PROGRAM MONITORING AND EVALUATION SYSTEM ASSESSMENT

A.   Description of the Monitoring and Evaluation System

1.   The system for monitoring and evaluation (M&E) of the progress and performance of the National Urban Health Mission (NUHM) is critical for smooth implementation of the program. It builds on the existing systems and institutional arrangements established under the National Rural Health Mission (NRHM). The NUHM Implementation Framework outlines a number of impact-, outcome-, and process-level indicators. NUHM M&E is coordinated primarily by the Urban Health Division, with support from the Statistics Division of the Ministry of Health and Family Welfare (MOHFW) (Figure 1). The Mission Steering Group and Empowered Program Committee provide overall oversight, as the highest policy-making and steering institutions for the National Health Mission (NHM), which encompasses both NUHM and NRHM. The Mission Steering Group is fully empowered to exercise delegated powers subject to the condition that a progress report regarding NHM, along with deviations in financial norms, modifications in ongoing schemes, and details of new schemes be submitted to the Cabinet for information on an annual basis.

2.   Key M&E information on NUHM comes from several sources: (i) health service delivery statistics collected through the health management information system (HMIS) from public health facilities and aggregated at the state level; (ii) a real-time "mother and child tracking system" (MCTS); (iii) quarterly and annual NUHM management information system (MIS) updates on program-related process and input-driven indicators; (iv) annual Common Review Missions (CRMs) comprising MOHFW officials, officials from different states, technical experts, and invited development partners conducted in selected states offering overall qualitative and quantitative assessments for monitoring; (v) accredited social health activist (ASHA) data in the form of ASHA MIS collected at the state level, with periodic ASHA evaluation; (vi) quality assurance of public health facilities; (vii) district or city-level vigilance and monitoring committees with representatives from the district health society and *Rogi Kalyan Samiti* (hospital management society) that monitor progress of implementation (fiscal norms, inter-sectoral convergence, community participation, and monitoring);[1] and (viii) analysis of national surveys, including periodic National Family and Health Surveys (NFHSs), annual state Sample Registration Systems, and annual socioeconomic surveys by the National Sample Survey Office.[2] NUHM envisions that the Urban Health Division will build on existing information collection processes of various entities such as the National Malaria Control Program and Revised National Tuberculosis Control Program. MOHFW also has a technical arm, the National Health Systems Resource Centre, which coordinates with a network of state health system resource centers and population research centers.

B.   Assessment of the Monitoring and Evaluation System

3.   An assessment of the impact, outcome, and input indicators identified in the NUHM Implementation Framework in terms of specificity, measurability, relevance, and frequency of data collection found the existing M&E system to be fairly robust and comprehensive. The main

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[1] Many states have yet to constitute district or city-level vigilance and monitoring committees; those that have been constituted may not have yet held meetings. MOHFW is communicating frequently with states to initiate the formation and ensure the holding of quarterly meetings of the committees.

[2] The NFHS is the only survey of this kind conducted by MOHFW; Annual Health Surveys at the state and district level for eight empowered action group states and Assam by the Registrar General of India and periodic district-level household surveys would be discontinued. The NFHS would be conducted every 3 years, starting with NFHS-4 (2014–2015). Minutes of the first meeting of the Empowered Program Committee of NHM. 20 November 2013.

sources of information come from existing systems: the NUHM MIS managed by the Urban Health Division, and the HMIS managed by the Statistics Division.

4.   Periodic surveys (NFHS, Sample Registration System, and National Sample Survey) will be the source of data for key health outcomes (e.g., infant mortality rate, under-five mortality rate, out-of-pocket expenditure). These will also be useful for trend analyses and for comparison with disbursement-linked indicators (DLIs). For example, NFHS, 2014–2015 (available in 2016–2017) will be able to disaggregate urban and rural data, and data by wealth status.

5.   In addition to building on the existing system to monitor and evaluate the impact, outcome, and output indicators under NUHM, independent assessments and M&E capacity development activities will be conducted by the Asian Development Bank (ADB) and independent third-party consultants. Areas for further strengthening and proposed actions are summarized below.

C.   Managing Risks and Improving Capacity

1.   Health Management Information System

6.   The HMIS has evolved significantly since launched under NRHM in October 2008. The HMIS is online with data obtained almost in real time; all states have shifted to facility-based reporting except Tamil Nadu, which submits data aggregated at the district level. Areas requiring refinement remain. For example, the HMIS needs to be further strengthened to capture information on main program beneficiaries (the urban population). At present, the HMIS aggregates rural and urban data. However, it is possible to disaggregate this data for rural and urban areas, and identify facilities in urban areas (serving populations over 50,000) and tag them as urban. Existing data collection forms will be adapted for urban health care facilities.

