

Training and Practices of HMIS Data Reporting at Health Facility Level Among Health Workers in Chhattisgarh

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Abbreviations

AMO	Assistant Medical Officer
AYUSH	Ayurvedic, Yoga, Unani, Siddha, Homeopathy
BPMU	Block Programme Management Unit
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
DDO	District Data Officer
DEO	Data Entry Operator
DH	District Hospital
DMP	District Programme Manager
GDM	Gestational Diabetes Mellitus
HMIS	Health Management Information System
JSSK	Janani Shishu Suraksha Karyakram
MAS	Mahila Arogya Samiti
MIS	Management Information System
MO	Medical Officer
MPW	Multi-purpose Worker
NHM	National Health Mission
NRC	Nutrition Rehabilitation Centre
OPD	Out Patient Department
PADA	PHC level Accountant-cum-Data Assistant
PHC	Primary Health Centre
PRC	Population Research Centre
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive Child Health
RHO	Rural Health Organizer
RMO	Rural Medical Assistant
SAM	Severe Acute Malnourishment
SHC	Sub Health Centre
SNCU	Sick Newborn Care Unit
UPHC	Urban Primary Health Centre

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1. Introduction

Public health challenges are undergoing a rapid transition throughout world. Necessity of a robust health information system has emerged as a key ingredient of health care delivery system particularly for public health. In order to substantiate public health decisions, and to monitor progress of public health interventions and outcomes, availability of health management system is a pre-requisite (Aqil et al, 2009). Globally significant amount of human and financial resources have been invested to improve health information systems (Lærum et al, 2004). India has launched its Health Management Information System (HMIS) in the year 2008, justifies the ever increasing data needs for planning, resource mobilization, assessing utilization and monitoring health care system.

Health management information systems in many health settings have experienced varying challenges. Despite the fact that data monitoring and evaluation has been improved through information systems, data demand and information use for decisions have often been negligible among stakeholders. As a result, many health systems fail to fully link evidence to decisions and suffer from inadequate ability to respond to priority health needs at all levels of the health system (Bechky, 2003). It is well accepted that information generated by health care systems is used for planning, management of health commodities, detecting outbreaks, and monitoring the overall performance of the health system that further maintains the quality of care (Shaikh and Rabbani, 2005).

Studies have assessed effectiveness of HMIS in many dimensions ranging from knowledge and understanding of HMIS (Parchure and Basu, 2019), systematic assessment of reported HMIS data (Parchure and Basu, 2017), implementation of HMIS (Krishnan et al, 2016), assessment of level of utilization of routine health information system (Atsede et al, 2017). Studies have found various limitations in implementation of HMIS across health care settings in resources limited settings. Many countries are implementing a standardized health management information system for enabling continuous and comparable health service statistics.

There exists enormous diversity in size and scope of health care system across states of India. This has resulted in need for unification of HMIS processes and its implementation from state level to down at district level and further at health facility level in the periphery. Presently more than 2.15 lakh public health facilities are mapped for monthly reporting of health care services statistics under HMIS in the country.

In Chhattisgarh state many health programmes are being added in HMIS to capture their service statistics from periphery level health institutions such as sub health centres (SHC) in rural areas and mahila arogya samiti (MAS) in urban slums. These health institutions report on a range of health service statistics and also provide linkage with the services provided at the upper level health facilities.

It is felt that data demand and information use for decisions has not been equal at all levels of health care facilities. In the periphery level health facilities use of HMIS for decision making has not been observed. However, the universal fact that public health system requires robust and reliable data for decision-making remains important. Public health decision-making is seriously reliant on a timely availability of sound data.

In this context it is important to understand training and practices being followed for the data reporting in HMIS at the health facility level.

2. Objectives

- a. To assess the coverage of training regarding new HMIS formats among health workers.
- b. To study the practices prevailing among health workers regarding reporting under new HMIS format.
- c. To ascertain the completeness of data reporting under new HMIS format.

3. Study Design and Methodology

The study was conducted in Mahasamund district of Chhattisgarh. The district was randomly selected from 27 districts of the state. There are five blocks in Mahasamund district – Mahasamund (Tumgaon), Bagbahara, Basna, Saraipali and Pithora. All the blocks were covered under the study. There are 260 public health facilities in the district. Out of these respondents from 49 facilities participated in the study.

