project.

ORGANISATION STRUCTURE

The Health Secretary heads the Department of Health & Family Welfare of the State and sits in the new Secretariat building. The Special Secretary looks after Family Welfare activities, assisted by a Joint Secretary, a Deputy Secretary, and an Under Secretary. The Directorates are headed by the Director General who coordinates the activities of six Directors: Director of Health Services, Director of Family Welfare, Director of Medical Education, Director of Ayurvedic, Director of Homeopathy, and Director of Administration.

The Directorate of Health Services is situated at Swasth Bhawan with its Malaria Wing in Jawahar Bhawan, while the Directorate of Family Welfare is located in Jubilee house. The Directorates of Medical Education, Ayurvedic Medicine, and Homeopathy are in different buildings.

Each of these Directors has total responsibility for conducting the affairs of his/her Directorate. The Directorate of Health and the Directorate of Family Welfare have a common seniority list, and their Officers are interchangeable Because of its size, Uttar Pradesh has a large health services organisation, with 31 Additional Director positions and 72 Joint Director positions.

All the Divisional Heads hold the rank of Additional Director, with responsibility for coordinating the Health and Family Welfare activities of four or five Districts. Since the Director of Health Services and the Director of Family Welfare are two separate offices, there is no unity of command, and this has made administrative control of Divisions and Districts a major problem.

Since the organisation is so large, the current study was limited to the Family Welfare Directorate and the Malaria Department of the Directorate of Health Services. The post of Director (Family Welfare) has been vacant ever since the previous Director retired a few months ago. Presently the Director of Health Services is overseeing both the Directorates. The Additional Director of Family Welfare was recently transferred to the post of Additional Director (Hills). The present Additional Director (Family Welfare) has just been appointed and has yet to settle in office. The other executives of the Directorate of Family Welfare have held their position for a considerable period of time.

The Director of the Population Centre reports directly to the Health Secretary. The Population Centre conducts independent evaluation studies and works as a consultant group to the Ministry. The Centre is

responsible for implementing the new MIS under the IPP. As part of the Area Project, a post of Project Director in the rank of Additional Director was created, directly under the Director General, but this post will be eliminated when the project ends.

Many of the Officers are seasoned executives in the Directorate, having held their positions for more than 25 years. In the Directorate of Family Welfare, there are two Additional Director positions, for Family Welfare and MCH. Under the Additional Director (Family Welfare), there are four Joint Director Posts, for Family Welfare, Urban Services, Stores, and Training. The Research and MTP Cell reports to the Joint Director (Family Welfare). Under the Additional Director (MCH) there are three Joint Director posts, for MCH, EPI & UIP, and IEC. The Administrative Officer and the Officers of the Demographic and Evaluation Cell report directly to the Director (Family Welfare). (See Appendix I.)

PROFILE OF RESPONDENTS

Offices at the Secretariat and Directorate level were interviewed (see Appendix II) with the help of an interview schedule or checklist. The previous Additional Director (Family Welfare) was interviewed, since the post of Director of Family Welfare is currently vacant.

The Secretary of Health Services has held his position for over six months; the Joint Director (Family Welfare) is a clinician who was previously Director of the Population Centre. The Technical Officers have post-graduate degrees in either Medical Science or Public Health. Most of them have been in service for a considerable period of time. The Director (Administration) is a very senior Officer from the State Civil Service. He was nominated for IAS but refused to accept the nomination.

All Technical Officers oversee their offices, supervise field work, and provide technical advice to the District Officers. The Joint Director (Urban), who will retire very shortly, is responsible for all special schemes like urban revamping, post-partum care, etc. The Joint Director (Training) is in charge of Regional Health & Family Welfare Training Centres. The Joint Director (MCH) is the administrative head of all categories of female workers and their respective training institutions. All supplies related to Family Welfare services are controlled by the Joint Director (Stores). The Joint Director (EPI & UIP) is in charge of all Immunisation activities.

The respondents appear to be working as vertical Programme Officers with little intra-departmental coordination. In regard to the MIS, the Programme Officers are mostly oriented towards GOI requirements and have very little understanding of the integrated MIS. Their perceptions of performance indicators are oriented towards gross figures rather than analytical reports.

While interviewing the Director and the Joint Director of the Population Centre, the consultants discovered that the person associated with coordinating the new MIS had left the services and removed most of the file documents. As a consequence, the Population

Centre has encountered considerable difficulty in implementing the new MIS. Moreover, the constant changes of Director of the Population Centre have deprived this institution of effective leadership.

REPORTS AND THEIR RELIABILITY

On the fourth of every month, the Demographic and Evaluation Cell of the Family Welfare Directorate receives all the reports related to Family Welfare, MCH, Immunisation, and Training, sent through special messengers. These reports provide data on the number of sterilisations conducted, IUDs inserted, and conventional contraceptives and oral pill cycles distributed. The D&E Cell also receives the report of sterilisation performance by method and motivation of cases by different departments, and copies of Post-Partum Programme reports and those of voluntary organisations, as well as an annual report on eligible couples from the Districts. The D&E Cell compiles and analyses all these reports. The reports on prophylaxis against nutritional anaemia, vitamin A deficiency, immunisation are passed over to the respective Joint Directors, as are the training reports.

On the day the D&E Cell receives the courier from the Districts, the staff manually ranks the Districts for sterilisations conducted and sends the rankings back to the Districts through the same courier who brought the reports. The other reports are analysed later. The provisional report is sent to the Government of India in the prescribed format by the 5th and the final report by the 20th of every month. Some respondents suggested that if wireless systems could be organised, the data transmission process would be greatly facilitated.

To verify the reliability of the data received from the Districts, the Demographic Cell conducts occasional evaluation surveys of sterilisation acceptors, but this is not done on a regular basis. It appeared that the Officers of the Directorate prefer to accept the records of the Districts as genuine; some of them even expressed annoyance when asked whether they have any mechanism for verification. However, the Population Centre professionals stated something quite different. According to them, some of the evaluations they have conducted on impact of services and verification have revealed that up to 30% of sterilisations reported were found to be bogus, and even this figure is considered a conservative estimate. These evaluation studies are conducted with systematic sample selection of Districts and PHCs.

In the Directorate of Family Welfare, the Mass Media Cell organises all the IEC activities carried out at the State, District, and block levels. All State-level mass media activities are coordinated with radio, TV, press, and other departments. This cell also develops and prints such educational materials as cinema slides, hoardings, pamphlets, booklets etc. At the District level, the Education and Publicity Departments receive all materials from the State and draw up a programme of activities to be carried out at the block level. These activities include organisation of orientation camps, film shows, hoardings, etc. At the block level, these activities are carried out by the Education and Publicity Officer.

A monthly return of all IEC activities is sent from every District to the Mass Media Cell on the 4th of the month, through special courier service. The Mass Media Cell then prepares the State report and sends a quarterly return in the prescribed formats to the Media Wing of the Ministry, New Delhi. The Accounts Officer is the drawing and disbursing Officer of the Family Welfare Department, with responsibility for supervising the administration of all the accounts of the Family Welfare Department. He inspects the accounts of the State and Districts; audits grant-in-aid claims of Central assistance; carries out enquiries connected with accounts matters, construction work, and all schemes connected with Family Welfare; inspects accounts of voluntary organisations; budgets plan and non-plan expenditures; and plans for infrastructure development.

The Accounts Officer receives monthly expenditure reports, quarterly miscellaneous purpose accounts, annual lists of excess and surrender (accounts that have not been used), and annual budgets from all the Districts. The monthly expenditure statements are reconciled with Treasury records. There are often delays in receiving the first two reports due to compilation problems; these delays, in turn, lead to delays in preparing the annual report. However, the Ministry of Health and Family Welfare, Delhi, does not make any ad-hoc request for information regarding expenditure statements.

The NMEP records and returns are also submitted by the Districts directly to the Malaria Department on the 4th of every month, through special courier service. No further details could be collected on this area of reporting, as most of the Officers were not available at the time of this study.

FEEDBACK

The annual target given to the State by the Centre is divided among the 57 Districts at the beginning of the fiscal year. The targets are set for activities like contraceptive methods, immunisation, and prophylaxis against nutritional anaemia and night blindness. The allocation of targets to Districts is done on the basis of population size and past performance. The achievement of targets is monitored monthly; percentages of cumulative achievement of targets are calculated and Districts are ranked on such performance indicators as sterilisations conducted, Copper-Ts inserted, conventional contraceptives distributed, oral pill cycles distributed, and immunisations administered.

Under the NMEP Programme, blood slides are collected and examined, and Districts are ranked. Along with information on the ranking of each District in a particular month, letters are sent to encourage improvements in performance. Whether the Accounts Officer gives any feedback to the Districts on discrepancies in expenditure statements could not be ascertained. Training institutions are evaluated for adherence to targets on the number of personnel to be trained; a monthly progress report is prepared and feedback is given to the Districts. Personnel are selected for training more to fulfil the targets than to develop skills among those who have not been previously trained. Post-training evaluation is routinely carried out immediately after the course, but the findings are never used.

At the State level, the Health Secretary holds meetings from time to time, followed by meetings of Senior Officers of the Family Welfare Directorate with the Chief Medical and Health Officers. These meetings are held to discuss performance and to identify shortcomings in manpower, transport, vaccine and equipment supplies, building construction, etc. Steps to be taken to rectify problems are discussed and actions initiated. Sometimes inter-departmental meetings are held among the Secretaries of different departments, to promote Family Welfare Services.

UTILISATION

The present MIS is meant to fulfill the Government of India's requirements, with no innovative changes. Even efforts made by the Population Centre to change the MIS are not appreciated by the majority of the Officers of both the Directorates. Administrative bottlenecks are considered a major hindrance to change. Computers have been installed but no software packages for data analysis have been developed. A huge amount of money was spent printing the formats for the new MIS, without an effort to ascertain whether the MIS could actually be implemented. Some of the Officers even remarked that if the new MIS was an effective tool for management, some visible changes should have been noticed in the 20 PHCs where it was introduced in 1980. But in reality, according to them, there were no improvements.

The Directorate of Family Welfare has introduced a prepaid, printed postcard for follow-up services. Every adopter of sterilisation or copper-T is given this card with instructions to post it if they feel that they are not receiving appropriate follow-up services. On receiving these cards, the Directorate takes action against the concerned worker.

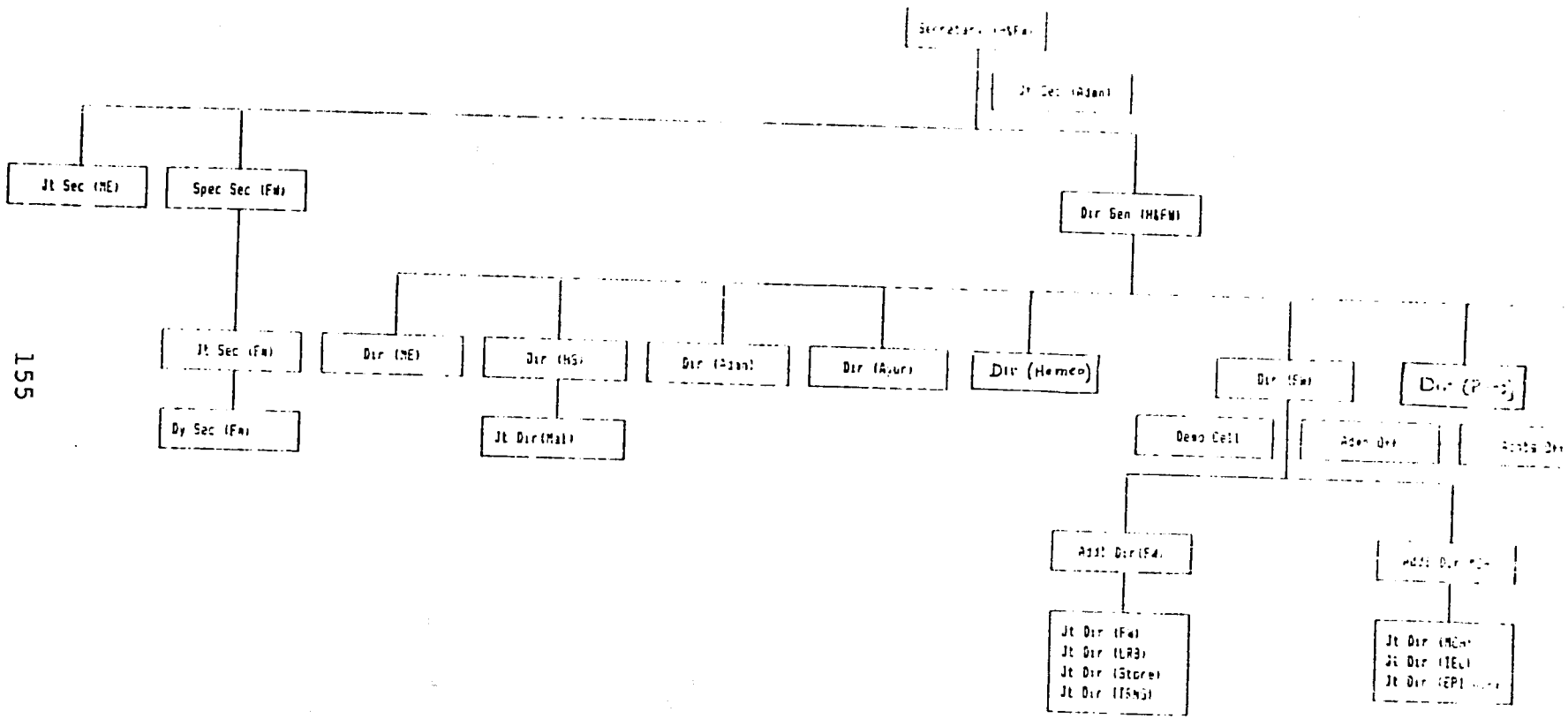
FUTURE PLANS

The Population Centre is making every effort to introduce the new MIS. The thrust areas of this system are the Family Welfare, MCH, Immunisation, Control of TB, Leprosy, Malaria, Diarrhoea and Blindness Programmes. Altogether 15 formats have been developed incorporating all the information related to these programmes. These formats will be manually filled in and/or collated at different levels, from the subcentre to the Districts, and then sent to the Demographic and Evaluation Cell for further analysis. The D&E Cell will feed the data to the computers, and the output tables will be sent to the Government of India and to various Programme Officers.

The Population Centre claims that the new MIS will have sufficient scope to monitor the programmes with the help of input and activity indicators. They further claim that the performance of the programmes can be improved if the Programme Officers take necessary corrective steps. However, the Officers of the Directorates have reservations about the reality of this prediction. Moreover, the D&E Cell is not prepared to take the task of collating and analysing data for any programmes other than Family Welfare. In view of these differences, it is difficult to predict the future of the new MIS.

APPENDIX I

ORGANIZATION CHART OF UP MOHFW
SECRETARIAT & DIRECTORATE



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN UTTAR PRADESH

1. Health Secretary
2. Joint Secretary (Family Welfare)
3. Director General (Health and Family Welfare)
4. Director General (Health Services)
5. Additional Director (Family Welfare)
6. Additional Director (MCH)
7. Additional Director (Hills)
8. Joint Director (Family Welfare)
9. Joint Director (Urban)
10. Joint Director (Training)
11. Joint Director (MCH)
12. Joint Director (EPI & UIP)
13. Deputy Director (Demography)
14. Deputy Director (Malaria)
15. Director of the Population Centre
16. Joint Director of the Population Centre

VACANT POSITIONS

1. Director (Family Welfare)

POSITIONS THAT COULD NOT BE INTERVIEWED

1. Joint Director (IEC)
2. Accounts Officer
3. Joint Director (Malaria)
4. Joint Director (Stores)

WEST BENGAL

STATISTICS

Area: 88,752 sq km

Number of Districts = 16

Population 1981 census: 54,580,647
Projected Population 1988: 62,542,000

Number of Eligible Couples per 1000 pop. = 162.4

Eligible couples (000's) = 9,852

Birth rate = 29.4

Death rate = 9.6

Infant mortality rate = 74

CPR (%) = 27.2

BACKGROUND

The management information system in West Bengal has recently gone through a metamorphosis. The process of introducing the major changes as part of India Population Project has been unique. First, the Directorate Officers, headed by the Joint Director (MIS), visited several States (Andhra Pradesh, Karnataka, Kerala, and Maharashtra) to obtain firsthand knowledge of the new information systems introduced in these States a few years back. A report based on field-level observations of new systems in these States formed the basis for further discussions on the need to introduce changes in the management information system in West Bengal, to integrate reporting formats, and to modify registers. Following these discussions, the change process was set in motion. The Joint Director was entrusted with the responsibility of preparing new registers and report formats, with an emphasis on simplifying, integrating, and avoiding duplication. Registers were redesigned, pretested, modified, and finalised to the satisfaction of all Program Officers concerned.

One significant decision taken by the West Bengal Government was to introduce the new MIS in the entire State, unlike most other States which largely limited changes to the Project districts. After this decision, integration and standardisation of monthly report forms was taken up. This task could not be accomplished in one stroke because of the difficult but important task of accommodating to the different needs and interests of Programme Officers in charge of various vertical programmes. Several meetings were conducted to arrive at consensus. Integrated Subcentre Monthly Reports and PHC Monthly Reports were pretested and standardised. All these forms have been centrally printed and supplied to the subcentres, PHCs, and Districts. A

village-level modified eligible couple register, known as the Eligible Couple and Children Register, has now been printed and supplied to all workers in the State, with the intention of using it for the next three years. (The previous eligible couples register had not been supplied to workers for the past 25 years).

Computors who consolidate the information collected from subcentres at the PHC level were given a week's training on the new MIS. This was followed by one-day training for Block Medical Officers and first-line supervisors and three-day training for District-level Officers.

District statistical cells have been strengthened by adding one full time Statistical Officer, one computer, and one typist. All Districts have been supplied with a typewriter and a duplicating machine. The new information system is now operational in all subcentres, PHCs, and districts in West Bengal. It has not yet been introduced at the State level.

ORGANISATION STRUCTURE

In West Bengal, the Secretariat consists of one Secretary, one Special Secretary, and two Joint Secretaries. While the Secretary has overall responsibility for Health and Family Welfare services, the Special Secretary looks after only Family Welfare activities. This means that Family Welfare receives twice as much attention as health. One of the two Joint Secretaries is responsible for Health and the other for Family Welfare. (All the Secretariat-level Officers were in position at the time of the interview.)

At the Directorate level, the Department of Health and Family Welfare is headed by the Director of Health Services. Reporting to him are the Additional Director (Family Welfare), Additional Director (Administration), and Joint Director (Public Health and Communicable Diseases). The Additional Director (Family Welfare) oversees one Deputy Director (Family Welfare), three Assistant Directors (IUD Training, MCH, and EPI), the Joint Director (MIS), the State Mass Education Information Officer, the Stores Officer, and the Administrative Officer. The Additional Director (Administration), is assisted by Deputy Director (Administration). The Joint Director (Public Health) oversees five Deputy Directors: Equipment and Stores, Planning and Development, Malaria, Leprosy, and Epidemic Control.

