Chapter 11 Monitoring

11.1 Institutional mechanism for monitoring

NRHM envisaged a robust accountability framework through a three pronged mechanism of internal monitoring, community based monitoring and external evaluations. The State Government issued order (16 November 2006) defining the composition and functions of the Mission and Societies at the State, district and sub-district levels for implementation and monitoring of NRHM activities. This order provided the following framework:

1. State Health Mission with the Chief Minister as Chairperson.
2. State Health Society comprising:
    a. Governing Body chaired by the Chief Secretary;
    b. Executive Committee chaired by the Principal Secretary, Medical, Health and Family Welfare; and
    c. State Project Management Unit headed by the Mission Director.
3. District Health Mission chaired by the Minister in-charge of the district.
4. District Health Society comprising:
    a. Governing Body headed by the District Magistrate;
    b. Executive Committee headed by the Chief Medical Officer; and
    c. District Programme Management Unit headed by the Additional CMO/RCH.
5. *Rogi Kalyan Samiti*:
    a. At the district level RKS will comprise:
        i. Executive Committee headed by the Chief Medical Superintendant (Male) and co-chaired by Chief Medical Superintendant (Female); and
        ii. Advisory Committee headed by the Mayor/Chairperson, *Nagar Palika*/ Chairperson, *Zila Panchayat*.
    b. At CHC/ PHC level, RKS:
        i. Executive Committee headed by the Medical Officer in-charge; and
        ii. Advisory Committee headed by the representative of *Panchayat Samiti*.

The committees were to meet periodically and *inter alia* review the progress of implementation of NRHM.

Audit observed that the State Health Mission never met since its inception and the Governing Body of State Health Society was convened only twice during 2005-11. The Executive Committee of the State Health Society, however, met regularly but deliberated only administrative and financial matters. As discussed in the chapter on Planning of this Report, in the 23 sampled districts the District Health Missions were not constituted and the meetings

of the Governing Bodies/Executive Committees of District Health Societies were not convened at designated intervals. Similar situation existed at sub-district level. Thus, the institutional mechanism for monitoring of NRHM activities remained ineffective.

The State Government stated that the first meeting of SHM was held on 01 December 2011. Although, the State Government replied that DHM had been constituted in most of the test checked districts and their meetings were held in five districts, no records in support of the assertion were made available. Further, the Government intimated that DHSs were functional and regular meetings were being conducted but dates, records of minutes *etc*. of these meetings, although stated to have been annexed to replies were not furnished.

The Financial Management Groups (FMG), consisting of skilled persons, were to be formed both at the State and district levels to ensure timely transfer of funds, obtain utilisation certificates, prepare accounts and get those audited by the Chartered Accountants *etc*. However, FMGs were not formed. The Government stated that in place of FMG separate Finance and Accounts wings had been formed at State and district levels but were non-functional due to vacancies in various cadres.

The Executive Committee was to review physical and financial progress. Test check of agenda papers revealed that physical and financial progresses were reported without identifying key areas of concern, constraints, poorly performing districts and best practices. In fact, EC meetings were held largely for financial sanctions. Moreover, there was little participation of senior members from other departments, GoI nominee and development partners.

The Government stated that Regional Director, NRHM, MoHFW, GoI participated in most of the meetings and his views/advice was considered and accordingly included in the minutes. In the meetings, apart from financial sanctions, achievements of important programmes were also reviewed and instructions given to the concerned programme officers for improvement. However, the fact remained that senior functionaries of other departments and representatives of progressive partners remained dormant/absent in EC meetings and most of the decisions taken therin were related to allotment and release of funds to various executing agencies and districts.