For selection of participants, district level officials CMHO and Civil Surgeon were approached prior to the data collection and were briefed about purpose of the study and plausible outcome of the study. At District Hospital, Mahasamund all the sections were visited and available staff on the day of visit were contacted and briefed about study objectives and procedure of filling the questionnaire. The same approach was followed in the rural health institutions in each block and block medical officers were approached for contacting the respondents. At PHCs and SHCs all the available staffs were contacted. At the few PHCs, health personnel assembled for monthly meeting were contacted for participation in the study.

In all 175 health personnel from 49 health facilities consented to participate in the study. List of health facilities covered in the study is given in annexure. All the participants were subjected to a self-administered structured interview questionnaire. Participants were informed about the confidentiality of the information provided by them and objectives of the study and they were asked to read the written consent and only those participants who were willing to participate in the study were instructed to fill the questionnaire. It was informed to the respondents that participation in the study is voluntary and they can skip questions if they do not want to record their answer.

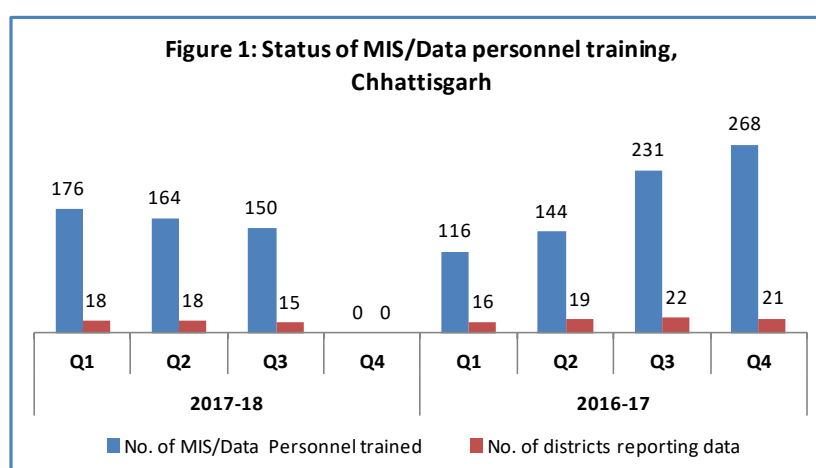
Key stakeholders, e.g. district programme manager, district monitoring and evaluation officer, chief medical and health officer, civil surgeon, block programme manager were interviewed in-depth to ascertain their perspective on HMIS training and data reporting among health personnel.

HMIS reports of selected health facilities were also checked and discussed with the concerned facility in-charge or health personnel involved in HMIS reporting to understand the quality of HMIS reporting. Salient observations were then discussed with the health personnel for assessing issues involved in HMIS reporting.

The data collection and field survey was done during January, 2019. The data was analysed and presented in the tables and graphs. Percentage, ratios and proportion are used for analysing data.

4. Status of HMIS Training

HMIS provided crucial data on training of health personnel on quarterly basis. In district quarterly MIS reports, total number of personnel trained in the district on various health dimensions and services is reported. Table 1 shows the status of reporting of information about number of MIS/Data personnel trained in the districts of Chhattisgarh. It is seen that during 2016-17 and 2017-18, respectively 759 and 490 MIS/data personnel were trained respectively. It was the time new HMIS was in process of implementation. During this period most of the districts have reported about the status of training of MIS/Data personnel (Figure 1). Number of trained personnel has decreased gradually in each quarter during 2017-18 while it was an increasing trend during 2016-17.