The organisation structure in West Bengal is similar to that of other States, with emphasis on vertical programs and with differentiation between Family Welfare and Public Health services. While the Secretaries, the Director of Health Services, and the Additional Director of Administration sit in the Secretariat, the other Officers have their offices in different buildings. The physical location of Family Welfare, Malaria, Mass Media, and Stores offices at different places often makes communication and coordination difficult. In addition, vertical program structures are not particularly compatible with the integrated objectives of Health and Family Welfare. To overcome this problem, the District and State-Level Officers are advised to look into all programmes during their supervisory visits. It is not clear how well this arrangement is working.

The presence of the Joint Director (MIS), helped by the Assistant Director (MIS), shows the importance given to data consolidation and analysis. Similarly, the presence of the Additional Director at the Secretariat mainly to look after administrative matters clearly illustrates a concern with overall management.

The present structure, with its emphasis on vertical programmes, has to interact with an integrated management information system. This is likely to have some impact on the functioning of the new management information system. Though many of the Officers at the State level think that the current structure is antiquated and requires major modifications, no attempt has been made in that direction.

PROFILE OF RESPONDENTS

All the Officers in the West Bengal Directorate and Secretariat were interviewed with the help of either an interview schedule or checklist, except the Secretary of Health Services and Director of Health Services. The Secretary was away in Delhi attending a meeting and the Director was busy with the Health and Family Welfare discussions in the Assembly. All Programme Officers interviewed have post-graduate qualifications in medical sciences. The Deputy Director (Malaria) was interviewed on the day he was supposed to retire. A few Officers, though stationed at Directorate for more than one year, have been given either new portfolios or additional responsibilities. The Director of Health Services and Additional Director of Administration are about to retire in a few months.

The seniority list and service rules for promotions are considered to be clear, though there may be administrative delays in the promotion of officers to vacant positions. For instance, the replacement for the Deputy Director (Malaria) was not announced till his retirement day. All Technical Officers are expected to make field visits and supervise the activities of the District, but the number of days different officers spend in the field vary greatly.

The Joint Director (MIS) has a statistical background appropriate to his role in directing the management information system. He is assisted by an evaluation team to conduct studies and carry out reliability checks. The mass media unit presents a less optimistic picture. While the posts at State level are filled, the District Media Officer positions are vacant in all 18 Districts. Efforts by the State Government to recruit qualified persons for these positions have often been frustrated due to prolonged legal battles.

REPORTS AND THEIR RELIABILITY

Most of the Family Welfare information reaches the Joint Director (MIS) in the form of a report called 'Achievement of Family Welfare Programme by Centres.' This is a simplified version of the forms supplied by the Centre which still retains all the information needed. Reports for urban and rural centres are different. Information collected through these reports includes targets given for the year, achievement during the year, and progressive totals. The printed forms, given to the

Districts, list the names of all institutions in a District. Two different reports are used for the Immunisation Programme -- one for EPI Districts and the other for UPI Districts. Though most information collected for both reports is the same, EPI Districts are required to provide additional information on prophylaxis against nutritional anaemia and blindness among children. The District Statistical Officer is responsible for sending information to the Joint Director (MIS) at the State level; the Joint Director in turn consolidates the data and carries out separate analyses to highlight performance in regard to sterilisations; IUDs; CC and oral pills; DPT, Polio and BCG; DT/TT and Measles; TT 10 and 16 years; Vitamin A; and Folifer Mother and Child.

Targets given to the Districts form the basis for analysis of performance, though the extent of the analysis varies from one programme to another. Target setting is done on the basis of weighting various indicators. Population size and infrastructure are, for example, weighted at 40% apiece, and female literacy at 10%. Adjustments are made in the target figures based on performance in previous years. At the District level, each of the sterilisation and IUD reports contains annual and proportionate targets and achievement figures up to the month under consideration. Based on this, the percentage of achievement is calculated against annual and proportionate targets. For other programme activities like oral pills, condoms, MCH, and EPI, achievement figures are given up to the month under consideration, and the percentage of achievement is calculated against annual targets. All PHCs in a district are ranked on the basis of performance for each separate set of activities. A consolidated statement for all the institutions is then sent to the State headquarters.

Information received from the Districts is consolidated and further analysed at the State level, and the MIS section prepares three statements based on this analysis. First, a statement on achievement by method is prepared for the State. The results are compared to last year's performance for the same period, and any variations are noted. The second statement is on achievement by District and by method. The third statement is on method-wise proportional target achievement. An identical programme performance report is prepared for MCH and EPI. The emphasis in the EPI report is on annual targets, performance, and percentage of achievement for DPT, TT, polio, and measles. The Districts are ranked on the basis of proportionate targets by method achieved for each District.

The Deputy Chief Medical Officer of Health at the District level telegraphs provisional figures to the State Family Welfare Bureau before the 10th of every month and submits a detailed report with final figures by the 20th. Some Districts send their information on time while others do not, citing postal delays as the reason for their lateness. Delays in sending the information by even a single District makes it difficult to complete the analysis at the State level.

Consolidated, analysed, and ranked information is circulated to all Programme Officers. Then the Secretary sends the consolidated reports to the Centre. The Centre generally does not request any special information except for occasional parliamentary questions, usually

pertaining to vaccines, infant mortality, and performance of a particular primary health centre. In a few cases, the Centre also requests the State Government to provide information on birth rates and expenditure statements. In most of these cases special efforts are made to collect the information from the appropriate levels.

The District Statistical Officers are responsible for conducting reliability checks, and at times the evaluation teams from State headquarters are asked to do the same job. The main purpose of such checks is to identify instances of over-reporting although the respondents do not think that over-reporting constitutes a significant problem. The Evaluation Wing conducts special studies whenever a particular problem is brought to their notice For instance, a few years back a study was conducted to explore factors influencing high and low levels of performance of Districts. This study indicated that leadership is a more important factor than infrastructure facilities. At present two studies are in progress -- one on differences in performance between subcentres with their own buildings and subcentres with rented buildings, and the other on evaluation of vaccine coverage in EPI and UPI districts.

In regard to EPI Programme, the respondents observed that there is considerable under-reporting of performance, which they attribute to the fact that performance figures from the N O sector are not available. Monitoring and supervision of the EPI Programme are considered weak, so it is difficult to assess the reliability and completeness of the data provided. In cases where inconsistencies in reporting have been found, explanations were called for and corrective actions were taken. The respondents considered lack of interest among Medical Officers in carefully scrutinizing filled-in forms as the main reason for these inconsistencies.

The National Malaria Eradication Programme submits monthly reports on surveillance/vigilance data, species radical measures data, assessment of spraying, monthly hospital dispensary statistics, and clinic performance. The Districts send these reports to the Regional Director (Malaria). Again the consolidated data of all Districts are sent from the state level to the Centre in the form of eleven reports every month. The reports do not cover the targets given, the percentage of achievement, or the comparative statement on performance for the corresponding period last year. Nor is there a ranking of Districts based on performance. However, the amount of information collected is enormous, perhaps more than any one person can handle without recourse to selection and further analysis of key indicators.

NMEP Officers have accepted the new information system only with some reluctance. They attribute delays in getting monthly NMEP returns to lack of control of the field staff. For instance, it was suggested that because the Computor at the PHC level receives his salary under the Family Welfare budget head, he does not pay adequate attention to the health data. They also feel that uniform data should be collected from the States to allow inter-State comparisons. In general, the Malaria Programme Officers seem to look at new developments in the department as a way of undermining the importance and independence of NMEP. For this reason, they have resisted decentralisation of

financial powers and delegation of drawing and disbursement rights to Block Medical Officers, strengthening of the statistical cell at the District level, and centralisation of data collection and consolidation. Thus it is useful to consider all their observations on the new MIS in light of their general reaction to the changing status of the programme.

Information, Education and Communication informatio addresses targets and achievement figures of various media activities, as required by the Centre. The Districts submit this information to the State Media Officer, and the Mass Media Division prepares action plans for IEC activities in West Bengal. These plans include District-wise monthly plans on community involvement, mass media activities, workshops and conferences, and innovative schemes. The expenditures estimated to accomplish these tasks are calculated for each District. Action plans are also prepared for State-level IEC activities at the State headquarters. Advanced tour programmes of IEC Officers at the District level are obtained and approved. Analysis of data is based on targets and achievement figures, though there is no ranking of Districts. The respondents do not consider the new quarterly report formats supplied by the Centre very useful in monitoring the programme.

Expenditure statements on Family Welfare include expenditures incurred under the heads of Administration, Rural Family Welfare Services, Maternal and Child Health, Transport, Compensation, Other Services and Supplies, Mass Education, Training, Research and Statistics, and Village Health Guide Scheme. This information is obtained quarterly by the Administrative Officer from the Districts. Similarly, quarterly expenditure statements on the Malaria Programme are submitted directly to the Deputy Director (Malaria). The new MIS has, however, not taken the financial reporting systems into consideration. Delays in submission of expenditure statements are quite common; it often requires several requests before Districts send their information, and this understandably leads to delays in allocation of funds. For instance, as part of the mass media budget only one lakh was sanctioned for the entire State in the first quarter of last year; the second and third installments were released at the end of the third quarter and there was no release for the last quarter until the end of the fiscal year.

Stock registers are maintained, and the stock position on Nirodh pieces is sent each quarter to Central Family Planning Stores. There is a separate stock position report for Copper-T, and oral pills. Similarly, fortnightly reports are sent to Central Stores on the stock position of various types of vaccines. Whenever stocks are received, the Districts submit information about names of articles, quantity received, in hand and issued. There are special reports to verify stock and balance the amounts in stores at the District, State, and Central levels. The stock requirement report is done for the entire year on the basis of the set targets. Sometimes when the State asks for more supplies of a particular item, the Centre's immediate reaction is that enough supplies have already been provided. After prolonged correspondence, new forms are designed to collect data on stock position at various levels and based on the findings, decisions are taken. In such cases, the Additional Director (FW) issues special

instructions about the information to be collected. Till all the formalities are complete, the requests for new stocks have to wait.

Reconciliation of figures on the stock position of Nirodh is considered a major problem, since the data on date expiry and distribution figures at various levels are not readily available. At times, intimation about the despatch of Nirodh stocks arrives all of a sudden, even without indenting. Telegrams from the State not to send the stocks are brushed aside. Quite often, the stocks are not lifted in time because there is not enough storage space. A year back, similar problems were faced with vaccine supplies but the situation is considered better now with the introduction of quarterly indenting system.

Each PHC submits monthly reports on the number of refrigerators and vehicles functioning and out of order; the number of positions vacant; and the medicines, contraceptives and vaccines requisitioned during the month. (Refrigerators in UIP Districts reportedly function better than in EPI Districts because of special attention the former Districts receive.) Statistical Officers at the District level consolidate this information to form part of the 'Monthly Analytical Report.'

There is no regular flow of information on training, but the figures on number of individuals who have undergone special training are available from the diary of the concerned Programme Officer. For instance, we could obtain figures on total ANMs trained as part of the post-partum programme and the number of laparoscopic sterilisation teams trained from such sources. There is no training plan made based on needs assessment and no systematic monitoring or evaluation of effectiveness of training programmes.

FEEDBACK

Analytical reports prepared by the MIS Unit at the State level are sent to all concerned Programme Officers and to Officers at the Secretariat and Central levels. Based on this information, the Secretary writes to urge Districts to improve their performance. There are no regularly scheduled District Officer meetings; although about seven such meetings were conducted last year, they did not occur at any fixed time. When meetings are held, the discussion usually centres on non-achievement of targets and immediate problems associated with input.

There are regular monthly meetings at the supervisory sector, PHC, and District levels. At some of these meeting, some State-level Officers are present. Opinions about performance are expressed and administrative bottlenecks are discussed and removed.

Some of the Programme Officers are not very satisfied with the type of analytical reports submitted every month. They are of the opinion that mere compilation of data is not enough to provide useful feedback. They believe the data should be analysed in greater detail to identify trends and help develop new strategies of service delivery. This would help to overcome the problems of routine feedback. An attempt in this direction has been made recently in the Expanded Programme of Immunisation.

With the exception of Family Planning performance, the Centre gives no written feedback to other programmes. The informal comments are made in meetings at the Central level, and new instructions and targets are given. In many cases, the feedback given by the Centre is not considered very useful.

UTILISATION

The respondents consider the use of information for identification of problems and decision making the weakest link in the chain of activities under the new MIS. Though the flow of information has been meticulously followed, at least up to the District level, the Chiefs of various units are not enthusiastic users of information. Several reasons are given for this:

- Lack of interest on the part of Medical Officers in reading the data collected

- Inadequate skills among Medical Officers to analyse the data sets and draw meaningful conclusions

- Insufficient delegation of authority to handle the problems at one's own level.

A few of the Officers feel that the new MIS has just created a statistical superstructure and that not enough is known to plan the activities. Some of the Programme Officers commented that mere service statistics based on targets are not useful in improving program effectiveness and that information on quality of services should form a part of the system. They believe that what has to be done is to improve base-level information to identify the target population. Whatever might be the reasons, lack of utilisation of information remains a major constraint.

West Bengal has systematically reviewed the old MIS and introduced the new system in its place, up to the District level. Integration of formats for various programmes, training of supervisors at various levels, supply of registers and formats, and emphasis on timely flow of information are significant attributes of the new system. However the new system places no emphasis on key indicators. In fact, most of the data collected was part of the old system. Reluctance on part of Programme Officers to simplify the system was one of the major problems faced at the design stage. (For instance, the Malaria Program Officers insisted on the supply of subcentre-level data to the District level.) The new system does not cover the financial aspects of programmes, and coverage of supplies is not very effective, though there has been some emphasis on these aspects at the District level. Monitoring of outputs, particularly Family Planning Programme performance, takes precedence over the inputs. Target and achievement figures form major part of discussion in all meetings and supervisory visits.

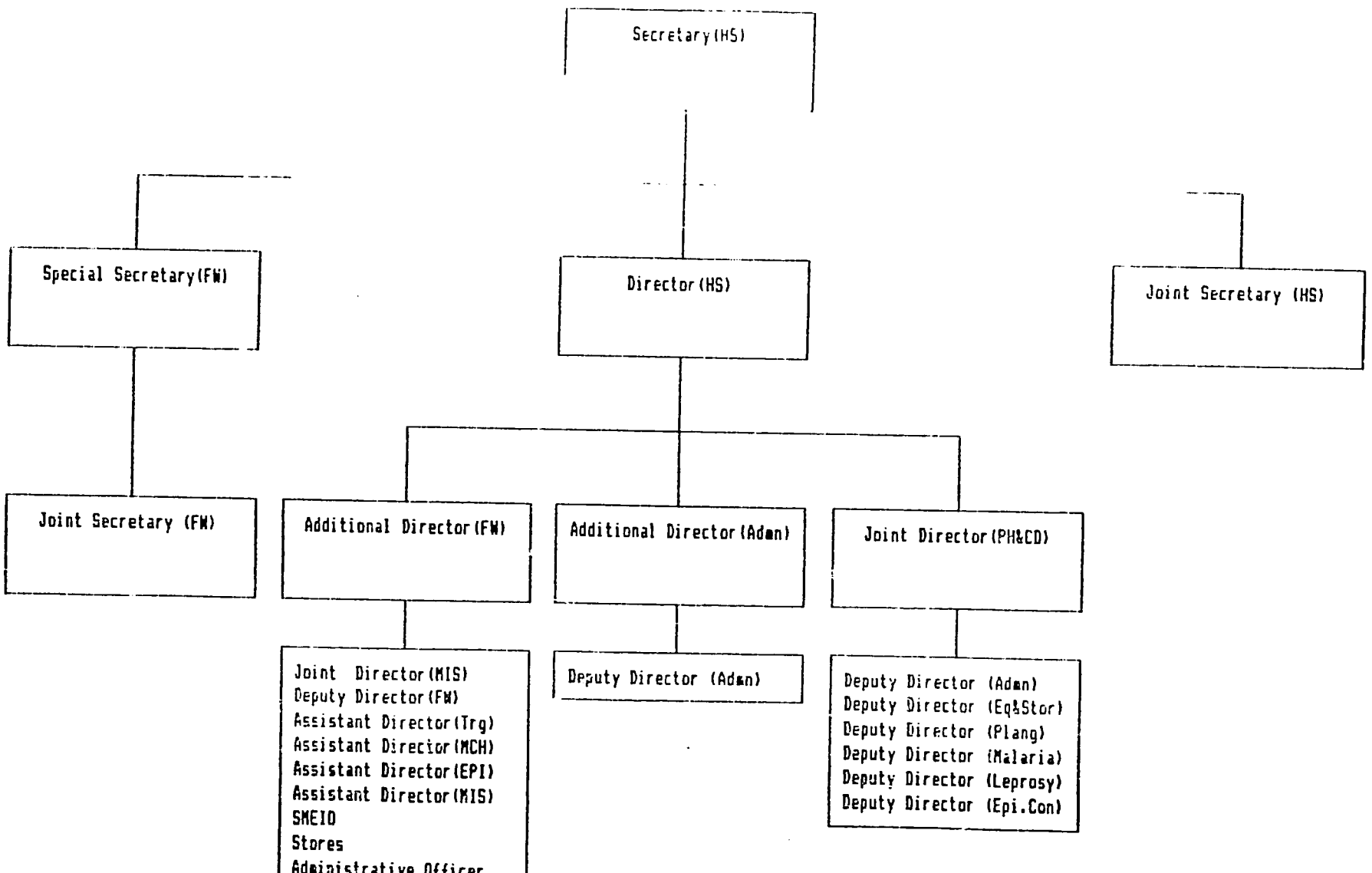
FUTURE PLANS

West Bengal's immediate priority is to extend the new MIS to the State level. This will require considerable work to convince many Programme

Officers at the State level to accept the integrated system without disturbing the present structural arrangements of the organisation. There is a general awareness of inadequate use of information generated at various levels. Training programmes are planned to help improve the skills of decision makers to interpret data; not many at the Directorate level have gone through training themselves. Such training programs should cater to the specific needs and requirements of Officers in West Bengal. Another set of activities planned is to establish trends in performance for various programmes and to derive meaningful conclusions with the goal of developing alternate strategies for service delivery. All these activities, when complete, are expected to further strengthen the new management information system.

APPENDIX I

Organization Chart of West Bengal MOHFW
DIRECTORATE&SECRETARIAT



APPENDIX II

OFFICERS INTERVIEWED IN THE SECRETARIAT AND DIRECTORATE IN WEST BENGAL

1. Special Secretary (Family Welfare)
2. Joint Secretary (Family Welfare)
3. Additional Director (Family Welfare)
4. Additional Director (Administration)
5. Deputy Director (Family Welfare)
6. Deputy Director (Family Welfare)
7. Assistant Director (Training)
8. Assistant Director (EPI)
9. Joint Director (MIS)
10. Assistant Director (MIS)
11. Stores Officer
12. Administrative Officer
13. Deputy Director (Malaria)

APPENDICES

APPENDIX I

STATE LEVEL SURVEY STATISTICS

STATE LEVEL SURVEY STATISTICS

	State	Population* (in 000's)	No. of ECs per 1000 population	CPR @ (%)	Eligible couples (000's)	Crude birth rate **	Crude death rate **	Infant mortality rate
1	Andhra Pradesh	[illegible]	131.6	32.6	11378	33.9	10.3	83
2	Assam	22783	44	24.3	3383	34.3	13.2	111
3	Bihar	[illegible]	132.7	18.3	14827	37.8	15.0	105
4	Gujarat#	34235	160.1	33.0	6437	33.0	10.6	98
5	Haryana	13513	134.5	33.6	2552	35.7	8.1	85
6	Himachal Pradesh	4866	137.5	33.5	815	30.2	10.5	84
7	Jammu Kashmir	6335	153.1	17.6	1106	33.6	9.9	85
8	Karnataka	[illegible]	163.5	33.2	7026	29.6	8.8	63
9	Kerala	25782	146.0	39.0	4202	23.3	6.5	31
10	Maharashtra	[illegible]	172.8	42.3	12457	29.0	8.4	88
11	Madhya Pradesh	66626	177.3	27.5	10773	33.4	14.2	122
12	Orissa	28832	165.7	30.6	4953	30.7	14.0	132
13	Rajasthan	41235	178.2	21.3	7279	33.7	13.2	108
14	Tamil Nadu	54178	163.0	39.5	8156	24.7	9.5	81
15	Uttar Pradesh	128241	174.3	15.3	22352	37.6	15.8	142
16	West Bengal	62542	162.4	27.2	10157	29.4	9.6	74

* Projected population figures 1988

@ As of March 1987

** Estimated figures for 1985

\# The population has been estimated for Gujarat

APPENDIX II

EXPERIMENTS IN M.I.S.