11.2 Programme Implementation Committees (PIC)

The Government order dated 16 November 2006 envisaged formation of two Programme Implementation Committees headed by the Principal Secretary, Medical, Health and Family Welfare. These committees were to operate, supervise, monitor RCH-II programme, to ensure outreach of the services to rural areas through coordination among different projects related to health and nutrition, disease control programmes, AYUSH, disease surveillance, rural cleanliness, water supply besides inter-departmental coordination and to release funds and furnish expenditure statement to EC. However, the responsibilities and role of the two committees was not distinctly segregated. The composition of these committees was as below:

Table 11.1: Composition of Programme Implementation Committees

Sl. No.	Family Welfare Programme Implementation Committee	Medical and Health Programme Implementation Committee
1.	Secretary, Medical, Health and Family Welfare	Secretary, Medical Health and Family Welfare
2.	Director General, Medical and Health	Director General, NPME
3.	Director General, Medical Education	Director General, Medical Education
4.	Finance Controller, Directorate of National Programmes, Monitoring and Evaluation	Finance Controller, Directorate of Medical and Health Services
5.	Director, Women and Child Development	Director, Women and Child Development
6.	Director, Basic Education	Director, Basic Education
7.	Director, State Health and Family Welfare Institute	Director, State Health and Family Welfare Institute
8.	Director, Homeopathy	Director, Homeopathy
9.	Director, Ayurvedic and Unani	Director, Ayurvedic and Unani
10.	Director General, NPME, was Member Secretary	Director General, Medical and Health was Member Secretary

It was noticed that these committees were not functional as no monitoring reports were being sent to SHS/SHM. Incidentally, the team of GoI in its report mentioned that DGMH and DGNPME (and also Family Welfare for 2010-11) were not aware of existence of these two PICs.

The Government stated that PICs were supervising, monitoring and evaluating the programme, but did not furnish any record in support of its assertion.

11.3 Health Management Information System Reporting

NRHM Framework also envisaged accountability through computer based monthly Health Management Information System (HMIS). In order to implement HMIS, all officers/officials at blocks and district facilities, CMOs offices were to be trained and provided with computers and personnel for data entry. Accordingly, PIP for 2010-11 made provisions for ₹ 10.86 crore, against which SHS spent ₹ 10.06 crore up to March 2011.

SHS procured 951 computers which were supplied and installed up to January and March 2011 respectively at the block and district level health facilities, with delay exceeding one year, as supply was to be completed within two to four weeks, i.e. by September 2009, against the supply orders placed in July 2009. Further, in 48 districts only 151 Data Entry Operators (DEOs) were posted against required 641 DEOs (November 2011).

Status of uploading of data in HMIS was delayed as data was first uploaded during April 2008 to April 2009 in 22 out of 23 sampled districts. Similarly, data uploading in other web based MIS was delayed as first uploading of data for Routine Immunisation Management System took place from September 2006 to November 2008, Integrated Disease Surveillance Project (IDSP) from April 2008 to July 2011 and Personnel Information System from March 2006 to December 2009 and Mother & Child Tracking System (MCTS) from June 2011.

Thus, due to delay in procurement of computers and appointment of DEOs, HMIS was not implemented in a meaningful manner depriving the senior management of a very important monitoring tool as envisaged under NRHM.

While accepting the facts the State Government stated that the system implemented would act as monitoring tool in effective decision making.

11.4 State Quality Monitors

It was proposed in PIP of 2008-09 to place State Quality Monitors (SQMs) in the form of one person at each division for monitoring availability and quality of services in various districts of the division. People from outside the Government system, preferably retired Government officers having requisite experience of functioning of health sector were to be deployed. Eight SQMs were deployed during 2008-09 in eight divisions and remaining ten divisions remained without SQMs. No SQMs were engaged during 2009-10 and only one more person was engaged during 2010-11 raising the number of SQMs to nine. Thus, the quality of services provided by the health facilities remained un-monitored in nine out of the 18 divisions. No records relating to follow up action on SQMs monitoring were made available at the State level and 23 sampled districts.

The State Government attributed that the shortage of SQMs to non-availability of qualified candidates and non-joining of selected candidates. Further, only 18 reports were issued during 2010-11 with nine SQMs against 57 reports issued during 2009-10 with eight SQMs indicating weakening of intended monitoring.

11.5 Procurement Cell

PIP of 2008-09 included a proposal to establish a procurement cell at State level for inspection and testing of the material procured under NRHM. This proposal was repeated in PIPs of subsequent years, including PIP for 2011-12. The Procurement Cell, a centralised facility to inspect the material procured under NRHM, was yet to be established.

The Government stated that purchase committee was established (06 October 1987) at Directorate of Medical and Health. A medicine review committee was established (18 July 2009) for various procurements and purchases under NRHM. However, the fact remained that "medicine review committee" only reviewed the medicines and a dedicated purchase committee to attend to the requirements of NRHM was yet to be formed.