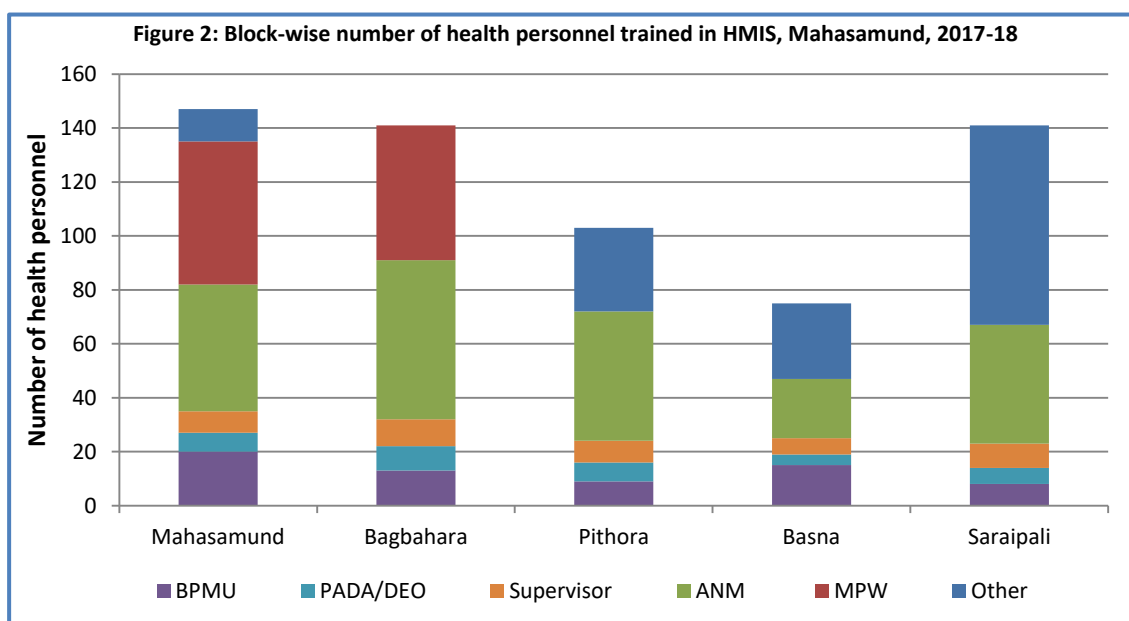


Gaps in reporting of data on training of MIS / data personnel are also evident. Quarterly HMIS reports shows Gariyaband, Champa-Janjgir, Kanker, Rajnandgaon and Sukma have not reported any data on number of MIS / data personnel trained during 2017-18. Similarly, Balrampur, Bijapur, Durg, Kawardha, Kondagaon, Koriya, Narayanpur, Raipur and Surguja have reported less than 10 MIS/Data personnel trained during 2017-18. It is noted that majority districts have trained MIS/Data personnel during 2016-17. However, in the light of revised HMIS reporting, it was expected that districts should have given training / orientation to more and more MIS / Data personnel.

Details of HMIS trainings held during 2017-18 were provided by the district data officer of Mahasamund. It revealed that during 2017-18, training of health personnel along with MIS and data personnel was conducted at district as well as at the block level in Mahasamund district. The district level training was conducted during May to July, 2017 and

at block level training was conducted in 4 to 7 batches in each of the block of district during April to December, 2017. In all 124 health personnel were trained in HMIS in district level training. Nearly half of them were data and MIS persons (Table 2). It is pertinent that regular orientation training of data and MIS personnel is extremely necessary to maintain continuity in the HMIS reporting and thereby improving quality of HMIS data.

Information obtained regarding HMIS training at block level revealed that not only MIS/data personnel, but health service providers were also involved in HMIS training. This is a much needed requirement, since data on health services provided at periphery level health institutions are reported by services providers. Various studies on data quality of HMIS done by PRC have highlighted the necessity of training of service providers which has a direct linkage with HMIS reporting and quality of HMIS data. Figure 2 shows that during 2017-18 majority health personnel were trained in HMIS along with BPMU and other staffs of health programme.



It was observed that HMIS training was imparted to all the health personnel posted at PHC and SHC in the district. The duration of training was spread over several months and training was imparted during monthly meetings mostly in an informal way. It is informed by the district data officer that stress was on understanding of new HMIS data and particularly revised data items. The reason behind splitting of training in several months was to monitor

the reporting of key indicators in the new HMIS format. It also allowed the district level HMIS officials to provide on-spot training and rectification of erroneous reporting.