1. Andhra Pradesh

New registers were designed for subcentre-level workers and integrated monthly report formats were developed combining all programmes. The experimentation was done in three Districts as part of India Population Project II.

2. Gujarat

Experimentation is being done in one District to integrate the information systems being used by the State with the newly introduced MIS designed by the Central Bureau of Health Intelligence.

3. Haryana

The reporting formats for the National Malaria Eradication Program were streamlined and computerisation was done as part of Integrated Rural Health Project. After the Project, no further development took place.

4. Jammu & Kashmir

Formats with four different colours were designed to report on curative, promotive, and preventive aspects and establishment details. These reports cover all the information collected in the earlier system, and only the format design is different.

5. Kerala

Key indicators were identified for all programmes and an integrated report format was introduced all over the State. The new system runs parallel to the old system. Computerisation of performance data is done at the State level.

6. Maharashtra

The State developed its own reporting formats in 1981; these were modified in 1987. Recently two more experiments were started, one with technical assistance from ESCAP and the other by GOI, in one District each.

7. Uttar Pradesh

In 13 Primary Health Centres, the card system for maintenance of household records was introduced as part of the India Population Project, but later withdrawn.

8. West Bengal

The number of registers at village level was reduced; registers were printed and supplied to all workers. New integrated report formats were developed and introduced. Training was imparted to personnel at various levels.

9. Central Health Intelligence Bureau

A new integrated report format was designed and introduced at the District level in all States. The Districts are supposed to send information directly to the Centre. Not many Districts report, but the system continues.

APPENDIX III

LIST OF REPORTS

All the reports included here are the reports received from Districts or sent to the Districts by the State Health and Family Welfare Directorate. While these are common report formats used by all States, there are additional report formats unique to each State. These additional formats have not been included here, and only list of common formats are provided. The title of reports indicates their periodicity. For some, there is no well established periodicity. Reports are divided into Malaria and Family Welfare categories, and within each category sub-categories such as performance, supplies, transport, etc. have been identified.

1. FAMILY WELFARE

1.1 PROGRAMME PERFORMANCE REPORTS

1.1.1 Monthly Return on the number of sterilization and IUCD Service Units and their performance.

1.1.2 Monthly Return on distribution of conventional contraceptives to individual couples for the month

1.1.3 Monthly Progress Report on Oral Contraceptive Programmes

1.1.4 Monthly Return on Medical Termination of Pregnancy

1.1.5 EPI Monthly Surveillance and Vaccination Performance Report

1.1.6 Monthly Report on Universal Immunization Programme

1.1.7 Form for collection of statistics on maternal and child health schemes in India

1.1.8 Half yearly return on MCH services (Ante-natal care etc.) in the state for the Half year ending

1.1.9 Monthly report on mass education and media activities

1.1.10 Quarterly report on mass education and media activities

1.2 FEEDBACK REPORTS

1.2.11 Method wise Family Planning performance in the Districts for the Month

1.2.12 District wise Immunisation performance for the month

1.3 RELIABILITY TEST REPORTS

1.3.13 Summary findings of sample verification of FP acceptors - all methods

1.3.14 Summary findings of sample verification of sterilisation acceptors

1.3.15 Summary findings of sample verification of IUD Acceptors

1.3.16 Summary findings of sample verification of oral contraceptive acceptors

1.3.17 Summary findings of sample verification of CC Users

1.3.18 Statement showing the maintainance of Records/Registers

1.3.19 Details of fakes cases/cases reported twice/ineligible cases/short payments etc.

1.4 SUPPLIES

1.4.20 Annual requirement of CC, Oral Pill and IUD for the year

1.4.21 Quarterly statement showing stock and distribution of Nirodh (free supply)

1.4.22 Statement on stock of Oral Pill and CU 'T'

1.4.23 Delivery schedule of contraceptives

1.4.24 Additional information relating to the annual requirement of CC and IUD for the year

1.4.25 Stock position of different vaccines, central FW stores for the fortnight ending on _____

1.5 EXPENDITURE STATEMENTS

1.5.26 Monthly expenditure and performance of the office of the Additional Chief Medical and Health Officer (FW) under the Head of Account - "2211-FW-111-C-S-Scheme (Plan) 6 - F. Compilation for the month

1.5.27 Monthly expenditure statement of office of the Additional Chief Medical and Health Officer (FW) for the Month of _____

1.5.28 FW Programme : Expenditure under Family Welfare Programme - A centrally sponsored plan scheme (For State and for Quarter)

1.5.29 Head 2211/ Family Welfare Programme/District Wise Expenditure Report for the Quarter ending _____

1.5.30 FW Programme - Expenditure under Family Welfare Programme: A centrally sponsored Plan Scheme - State (Actual expenditure for Quarter ending ____ And Anticipated expenditure during _____)

2 NATIONAL MALARIA ERADICATION PROGRAMME

2.1 PERFORMANCE REPORTS

2.1.31 1st round spray completion report under state of - for the year _____

2.1.32 Monthly epidemological situation for the month

2.1.33 Monthly report of Malaria Programme for the month (M.F.4)

2.1.34 Monthly report of Malaria Programme for the month (M.F.5)

2.1.35 Monthly report of Malaria Programme for the month (Assessment of spray operation)

2.1.36 Passive agency including FTO report for the month

2.1.37 Annual report of National Malaria Eradication Programme (NMEP) (Surveillance/Vigilance Data)

2.1.38 Annual report of NMEP for the year (Surveillance/Vigilance Data)

2.1.39 Annual report of Malaria Eradication Programme (Species and radical treatment data)

2.1.40 Annual report of NMEP for the year (Assessment of spraying)

2.1.41 Annual report of NMEP for the year (section wise position)

2.1.42 Annual report of NMEP year - monthwise distribution of positive cases based on data

2.1.43 Annual report of NMEP year - population distribution as per A.P. 9 section wise based on _____

2.1.44 Annual report of NMEP for the year - API wise and insecticides wise, distribution of of population, sprayed in different districts based on - data in the state of _____

2.1.45 National Malaria Eradication Progrmme - Annual report for the year (Urban Malaria Sperms)

2.1.46 Annual report of NMEP year - Basic information as on (AMF IX & X have same format)

2.1.47 PHC wise data regarding Japanese encephalitis

2.1.48 Incidence of encephalitis in __ (District wise) from _____ to _____

2.1.49 Monthly FTD/DDC reports for the month _____, state _____

2.1.50 Malaria Clinic Report

2.1.51 Weekly Savingram Report

2.1.52 Monthly incidence of Malaria for (district)

2.1.53 Monthly Kala-Azar report for the month _____

2.1.54 Register of blood smear received and examined

2.1.55 Epidemological evaluation master register (section wise, village wise and month wise)

2.1.56 Suggested sections with population, PHC wise, District wise to be sprayed during 1988

2.1.57 Statement of blood slides collection for the month

2.1.58 Monthwise details of JE cases 19__ (Proforma A)

2.1.59 Monthly spraying operations report

2.1.60 District wise, Round wise percentage of population and room coverage for the year

2.1.61 Details of spray data against JE 19 _____

2.1.62 Details of malaria deaths for the month __

2.2 SUPPLIES

2.2.63 Requirement of insecticides for the year _____

2.2.64 Statement showing the position of advance allotment of insecticides made for the year - spray operation

2.2.65 Requirement of anti-malaria drugs for the year - and the stock position of last year

2.2.66 Indent-cum-receipt expenditure statement of anti-malaria drugs under Darrang district for the month _____

2.2.67 Statement showing the stock position of insecticides for the year _____ and requirement thereof for _____ spray operation

2.2.68 Staff pattern statement for the month (state)

2.3 TRANSPORT

2.3.69 Statement showing NMEP vehicle position from _____ to _____

2.3.70 Monthly NMEP vehicle report for the month (district)

2.4. EXPENDITURE STATEMENTS

2.4.71 Statement showing operational cost and M&E on NMEP (rural) in the state of _____ for the month _____

2.4.72 Statement showing the operational cost on NMEP in the state of _____ for the month of _____ total number of districts

APPENDIX IV

REVIEW OF FAMILY WELFARE PROGRAMME DURING 1986-87

The following section is intended as background information for the reader. The review of the Family Welfare Programme in India covers the years 1986-87; since that time several major policy changes have occurred. The article is nevertheless useful in demonstrating the Family Welfare Programme's past goals and accomplishments, thus shedding light on its more recent developments. The article also gives demographic information relevant to this report, including statistics on population, birth control, and fertility.

5. REVIEW OF FAMILY WELFARE PROGRAMME DURING 1986-87

Introduction: The importance of Family Welfare Programme in our socio-economic developmental plans is well recognised and needs no emphasis. The most crucial problem facing the nation today is the galloping population which has been growing at an alarming rate. The population of the country which was only 342 million in 1947 after independence grew to 361 million in 1951, 439 million in 1961, 548 million in 1971 and 685 million in 1981 as per census enumerations; the population, thus doubled in even less than 3½ decades from 1947 to 1981. India presently has 15% of the world's total population and 2.4% of the land area.

2. The country is passing through a demographic phase which is marked by a fairly high fertility and moderate mortality. Currently, the birth rate is around 32.9 (1985 SRS) and death rate is around 11.8 (1985 SRS) per thousand population with infant mortality rate of 97 per thousand live births. Population of the country as on 1st March, 1987, is estimated at around 776 million and it is increasing by about 15 million every year. This rapid increase in population has serious implications for the overall socio-economic development of the country. Success on the population front is vital for the success of all national development and anti-poverty efforts and is highest on the agenda of the Prime Minister on the overall strategy to steer the nation into the new millennium.

3. India has a multi-lingual society with wide variations in demographic situation and socio-economic conditions. People practise different religions and there are numerous cultural identities. Varying social customs and beliefs favour large family size and militate against adoption of modern methods of contraception.

4. The mean age of marriage of women is 18.3 years which is considered to be still low. About one third of the population lives below the poverty line. A vast majority of poor people still perceive children as assets in financial and other terms. There is near universal desire to have at least one or two male children. Moreover, there exist large scale variations and diversities in the demographic situation and socio-economic and cultural milieu between and within the States and regions of the country which make the programme of population control a most challenging task.

5. The National Family Planning Programme started in 1951 with a clinical approach. Extension approach was adopted in mid-sixties and since late seventies the Family Planning service delivery system has gradually expanded into a community oriented service network in which family planning services are offered as part and parcel of the overall health package of services particularly the maternal and child health and nutrition activities. Although, reduction in birth rates over the years has fallen short of the plan targets, the programme has made a significant impact on fertility. During 1970's, the birth rate declined from 40 to 34, but during 1979-84, it had been stagnating around 33. In 1985, it has come down to a level of 32.9.

6. The programme is estimated to have averted over 85 million births in the country so far. The average annual population growth rate which rose from 1.25% in '40s to 1.96% in the '50s and 2.20% in the '60s reached a plateau during 70s when the growth rate was 2.25%. Since the inception of the programme, in every plan period. there have been varying levels of shrotfalls in the Family Planning performance. In particular, the programme suffered a serious set-back during 1977-82 and picked up during the later period of the VI Plan. During the VI Plan period, achievements in sterilisation, IUD, CC and OP users were 79%, 82%, 85% and 129% respectively. During the first two years of the VII Plan, the total number of acceptors in 1985-86 was 18.92 millions and during 1986-87 this figure touched an all time high record since the inception of the programme when the total number of 20.57 million acceptors were recorded. The couple protection rate as on 31.3.87 worked out to be 37.5%.

7. POLICY ON FAMILY WELFARE PROGRAMME

The family Welfare Programme in India is

being promoted on voluntary basis as a people's movement in keeping with the democratic traditions of the country. The programme seeks to promote responsible parenthood, with a two-child norm—male, female or both-through independent choice of the family planning method best suited to the acceptor. For conveying the message of small family norm to the masses, motivational, educational and persuasive efforts are made without any resort to any form of coercion. In his recent communication to the Chief Ministers of States/U.Ts., the Prime Minister has reiterated our commitment to the implementation of the Programme on a voluntary basis. There is also no proposal to bring in any element of compulsion in family planning.

8. Family Planning services are offered through the total health care delivery system. People's participation is sought through all institutions, voluntary agencies, opinion leaders, people representatives and government functionaries. Imaginative use of the mass media and interpersonal communication is resorted to for explaining the various methods of contraception and removing the socio-cultural barriers wherever they exist. As a result of this strategy, the number of acceptors of various methods of family planning has started registering an increase from year to year.

9. NATIONAL DEMOGRAPHIC GOALS

The long-term goal is to reach Net Reproduction Rate of Unity (NRR: 1) by 2000 A.D. with a birth rate of 21, death rate of 9, infant mortality rate of below 60 per thousand live births and couple protection rate of 60 percent. According to the 7th Five Year Plan objectives, the goals to be reached by 1990 (medium term goals) are birth rate of 29.1, death rate of 10.4 and infant mortality rate of 87 per thousand live births and couple protection rate of 42 percent.

10. STEPS TAKEN TO IMPROVE PROGRAMME PERFORMANCE UNDER THE FAMILY WELFARE PROGRAMME

(i) In order to ensure maximum utilisation of infrastructure available under the Family Welfare Programme, a procedure has been laid down to schedule weekly camps at each P.H.C. area for provision of family welfare services and also one day weekly camp at sub-centre level for IUD insertions.

(ii) Performance under the Family Welfare Programme is being reviewed periodically in the meetings of the State Health Secretaries.

(iii) To meet the shortfall in achievement of targets under spacing methods, special drives were organised during the months of June, July and August, 1986. Another campaign was launched from September, 1986 with the primary objective of fully meeting the planned targets assigned to the States during 1986-87 by optimal utilisation of the available infrastucture. During 1987-88 also, Family Welfare Programme activities will be carried out on an intensive basis as was done during 1986-87.

(iv) A technical committee has been constituted to supervise the quality of services and related aspects. This Committee has already held its meetings.

(v) A scheme of Popular Committees has been introduced at State, District and Block levels. The State level committees are under the Chairmanship of Chief Minister, the District level Committees are under the Chairmanship of District Collector or a prominent social worker of the District and the block level committees are under the Chairmanship of the Pramukh of the block. These Committees are to assist the State and local administration to implement the Family Welfare Programme in a more effective manner and ensure political commitment and community involvement.

(vi) Under the Universal Immunisation Programme, 60 districts were covered during the year 1985-86 and 90 districts during 1986-87 in addition to the catchment areas of all the medical colleges in the country. During the year 1987-88, another 120 districts are proposed to be covered under the programme. The efforts at universal immunisation are expected to go a long way in reducing infant and child mortality and enhancement of acceptance of family planning.

(vii) A study was got conducted through the Indian Institute of Management, Ahmedabad into the low facility utilisation in the four poor performing States of U.P., M.P., Bihar and

Rajasthan. Follow up action on its recommendations is being taken by the State Governments concerned to bring about a qualitative improvement in the management of the programme.

(viii) Report of the Committtee on Staffing Pattern in the States/U.Ts. for Family Welfare Programme has been finalised. States/U.Ts. having been requested to formulate their proposals regarding staffing pattern in their States keeping in view their local requirements and send the same for consideration and finalisation by a Committee appointed for this purpose. New staffing pattern has to take effect from 1.4.87.

(ix) Instructions have been issued by the Ministry of Urban Development to allow the incentive rebate of ½% in interest on House Building Advance to loanee Central Government employees if they or their spouses undergo sterilisation operation after one surviving child.

(x) A decision has been taken to allow the States/U.Ts to utilise the award money at their discretion so long as it is for vital aspect of the Family Welfare Programme.

(xi) Following States/UTs. have been awarded National Awards for 1986-87

Group	'A'	Punjab	1st Prize	Rs. 2.50 Crores
		Kerala	2nd Prize	Rs. 1.00 Crores
Group	'B'	Tamil Nadu	1st Prize	Rs. 2.50 Crores
		Madhya Pradesh	2nd Prize	Rs. 1.00 Crores
Group	'C'	Uttar Pradesh	1st Prize	Rs. 2.50 Crores
		Rajasthan	2nd Prize	Rs. 1.00 Crores
Group	'D'	Goa, Daman & Diu		Rs. 0.50 lakhs
Group	'E'	D. & N. Haveli		Rs. 0.25 lakhs

11. CONFERENCE OF CENTRAL COUNCIL OF HEALTH & CENTRAL FAMILY WELFARE COUNCIL

The XIIth Joint conference of Central Council of Health and Central Family Welfare Council was held in New Delhi from 22-24 September, 1986. Resolutions passed in the Conference are given at Annexure-II.

12. AREA SPECIFIC ATTENTION

Area Specific Attention is to be given to States and within States, districts or Primary Health Centres (PHCs) requiring further attention. As the popular family planning methods currently available require clinical intervention and as health sector has been closely involved in the programme, family planning would continue to be integrated with a package of health services through an ever-expanding outreach system.

13. During the year under review, "Area Projects" continued functioning in various States with the help of foreign agencies in order to strengthen available infrastructure facilities for the Family Welfare Programme.

14. TARGETS AT NATIONAL LEVEL

The targets for 1986-87 were fixed at 6.00 million sterilisations, 3.75 million IUD insertions, 10.50 million C.C Users and 1.00 million Oral Pill users. The State/UT-wise targets were arrived at by keeping in view the following factors:-

(i) Targets and likely achievements for the year 1985-86.

(ii) Targets proposed by the States for the year 1986-87.

(iii) Targets worked out keeping in view the goal of 60% Couple Protection Rate to reach by each State/UT.

15. OVERALL PERFORMANCE

The performance in respect of different family planning methods during the year 1986-87 as compared to that in 1985-86 and in relation to targets set for the two years is summarised in the table at the next page.