7.   There are three main categories of HMIS issues: (i) data reliability, where data entry operators need basic HMIS training, including how to enter data, and what to enter (e.g., nil versus zero). Making HMIS more reliable requires using the *Service Provider's Manual: Understanding Health Management Information Systems* (2011) and aligning training to its comprehensive set of standard definitions for indicators; (ii) coordinating across multiple information systems, e.g., MCTS and HMIS, which requires integrating systems and incorporating geographic information system data from mapping exercises. It may be possible to harmonize all existing data (e.g., HMIS, MCTS, ASHA MIS, Geographic Information System) into a one-stop data platform used for district-level planning; and (iii) greater focus and resources required to meet the emerging needs of M&E, e.g., (a) posting trained data entry operators in every facility to improve HMIS coverage; (b) inclusion of additional HMIS indicators (quality assurance, for instance); and (c) development of a completely web-based HMIS, which would potentially address problems of quality and timeliness of reporting.

8.   The key actions for progressively improving HMIS to meet NUHM requirements are: (i) HMIS captures delivery and use of health services in urban areas (disaggregated urban data); (ii) HMIS indicators capture information on equity and the reaching of poor and vulnerable groups;[3] (iii) HMIS captures information on unique users of services, (i.e., urban or rural

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[3]   It may be possible to do this through (i) proxy by geo-tagging urban health facilities serving in or in close proximity to urban slums, resettlement areas, and vulnerable populations; (ii) system integration with MCTS (which would collect more detailed information, although coverage of MCTS is still rather poor compared to HMIS); and (iii) development of a web-based atlas using data from facility and vulnerability mapping and assessments along with gap analyses (which are being conducted by states and cities) that is linked with the integrated HMIS and MCTS

residence, male or female, and age) to improve the accuracy of reporting, attribution of results, and avoid double-counting;[4] and (iv) HMIS includes a module on monitoring community outreach, at the state and/or central levels, to encompass monitoring of performance on activities and functions of ASHAs; and link workers, health volunteers, community health workers, and auxiliary nurse midwives who conduct outreach. These efforts can be supported through the NUHM capacity development component.

2. Disbursement−Linked Indicators

9. The DLI on capacity development in 2015 includes disaggregation of HMIS data for urban areas. Moreover, strengthening M&E is defined in the verification protocols for 2016 and 2017: (i) adapting the NRHM MIS format for NUHM, (ii) expanding reporting of HMIS by facilities, (iii) training data entry operators and data administrators in data quality, and (iv) community processing of data collected under the ASHA MIS.

3. Program Action Plan

10. The M&E actions in the program action plan include: (i) review and strengthen HMIS and NUHM MIS indicators to adequately capture key processes and outcomes related to urban health and the NUHM Implementation Framework (e.g., referrals and diarrhea); (ii) include a quality assurance module in HMIS formats to reflect quality aspects of health services delivery, as per Quality Assurance Guidelines, 2013; (iii) CRM reports of NHM will substantively review NUHM and urban health issues, and provide recommendations and action plans to address any gaps; and (iv) (a) develop an NUHM MIS by adapting NRHM MIS formats to meet NUHM program reporting requirements, including on key indicators, components, and processes; and (b) generate NUHM program quarterly and annual progress reports.

4. Review Missions

11. Annual CRMs introduced under the NRHM would be strengthened to cover substantive review of NUHM and urban health issues. These in-depth, consultative review mechanisms are valuable and could be improved with a systematic mechanism to follow-up on recommendations identified in previous missions, so that the missions serve as instruments for continuous monitoring and feedback, rather than isolated exercises. In addition, the annual and midterm reviews to be conducted by ADB with MOHFW will provide an opportunity to jointly assess implementation performance against NUHM targets and DLIs set under the program. The annual review will assess and verify the achievement of DLIs, which form the basis for fund disbursement. ADB will monitor the implementation of the NUHM through additional review missions as needed, including annual fiduciary reviews, which include a procurement performance review carried out by an independent entity. These additional monitoring missions will be aligned with the existing NUHM mechanisms as required.

5. Use of Information and Communication Technology

12. NUHM calls for strengthened information and communication technology applications to improve health information management. Currently, the private sector is not integrated in the

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for reporting of health statistics by facility (similar to International Centre for Diarrheal Diseases Research Bangladesh's Urban Health Facility Atlas in Bangladesh: *http://urbanhealthfacilities.icddrb.org*).

4 This could be facilitated through mainstreaming the national ID "Aadhaar" card and development of a web-based system that maintains individual-level health records at all facility levels, and can aggregate and generate population health statistics.

government HMIS except for accredited providers under *Janani Suraksha Yojana* (Safe Motherhood Intervention), and is not reporting mortality or morbidity data. This leads to incomplete civil registration and vital statistics and limits analysis, planning, monitoring, and evaluation of the urban population's health needs and the quality of health care which they receive. It also limits adequate disease surveillance, and the control and response to outbreaks, which is particularly sensitive in densely populated urban settings. There is a need to strengthen the capacity of cities to collect, analyze, and translate disaggregated urban health information to ensure that urban health service planning is evidence based. The lack of HMIS data from the vast majority of private facilities may be addressed with appropriate incentives to upload data to the HMIS.

6. Community Outreach

13. Under NRHM, most information on ASHA performance is available through program quarterly and annual progress reports. Separate monitoring information is available (in some cases computerized and called ASHA MIS) collected by ASHA facilitator, supervisors or community organizer and submitted up through the district to the state level. These are not compiled at central level; however, an evaluation will be done through household surveys at the end of the program for a representative sample of selected cities and municipalities to assess the outreach of ASHA activities and performance.