5. Background Characteristics of Respondents

To understand the level of training and issues related to HMIS reporting at facility level 175 health personnel were interviewed using self-administered interview questionnaire. Table 3 presents the background characteristics of the respondents. More than half (54 percent) responds were in the age group of 26-35 years. Nearly a quarter of respondents were age 41 years and above. Half of the respondents were females.

One-fourth of respondents were 12th pass and another quarter of respondents were graduate. The data shows that one-fourth of all the respondents were either medical graduate or qualified with clinical diploma in their respective domain – such as diploma in medical laboratory technician, diploma in radiography etc.

It is seen that more than one-third of all the respondents were multi-purpose health workers (MPW) re-designated as rural health organizers (RHO). Nearly one-fourth were other paramedical such as lab technician, radiographer, feeding demonstrator of NRC etc. There were 15 percent staff nurse and 5 percent medical officers including Assistant Medical Officer (AMOs) previously known as Rural Medical Assistant (RMA).

Type of employment is a crucial determinant in quality of health care services. Under NHM, initially, majority staffs were recruited on contract basis, and majority health services in Chhattisgarh were supported by these contractual staffs. Gradually, periphery level health care providers were regularized for sustainability of health care services. Among respondents, 71 percent were regular employees and rest were contractual. Among all the

respondents, nearly one-thirds were posted at CHCs and another 27 percent were posted at SHCs. Seventeen percent of respondents were working at DH.

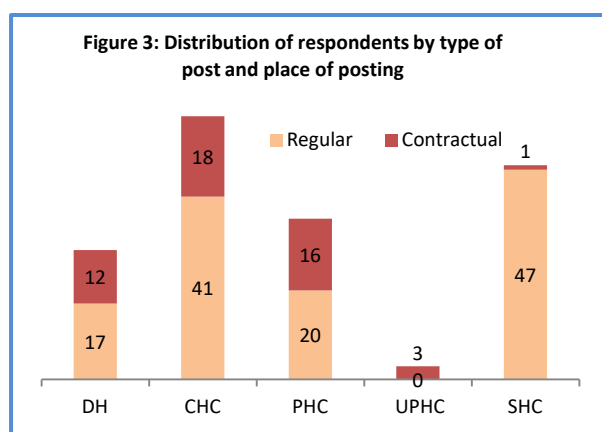


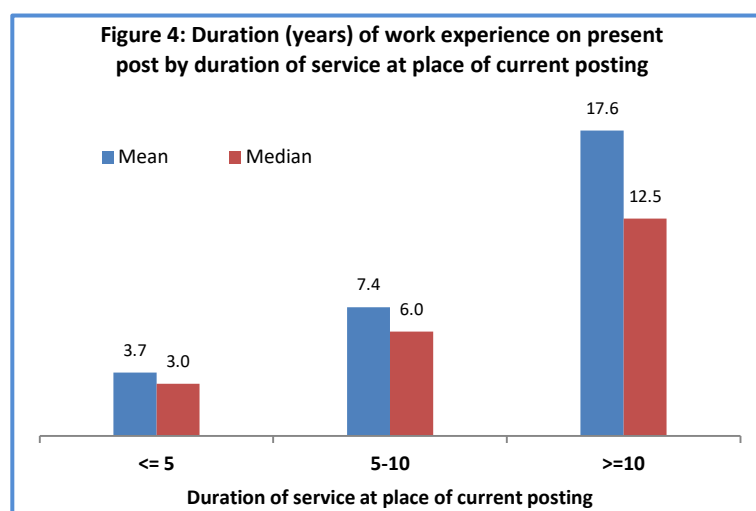
Figure 3 shows the distribution of respondents by place of posting and type of post. It revealed that majority of the respondents posted at CHC were regular

while nearly equal proportion of respondents at PHC were regular and contractual. Except one respondent posted at SHC all were regular. In UPHC all the three respondents were contractual.

Nearly one-fourth of all the respondents affirmed that they were assigned other responsibilities along with their designated duties. Majority among them were DEOs and few male RHOs were given responsibility of health supervisor.