(Figures in million)

Methods	Targets		Achievements		%Achievements#		%Change in
	1986-87	1985-86	1986-87*	1985-86	1986-87	1985-86	Performance in 1986-87 over 1985-86
1	2	3	4	5	6	7	8
1. Sterilisation	6.00	5.56	5.03	4.90	83.8	88.2	(+) 2.6
a) Vasectomy	—	—	0.81	0.64	—	—	(+) 26.4
b) Tubectomy	—	—	4.22	4.26	—	—	(−) 1.0
2. I.U.D	3.75	3.24	3.94	3.27	105.0	100.9	(+) 20.3
3. Other Methods (Eq. Users)	11.50	10.47	11.60	10.75	100.9	102.6	(+) 8.0
a) C.C.Users	10.50	9.51	9.83	9.39	93.6	98.7	(+) 4.7
i) Free Dist. Scheme	5.50	5.01	5.95	5.06	108.1	100.8	(+) 17.7
ii) Commercial Scheme $	5.00	4.50	3.88	4.33	77.6	96.2	(−) 10.4
b) Oral Pill Users	1.00	0.96	1.77	1.36	177.2	141.4	(+) 30.6
Total Acceptors			20.57	18.92			(+) 8.7

* Figures provisional # Worked out on the basis of absolute figures.

$ Includes C.C. Users (1986-87 = 0.72 million; 1985-86 = 0.89 million) under full cost commercial sales of condoms directly from manufacturers.

The year 1986-87 showed much improvement in the performance of the family planning programme, over the performance of the year 1985-86. In all the spacing methods viz., IUD, Conventional Contraceptives and Oral Pills, 1986-87 recorded the highest performance so far and in sterilisation, the second highest. The total number of acceptors of different family planning methods in 1986-87 was of the order of 20.57 million, an all time record figure in any year since the inception of the programme. In 1985-86, the corresponding figure was 18.92 million. Method-wise the number of Sterilisation acceptors went up by 2.6%, IUD acceptors by 20.3% conventional contraceptive users by 4.7% and oral pill users by 30.6% over the last year.

Achievements at national level in relation to annual targets were 83.8 percent in sterlisation, 105.0 per cent in IUD and 100.9 per cent in other methods (C.C. & O.P.) during 1986-87; 9 out of the 31 States/Union Territories exceeded the targets for sterilisation, 17 for IUD, 20 for Conventional Contraceptives and 15 for Oral Pills. A method-wise review of the performance is given in paragraphs below alongwith important developments under each programme.

16. STERILISATION

Madhya Pradesh, Punjab, Sikkim, Tripura, Uttar Pradesh, A & N Islands, Arunachal Pradesh, Chandigarh and D&N Haveli exceeded their targets.

Himachal Pradesh (94.4%), Karnataka (95.4%), Kerala (95.2%), Maharashtra (97.4%), Goa, Daman & Diu (96.4%), Mizoram (90.3%) and Pondicherry (95.8%) achieved 90 per cent or more than the targets. 16 States/UTs showed higher performance in 1986-87 as compared to that in 1985-86 (vide Table D.6).

17. VASECTOMY AND TUBECTOMY

The proportion of the tubectomies to total sterilisations was 83.9 per cent in 1986-87 as against 87.0 per cent in 1985-86. Of the total number of 4.22 million tubectomy operations performed during 1986-87, technique-wise break-up was available for 3.33 million operations. Of these, 1.37 million operations (41.2 percent) were done by laparoscopic technique. In 1985-86, 1.97 million operations were done by laparoscopic technique, forming 46.3 per cent of the total

number of tubectomy operations performed (vide D.11, D.12 & D.13).

18. RURAL/URBAN BREAK-UP

As per information available so far, the proportion of rural acceptors of sterilisation was 71.1 per cent (Provisional) in 1986-87 as against 71.3 per cent in 1985-86 (Vide Table F.1.1). The highest proportion of rural acceptors was from Orissa (87.9%) followed by Madhya Pradesh (79.3 per cent), Punjab (77.6 per cent) and Rajasthan (76.6 per cent) and the lowest from Kerala (47.2 per cent) amongst the major States for which rural/urban break-up was available.

19. CUMULATIVE PERFORMANCE

Since the inception of the sterilisation programme (1956), 58.79 million sterilisations (25.08 million vasectomies and 33.71 million tubectomies) were done upto the end of March, 1987, thereby recording a rate of 74.9 per thousand population. Andhra Pradesh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, D & N Haveli and Pondicherry continued to show a higher rate of cumulative performance per thousand population in 1986-87 as compared to the all-India rate 74.9 (vide D.11).

20. IUD INSERTIONS

During the year under review, 3,938,962 (figure provisional) insertions were performed as against 3,273,860 in 1985-86, thereby registering an increase of 20.3 per cent. All the States/Union Territories except Andhra Pradesh, Gujarat and Haryana had done better in 1986-87 than in 1985-86. Targets were over-reached by Assam, Haryana, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Meghalaya, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh, Arunachal Pradesh, D &N Haveli, Goa, Daman & Diu, Lakshdweep and Mizoram. Gujarat (95.9%), Madhya Pradesh (98.2%), A &N Islands (96.2%), Chandigarh (96.4%) and Pondicherry (99.6%) achieved over 90 per cent of the targets (vide Table D.7)

21. LIPPE'S LOOP & Cu. 'T'

Of the IUD insertions, for which break-up for loop or Cu. 'T' was available 3,786,351 were Cu. 'T' insertions in 1986-87 as against 3,084,284 in 1985-86, registering an increase of 22.8% (vide Table No. D.14). The proportion of Cu.'T' insertions to total IUD insertions was 96.1 per cent in 1986-87 as compared to 94.2 per cent in 1985-86. Quite impressive increase in Cu.'T' insertions were shown by Assam and Tamil Nadu.

22. RURAL/URBAN BREAK-UP

Of the IUD acceptors for whom rural/urban break-up was available, 71.7% were from rural areas in 1986-87 as against 76.0% in 1985-86 (vide Table F.1.5). The biggest proportion of rural acceptors was from Orissa (87.1%) and the lowest from Kerala (61.2%) among the major States.

23. CUMULATIVE PERFORMANCE

Since the inception of IUD Programme (1965), a total of 22.54 million insertions had been effected upto March 1987, giving a rate of 28.7 per thousand population. Gujarat, Haryana, Himachal Pradesh, Maharashtra, Punjab, Uttar Pradesh, A &N Islands, Chandigarh, Delhi and Pondicherry continued to show a higher rate of cumulative performance per thousand population in 1986-87 as against the all-India rate (28.7).

24. This Department had already issued instructions to the States regarding utilisation of the services of trained PHN/LHVs for the insertion of both Lippe's Loop and Cu.'T'. Besides these para-medicals, ANMs are also being allowed to do Lippe's Loop insertion after their proper training in selected sub-centres. In view of the growing popularity of Cu. 'T' instructions were issued in August, 1982 that the services of ANMs may also be utilised for doing Cu.'T' insertions in the selected sub-centres subject to certain conditions (i) only experienced and properly selected ANMs who have rendered a minimum of 5 years' service may be trained in the insertion of Cu.'T' at 'A' type teaching and non-teaching Post Partum Centres, (ii) only those ANMs who have successfully inserted atleast 25 Cu.'T' may be allowed to undertake the work.

25. CONVENTIONAL CONTRACEPTIVES

Nirodh, a widely used male contraceptive is being provided under the Family Welfare Programme through the following Schemes, besides open market sale (under brand name by manufac-

turing companies at a price which the market can bear) and Social marketing:-

(i) **FREE DISTRIBUTION:** Under this Scheme, Nirodh is being made available to eligible couples free of charge through the Primary Health Centres and Sub-Centres in rural areas and hospitals, dispensaries, M.C.H. Centres and urban Family Welfare Centres in urban areas. In addition to Nirodh, other contraceptives like Jelly Cream, Foam Tablets and diaphragms are also made available and the choice of selecting a method is left entirely to the eligible couples.

(ii) **DEPOT HOLDER:** Under this scheme, Nirodh in a pack of 6 pieces supplied through the Village Health Guides Kits and Village Health Guides are allowed to sale the same at a price not exceeding 50 paise and retain the entire sale proceeds as their incentive. During 1985-86 this scheme was extended to all the States.

26. During 1986-87, a total of 707.46 million pieces of condoms (net after deducting those supplied to vasectomised cases and free samples in fairs, etc.) including those under commercial scheme and direct sales to public by manufacturers, 625 diaphragms, 24,582 jelly/cream tubes and 4,331 foam tablets were distributed. This works out to 9.83 million Conventional Contraceptive users (provisional) as against 9.39 million in 1985-86, thereby registering an increase of 4.7 percent. At national level, achievements under the free distribution scheme surpassed the targets (108.1%). Assam, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, A.&N. Islands, Arunachal Pradesh, D.&N. Haveli, Delhi, Goa, Daman & Diu and Pondicherry exceeded their targets under the free distribution scheme (vide Table D.8).

27. The procurement is made through the DGS&D from the supplying firms viz. M/s Hindustan Latex Ltd., Trivandrum, M/s London Rubber Co., Madras and M/s LORCUM, Bombay in case of Nirodh and M/s Ethnore in the case of contraceptive cream and applicators.

28. COMMERCIAL MARKETING OF NIRODH

For promoting the use of Contraceptive for spacing Social Marketing of Nirodh was launched in 1968 with the active participation of leading companies both in Public and Private Sector. At present 12 Giant Consumer Goods, Pharmaceuticals and Oil Companies viz. Brooke Bond, Hindustan Lever Ltd., I.T.C., Tata Oil Mills, Union Carbide, I.D.P.L., Smith Stainstreet Pharmaceutical, Indian Oil, Bharat Petroleum, Hindustan Petroleum and Arsan Match Company, Sivakasi, having a wide net work of marketing and capabilities are engaged in Social Marketing of Nirodh. The product is made available through over 3 lakhs outlets of these companies both in rural and urban areas at a highly subsidized price. Areas have been earmarked for the companies. Two brands of Nirodh-'Dry Nirodh' at a price of 25 paise for 3 pcs. and 'lubricated Nirodh' under the brand name 'Deluxe Nirodh' at a price of Rs. 1/- for 5 pcs. are being sold. A third product to provide product choice to the acceptors under the brand name 'Super Deluxe' is proposed to be launched during 1987-88. This will be of thinner variety, lubricated and coloured and will be sold by the companies to the consumers at a price of Rs. 2/- for 4 pcs. In addition to Social Marketing, Condoms are also being sold by the manufacturers under their own brand names.

29. The Companies involved in Social Marketing are selling Nirodh as one of their own product. The programme is supported by an intensive advertising and publicity campaign using all available mass media. Publicity campaign through TV, Radio and Cinema is being carried out through DAVP and other publicity campaigns like Press advertisement, Printing of POP material, Out-door publicity, Display contest, participating the Melas etc. is being carried out by the Marketing Companies in their own areas of distribution. The objective of the campaign is to project Nirodh as a simple non-clinical dependable contraceptive methods for spacing. For carrying out this publicity campaign as well as trade incentive to the field force, the Department of Family Welfare is providing assistance to the Marketing companies@ 3 paise per piece sold. In addition, the Marketing companies are also contributing one paise per piece from their own sources for this activity. The companies involved in Social Marketing in addition to selling Nirodh for spacing are also promoting the concept of small family norm.

30. The Social Marketing Programme picked up considerably during 1985-86 when the sale

recorded an increase of 22% over the sale during 1984-85. However, during 1986-87 though a target of 315 million pcs. was fixed but the sale recorded is only 227.76 million pieces. This was mainly due to:

i) Non availability of supplies in proper mix due to lock-out in LORCOM Protectives, Aurangabad, which was supplying about 200 million pieces for the programme every year.

ii) Delay in receipt of supplies from UNFPA.

iii) Delay in launching of Super Deluxe.

The sale during the past five years was as under:

Year	Sale under Social Marketing (in million pieces)
1982-83	162.70
1983-84	198.50
1984-85	202.55
1985-86	247.94@
1986-87	227.76@

@ Provisional

In addition to 227.76 million pieces sold under Social Marketing during 1986-87, 51.88 million pieces were also sold by the manufacturers under their own brand name.

31. ORAL PILL PROGRAMME

Oral contraceptives were introduced in July, 1967 on pilot project basis under certain restricted conditions as an adjunct to the IUD programme. After sufficient experience gained during the pilot project stage, the programme was further extended in November, 1974 to all urban centres and such PHCs, which State Governments felt had adequate man-power and monitoring facilities. Instructions have been issued in August, 1977 to further extend the oral pill programme to all PHCs, with doctors.

After carefully considering the experience of other countries in this field, as well as the opinion of renowned authorities and expert panels in this country and abroad, it has been decided that oral pills may be disbributed by certain categories of para-medical personnel such as PHNs, LHVs, Graduate Nurses and those ANMs posted in subcentres regularly visited by PHC doctors, with the condition that the acceptor must be examined by a doctor within three months of acceptance of pills. A check list for selection of oral pill acceptors by para-medical personnel has been sent to the State/UT. Governments. Instructions have also been issued that the para-medical personnel employed by the Voluntary Organisations may also distribute oral pills on the same conditions.

32. The I.C.M.R. has recommended that Village Health Guides may also distribute oral pills subject to certain guidelines with the condition that the acceptors should be examined by a doctor within three months of acceptance. The recommendation has been accepted by the Government and accordingly instructions have been issued to the State Governments of Andhra Pradesh, Haryana, Uttar Pradesh and West Bengal with the stipulation that the acceptor should be examined by a doctor within three months of the use of contraceptives. Necessary precautions have been incorporated in the instructions to avoid risk factors as far as possible. The results in these States would be watched before extending the Scheme to other States.

The following two types of oral pills are supplied under the programme.

i)	Contraceptive pills	Norethisterone Acetate	1.0 mg.
		Ethinyl Estradiol	0.03 mg.
ii)	Contraceptive	Dl-Norgestrel	0.50 mg.
		Ethinyl Estradiol	0.03 mg.

33. During the year under review, a total of 230.41 lakh cycles (Figures provisional) of oral pill including those under commercial sales were distributed giving 17.72 lakhs equivalent users of oral pills as against 13.58 lakhs in 1985-86 registering an increase of 30.6% over the previous year. In terms of annual oral pill targets fixed for the year 1986-87, achievement was 177.2%. As of March 1987, there were 20,901 PHCs (including sub-centres where such facilities were available) in rural areas and 2,853 urban centres distributing oral pills (besides 21 centres for which rural/urban break-up is not available) in the country (Table-D.16).

34. SOCIAL MARKETING OF ORAL PILL

The programme for Social Marketing of Oral Pill has been under consideration for sometime and during 1986-87, series of meetings were held with the Pharmaceutical companies and the programme is likely to be initiated in November, 1987. The major decisions taken in this regard so far are as under:-

i) The brand name will be 'MALA-D'

ii) The logo and design of catch cover has been finalised in consultation with the National Institute of Design, Ahmedabad.

iii) The package of the product will be 28 tablets (21 of Oral Pills and 7 of placebo)

iv) The consumer price will be Rs. 2 -per packet.

v) The product will be sold on the prescription of a Registered Medical Practitioners.

vi) Active sales and advertisement campaign including pre-launch moves will be done before introduction.

vii) In order to enlist the support of medical practitioners Gyanecologists in the programme, 5 Regional and one national level seminar have been planned in consultation with ICMR.

IMPACT OF THE PROGRAMME

35. COUPLES PROTECTED

Taking into account the attrition due to ageing (going out of the reproductive age-group), mortality and in the case of IUD, additional factors of expulsions and removals, the number of couples currently protected, as of March 1987, was estimated at 54.94 million, forming 41.4 per cent of the estimated 132.6 million eligible couples in the country. Taking into account the use-effectiveness of various methods, which is taken as 100% for sterilisation and Oral Pills, 95% for IUD and 50% for Conventional Contraceptives, the number of couples effectively protected as of March 1987 was 49.70 million forming 37.5% of the total eligible couples. Of this, 27.9% were protected by sterilisation, 4.5% by IUD, 3.7% by Conventional Contraceptives and 1.3% by Oral Pills. Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Chandigarh, D & N Haveli, Delhi and Pondicherry have a higher percentage of effectively protected couples than the all-India average (37.5%) (Table-E.2).

36. BIRTHS AVERTED

As a result of the implementation of the programme upto the end of 1986-87, it is estimated that 9.00 million births would have been averted during the year and 85.37 million since the inception of programme.

37. FERTILITY LEVELS

The birth rate has declined from 41.2 in 1961-71 to 32.9 in 1985. The three-year moving average of SRS estimate of birth rate was 37.2 in 1970-72 and 33.5 in 1983-85 (Table B.5). Estimates of different fertility indicators (Table B.2) also showed decrease in 1984 as compared to 1972 for both rural and urban areas. Though factors other than programme performance such as increase in age at marriage and contraceptive use not reflected in programme statistics might have played a part in the reduction of fertility, there can be no doubt that the major contribution to

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* It may be mentioned that for estimating births averted, a cohort of acceptors is followed till their exit from the reproductive period on account of ageing, mortality of wives or husbands, discontinuation of use of family planning in case of non-permanent methods viz. IUD, Oral Pills and Conventional Contraceptive. Age specific fertility schedule consistent with the assumed potential birth rate of 42 or 45 in 1961, is applied to the survivours of the cohort of acceptors for obtaining estimates of births averted. The hypothetical birth rates which would have obtained in the absence of family planning programme are obtained by applying the same constant fertility schedule to the projected numbers currently married women in the reproductive age group. The resultant births rates are obtained by substracting the decline in birth rate (births averted divided by population) from the estimated hypothetical birth rates in absence of family planning.

BIRTH RATES ACCORDING TO SRS AND ESTIMATED PROGRAMME BIRTH RATES ON THE BASIS OF BIRTHS AVERTED DUE TO FAMILY PLANNING PROGRAMME 1971-72 TO 1985-86

Year	S.R.S**	Estimated "Programme birth * rates" if potential birth rate in 1961 was:	
1	2	3	4
		42.3	45.0
1971-72	36.9	36.1	38.4
1972-73	36.6	35.1	37.7
1973-74	34.6@	34.8	37.0
1974-75	34.5@	34.8	37.0
1975-76	35.2	34.7	36.9
1976-77	34.4	33.9	36.1
1977-78	33.0	32.5	34.6
1978-79	33.3	32.8	34.9
1979-80	33.7	32.9	35.0
1980-81	33.7	32.9	35.0
1981-82	33.9	32.8	34.9
1982-83	33.8	32.5	34.6
1983-84	33.7	31.8	33.8
1984-85	33.9	30.5	32.5
1985-86	32.9	29.7	31.6

** Birth rates refer to Calendar Year. The aggregate estimated for India exclude Bihar and West Bengal fot the period 1971-78.

@ SRS rates considered deficient due to relaxed supervision.

* Refer to preceding page

the decline was from the programme. This is also brought out by the decline in the birth rates* estimated on the basis of programme statistics which are given in the table at the next page.

38. GROWTH RATE FROM CENSUS

In spite of the steep fall in death rate from 27.4 in 1941-51 to 12.5 in 1981, the decadal growth rate which had steadily increased from 13.31% in 1941-51 to 24.80% in 1961-71 has been steadied around 25% in 1971-81. As against 8 of the 31 States and Union Territories, with 13% of the population which had shown a decline in growth rate in 1961-71 over the previous decade, 15 States and Union Territories, with 47% of the population, showed a declining trend in 1971-81. Thus about half the population of the country was subject to a decline in growth rate during 1971-81.

39. CHARACTERISTICS OF STERILISATION & IUD ACCEPTORS FOR 1985-86.

Percentage distribution of acceptors by age of wife: The table-1 given at the next page presents the age distribution of sterilisation acceptors (wives) and IUD acceptors for 1985-86.