7. Capacity Development

14. The attached capacity development technical assistance will support MOHFW to monitor progress of program results, particularly the progress, achievement, verification, and reporting of DLIs. It will help strengthen the national health statistics system to enable population-level reporting of outcomes such as child immunization rates and case detection of communicable diseases (malaria, dengue, tuberculosis) among the urban poor. It will help plan and organize third-party validation surveys for selected DLIs as required. The technical assistance will also help to develop the capacity of units in charge of planning and M&E in MOHFW and selected states and urban local bodies, to plan, monitor, and report on output-level DLIs. This includes developing monitoring plans for timely delivery of essential drugs at health facilities. Under DLI7, there is scope to conduct rigorous impact evaluations, operations research, and case studies in select states and cities to examine specific topics, such as health-seeking behavior of the urban poor and out-of-pocket health care expenditures.

Figure 1: Organogram for National Health Mission Monitoring and Evaluation
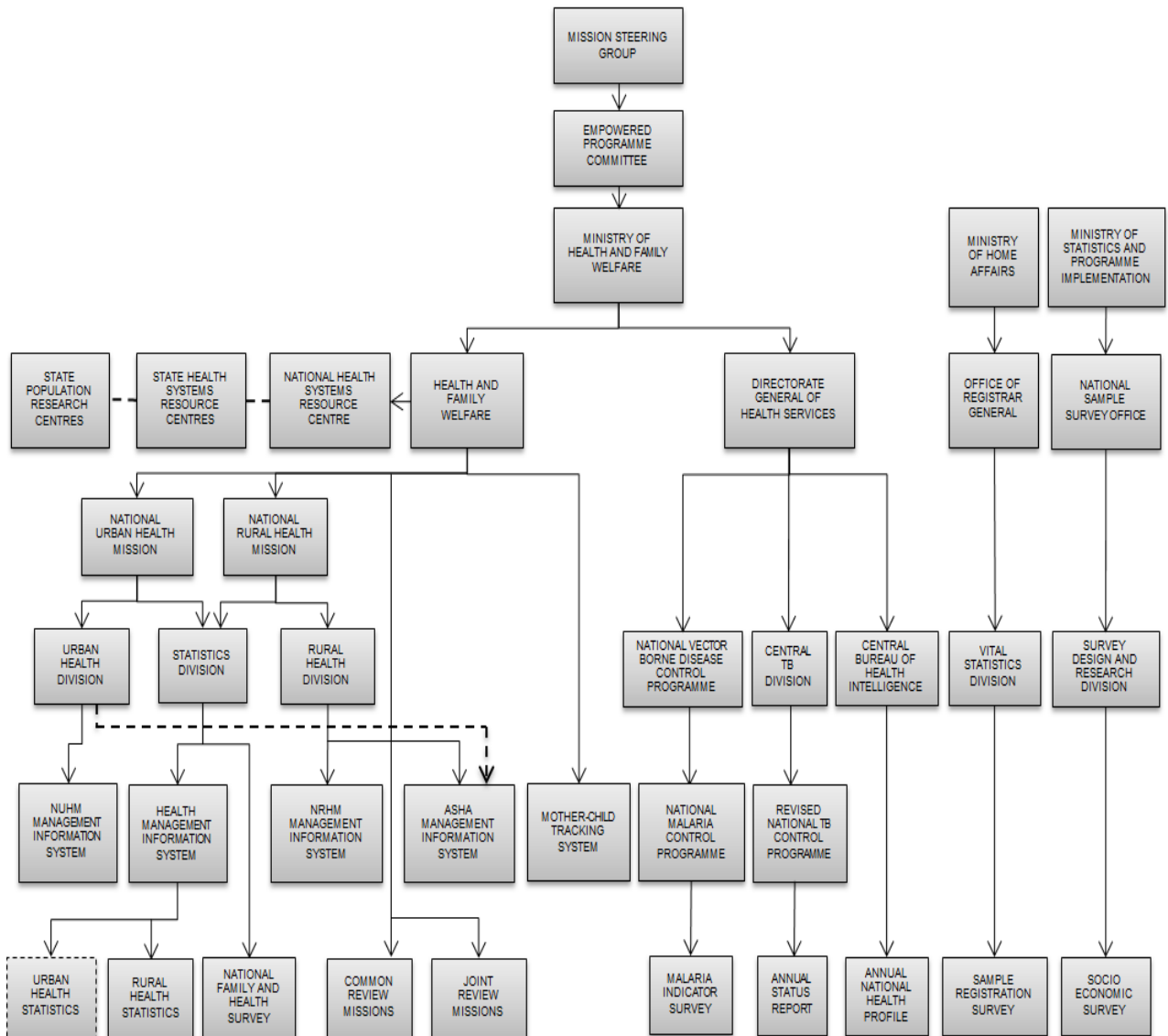
Source: Asian Development Bank and MOHFW.