Nearly one-third of all the respondents had been working for less than 5 years on the current position and another one-fourth respondents had worked for more than 10 years on their present post. On an average respondents were working on their current position for 9 years. Duration of service of health personnel at any health facility can determine the status of awareness and quality of reporting of HMIS. The study found that two-thirds of all the respondents were working on the current place of posting for more than 5 years. Figure 4 shows mean duration of work experience on current post on current place of posting. It

revealed that half of the respondents serving for up to 5 years at their current place of posting had been working on their present post for 3 years. Similarly, half of the respondents serving for more than 10 years at the same place had been working for nearly



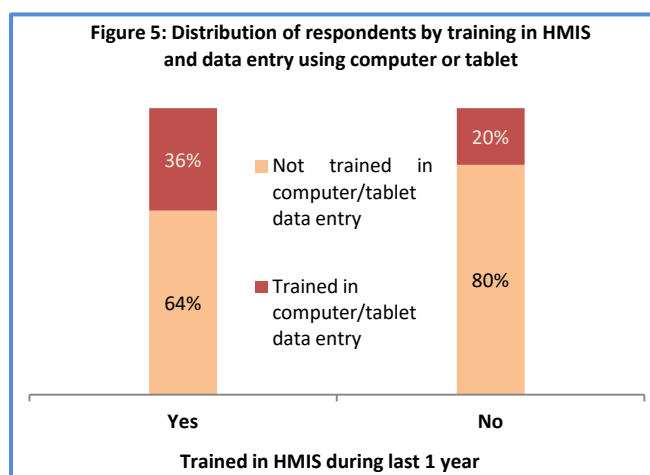
12.5 years at the current post. This indicator is important to understand the training and practices of health personnel regarding HMIS reporting. Involvement of health service providers in HMIS reporting is key for monitoring and supervision of health programmes and timeliness, accuracy, consistency and validity of HMIS data depends on person responsible for data reporting and recording.

6. Training and Awareness on HMIS

The study ascertained the level of awareness about HMIS and its reporting. Table 4 presents the proportion of respondents on status of training about HMIS. It revealed that only half of all the respondents had undergone any training during the year preceding the

study. Universally, respondents did not receive any HMIS training of 2 or more days' duration. However, more than two-thirds of respondents said that their colleagues have undergone HMIS training.

HMIS is computer intensive and with introduction of ANMOL, health service providers are encouraged for online reporting of health services data under HMIS. In fact in Kerala and Tamil Nadu states health care providers are submitting their HMIS reports by themselves. In this context, it is found that only 27 percent of all the respondents are



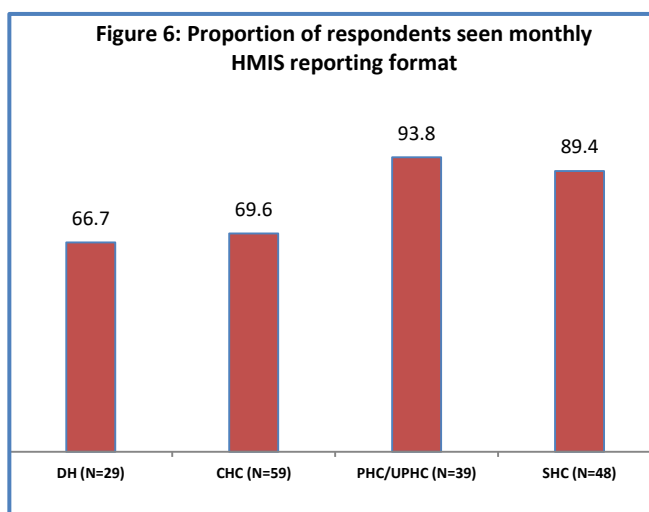
trained in data entry using computer or tablet. Figure 5 shows that one-third of the respondents who had received HMIS training during last 1 year, were also trained in data entry using computer / tablet. Similarly, 20 percent respondents were trained in computer/ tablet data entry, though they were not trained in HMIS.