40. The mean age of wives of vasectomy acceptors in 1985-86 was 32.2 years, that of tubectomy acceptors 30.3 years and IUD acceptors 27.5 years, as compared to the mean age of 29.6 years of all the married females in the reproductive age-group in the country as of 1981. The highest proportion of vasectomy acceptors (32.3%) had wives in the age-group 30-34 years: while peak for tubectomy and IUD was in the age-group 25-29 years. The age group of 20-29 years which has the highest fertility, contributed 36.1% of vasectomy acceptors, 49.6% of tubectomy acceptors and 64.8% of IUD acceptors.

TABLE-1

Age of Wife (Years)	Percentage distribution			Percentage distribution of married women in general population (1981 Census)	Marital @ age specific fertility rate 1978	
	Vasectomy acceptors +	Tubectomy acceptors	IUD acceptors		Rural	Urban
1	2	3	4	5	6	7
15-19	0.5	0.9	5.5	11.7	175.2	197.3
20-24	8.9	14.5	30.7	21.3	270.7	278.4
25-29	27.2	35.1	34.1	21.0	243.4	204.2
30-34	32.3	30.8	19.8	17.6	181.5	123.9
35-39	23.0	15.3	8.3	15.7	122.8	73.4
40-44	8.0	3.3	1.5	12.7	62.0	28.3
45-49	0.2	0.0	0.1	—	—	—
	100.0	100.0	100.0	100.0		
Mean age (in year)	32.2	30.3	27.5	29.6		

@ Estimates of the SRS of the R.G., INDIA
+ For vasectomies, age of wife is taken into account.

TABLE-2

Age of Wife (Years)	No. of acceptors per 1000 married women					
	Sterilisation acceptors			IUD acceptors		
	1983-84	1984-85	1985-86	1983-84	1984-85	1985-86
1	2	3	4	5	6	7
15-19	2.1	2.5	2.7	9.2	9.6	12.1
20-24	22.2	19.4	24.8	27.4	29.7	36.7
25-29	57.8	52.7	62.2	27.2	33.2	41.6
30-34	65.5	61.3	67.5	18.7	22.8	28.8
35-39	42.7	32.6	39.7	8.1	10.5	13.6
40-44	12.6	9.2	12.0	1.6	2.7	3.2
Total (15-44 years)	36.9	32.6	38.3	17.4	20.4	25.8

41. Number of acceptors per 1000 married women in different age groups during the years 1983-84, 1984-85 and 1985-86 are given in the above table.

The Table-2 above reveals that the acceptance rate per 1000 married women in case of sterilisation was highest among women in the age-group 30-34 years followed by women in the age-group 25-29 years. In case of IUD, the acceptance rate was found highest among women aged 25-29 years during the years 1984-85 and 1985-86. The proportion of married women in the highest fertility age-group 20-24 years increased from 2.2% in 1983-84 to 2.5% in 1985-86 in case of sterilisation and 2.7% in 1983-84 to 3.7% in 1985-86 in case of IUD. This shows that the programme is showing definite improvement in respect of its potential demographic impact.

42. Trends in mean ages of acceptors of different family planning methods (1973-74 to 1985-86) are shown in Table-3 at the next page.

TABLE-3

Sl. No.	Item	Years	Vasectomy acceptors	Tubectomy acceptors	I.U.D. acceptors
1	2	3	4	5	6
1.	Mean age of wife	1973-74 to 1977-78	33.1	31.3	29.2
		1978-79	32.4	30.4	28.3
		1979-80	31.9	30.4	28.2
		1980-81	31.6	30.5	28.0
		1981-82	32.0	30.5	27.9
		1982-83	32.1	30.8	27.7
		1983-84	31.8	30.7	27.1
		1984-85	31.8	30.3	27.4
		1985-86	32.2	30.3	27.5
2.	Percentage of wives below 30 years	1973-74 to 1977-78	35.5	42.8	57.2
		1978-79	36.7	49.4	64.2
		1979-80	38.3	50.1	65.1
		1980-81	40.2	49.3	66.7
		1981-82	37.2	49.1	67.8
		1982-83	36.3	46.5	68.9
		1983-84	39.6	47.5	72.6
		1984-85	38.4	49.1	70.6
		1985-86	36.6	50.5	70.3

The above table shows that the proportion of younger acceptors in case of tubectomy had increased in 1985-86 from 1984-85 level. While the mean age of tubectomy acceptors remained at the same level during 1984-85 and 1985-86, the mean age of the wives of vasectomy acceptors and IUD acceptors showed nominal increase in 1985-86 from the level in 1984-85.

43. PERCENTAGE OF ACCEPTORS BY NUMBER OF LIVING CHILDREN

The Table-4 gives the percentage of vasectomy, tubectomy and IUD acceptors by their number of living children based on the available data for 1985-86.

The mean number of living children in the case of vasectomy acceptors was 3.4, tubectomy acceptors 3.5 and IUD acceptors 2.3. The proportion of vasectomy acceptors with three or less number of living children was 62.7% whereas the corresponding figure in the case of tubectomy acceptors stood at 60.1%. The proportion of IUD acceptors with one child was 25.3% of the total IUD acceptors enrolled in 1985-86 and that with 2 children was 34.0% of the IUD acceptors. 38.8% of acceptors had 3 or more children and should have been motivated for sterilisation.

44. PERCENTAGE DISTRIBUTION OF ACCEPTORS BY EDUCATIONAL STATUS OF HUSBAND AND WIFE 1985-86.

The educational status of the couples as shown in Table-5 indicates that the highest proportion of the women and male acceptors were illiterate. This shows that even among the illiterate community, motivation for a small family norm is strong.

45. MATERNAL AND CHILD HEALTH PROGRAMME

One of the important aspects of the Family Welfare Programme is the promotion of health of mothers and children. It creates a sense of security in the minds of parents that the children born, will live a healthy life which in turn will contribute greatly to the acceptance of small family norm as a way of life. With this objective in view special schemes have been sponsored by the Ministry of Health and Family Welfare. Under the basic MCH services the health care for mothers and children was provided as non-plan activity of the States. The States and UTs were required to furnish half-yearly reports regarding services like:– Ante-Natal, Natal and Post Natal

TABLE-4

No. of living children	Percentage distribution of		
	Vasectomy acceptors	Tubectomy acceptors	IUD acceptors
1	2	3	4
0	—	—	1.9
1	0.9	0.8	25.3
2	24.5	21.7	34.0
3	37.3	37.6	24.0
4	23.9	24.5	11.8
5+	13.4	15.4	3.0
Total	100.0	100.0	100.0
Mean number of living children	3.4	3.5	2.3
Acceptors having 2 or less (%)	25.4	22.5	61.2
Acceptors having 3 or less (%)	62.7	60.1	85.2

TABLE-5

Literacy status	Percentage distribution of acceptors of					
	Vasectomy		Tubectomy		IUD	
	Wife	Husband	Wife	Husband	Wife	Husband
1	2	3	4	5	6	7
Illiterate	46.2	38.3	49.5	39.6	39.9	31.6
Below Primary	19.6	20.8	18.1	19.2	18.9	19.2
Primary	15.9	17.0	15.3	17.7	16.2	17.5
Middle	10.8	13.0	10.1	12.5	13.1	15.2
Matric/Higher Secondary	6.0	8.1	5.4	8.2	8.3	10.9
Graduate and above	1.6	2.8	1.5	2.8	3.6	5.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

NB: Individual figures in columns may not necessarily add to 100 due to rounding off.

care of mothers as well as infants and pre-school children. During the year under review targets in respect of different schemes under MCH Programmes were set and pursued vigorously.

PROPHYLAXIS SCHEMES

The targets and achievements of prophylaxis schemes during the years 1985-86 and 1986-87 are summarised in the next page.

(in lakhs)

Prophylaxis Schemes	1985-86		1986-87	
	Target	Achievement	Target	Achievement
1	2	3	4	5
1. Prophylaxis against nutritional anaemia				
i) Mothers	140.00	180.50	186.38	200.70
ii) Children (1-5 years)	140.00	171.60	194.33	177.35
2. Prophylaxis against blindness due to Vitamin 'A' deficiency				
i) Children (1-5 years)	249.60	294.00	289.70	301.2

ACTIVITIES UNDER WORLD HEALTH ORGANISATION (WHO) PROJECT

46. STRENGTHENING OF MCH SERVICES WORKSHOP FOR STATE LEVEL MCH OFFICERS

A 3 days workshop of State level MCH officers was held during 1986 at Trivandrum. The workshop was designed to improve their knowledge and skill in efficient management of MCH Programme in respective States.

47. AWARD OF FELLOWSHIP TO STATE/ NATIONAL LEVEL MCH OFFICERS

8 fellows from Centre and States have been sponsored to see the implementation of MCH Programme in South East Asian Countries.

48. COUNTESS OF DUFFERIN'S FUND SCHOLARSHIP AND PRESIDENT'S MEDAL

Under Countess of Dufferin's fund, women medical and nursing students were awarded scholarships. 83 MBBS, 38 B.Sc. (Nursing), 8 M.Sc. (Nursing), 2 DHCW and 4 Public Health (Nursing) students were being awarded Scholarship under this programme. President's Silver Medals to 10 B.Sc. (Nurses), 30 Doctors (MBBS) best in the Universities and gold medals to 2 best Doctors were being awarded.

49. NATIONAL INSTITUTE OF MATERNAL AND CHILD HEALTH

Efforts are on to establish a National Institute of Maternal and Child Health to impart training in MCH for various categories including trainers.

50. PROGRAMME OF ORAL REHYDERATION THERAPY

To control deaths due to dehyderation from Diarrhoeal diseases, the programme of Oral Rehyderation Therapy has been taken up and a sum of Rs. 25.00 crores has been allocated during 7th Plan. During 1986-87, a sum of Rs. 116.215 lakhs have been allocated to various States and UTs for incurring expenditure on training of Medical and Paramedical workers, extensive health education of the population and supply of oral rehyderation salt. Further vehicles have been provided to 47 Health and Family Welfare Training Centres and 20 State/UT Headquarters. A budget provision of Rs. 500 lakhs have been kept for the programme of Oral Rehyderation Therapy during 1987-88.

51. THE EXPANDED PROGRAMME ON IMMUNISATION

The Expanded Programme on Immunization was started by the Government of India in 1978 with the objective of reducing morbidity, mortality and disabilities due to Diptheria, Pertussis, Tetanus, Polio-myelitis, Tuberculosis and Typhoid fever by making free vaccination services easily available to all eligible children and expectant mothers. T.T. Immunization was started to expectant mothers in 1975-76 which was integrated with EPI in 1978. Polio and Typhoid was included in 1979-80 and T.T. (School children) in 1980-81 and BCG was brought under purview in EPI during 1981-82. Measles vaccine was initiated in 1985-86.

52. PLAN OF ACTION FOR IMMUNIZATION IN THE WHOLE COUNTRY

National Immunization Programme is aimed to achieve Universal Immunisation in respect of all eligible infants and children against 7 most common vaccine preventable diseases (Diptheria, Pertussis, Tetanus, Polio-myelitis, Tuberculosis, Measles & Typhoid) and expectant mothers with Tetanus vaccine to prevent maternal and neo-natal Tetanus by the end of 7th plan i.e. 1990. The coverage is being extended over a 5 year period during VIIth Five Year Plan in a phased manner immunizing about 18 million infants and 24 million mothers every year.

Expanded Programme on Immunization will help the National Health Policy to bring down infant mortality rate from 110 to 87 in 1990 and 60 per 1000 live-births by 2000 A.D. It will also reduce peri-natal mortality rate from 67 to 30-35 and pre-school child mortality from 20 to 10 by 2000 A.D, neo-natal Tetanus mortality rate to less than 1 per 1000 live-births and reduce polio-myelitis incidence rate to less than 0.33 per thousand (0-4 years) by 1990 from the present level (1981) 1 per 1000.

53. VACCINATION PERFORMANCE 1986-87.

Performance under on-going EPI Programmes during 1986-87 (April '86 to March, 1987) was as under:-

54. TRAINING PROGRAMME ON EPI

For effective implementation and management of time bound EPI programme and to improve the skills of the Medical and Para-Medical personnel, various training programme activities are being conducted regularly since 1978. So far about 1238 Medical Officers had attended the course of Mid-level Managers at National and State level and about 609 para-medical staff have also been trained out of which [illegible] candidates were trained in 1987. The refrigerator repair technicians course to train Technicians and Mechanics employed by State Health Authorities for better maintenance and repair of the cold chain equipment was started in 1982.

55. VACCINE SUPPLY

Government of India has approved the targets for vaccination for National Expanded Programme on Immunization in a phased manner during the 7th Plan period to achieve the Universal Immunization by 1990. To meet the requirement of various vaccines for Expanded Programme on Immunization of vaccine manufacturing Institutes have also drawn up a plan proposal for the 7th plan period to augment the production of various vaccines in a phased manner. All the vaccines, except measles are being manufactured in India. Measles Vaccine is being imported from abroad through UNICEF and supplied for use in EPI programme. UNICEF is committed to supply Measles Vaccine till 1990. All the vaccines are supplied on quarterly basis and Polio is being supplied on monthly basis. All the vaccines are despatched by air by vaccine production institutes for those destinations except which are nearby and surface transport is easily available. All the vaccines are supplied without cold chain except

(Figures in lakhs)

Vaccine	Annual target 1986-87	Achievement 1986-87	Percentage coverage of target
1	2	3	4
TT	152.00	116.64	76.7
D.P.T.	153.00	115.64	75.6
Polio	153.00	102.63	67.1
B.C.G.	153.00	111.23	72.7
Measles	57.00	37.12	67.5
D.T.	121.00	107.96	89.2
Typhoid	121.00	78.42	64.8
T.T. (10 years)	67.00	52.75	78.7
T.T. (16 years)	41.00	34.75	84.8

polio, which is supplied in cold chain. The allocation of vaccines were made to States and UTs according to the target with due consideration to the performance and infrastructure available in the States and UTs and the budgetory provisions and resources available at the Centre. The allocation of vaccines to Vaccine Production Institute were made in such a way so that they can supply the vaccine to States/UTs smoothly. UNICEF also supplied 160.60 lakh doses of Measles Vaccine during 1986-87. The Annual targets, allocation of various vaccines and its utilisation by States and UTs for the year 1986-87 are as under:-

(Figures in Lakhs)

Vaccine	Target 1986-87	Total Requirement	Utilization
1	2	3	4
D.P.T.	153.00	699.42	581.95
Polio	153.00	653.25	492.68
B.C.G	153.00	198.23	144.05
T.T.	260.00	628.00	527.26
D.T.	121.00	270.70	298.33
T.A.	121.00	270.70	226.56

56. FUNDING OF THE IMMUNIZATION PROGRAMME AND ASSISTANCE FROM INTERNATIONAL ORGANISATION LIKE UNICEF, WHO ETC.

During the 7th plan period total amount allocated for the programme is Rs. 24,000 lakhs. The external assistance for the Immunization programme is mainly received from WHO pojects and UNICEF assistance which are helping to reduce morbidity, mortality and disabilities due to EPI diseases by better implementation of EPI programme in short time. WHO projects are helping in improving skill and knowledge, better planning and Management of the programme timely. UNICEF is assisting the immunization programme to large extent by providing cold chain equipments, vehicles, Syringes, Needles, training, supply of vaccines like Measles etc. as well as spare parts, chemicals and equipments to Vaccine Production Institutes.

To meet the requirement of various vaccines to achieve Universal Immunization Programme by 1990, CRI, Kasauli; PII, Coonoor and BCG Laboratory, Guindy, Madras have taken necessary steps to augment the production of vaccines. Accordingly, they had drawn up the plan proposal during 7th plan period. The fund is provided by Government of India and UNICEF is arranging imported equipments and chemicals.

57. COLD CHAIN

Under the cold chain and logistic system various equipment have been provided for transportation of vaccines from the manufacturers to the outreach areas. These include walk-in-coolers, refrigerated vans, ice-lined refrigerators, cold boxes, vaccine carriers, day carriers, thermocole boxes and delivery vans. The vaccines are despatched from the manufacturing concerned institutions which had been provided with cold rooms i.e. walk-in-coolers and refrigerator vans. Regional stores have walk-in-coolers where the vaccine is stored. Some of the states have got walking freezers. The vaccine is delivered from those States' regional stores to the district headquarters in delivery vans which can carry the cold boxes in which the vaccine is shipped. At PHC-level ILR is given. Dial thermometers to PHC @ two per PHC for recording temperature have been supplied.

58. SOCIAL MOBILIZATION AND PUBLIC INFORMATION AND HEALTH EDUCATION INCENTIVES

Efforts to augment demand generation and community participation depending upon the need of the people at large require a very high level of political commitment and concerted efforts to appropriately educate and inform the people at large for the benefits of this programme. Community participation can be increased by certain methods and group based approaches.

The following methods to enhance community participation are being used as under:-

(i) Mass Media
(ii) Inter-personnel efforts
(iii) Inter-personnel communication

In Mass Media, the newspapers, radio, TV, Cinema slides, leaflets and posters are being widely used.

As far as the group based approach is concerned, the following groups are important and are being approached for the necessary health education initiatives:-

(i) Health and ICDS workers
(ii) Political and Social Leaders
(iii) Primary School Teachers and personnel of other Government Welfare Departments.
(iv) Medical students and medical professionals.
(v) Organised and cooperative sectors.

59. MEDICAL TERMINATION OF PREGNANCY

Medical Termination of Pregnancy (MTP) is a health care measure which helps to reduce maternal morbidity and mortality which results from illegal abortions. Though this is mainly a health care measure, it can supplement family welfare planning as a large percentage of women undergoing MTP are wedded to the acceptance of small family norm and will therefore, accept family welfare procedure. The current strategy aims at widely disseminating the information about the provisions of the ACT amongst the public, para-medical amd medical profession. Training of medical personnel in M.T.P. and opening of more centres for providing services is being taken up by the States which are responsible for implementation of the Act. To get more trained hands in the field, doctors from various sources of employment e.g. Medical Colleges, District Hospitals. P.H.Cs., Voluntary Organisations and Private Practitioners are being trained in 161 'A' type Post Partum Centres (having 3,000 or more obstetric/abortion cases per annum). Crash training programmes were also conducted for Lady Health Visitors/ANMs for IUD insertions/Oral Pill administration. At the end of March '87, 5,820 institutions were rendering MTP services as compared to 5,528 at the end of March, 1986. During the year under review 584,218 MTPs were performed as against 583,704 in 1985-86. Since inception of the programme in April, '72, 5.22 million terminations upto March, '87 were effected under the MTP Act.

60. SPECIAL SCHEMES

The undermentioned schemes are being implemented as Special Schemes under the Family Welfare Programme.

(i) All India Hospitals Post Partum Programme at District and Sub-district hospitals and PAP Smear Test facilities in selected Medical Colleges.
(ii) Sterilisation Beds Scheme.
(iii) Renovation of IUD room at Rural Family Welfare Centres attached to Primary Health Centres.
(iv) Re-organisation of Service delivery outreach system in urban areas including existing urban centres. Scheme-wise details of the outlay approved for each scheme are given in Table-J.1.1.

