Chapter 3 Planning

3.1 Baseline survey

NRHM strives for decentralized planning and implementation arrangement to ensure that need-based and community owned District Health Action Plans form the basis for interventions in the health sector. For this purpose, the Mission envisages carrying out preparatory studies, mapping of services and household and facility surveys to be conducted at village, block and district level. Fifty *per cent* of the household and facility surveys were to be completed by 2007 and hundred *per cent* by 2008. Scrutiny revealed that household survey was conducted by the GOI at the district level during 2002-04 to assess the healthcare requirements and to identify the under-served and unserved areas. Partial household survey is being conducted by Auxiliary Nurse Midwives (ANMs) during March every year, in order to assess the target population of 0-1 year, 1-5 years, pregnant women and eligible couples. To assess the status of availability of healthcare facilities in rural areas, a facility survey was conducted by a private agency (ADVENT Group) in all 839 PHCs and 4,592 SCs of the State during 2007, and by Regional Resource Centre (RRC) in 102 out of 108 CHCs during 2008.

A central database was prepared at the State level consisting of (a) Routine data – prepared on the basis of monthly reports from districts, (b) Infrastructure data – based on Facility Survey (2007), District level Household Survey (2002-04) by the GOI and National Family Health Survey I and II and (c) Semi permanent data – based on Census report and village level partial surveys conducted by ANM once a year.

The data collected through partial household survey by the GOI as well as local health activists and facility survey by the private agency was, however, not ratified by the Panchayati Raj Institutions (PRIs) as was required to be done.

3.2 Perspective Plan and Annual Plans

The SHS was required to prepare a Perspective Plan for the entire Mission period (2005-2012) covering the gaps in the healthcare facilities, areas of interventions and probable investment. The districts are also required to prepare a Perspective Plan as well as Annual Action Plans (AAPs). The District Health Action Plans (DHAPs) are to be prepared by the DHS and approved by the District Health Mission (DHM). The NRHM also focuses on the village as an important unit for planning, although the Mission did not insist on village plans for the first two years. Therefore, DHAPs were required to be prepared on the basis of Block Health Action Plans (BHAPs).

Scrutiny revealed that Perspective Plan was not prepared either at the district or at the State level. However, DHAPs as well as the State Programme Implementation Plan (PIP) were prepared annually for the years 2006-08. BHAPs were also not prepared during 2005-08 except in eight blocks under Sivasagar district during 2007-08. Thus, DHAPs were not based on plans from block/periphery level.

Also, due to non establishment of Village Health and Sanitation Committees (VHSC) in the State as envisaged, the villages could not be equipped to take up planning exercise for

extensive capacity building. However, the State Health Action Plans-RCH-II for 2005-06 and NRHM for 2006-07 and 2007-08 were prepared on the basis of DHAPs, District Level Household Survey (RCH) 2002-04 conducted by the GOI, National Health Family Survey (NHFS)-II & III by the GOI, Facility Survey-2007, Sample Registration System (SRS) data, State Health Bulletin and the GOI guidelines.

While accepting (January 2009) the facts, the Department assured that the Perspective Plan would be prepared from 2008-09 onwards.

3.3 Convergence of programmes under NRHM

The Mission aimed at an architectural correction in the health care delivery system by converging various existing stand alone national disease control programmes of the Union Ministry of Health and Family Welfare (MOHFW). In the Memorandum of Understanding (MOU) signed between the State Government and the GOI in April 2006, it was declared that the State had completed the merger of the programmes in the Health and Family Welfare Sector and had ordered merger of all district level societies. However, after a lapse of more than two years, actual merger with financial integration of national disease control programmes like RNTCP, NPCB etc. had not taken place as of March 2008 and these vertical programmes continued to be funded separately by each programme division in the MoHFW in violation of the GOI guidelines. The absence of financial integration of all vertical disease control programmes resulted in implementation of these programmes independently, outside the ambit of NRHM framework and the SHS distanced itself from their activities. As a result, programmes were implemented in a disjointed manner at the State and district levels. The SHS was involved only in incorporating the action plans of these societies in the Mission PIP. Hence the desired architectural correction aimed for in the health care delivery system remained unfulfilled.

The Department accepted the audit observation and stated that merger of stand alone programmes with NRHM framework has been taken up during 2008-09.

3.4 Monitoring

3.4.1 Internal control and institutional monitoring

Institutional monitoring requires Mission Steering Group and Empowered Programme Committees both at the Central and the State levels, to monitor progress of the Mission activities periodically. In Assam, no such committee or group was constituted. It was only in April 2008 that the State Health Mission adopted a system for internal monitoring at the block and district levels, whereby it was to constitute District Monitoring Teams headed by Joint DHS and Block Monitoring Teams headed by Sub Divisional Medical & Health Officer, i/c Block Primary Health Centre for monthly monitoring of all institutions.

3.4.2 Health Monitoring and Planning Committees

The NRHM envisages an intensive accountability framework through a process of community based monitoring and stringent internal monitoring. It also prescribed formation of monitoring and planning committees at the village, PHC, block, district and State levels to ensure regular community based monitoring.

As of March 2008, community based monitoring and planning committees were not set up at any level i.e. from village to State against 868 Health Monitoring and Planning Committees (HMPCs) required to be formed in the State (State, District-23, Blocks-149 and PHCs-695). This adversely affected the planning process at the primary level and consequent upward flow of information and diluted the concept of monitoring the activities.

The Department accepted the audit observations and assured that HMPCs were in the process of being set up.

Conclusion

In the absence of a proper planning exercise at all levels-from the village to the State, with requisite inputs from the lower units, the aim of decentralized planning and implementation arrangement, which is need based and community owned, remained largely unfulfilled. Also, due to lack of a strong monitoring mechanism, the planning process did not receive the required feedback for future planning of Mission activities.

Recommendations

- ***The State Health Society needs to ensure completion of household survey at all levels viz. district, block and village.***
- ***Perspective plan for the entire Mission period should be prepared after consolidating the Block Health Action Plans covering all its components by prescribing long-term and medium term goals.***
- ***Community based monitoring committees need to be formed at all villages, blocks and districts with prescribed composition.***