11.6 JSY Cell

A proposal was included in PIP of 2008-09 to form a Cell at SPMU/Directorate level to maintain a good reporting system, to update records, for fund management and monitoring issues relating to JSY. This Cell was to comprise of two DEOs and one post each of data analyst, financial analyst and accountant. The Cell was not constituted up to March 2010. Further, PIP of 2009-10 included a proposal for monitoring of five to 10 *per cent* cases of JSY through deployment of monitors and posts of four monitors were also included in the Cell. PIP of 2010-11 revealed that though the Cell was formed (2009-10), however, 'monitors' were not appointed (December 2011). Thus, the reported cases of JSY remained unmonitored.

The Government confirmed non-appointment of monitors.

11.7 Internal Audit

Directorate of Internal Audit, established in Finance Department, headed by the State Internal Auditor, monitors internal audit in all departments and undertakes special investigations.

Internal Audit Unit (IAU) was not constituted at SPMU. Two IAUs- one in each of the Directorates - were functioning in Medical, Health and Family Welfare Department under the control of respective Finance Controller. No internal audit manual was available in either of the Directorates. DGMH and DGNPME informed (December 2011) that NRHM records were not being scrutinised by their auditors as the concurrent auditors[1] were carrying out necessary examination. The decision not to submit the records to internal auditors was flawed as the concurrent auditor was mandated to examine records for the purpose of preparing the accounts of DHSs whereas compliance issues formed the basis of scrutiny of records by IAUs.

11.8 Community based Monitoring

NRHM envisaged community based monitoring besides external surveys and internal monitoring. Facility and Household Survey, NFHS-II, RHS (2002) was to act as the baseline for the Mission against which the progress was to be measured. Health Planning and Monitoring Committees were to be formed at PHC, Block, District and State levels for ensuring continuous community based monitoring of activities at respective levels along with facilitating relevant inputs for planning. Details about formation of these committees were not available with SPMU. The community and community based organisations were not involved to report on the quality and effectiveness of the health care delivery system.

The Government stated that the district, block and PHC level monitoring and planning committees were not constituted as GoI did not select Uttar Pradesh for initiation of Community Based Monitoring in the first phase. The reply was not tenable as GoI included the State under the scheme of community based monitoring vide MoHFW letter dated 26 March 2008. Further, the Government accepted, in their reply to the *Paragraph 2.3.3 ante*, that on suggestion of GoI a detailed proposal for implementing the community monitoring was put up but a decision in this regard was not taken (December 2011).

11.9 Public hearings and Public dialogues

NRHM framework provided for holding of periodic public hearings (*Jan Sunvai*) or public dialogues (*Jan Samvad*) to strengthen the accountability of the Health System to the community. Details about these hearings were not furnished to audit. The public hearings and dialogues, as envisaged in NRHM were not organised at any level in any of the sampled districts. Further, a system of organising *Tehsil Divas*, for redressal of all kinds of grievances, at that level on first and third Tuesday of the month (one *Tehsil* can cover more than one block) was prevalent in the State. On the specified days all district authorities assembled at one place to redress grievances of the public. These included health related grievances also but were not NRHM specific. No records in support of NRHM specific issues having been discussed and acted upon during *Tehsil Diwas* were made available.

[1] Chartered Accountants' Firms engaged by SPMU for checking of accounts records.

The Government accepted non-implementation of system of holding *Jan Sunwai* and *Jan Samvad*. The Government, however, confirmed that issues of JSY, ASHAs and functionalities of subcentres were discussed in *Tehsil Diwas*.

11.10 Publication of Health Reports

Public Reports on Health were envisaged to be published annually at the State and the district levels to inform the community on progress made under NRHM. The report on health at State level and in the test-checked districts was not published. No specific reply about publication of Health Reports was furnished by the Government.