Other relevant details of each of the schemes are as follows:-

61. ALL INDIA HOSPITALS POST PARTUM PROGRAMME AT DISTRICT LEVEL

The Post Partum Programme, a maternity centred hospital based approach to Family Welfare Programme now covers 554 Medical Institutions at National, State and District level all over the country, inclusive of 104 Medical Colleges and 2 Post-graduate Institutions. State-wise and type-wise details of Post Partum Centres established at district level are given in *Table J.1.2 and J.1.3*

The analysis of the data received during 1986-87 reveals that 14.77 lakhs obstetric and abortion cases were attended to as against 14.07 lakhs during the year 1985-86.

In all 8.93 lakhs acceptors of various family welfare methods were enrolled during the year 1986-87 as against 8.51 lakhs during the year 1985-86 and 8.40 lakhs during the year 1984-85. The progress of work done in various states under Post Partum Programme at district level hospitals is given in Table J.1.4. to J.1.7.

62. MATERNAL AND CHILD HEALTH SUPPLEMENTAL PROGRAMME AT DISTRICT LEVEL HOSPITAL

The objective of the P.P. Programme is to improve the health of the mother and the children through maternal and child health and family welfare programme which includes neo-natal, ante-natal and post-natal services by providing the facility for immunisation and vaccination for mothers and children and prophylaxis against anaemia and night blindness. The Post Partum Institutions are performing the following services under the MCH supplemental programme:-

(i) Ante-natal and Post-natal are including prevention against anaemia by multi-vitamin therapy and protection against tetanus through regular immunisation programme.

(ii) Children are provided protection against diptheria, tetanus and whooping cough by regular immunisation and pro-phylaxis against anaemia and night blindness is achieved through regular administration of Iron and Folic Acid and Vitamin 'A' concentrate. The details of comparative performance for the year 1985-86 and 1986-87 are given in *Table J.1.8.*

63. ALL INDIA HOSPITALS P.P. PROGRAMME AT SUB-DISTRICT/TALUKA LEVEL HOSPITALS

With a view to provide maternal and child health and family welfare services in rural and semi-urban areas, as well as to bring an over all improvement in the health status of the mother and the infants, the Post Partum Programme has been extended in 400 sub-divisional Hospitals during 6th Plan period. The programme has further been extended to another 300 Sub-District hospitals during the year 1985-86 and another 129 sub-district hospitals approved to 829. The programme has been sanctioned in 754 sub-district hospitals by various State Governements. Phase-wise and State-wise details of number of sub-divisional hospitals approved for extension of the programme upto 1986-87 are given in *Table J.2.1.*

According to the information received from 281 hospitals, a total of 2,04,051 acceptors of various family welfare methods were enrolled during 1986-87 as against 61,685 acceptors during 1985-86. This shows an increase of 230.8% as compared to an increase of 70.5% during 1985-86. Details are given in *Table J.2.2.* Category-wise availability of staff in respect of 337 Sub-divisional hospitals for which information could be received is shown in *Table J.2.3.* State-wise number of tubectomies per bed per annum are listed in *Table-J.2.4.* performance of MCH activities at sub-divisional level hospitals is given in *Table J.2.5.*

64. POST PARTUM PAP SMEAR TESTING FACILITIES PROGRAMME

For early detection of cervical cancer and pre-cancerous lesions among women acceptors and non-acceptors of various family welfare methods, a scheme of PAP Smear Test Facility was introduced by the Government of India in a phased manner in 25 Medical Colleges running P.P. Programme. The programme has since been sanctioned in all Medical Colleges by various State Governments. It is proposed to extend the facilities to all the 106 Medical Colleges during the 7th Plan in a phased manner of which 74 Medical Colleges have since been covered upto 31.3.87. Performance of the list of institutions approved are given in *Table J.3.1 and J.3.2.*

65. STERLISATION BEDS SCHEMES

This scheme provides for immediate facilities for tubectomy operations in the hospitals where such cases could not be admitted due to lack of facilities. Under the scheme, beds are sanctioned to these Medical Institutions/Hospitals which are run by the voluntary organisations on the basis of their performance during the previous year. Beds are sanctioned to the volunatary organisations on the recommendations of the State Governments and Regional Directors of Health and Family Welfare of the respective States. Maintenance grant of Rs. 2400/-per bed per annum is provided to each institution subject to the condition that a minimum of 45 tubectomies per bed per annum are performed. This maintenance grant of Rs. 2400/- per bed per annum has been enhanced to Rs. 3000/- per bed per annum with effect from 1.4.86 due to increase in cost of linen, medicines and salary of the staff etc. The revision in the maintenance charges for sterilisation beds are subject to the following conditions:-

(a) A sum of Rs. 3000/- per bed per annum would be admissible as maintenance grant to Government hospitals on achievement of minimum of 75 tubectomies. Local bodies and voluntary organisations would receive the maintenance grant of Rs. 3000/- per bed per annum on achievement of minimum of 60 tubectomies.

(b) In case the Govt./Local Body and Voluntary Organisations fail to acheive the minimum target of 75 and 60 tubectomies per bed per annum respectively, then the maintenance charges would be admissible @Rs. 2400/- subject to minimum performance of 45 tubectomies per bed per annum.

(c) If the performance of all types of institutions, Govt./Local Body/ Voluntary Organisation, is less than 45 tubectomies per bed per annum, proportionate grant would be admissible.

(d) If a Voluntary Organisation/Local Body Institution has received construction grant for sterilisation beds and the level of performance of that institution is below the minimum target of 45 tubectomy per bed per annum, no maintenance charges would be admissible.

A total of 3018 sterilisation beds were functioning in various government institutions/Local body and Voluntary Oranisation as on 31st March, 1987 of which 252 sterilisation beds were approved during the year 1986-87. Details of the beds constructed by ownership status is various states is given in *Table J.4.1.*

66. SCHEME FOR PROVISION OF ADDITIONAL FACILITIES FOR STERILISATION AND MTP BY RENOVATION/REMODELLING OF IUD ROOM AVAILABLE AT RURAL F.W. CENTRES ATTACHED TO PHCs.

With a view to provide improved facilities of sterilisation and MTP in rural areas, a scheme for renovation of IUD room available at Rural F.W. centres attached to PHCs. was introduced in the year 1982-83.

An amount of Rs. 24,000/-per centre has been made available for renovation of IUD room including cost of replacement of surgical equipments needed. So far, 1175 PHCs have been approved by Government of India and States have selected 1011 PHCs. Details are given in *Table J.5.1.*

67. RE-ORGANISATION OF SERVICE DELIVERY OUT-REACH SYSTEM IN URBAN SLUMS AREAS-URBAN REVAMPING SCHEME

A Working-Group on re-organisation of Family Welfare and Primary Health Care Services was constituted by Government of India for formulation of recommendations regarding additional requirements for improving the out-reach system in urban slums. These recommendations of the working group for providing additional inputs in the form of staff etc. for re-organisation of Family Welfare and Primary Health Care services in urban slums were sent to the various State Governments for sending the proposals to this Department for further consideration and approval.

As per the recommendations of the working group, all the Urban areas have been categorised into 4 types of Health Posts to be established according to the population. Similarly City F.W. Bureau have also been categorised into 4 types according to the population of the cities. During the 5th Plan, the scheme envisaged establishement/re-organisation of various categories of Health Posts in cities with more than one lakh population and having at least 40% of slum population residing in slum area.

68. PROGRESS OF IMPLEMENTATION OF THE SCHEME

The urban revamping scheme was initiated at the fag end of the year 1983-84 and only 32 Health Posts could be approved in the State of Maharashtra and Union Territory of Delhi and Chandigarh. So far the administrative approval of Govt. of India for establishment of in all 960 Health Posts and 14 City F.W. Bureaux was conveyed for the States of Haryana, Karnataka, Madhya Pradesh, Maharashtra, Punjab, Gujarat, Orissa, Rajasthan, Tamil Nadu, Uttar Pradesh, Delhi and Chandigarh. A total of 872 Health Posts and 10 City F.W. Bureaux have been sanctioned by the State Governments. The details of the Health

Posts approved by Government of India and sanctioned by respective State Governments are given in *Table J.6.1* and category-wise staff approved is given in *Table J.6.2.*

69. ORGANISED SECTOR

The Family Welfare Programme in other Ministries/Departments, Public Sector Undertakings and in the Private Sector is financed by the Department of Family Welfare. The Ministries of Railways, Defence, Labour and P & T etc. have all along been participating in the National Family Welfare Programme. Together they employ and represent the largest labour force in the country which forms a readily available compact community for the furtherance of the programme. The budgetary provisions made in the budget of the Ministry of Health and Family Welfare for the Family Welfare Programme in these Ministries and Organisations for 1986-87 and 1987-88 are as under:-

target of 30,000 and 14,000 respectively. Besides there were 53,294 users of Conventional Contraceptives and Oral Pill Users.

71. The Indian Railways, the largest Public Sector Organisation in the country provides Health and Family Welfare Services to about 80 lakhs of Railway population including regular employees of the Railways and the casual labour, porters, catering staff etc. The Railways render advice and services on Family Welfare methods through network of Health and Family Welfare institutions as a staff welfare measure. The Programme is implemented through 62 Family Welfare Centres, 38 Sub-Centres, 107 Railway hospitals and 645 Health units, 2663 Nirodh Depot holders and 122 Oral Pill Distribution Centres. During 1986-87 the Railways performed a total of 20,250 sterilisations and 9,284 I.U.D. insertions against a target of 40,000 and 20,000 respectively. Besides, there were 2.77 lakhs users of Conventional Contraceptives and Oral Pills users.

BUDGETARY PROVISION FOR
1986-87 & 1987-88

(Rs. in Lakhs)

1	2	B.E. 1986-87	B.E. 1987-88
		3	4
1.	Ministry of Railways	214.50	248.00
2.	Ministry of Defence	152.00	162.00
3.	Ministry of Labour	92.00	92.00
4.	D.G.P. & T	4.00	5.00
5.	Department of Coal	4.00	4.50
6.	Border Roads Development Organisation	0.10	0.10
7.	N.C.U.I. Project under Ministry of Agriculture and Cooperation	12.00	13.00

70. The Ministry of Defence is running the Family Welfare Programme through 139 Family Welfare Centres established in the Armed Forces Hospitals in various stations under the administrative control of three Defence Services Headquarters and the Directorate General Ordinance Factories, Calcutta. Comprehensive Family Welfare coverage including Maternity and Child Health Care is provided in these Centres. MTP facilities are also provided in these hospitals. The performance during 1986-87 were 18,789 Sterilisations and 11,519 I.U.D. insertions against the

72. The Family Welfare Programme further continued during 1986-87 amongst workers employed by the various agencies coming under the purview of the Ministry of Labour. The Ministry of Labour has been coordinating the Family Welfare Programme in the Organised Sector, which are being executed through UNFPA/ILO assisted projects on Population Education and Family Welfare. For this purpose, a small cell has been set up in the Labour Welfare Division of the Ministry of Labour. The projects being im-

plemented relate to Textile Labour Association, Ahmedabad.

Indian Tea Association, Calcutta; Comprehensive Family Welfare Education Programme for the Organised Sector through the State Labour Department of Andhra Pradesh, Family Welare Education for Organised Sector workers through State Labour Centres, Maharashtra, Assam Branch of India Tea Association (ABITA), National Cooperative Union of India Phase-II on Sugar Industries, All India Organisation of Employers, Employers Federation of India Phase-II and Employees' State Insurance Corporation. Two proposals One for a Family Welfare Project for Beedi Workers and another for Introduction to Population Education as an Integral of Social Studies into Vocational Training in India have also been cleared by the Ministry of Health and Family Welfare and sent to UNFPA for approval.

73. The Posts and Telegraphs Department also continued their efforts of motivation and education of eligible couples and free supply of Nirodh through 54 P&T Dispensaries functioning all over India during the year 1986-87. Family Welfare staff has also been sanctioned by the Ministry of Health and Family Welfare for 27 Dispensaries.

74. Public Sector Undertakings where adequate Family Welfare facilities already exist, provide these facilities to their employees. The Department of Family Welfare also gives grant-in-aid for running of Family Welfare Centres in Public Sector Enterprises according to the approved pattern of assistance. The UNFPA/ILO are providing financial and technical support for organisations like SCOPE, FICCI and Indian Sugar Mills Association for providing Family Welfare Education and family planning services to the large labour force employed by them.

75. In the Private Sector, Government has agreed to financially support intensive motivation-cum-services projects for the Organised Sector in the Industrial Zone of West Delhi and Faridabad being implemented by the PHD Chamber of Commerce and Industry, New Delhi. These Projects aim at covering more than 50% of the target group under one method or another in family planning and would have child care centres which would also function as family counselling centres. A number of workshops and meetings have also been held with representatives of Employers' Trade Unions and Government Departments to work out the modalities of involving the Organised Sector further in the Family Welfare Programme.

76. INVOLVEMENT OF VOLUNTARY AGENCIES IN THE FAMILY WELFARE PROGRAMME

The National Family Welfare Programme seeks to promote Family Planning as a people's movement. The vital role of voluntary agencies in promoting this programme has been recognised and these have been involved from the inception. They continued to play this important role during the year 1986-87 also.

77. GRANTS TO VOLUNTARY AGENCIES ARE BEING CHANNELISED UNDER THE FOLLOWING TWO SCHEMES:-

(i) **Approved Pattern Schemes of Postpartum Centre, Sterilisation Beds, Urban Family Welfare Centres, Health Post, A.N.M. Training Centres and Opinion Leader's Camps:** These have been decentralised and the State Governments have been empowered to sanction grants upto Rs. 5 lakhs per unit per year.

(ii) **Grants-in-aid to Voluntary Organisations for Innovative and Experimental Projects:** These grants are released directly by this Ministry to Voluntary Organisations to promote new concepts and innovative ideas. Grants amounting to Rs. 99.98 lakhs were released during 1986-87 under this Scheme.

78. New initiatives have been taken to extend the programmes further and facilitate the Voluntary Organisations.

(i) **Setting up of Standing Committee on Voluntary Action:** To encourage community action and generate new ideas at grass-root levels in rural areas

and urban slums, a High Powered Standing Committee on Voluntary Action (SCOVA) has been constituted under the Chairmanship of Mrs. Sasmeeta Srivastava, Chairman, Central Social Welfare Board. Most of other members are eminent Social Workers from different voluntary organisations. The State Govt. have been requested to set up similar Committees at State Level.

(ii) **Rolling Fund:** The Family Planning Association of India, Bombay, was provided a Rolling Fund of Rs. 5 lakhs for giving Financial Assistance to Small Voluntary Organisations. A Consultancy Cell for this purpose has been set up to help small voluntary organisations to formulate small projects costing upto Rs. 1 lakh per year.

(iii) **Secretary Level Inter—Ministerial Committes:** To evolve a Policy of integration of Family Welfare with the Development Activities being run by the Ministry of Agriculture and Cooperation, Ministry of Welfare, Ministry of Labour, Department of Education, Department of Women and Child Development and the Department of Rural Development, a Coordination Committee of Secretaries was set up in October, 1986.

iv) **New Model Projects for Implementation by Voluntary Organisations Developed by a Committee of Experts:** The new project for performance linked model for MCH, Immunisation and Family Welfare activites has been finalised for providing financial assistance to voluntary agencies. This model is a new concept linking grant-in-aid with performance with substantial flexibility to voluntary agencies, for urban slums. This has been sent to State/Union Territories for implementation.

79. AREA PROJECTS:

Area Projects are currently under implementation in 67 backward districts of 15 Major States of the Country with partial assistance of 5 International/Bilateral Donor Agencies. These Projects are based on a model plan prepared by the Ministry of Health and Family Welfare and are designed to increase and strengthen facilities for delivery of Health and Family Welfare Services in an integrated manner in accordance with the approach outlined in the Sixth Plan. While the strengthening of infrastructure will be achieved in the rest of the country by the end of this century, the project Areas are to get the infrastructure and manpower in a period of Five Years.

80. The ultimate objectives of the Projects are to improve Health and Family Welfare infrastructure in the area covered and to reduce maternal and child mortality and morbidity. The various components of the Projects are:-

(i) Expanding the Health Care Delivery system quantitatively and qualitatively by providing One Village Health Guide (VHG) and one trained Dai in every village (1000 population). One Sub-Centre for every 5000 Population in the plains and one for every 3000 population in hilly and tribal areas which will be manned by 1 male and 1 female Health Worker. For every six male and female Health Workers, there will be one male and one female Health Supervisor under the Project. Additional manpower will be given basic training and the existing staff will be provided with in-service Training for upgrading their skills.

(ii) Construction of sizeable number of Sub-Centres with Quarters for HW(F) and HA(F) within the Villages to ensure regular service. This will also provide security to the female workers. Construction of certain number of RFWCs. Upgraded PHCs. with Operation Theatre and 11110 bedded Ward, quarters for medical and para-medical staff of some PHCs. as well as hostel for HW(F) training school etc. form a few major inputs of these projects.

(iii) Improving the managerial skill of Doctors of

PHCs.' Supervisory District Staff as well as para-medical personnel through proper training at appropriate institutions so that the available resources can be utilised properly.

(iv) Improving the IEC System by proper training of extension staff like District Media Officers, District Extension Educators and the Block Extension Educators in appropriate institutions followed up by refresher courses.

(v) Evolving an appropriate Management Information and Evaluation System (MIES) for concurrent evaluation of the Programme of the peripheral units through regular feed backs to these units so that the deficiencies can be rectified by taking adequate measures.

(vi) For the purpose of evaluation, the projects envisage a Baseline Survey to be undertaken at the beginning of the projects and an endline Survey at the end of the Projects so that the impact of the project inputs can be evaluated.

81. Some of the details of the projects are as under:-

Name of the Donar Agency	Name of the States covered	No. of Distts.	Project cost (Rs in crores)	Starting date of the project	Termination date of the project	Share of the Donar Agency
1	2	3	4	5	6	7
I. WORLD BANK						
IPP-II	Andhra Pr.	3	31.40	1.4.80	31.3.88	$46 M
	Uttar Pradesh	6	73.33	1.4.80	31.3.88	
			104.73			
IPP-III	Karnataka	6	71.31	1.4.84	31.3.89	$70 M
	Kerala	4	49.11	1.4.84	31.3.89	
			120.42			
IPP-IV	West Bengal	4	107.47	1.9.85	31.8.90	$51 M
II. USAID	Gujarat	2	15.76	1.8.80	31.12.86	
	Haryana	3	8.75	1.8.80	31.12.86	
	Himachal Pr.	3	14.75	1.8.80	31.12.86	$40 M
	Maharashtra	3	15.13	1.8.80	31.12.86	
	Punjab	3	12.34	1.8.80	31.12.86	
			66.73			
III. DDA (UK)	Orissa	5	33.67	1.8.80	31.3.87	£12.34 M
IV. DANIDA	Madhya Pradesh	8	24.88	1.11.81	31.10.87	D. Kr. 206.1 M
	Tamil Nadu	2	19.49	1.11.81	31.10.87	D. Kr. 176.4 M
			44.37			
V. UNFPA	Rajasthan	4	13.81	1.4.80	31.3.86	$13 M
	Bihar	11	16.51	1.1.81	31.3.87	$19 M
			30.32			

All the Project targets are to be achieved prior to the termination of the respective projects. The project in the state of West Bengal is in the initial stages of implementation and hence no tangible progress in the state has been madè in the Ist year of the Project.

82. MINIMUM NEEDS PROGRAMME (MNP)

In order to give priority to the development of Rural Health Services, Government introduced the concept of Minimum Needs Programme during the 5th Five Year Plan. The concept emerged out of the experience of previous plans that neither growth nor social consumption can be sustained, much less accelerated, without being supportive. The establishment of Primary Health Centres, Sub-centres, Upgradation of Primary Health Centres and construction of buildings of Primary Health Centres/Sub-centres and staff quarters were included in the State sector minimum needs programme. The scheme of establishment of sub-centres has been made 100% centrally sponsored from 1.4.1981 under Family Welfare Programme.

83. OBJECTIVE OF MINIMUM NEEDS PROGRAMME (MNP)

Under the MNP, the objective to be achieved in a phased manner through successive plan period by 2000 A.D. would be as follows:–

(a) One sub-centre with one health worker (Male) and one health worker (Female) for every 5000 population (3000 in tribal and hilly areas).

(b) One Primary Health Centre for every 30,000 population (20,000 population in tribal and hilly areas).

(c) One Community Health Centre upgraded PHC for every one lakh population with 30 beds (with specialised services in medicine, surgery, paediatrics, gynaecology and obstetrics and public health).

(d) One Health Guide for 1000 Rural population or one Health Guide for every village.

(e) One trained Dai for every village.

84. TARGETS DURING THE 7TH FIVE YEAR PLAN (1985-90)

In the 7th Five Year Plan, targets under the Minimum Needs Programme are:–

(a) **Establishment of 12390 Additional Primary Health Centres:** These additional Primary Health Centres will be established in areas where existing Primary Health Centres cater to relatively larger population.

(b) **Establishment of about 54,883 Additional Sub-centres:** The 100% sub-centres required by the end of the 7th plan will be 133,660 on the basis of accepted population norms. Keeping in view the capacity of ANM/Health Workers (female) and other para-medicals and constraint of financial resources, the plan proposes to establish about 54,883 additional sub-centres raising the number of 138,429 by the end of 7th Five Year Plan.

(c) **Establishment of Community Health Centres/ Upgraded PHCs:** As against the earlier policy of establishing 30 bedded Rural Hospitals by Upgrading one out of every four Primary Health Centres, Community Health Centres will be established in a phased manner, to cover one lakh population. Specialised Medical services will be provided in the discipline of medicine, surgery, paediatrics, Gynaecology and Obstetrics and Public Health. During the 7th Five Year Plan, about 1,553 PHCs will be converted into the Community Health Centres.

(d) **Completion of Backlog of Construction Components:** Apart from the above, all effort will be made to complete the backlog of construction of Primary Health Centres, Sub-centres and staff quarters.

85. PHYSICAL TARGETS AND ACHIEVEMENTS

The table at the next page gives the progress of the various components in relation to targets under the Minimum Needs Programme.

TARGETS AND ACHIEVEMENTS UNDER MINIMUM NEEDS PROGRAMME

Sl. No.	Components	No. functioning as on 1.4.80	No. functioning as on 1.4.85	7th Plan target (1985-90)	Target (1985-86)	Achvt. during 1985-86	Target (1986-87)	Achvt. during (1986-87)	No. functioning as on 1.4.87	Target (1987-88)
1	2	3	4	5	6	7	8	9	10	11
1.	Sub-Centres	47,172	83,546	54,883	6,132	6,771	8,766	8,670	98,987	9,233
2.	Primary Health Centres/Subsidiary Health Centres	7,540*	11,048*	12,377+ 13@	1,446+ 9@	1,444+ 1@	1,554	1,652	14,145	2,274
3.	Community Health Centres	217	675	1,553	298	83	278	147	905	257

@ SHC/PHCs established by conversion of dispensary.
* Combined figure for PHCs and subsidiary Health Centres functioning as on 1.4.85.

86. CONSTRUCTION COMPONENTS OF THE PROGRAMME

A brief review of the progress of the construction components of the Minimum Needs Programme in respect of the PHCs and Sub-Centres for the year 1986-87 is given at the bottom of the page.

87. MULTIPURPOSE WORKER'S SCHEME:

The scheme was launched in 1974 with the objective of establishing a health delivery system in the rural areas through a team of multipurpose workers, one male and one female for every 5,000 rural pupulation. Implementation of the scheme involves conversion of all existing unipurpose workers at different levels into multipurpose workers after suitable training. Accordingly, the training programme was initiated in 1974-75 and it was envisaged that the MPW scheme would be implemented throughout the country by 31.3.1985.

As on 1.4.87 training was completed in 349 districts. The number of various categories of personnel trained at 7 Central Training Institutes, 47 Health and Family Welfare Training Centres and at selected Primary Health Centres upto 1.4.87 is given below:-

Sl. No.	Category	No. trained
1	2	3
1.	District Level Medical Officers	1,650
2.	Key Trainers	706
3.	Medical Officers (PHC)	18,669
4.	Block Extension Educators	5,567
5.	Health Assistants (Male)	27,034
6.	Health Assistants (Female)	17,401
7.	Health Workers (Male)	88,453
8.	Health Workers (Female)	77,960

PROGRESS IN CONSTRUCTION COMPONENT UNDER MNP

Sl. No.	Components	No. of functioning as on 1.4.87	Availability of Building as on 1.4.87	
			No. constructed	No under construction
1	2	3	4	5
1.	Sub-Centres	98,987	29,007	4,302
2.	P.H.Cs.	14,145	9,046	463

88. FEMALE HEALTH WORKERS (ANM) TRAINING PROGRAMME

During the 7th Five Year Plan, it is expected to establish additional 54,883 sub-centres at the rate of one Sub-centre for every 5,000 rural population in plain areas and one sub-centre for every 3,000 population in hilly and tribal areas. Each sub-centre will be manned by one Female Health Worker (ANM), and one Male Health Worker. To train the additional required number of Female Health Workers (ANM), the training capacity has been suitably augmented by sanctioning additional training schools and also by increasing the admission capacity of the existing training schools.

According to the available information 440 training Schools with an admission capacity of 22,943 were functioning as on 1.4.87.

89. FEMALE HEALTH ASSISTANT TRAINING (LHV) PROGRAMME

One Female Health Assistant (LHV) is expected to supervise the work of 6 Female Health Workers. To train the additional number of Female Health Assistants, this Ministry has extended the training programme. Senior ANMs will be sent for additional training for 6 months after completion of their training. They will be posted as Female Health Assistants. 46 Female Health Assistant Training Schools with an admission capacity of 3,221 are functioning in the country.

90. DAIS TRAINING PROGRAMME

It has been envisaged to train at least one Dai for each village by the end of the 7th Plan and the overall aim is to train all the untrained Dais who are functioning in the country. The total number of trained Dais as on 1.4.87 was 554,090. It is proposed to train 20,000 Dais during 1987-88.

91. REGIONAL TEACHERS TRAINING INSTITUTES

To meet the shortage of Nursing Tutors and Public Health Nurses in the Health Workers Training Schools (ANM) and Female Health Assistant (LHV) Training Schools in the country, the Ministry has sanctioned 6 Regional Teachers Training Institutes to be located in the States of Haryana, Uttar Pradesh, Gujarat, Madhya Pradesh, West Bengal and Tamil Nadu. Except the State of Uttar Pradesh, all the remaining States have established their Institutes. Uttar Pradesh will establish the Institute shortly.

92. SUB-CENTRES

Sub-Centres will be established on the basis of one sub-centre for every 5,000 population in plain areas and for every 3,000 population in hilly and tribal areas. Each sub-centre will be manned by one male and one female health worker. The additional sub-centres to be established during the 7th plan period will raise the number to about 138,429 against the total requirement of 133,660.

(a) Target for the 7th plan period	54,883
(b) Target for 1986-87	8,766
(c) No. of sub-centre established during 1986-87	8,670
(d) Target proposed for the year 1987-88	9,233

93. VILLAGE HEALTH GUIDE SCHEME

The Community Health Volunteers Scheme introduced in the country on 2nd October, 1977 had been redesignated as the Village Health Guide Scheme as a 100% centrally sponsored scheme with the objective of training a local person selected by the community for Primary Health Care. On an average, one person per 1000 population of a village, is trained for three months and is equipped with a manual of instructions and a medicine kit box containing medicines besides Nirodh. A stipend of Rs. 200 per month is paid during the training. Thereafter, a monthly honorarium of Rs. 50/- and medicines worth Rs. 50/- per month are provided to the trained VHGs. The scheme suffered a set back in 1979 when it was included in the category entitled for 50% central assistance. After a detailed review in 1980, the scheme was included under Family Welfare Programme and 100% funding was resumed and a revised scheme was communicated to the States in 1981. The salient feature of the scheme was that females should be selected as Health Guides and should preferably be 30 years of age and should be residing in the village permanently. Male Health Guides were to be selected only if females were not available and preference was to be given to ex-servicemen, freedom fighter or a person known for his social

service in the village. It was emphasized that VHG should not consider his role as a source of income or a step towards future employment in Govt. The guide is meant to be a vital link between the community and health functionaries thereby ensuring community participation and preparing a cadre of volunteers selected by the community itself where social inclined people can provide primary health care services.

94. LAPAROSCOPIC TRAINING PROGRAMME

To capitalise on the increasing popularity of laparoscopic sterilisation and also to ensure that services of proper quality are provided in this regard, the Government expanded its training programme from the original eight centres at Delhi (2), Hyderabad, Jaipur, Baroda, Bombay (2), Hubli and by creating 4, more centres at Patna, Lucknow, Cuttack and Raipur. In addition, another 4 centres have been sanctioned at Uttar Pradesh, West Bengal, Tamil Nadu and Kerala recently.

A laparoscopic team consists of a doctor (Senior Gynaecologist with P.G. qualification) an operation theater nurse, and O.T. Technician. As on 31.3.87, 3251 trained teams were available in the country. Since laparoscopes are not manufactured indigenously, all necessary assistance is rendered to the States/U.Ts. to obtain these from the importing firms. A rate contract has also been finalised for the purpose. The Government also obtains laparoscopes as commodity assistance from external sources and distributes the same among the States/U.Ts. Details of number of laparoscopes/laparoscopic teams available state-wise is indicated in *Table D.13.1.*

95. ESTABLISHMENT OF 12 SERVICE CENTRES IN MICRO-SURGERY

In order to reach the goal of achieving birth rate of 21 per thousand population by 2,000 A.D., provision of service, for recanalisation operation by Micro-Surgery known as reversal of terminal methods (both vasectomy and Tubectomy) will further boost up the acceptance rate of terminal methods under sterilisation programme.

The main objectives behind the scheme is to increase the acceptance rate of F.P. Methods by increasing the technical quality of F.W. Services and reduce the rate of complications and failures, and provision of services of reversal of terminal methods when required. In this connection, establishment of 12 more recanalisation service centres in the country is under consideration, in addition to 4 recanalisation micro-surgery training cum-service centres functioning at Delhi, Calcutta, Madras and Bombay. This project is supported by UNFPA by giving 75% aid of the total budget.

96. ADMISSIBILITY AND AVAILABILITY OF VEHICLES UNDER F.W. PROGRAMME

This Ministry is committed to provide mobility to the States/Union Territories for effective implementation of Family Welfare Programme. During the year 1986-87, the emphasis was on computerisation of data on vehicles. The total data was collected, compiled and computerised. The position regarding availability and entitlement based on computerisation data during the year 1986-87 was as under:-

Entitlement	=	7715
Availability	=	7728

2. The procedure regarding provisions of replacement of vehicles was streamlined during this year. A proforma was devised and the same was circulated to all the States/UTs. This resulted in easy disposal of cases regarding replacement of 700 vehicles during the year.

3. The following norms for supply of vehicles were brought to the notice of all the States/UTs for optimum utilisation of the available fleet:-

1. PHC/RFWC	— One vehicle for each PHC/RFWC. (Supplied by GOI or UNICEF)
2. D.F.W.B.	1. One supervisory vehicle. 2. One vehicle for A.V. Unit.
3. S.F.W.B.	— 1. Two supervisory vehicles. 2. One vehicle for A.V. Unit.

4. RHFW Tig. Centre — Three vehicles for each Training Centre.

5. Post Partum Programme — One vehicle for each Centre.

4. The pattern of makes of vehicles admissible under F.W. Programme was also revised and was brought to the notice of all States/UTs as per circular No.T.11011/11/85-TPT dated 10.12.1986 (Annexure-V)

5. The case regarding replacement of UNICEF supplied vehicles at Block PHC level where no vehicle has been supplied by the Family Welfare Department was vigourously persued with the Planning Commission. With the result, the Planning Commission agreed for the replacement of these vehicles. All States/UTs were appraised of this during this year.

6. The procedure for condemnation of vehicles was further simplified for speedy disposal of condemnable vehicles, so that they are replaced in time.

97. MASS EDUCATION AND MEDIA ACTIVITIES

The success of the Family Welfare Programme depends primarily upon the voluntary and wide-spread acceptance of the concept of 'small family'. Delayed marriages and well spaced and properly-timed births are an effective way of achieving this objective. Mass Education and Media activities, therefore, form an important and integral part of Family Welfare Programme.

The Mass Education and Media activities are carried out by the respective mass education and media set-ups in the States and Union Territories as also the Mass Education and Media Division of the Ministry of Health and Family Welfare and the media units of the Ministry of Information and Broadcasting. The Central Mass Education and Media Division is the main plank on which all such activities rest. It also coordinates and monitors the media activities carried on by the State Media Units as well as media units of the Ministry of Information and Broadcasting. Besides, it designs and prepares proto-types in various media, formulates policies and provides guidelines and support for the actual implementation c the total media efforts in the country to promot family welfare and popularise the 'small famil norm'.

98. During the year, the media set-up at th centre was augmented with the induction o Adviser (Mass, Media and Communication) t provide a new thrust to the communicatio strategy. In addition, an officer in the rank o Director joined to give administrative support t the Media Division.

99. The media and education efforts undertaken so far have created high level of awareness--about 90-95 per cent with over 60 per cent expressing favourable attitudes towards family planning, according to some surveys. However, actual practice in contraception is found to be still only around the level of 38 per cent of the eligible couples. The National Health Policy envisages a higher level of acceptance and aims at pursuading 60 per cent of the eligible couples to adopt one or the other method of family planning by the year 2000 A.D.

Under the 'Cafeteria Approach' efforts are made to make the supplies and services available to the people as close to their door-steps as possible. Various methods of family planning are being popularised through the mass media and interpersonal communication so as to help the people to select and practise a method of their own choice.

All out efforts are being made to convert the existing wide-spread awareness into the acceptance and use of family planning methods by disseminating information and education not only to the eligible couples but also to the youth who are likely to enter married life in the near future. This, obviously calls for both formal and non-formal educational approach utilising the mass media, extension education and person-to-person communication.

100. The new communication strategy primarily centres round the country's commitment to achieve the twin goal of 'Health for all' and 'Net Reproduction Rate of Unity' by the year 2000 A.D. It recognises that these goals are intimately connected with the improvement of the condition of women and children. Thus, the new communication guidelines indicate areas of new thrust

including the areas 'beyond family planning'. These guidelines were communicated to all the States and Union Territories with the directions to draw up action plans for operationalisation of new communication strategy. They were requested to ensure the widest possible involvement and mobilisation of all development agencies and sectors of society directly dealing with the people and to bring about complete integration of family planning communication with primary health-care and socio-economic development programmes.

Mass Education and Media activities, accordingly, were given multi-dimensional and integrated thrust. Efforts were made to present information-education-communication activities in the form of a comprehensive package of social transformation. These activities were geared up to bring behavioural and attitudinal changes in the people so as to enable them to adopt family planning as a way of life.

101. In order to achieve programme objectives, a beginning was made in the form of a series of multi-media campaigns aimed at bringing about value-change and promote 'Planned Parenthood'. Messages related to the delaying of marriage and the birth of first child, promoting the idea of safe motherhood and limiting the family for the progress and prosperity of the individual and the community, and creating awareness about the need of raising the status of women have been infused in this multi-media campaign. Ideas like the equality of both sexes, equal responsibility of men and women for child care, child's survival and fertility control for better quality of life were also integrated into these multi-media campaigns on family welfare. The major change in the overall framework of MEM activities was that instead of having a demographic approach, value-change approach was envisaged and adopted. The States were motivated to explore the possibilities and avenues of free of cost publicity in place of paid publicity so as to enable them to save money and utilise the same for improving the quality of messages.

102. MEDIA UNTIS OF THE INFORMATION & BROADCASTING MINISTRY.

The new thrust in the communication strategy was explained to the key personnel of the Information & Broadcasting Ministry who in turn organised internal meetings at headquarters and regional level to provide suitable re-orientation at all levels. Various units of the Ministry thus continued their active support to project the message of 'planned parenthood' and 'small family norm' through their activities.

103. DOORDARSHAN

Doordarshan has now allocated one minute's free time for family welfare TV spots everyday on the national network after the Hindi news, one minute on the low-power transmitters and the Regional TV Centres. During the year 1986-87, 40 TV spots were produced and provided to Doordarshan Kendras for telecast. Every month about 150 programmes directly promoting family welfare were telecast by various Doordarshan Kendras. The coverage of the family welfare issues in the news and other programmes has also been intensified.

104. ALL INDIA RADIO

As per information available around 6,000 Radio programmes directly promoting the 'small family norm' were broadcast every month by various stations of the All India Radio. Spots on immunisation and family welfare are being regularly broadcast. Two minutes time has been allocated everyday in each transmission of the primary channels of the All India Radio for propagating family welfare messages.

105. FILMS DIVISION

33 family welfare films were produced through the Films Division. 10 films were released in the cinema theatres during the year. Prints of these films were also supplied for use by the mobile units. Every month, around 2500 film shows were organised through the Field Publicity Units of Govt. of India and around 12,000 by the mobile units of the Family Welfare Department functioning in the States and Union Territories.

106. DIRECTORATE OF FIELD PUBLICITY

During the year, all the 257 Field publicity units of the Ministry of Information and Broadcasting helped in publicising the theme of family welfare alongwith other national themes by utilising various channels of communication like films,

Songs, and Drama, group discussions, seminars, contests and competitions. 30 dedicated Field Publicity Units for family welfare have been deployed for intensive work in the high fertility districts.

107. SONG AND DRAMA DIVISION

The Division extends publicity support to the national health and family welfare programmes through Departmental Troupes and private registered parties. The division utilised selected flexible live media forms such as drama, dance drama, folk and mythological recital and puppets, folk and traditional plays etc. and reached the people in their respective folk-forms. Special drives were launched in the 25 identified high fertility districts of the country. The Division planned to present 25,000 programmes during the year. Apart from traditional mode of communication, the medium of Light and Sound was also utilised.

108. DIRECTORATE OF ADVERTISING AND VISUAL PUBLICITY

The Dte. of Advertising and Visual Publicity (DAVP) continued the advertising campaigns and arranged exhibitions at various centres throughout the country. Emphasis was laid on three themes—"Sons or daughters—two will do", "Second child after three years" and "Universal Immunization". The Ministry's pavilion—"Turning Point" in the India International Trade Fair—1986 was put up by D.A.V.P. This was done in coordination with Human Resources Development Ministry.

The special feature of the Pavilion was the provision of "On the spot facilities" to the visitors for free check-up of blood pressure, eye-sight testing and blood group identification etc. Consultation in regard to family planning and its various methods was also available. Nirodh and family planning literature were given to those who visited the family planning clinic.