11.11 Vigilance Mechanism

GoI, MoHFW directed (September 2010) formation of "District Level Vigilance and Monitoring Committee (DLVMC) in each district. DLVMC, headed by one of the Members of *Lok Sabha* (MP) of the district, nominated by the Ministry, was to comprise all MPs and all MLAs of the district, Chairperson of *Zila Panchayat*, District Magistrate, Chairpersons of *Panchayat Samitis* (*Block Pramukh*), officers in charge of Women & Child Development, Water Supply & Sanitation and CEO DRDA/ Project Director DRDA. CMO was to be the Member Secretary and Convener of DLVMC. DLVMC was to review the progress of implementation of DHAP and to provide guidance; to review the release of funds, utilisation thereof and unspent balance; and undertake regular monitoring visits to the field to ensure achievement of programme objectives and service delivery in an effective and efficient manner.

The DLVMCs were not formed in the State (December 2011). No reply was received from the Government in this regard.

11.12 Sensitivity to error signals

With a view to make the Mission accountable to the people, it was imperative that a system to detect error signals emanating from various sources together with a system for grievance redressal was put in place at the State, District and Sub-district levels. Further, as envisaged under NRHM, lessons-learnt mechanism was to be a part of the implementation strategy to effect mid-course corrections.

Some of the sources generating error signals were as below:

- Questions raised by the respected members of the Parliament and the State Legislature;
- Reports of the Statutory Auditors and Concurrent Auditors;
- Reports of the Comptroller & Auditor General of India tabled in the *Lok Sabha* and *Vidhan Sabha*;
- Inspection Reports of the State Accountant General;
- Reports of the Common Review Missions to monitor the performance of NRHM in the State;
- Reports of the Regional Evaluation Teams from the Regional Director of the Ministry;

- Reports of the Director of Internal Audit, the Government of UP;
- Reports of NRHM Finance Team on financial administration and utilisation of NRHM funds;
- Annual Reports of the Joint Review Missions to appraise Reproductive and Child Health component of NRHM;
- Information called for under RTI Act, 2005 by various applicants; and
- Reports appearing in media-electronic and print.

Audit observed that:

- No information relating to Questions on NRHM, although called for, was furnished either from the Secretariats of Legislative Assembly and the Council or the Government. Questions on NRHM in both the Houses of the Parliament were downloaded from the net. When analysed Audit observed that the issues agitating the respected Members kept recurring;
- The observations made by the Statutory and Concurrent Auditors recurred even in their following years' reports. These comments pointed towards serious financial irregularities but no worthwhile action was discernible at any level including that of SHM;
- Reports of the Comptroller & Auditor General of India for the period ending 31 March 2008 for both the Union and the State comprehensively pointed out gaps, weaknesses, deficiencies, irregularities *etc*. Inspection Reports (IRs) of Principal Accountant General (Civil Audit), UP, sent to the Department and the Government, for the period 2009-12 (up to June 2011) on NRHM revealed similar observations. Even the first replies of the Department/Government, required to be furnished within two months of IRs being issued, were not received in most of the cases;
- Similarly, the Reports of Common Review Missions (GoI & GoUP); Regional Evaluation Teams (GoI); Director of Internal Audit, Government of UP; NRHM Finance Team (GoI) and Joint Review Missions remained largely unattended;
- System of maintaining records of reports appearing in newspapers and television in the Government, bodies of NRHM and health centres were not working; and
- Information called for RTI applications received during 2005-2011 was not furnished by the Government.

Although adequate mechanisms to generate error signals relating to NRHM were in place but documentation of their detection and correctives thereon appeared to be largely absent. Far and few effective systemic remedial measures had been taken. Database, detecting the error signals and correctives effected thereon, was called for, but not produced. Thus, the State Government was not very sensitive in detection of error signals and effecting correctives thereon.

The Government stated that a cell for this purpose has been formed in DGMH and DGNPME, but deficiencies and irregularities persisted. During exit conference the Government also stated that post September 2011, mechanism had been geared up to ensure better monitoring of health schemes.

11.13 Recommendations

- *SHM should be invigorated to play its designated role in NRHM framework;*
- *Governing Body and Executive Committee of SHS/ DHS should hold regular meetings, undertake focused monitoring and be sensitive to error signals;*
- *System for Community monitoring should be devised and put in place at village, block and district levels and community monitors should be appointed and strengthened; and*
- *Computer based MIS like HMIS and HIS should be put in place to ensure an accurate and reliable reporting system from grass-root level to GoI.*