The Directorate of Advertising & Visual Publicity produced material on the themes were 'Right Age of Marriage, Safer Births, Male Responsibility, Women's status, Spacing methods, Immunisation, Two child norm, Terminal methods etc. A large number of advertisements on the identified themes were released and a number of print items were produced and widely distributed. DAVP also organised "Turning Point" Exhibitions at various placed particularly in low CPR districts.

109. PRESS INFORMATION BUREAU

The bureau arranged extensive publicity for the propagation of the revised family welfare strategy in its activities during the year. Regional/Branch offices of the PIB also lent a helping hand in press briefings about the programme for coverage in regional languages. A number of articles in Hindi, English and other languages were released.

110. RAILWAY BOARD AND POST & TELEGRAPH

Meetings were organised with the Chairman, Railway Board and Secretary, Post & Telegraph with a view to making more effectve use of the channels available with them for promoting family welfare. The Railway Board issued orders for playing family welfare video spots and Radio spots on the close-circuit television and public address system functioning at the railway stations. Copies of the Video cassettes were supplied to the railway stations for use at their CCTV system.

Two postage stamps, one of 60 paise and the other of 35 paise were released by the Postal Department during the year.

An Audio Visual Slide and Sound presentation on the new strategy titled "Turning Point" was prepared. This Audio Visual presentation was shown to top opinion leaders from all walks of life i.e. Members of Parliament, State Health Ministers, Health Secretaries, Directors of Health Services, State Mass Education and Media Officers, Senior Editors, Film, Television and Radio Producers, Directors and Writers, Members of the Advertising Agencies, Representatives of Voluntary Organisations, Cooperative Unions and others.

111. MASS MAILING UNIT

The Unit comprising of Editorial, Art & Design, Printing and Distribution Wings augmented with printed material the efforts at imparting information and education on Health and Family Welfare to specific audience groups

and opinion leaders throughout the length and breadth of the country for the promotion of the 'small family norm'. During the year, the unit produced sizeable informational materials to provide effective support to the mass education endeavours. It included the two regular monthly journals, "Centre Calling (English)" and "Hamara Ghar" (Hindi) and "Jan Swasthya Rakshak" (Hindi quarterly). The editorial unit prepared folders on Immunisation—"These Diseases Kill" in Hindi and English, another "Right Age of Marriage" also in Hindi and English and a booklet on Family Planning methods "Your child by Choice and not by Chance" in both the languages.

The printing component of the Mass Mailing Unit handled about 350 jobs during the period. Some of the important jobs include 'Revised Strategy for National Family Welfare Programme' 'Your Child by Choice and not Chance', 'Technology Mission on Vaccination and Immunization', Manual on Oral Pill, IUD, Manual on Copper T, 'A summary of the Revised Strategy', Pocket Book on Family Welfare Information', 'Year-Book 1985-86'. Besides these, the press also executed jobs like transcripts of speeches, material for important occasions like Joint Councils Conference, National Conference on Voluntary Organisations, Regional Meetings of Health Ministers etc.

The Unit mailed 21 lakh pieces of various educational, motivational and display material throughout the country. The Distribution Wing also despatched Manuals and other literature to para-medical and Medical Staff of States/Union Territories, supplied by other Divisions of the Ministry e.g. Rural Health Division, Maternal and Child Health Division etc. This wing also distributed publicity and motivational material in all seminars, conferences, meetings etc. organised by the Ministry.

The Distribution Wing has an Address Library of over 5 lakh addresses. A special effort was continued to expand its out-reach by inclusion of additional addresses. The existing lists were also revised and up-dated

112. DIRECT MAIL SCHEMES

With the objective of disseminating information about important schemes/subjects, Direct Mail Schemes were started for the first time by the Ministry. The Ministry produced TV spots on the six common child killer diseases which are screened by Doordarshan. The viewers were urged to write for more information. A folder on "These Diseases kill" is mailed to each respondent alongwith a copy of the booklet "Your Child by Choice not Chance". Similarly press advertisements are being released through DAVP promoting the right age of marriage. The readers have been urged to seek further information on the subject. A copy of the Folder "Vivah-Ke-Liya-Uchit-Umar" is mailed to each person who asks for it.

113. EXTENSION EDUCATION

In order to intensify the efforts and enable people to realise that Family Planning Programme is in their own interest as well as in the wider interest of the nation, family welfare messages have been linked with specific goal-oriented programmes like education of girls, raising the age of marriage and delaying the first child, child survival and status of women.

To ensure that doubts and misgivings hampering the adoption of family planning measures are removed and people's support to various health and family welfare programmes is enlisted, extension activities have been intensified. Organisation of opinion leaders' camps was the prominent feature of family welfare extension strategy during the year. About 18,000 camps were organised in rural areas and urban slums all over the country upto March 31, 1987. The prime objective of these camps was to make the opinion leaders understand various dimensions of population problem and realise their role in its control and to make them 'change agents' and 'centres of support' for the promotion of Family Planning Programme and execution of population policies at the peripheral level.

114. POPULATION EDUCATION

With a view to inculcating a favourable attitude towards 'small family norm' in the younger generation and to enable them to understand the population problem in its right perspective, population education is being institutionalised in the formal and non-formal channels of education both at school stage and college/

university stage. Similarly, population education activities are being integrated in the adult-education programme so that the adult learners are able to understand health-hazards of closely spaced and too many children with particular reference to the health of the mother and the children. Curriculum development, training of teachers and development of training and learning material are the major planks of population education programme in the country.

25 States have developed population education curriculum which is being integrated in the text books of various subjects. 35 universities have incorporated population education-related ideas in the teacher's training programmes for secondary school teachers and 32 universities have included population education in the courses for Master's Degree in education. About 6.75 lakhs of teachers including key-persons and allied functionaries have already been imparted training in population education. About 75.70 million students (about 60.09 per cent of total student population) have been exposed to population education. National Policy on Education, 1986 has included "Observance of small family norm", as one of the 10 core curricular areas of education from class I to 10th for which 'exemplar material' has been prepared and is being distributed to the schools all over the country.

University Grants Commission has been supporting a large programme of population education at the University level. The scheme of 'population club' in colleges and universities continues and presently, there are 1300 clubs in various colleges and universities for developing an understanding among the college and university students about the relationship between population and development issues and promoting awareness of 'small family norm'. These clubs conduct seminars and symposia for the student population and as a part of extension work, students go to adult-education centres attached to colleges and universities to convey population education messages to the community.

Population education and information regarding family welfare figure prominently in adult-education programme. In the new programme to be launched as a 'Mission for Eradication of Illiteracy in 15-35 age group' giving special focus to women's literacy, greater attention will be paid to education for family welfare including safe motherhood, child-care and adoption of 'small family norm'.

Jan Shikshan Nilayams are proposed to be established in clusters of 5 to 6 villages (for population of about 5,000) as centres of post literacy and continued education. These centres will serve as information window for the development programmes and particularly for communication regarding healthcare, child development and family palnning.

115. DEMOGRAPHIC RESEARCH AND EVALUATION

With a view to provide an independent and objective assessment of the working of the Family Welfare Programme, and its impact, a net work of 16 Population Research Centres were engaged in demographic research in different parts of the country. In addition to the 16 Centres, the newly sanctioned Centre in J & K at Srinagar is also expected to start functioning soon. A proposal for establishment of a new Centre in Himachal Pradesh at Shimla is also under consideration.

These Centres continue to undertake studies on various socio-economic, demographic and communication aspects of Population and Family Welfare Programme. The major studies undetaken by these centres cover various topics, like fertility, socio-economic determinants of family planning acceptance, utilisation of MCH services, co-relates of female's age at marriage, motivation and education, etc. The important studies undertaken by these Centres include a Study on the estimation of birth rate, death rate and couple protection rate, evaluation of Family Welfare and MCH Programmes, district-wise analysis of family planning performance and socio-economic indicators, an annotated bibliography of the research studies carried out by the Population Research Centres since inception, operational research on delivery of health and family welfare services, district level study on age at marriage, study to indentify factors responsible for target group not adopting spacing methods but preferring terminal methods, study to analyse factors which might have contributed to high population growth in certain districts in some of the States during 1971-81.

Lists of studies completed by the PRCs during the year 1986-87 and in progress as on Ist April, 1987 are given in Annexure-III.

116. OTHER RESEARCH STUDIES

In addition to the studies undertaken by the Population Research Centres, a detailed survey on family planning is being entrusted to the Operations Research Group, Baroda, basically with a view to make detailed analysis of the knowledge and attitude of the eligible couples on family planning, provide estimates contraceptive prevalence in the community by individual methods and to understand the reasons for couples not practising family planning particularly, among those who do not want additional children. The survey is envisaged to cover all the States/UT

A study to evaluate the scheme of involvement of Private Medical Practitioners in family welfare programme has been entrusted to Operations Research Group, Baroda with the major objective to decide whether this scheme should be continued or not. This study will be carried only in 3 states of Andhra Pradesh, Maharashtra and Tamil Nadu covering a sample of 100 doctors (inclusive of both doctors participating in the scheme and doctors not participating in the scheme) and 100 Family Planning acceptors of the selected doctors in each State. This study has already commenced.

Another study on status of Management Information and Evaluation System in the field of Health and Family Welfare has been entrusted to Institute of Communications, Operations Research and Community Developmnt, Bangalore. This study aims at collection of all prevalent formats and information, critical evaluation of their utility and purpose and finally to decide on the right type of Management Information and Evaluation System on the National scale in the field of Health and Family Welfare. This study which has already commenced, will be based on collection of information, formats etc. through post from 14 major states (except Punjab) at the first phase and then through visits to all these states and to districts and PHCs on sample basis for collection of other required materials and further discussions.

117. ALL INDIA CONFERENCE OF STATE DEMOGRAPHERS

The All India Conference of State Demographers was held at Pune from 28-30 May, 1986 to review the current status of family welfare information system, its problems and deciding the future strategies for making the system better oriented and more responsive to the needs of policy planners and programme managers. Recommendations of the conference are given in Annexure-IV.

118. HINDUSTAN LATEX LIMITED TRIVANDRUM

Hindustan Latex Limited, Trivandrum a Public Sector undertaking engaged in the production of rubber condoms was incorporated on Ist March, 1966. The first Plant for the manufacture of 'Nirodh' (Rubber Condoms) was set up at Trivandrum in 1967 with Japanese Collaboration. The plant commenced commercial production in July, 1969 with installed capacity of 144 million pcs. per annum. The second Plant was installed in 1977 with an installed capacity of 144 million pcs. per annum.

Under its expansion scheme the Company has since set up two additional Plants—one at Trivandrum and other at Kanagala, Belgaum District in Karnataka. These two new Units are designed to manufacture coloured condoms of thinner variety of 0.03mm to 0.04mm thickness. With the addition of these two new Plants the installed capacity of Company is now 608 pcs. per annum, thus making it the largest manufacturing unit of condoms in India. The new plant at Trivandrum has already started commercial production in August, 1986 while the plant installed at Belgaum started commercial production in March, 1987.

119. CAPITAL STRUCTURE: The authorised capital of the Company is Rs. 1350 lakhs. The issued subscribed and paid up capital is Rs. 1248 lakhs as on 31.3.1987. During the year the paid up capital was increased by Rs. 440.50 lakhs. The Company has repaid the loan instalment to the Government amounting to Rs. 119 lakhs as on September, 1987. The loan outstanding as on 31st March, 1987 is Rs. 1165 lakhs.

120. PLANT PERFORMANCE: Out of the total quantity of condoms of 357.5873 million pcs. produced during the year 1986-87, 346.5887 million pcs. was considered as saleable produc-

tion. The capacity utilisation of the Plant was:

New Plant	88.70%
Old Plant	94.35%

The total sales achieved in the year come to 340.4279 Million pcs. (Valued at Rs. 1135.84 lakhs) under different schemes of the Department of Family Welfare, Government of India.

121. FINANCIAL RESULTS: During the year 1986-87 the Company earned a net profit (after depreciation and interest before tax) of Rs. 53.40 lakhs.

122. DIVERSIFICATION PROGRAMME: The first stage clearance of the Project for the production and sale of disposable syringes has been issued to Company. A detalied feasibility report will be prepared by the Company after selecting a suitable latest technology. The Company has also plans to set up units for the manufacture of Cu T-200, an Intra Uterine Device and for tabletting, packing and supplying of Oral Contraceptive pills to the Government of India.

123. MODERNIZATION: The proposal for the modernization of the existing Plant at Trivandrum is under consideration. A Group of technical officers has been constituted to undertake the modernization project involving a total capital outlay of Rs. 3 crores thereby reducing the imported component substantially. The programme will be implemented in stages in a phased manner and it is hoped that this will improve the quality and reduce the percentage of rejection and wastages.

124. LABOUR RELATIONS AND WELFARE ACTIVITIES: The management has maintained cordial industrial relations and has abided by the existing settlement with the Trade Unions. Attempts are being made to involve the productivity linked bonus scheme. The Company is following strictly the reservation policy of Government of India regarding SC/ST and others.

APPENDIX V

TWENTY-POINT PROGRAM 1986

TWENTY-POINT PROGRAM 1986

The following is the text of the new Twenty Point Program as announced by the Union Minister of Program Implementation, Shri A.B.A. Ghani Khan Choudhury in Parliament on August 20, 1986:

"The war on poverty is our first priority. In the past five years, more than ten crore of our poor have been raised above the poverty line. Our goal is to remove poverty and create fuller employment.

The Twenty Point Program is the cutting edge of the plan for the poor. The program has been restructured in the light of our achievements and experience and the objectives of the Seventh Plan. The restructured program renews our commitment to:

-- eradicating poverty
-- raising productivity
-- reducing income inequalities
-- removing social and economic disparities, and improving the quality of life.

1. Attack on Rural Poverty

We shall:

Ensure that poverty alleviation programs reach all the poor in every village;

Dovetail wage employment programs with programs for area development and human resource development and create national and community assets like school buildings, roads, tanks and fuel and fodder reserves;

Correlate the various rural development programs to:

- improve productivity and production
- expand rural employment

Promote handlooms, handicrafts, village and small industries, and improve skills for self-employment;

Revitalize Panchayats, cooperatives and local bodies.

2. Strategy for Rain-fed Agriculture

We shall:

Improve the technology for conserving moisture and ensure better management of land and water resources;

Develop and distribute appropriate and improved seeds;

Reduce vulnerability to drought through suitable changes in drought-prone area and drought-relief programs.

3. Better use of Irrigation Water

We shall:

Develop the catchment areas and improve drainage in basins and deltas;

Improve irrigation management in command areas;

Prevent water logging, salinity and wasteful use;

Coordinate the use of surface and ground water.

4. Bigger Harvests

We shall:

Revolutionize rice production in the Eastern Region and other areas of low productivity;

Achieve self-reliance in edible oils;

Secure greater production of pulses;

Intensify the cultivation of fruit and vegetables;

Augment facilities for modern storage, processing and marketing of agricultural produce;

Help livestock and dairy farmers to increase productivity;

Develop fish farming and sea fishing.

5. Enforcement of Land Reforms

We shall:

Complete compilation of land records;

Implement agricultural land ceilings;

Distribute surplus land to the landless.

6. Special Programs for Rural Labor

We shall:

Enforce minimum wages for unorganized labor in agriculture and industry;

Fully implement laws abolishing bonded labor;

Involve voluntary agencies in programs for the rehabilitation of bonded labor.

7. Clean Drinking Water

We shall:

Provide safe water for all villages;

Assist local communities to maintain the sources of such water supply in good condition;

Pay special attention to water supply for Scheduled Castes and Scheduled Tribes.

8. Health for All

We shall:

Improve the quality of primary health care;

Fight leprosy, TB, malaria, goitre, blindness and other major disease;

Improve sanitation facilities in rural areas, particularly for women;

Pay special attention to programs for the rehabilitation of the handicapped.

9. Two-child Norm

We shall:

Bring about voluntary acceptance of the two-child norm;

Promote responsible parenthood;

Reduce infant mortality;

Expand maternity and child care facilities.

10. Expansion of Education

We shall:

Universalize elementary education with special emphasis on girls' education;

Improve the content of education at all levels;

Promote non-formal education and functional literacy programs, including promotion of skills;
Stimulate adult literacy programs, with the participation of students and voluntary agencies;

Emphasize national integration and social and moral values and instill pride in our heritage.

11. Justice to Scheduled Castes and Scheduled Tribes

We shall:

Ensure compliance with the constitutional provisions and laws for the Scheduled Castes and Scheduled Tribes;

Ensure possession of land allotted to Scheduled Castes and Scheduled Tribes;

Revitalize the land allotment program;

Organize and assist special coaching programs to improve educational standards;

Eradicate scavenging and undertake special programs for the rehabilitation of Safai Karamcharis;

Provide better direction and adequate funds for the special component programs;

Pursue programs for the fuller integration of Scheduled Castes and Tribes with the rest of society;

Ensure the rehabilitation of tribals displaced from their habitat.

12. Equality for Women

We shall:

Raise the status of women;

Enhance awareness of the problems of women;

Create mass consciousness about women's rights;

Implement a national program of training and employment for women;

Enable women to participate with equality in socio-economic development and nation-building;

Rouse public opinion against dowry and ensure effective implementation of anti-dowry legislation.

13. New opportunities for Youth

We shall:

Enlarge opportunities for youth in sports, adventure and cultural activities;

Promote physical fitness;

Involve youth on a massive scale in projects of national development such as;

- the cleaning of the Ganga;

- the conservation and enrichment of the environment;

- mass education.

Identify outstanding young persons in all fields to encourage and develop their talents;

Involve youth in promoting national integration, cultural values, secularism and the scientific temper;

Expand the network of Nehru Yuvak kendras;

Strengthen the National Service Scheme and the National Cadet Corps;

Encourage voluntary agencies working for the welfare of rural youth.

14. Housing for the People

We shall:

Make available house sites to the rural poor;

Expand programs of house construction;

Pay special emphasis on construction of houses for Scheduled Castes and Scheduled Tribes;

Develop low cost building materials.

15. Improvement of Slums

We shall:

Restrict the growth of slums;

Provide basic facilities in existing slum areas;

Encourage planned house building in urban areas.

16. New Strategy for Forestry

We shall:

Grow more trees and raise more forest, with the full involvement of the people;

Protect the traditional rights of tribal populations and local communities of access to limewood and forest produce;

Reclaim wastelands for productive use;

Plant appropriate vegetation in hill, desert and coastal areas.

17. Protection of the Environment

We shall:

Enhance public awareness of the dangers of environmental degradation;

Mobilize popular support for environmental protection;

Promote recognition that enduring development demands preservation of the ecology;

Ensure judicious site selection for projects and proper choice of technology.

18. Concern for the Consumer

We shall:

Bring essential consumption goods within easy reach of the poor;

Build a consumer protection movement;

Restructure the distribution system so that subsidies reach the most needy;

Strengthen the Public Distribution System.

19. Energy for the Villages

We shall:

Expand the supply of electricity for productive use in the villages;

Develop alternative sources of energy, particularly bio-gas;

Promote integrated area specific programs for rural energy.

20. A Responsive Administration

We shall:

Simplify procedures;

Delegate authority;

Enforce accountability;

Evolve monitoring systems from block to national level;

Attend promptly and sympathetically to public grievances."