The study revealed that close to three-fourths of all the respondents knew that HMIS was introduced in 2008 and facility level reporting was initiated in the year 2013 (Table 5). Nearly one-fifths did not respond the question on initiation of HMIS. Less than two-thirds respondents were aware that different types of health facilities have separate HMIS reporting formats. About two-thirds of all the respondents were aware that changes were made in HMIS reporting formats. It is necessary to understand that majority health service providers are not actively engaged in preparation of monthly facility level HMIS reports. More than four-fifths of respondents were shown HMIS formats during training.

HMIS is a web-based data management system. It is imperative that all the data reporting personnel and health care providers should be aware about HMIS web portal. Awareness about three key features of HMIS web-portal – HMIS reports of all the rural health facilities of the country can be seen, HMIS reports of all the DHs of the country can be seen and HMIS reports of all the health facilities of previous 5 years can be seen were ascertained among respondents. Study has found that only half of all the respondents were aware about all the three key features of HMIS web-portal. Nearly one-tenth of respondent

did not have any information about HMIS portal and another 11 percent respondents did not answer the question.

Nearly four-fifths of all the respondents had seen monthly HMIS format of their respective health facility type during training. Majority respondents did not know about any other kind of HMIS reporting format. Nearly 18 percent of all the respondents did not answer this question. Figure 6 shows that nearly two-thirds of respondents from DH and



CHCs have seen HMIS monthly reporting formats of their respective facilities. Majority respondents from PHCs and SHCs have seen monthly HMIS format of their health facility.

7. Practices of Data Reporting in HMIS

The HMIS manuals for service providers and programme managers provide details of HMIS training to be given and practices to be followed for HMIS reporting. After incorporating changes in the existing HMIS in 2017, the same process was expected to be followed. It is necessary that all the dimensions of HMIS reporting – timeliness, completeness, correctness and validation are adhered by health personnel involved in HMIS. The study ascertained the practices of HMIS data reporting in various scenarios where HMIS reporting vary according to the type of health facility.

It is imperative to mention that reporting of health care services provided in monthly facility level HMIS reports are different for DH, SDH and CHC than that of PHC/ UPHC and SHC. At secondary and tertiary care health facilities, only services provided at institutions is to be reported in HMIS. In PHCs and SHCs, data of services provided at health facility as well as in the periphery or catchments area is also provided in HMIS reports.

HMIS manuals contain detailed data definitions, source from where data is to be captured and periodicity of data item reporting for all the data elements for HMIS reporting formats for different types of health facilities. Four-fifths of all the respondents reported

that guidelines for preparing HMIS reports of their respective health facilities were provided during the training.

Respondents were asked about following –

- a. Provision of certain health services for which data is to be reported in revised HMIS formats.
- b. Practices being followed for reporting of certain health care services data items at their respective health facilities.
- c. Practices or conditions applicable for reporting certain health / vital events.

Table 6 provides distribution of respondents on data reporting practices for various services and data items. It is found that non-response by respondents to the specific questions ranges from 7 to 23 percent. This reflects that all the respondents are not equally involved in facility level HMIS reporting. Among respondents from PHC and SHC, non-response is very limited and is in the range of 1 to 17 percent.

Majority (93 percent) responded that total number of OPD cases at their health facility is reported on the basis of number of all types of patients visiting health facility. Sixty-eight percent responded that reporting of pregnant women having Hb<11 mg/dl is done on the basis of pathological test using Sahli or other methods. It is seen that only about half of the respondents from DH and PHC reported about Sahli method of checking Hb level for reporting of anaemic pregnant women in HMIS. Nearly three-fourths respondents said that, in HMIS report of the health facility, number of pregnancy testing kits used is reported on the basis of record of pregnancy test kits utilized. Seventeen percent respondents from DH and one-fifth from SHC mentioned about reporting of number of pregnancy testing kits used on the basis of number of ANC registration.

It is found that overall 69 percent respondents reported about availability of diagnosis for GDM among pregnant women at their respective health facilities. Three-fourths of respondents at DH and 90 percent respondents from CHC reported about diagnosing pregnant women for GDM. As per HMIS data reporting manual, reporting of number of pregnant women tested for GDM is to be done from all levels of health facilities except SHCs. GDM is diagnosed using OGTT test which has specific protocol and should be done by a trained health care provider. It is found that 67 and 58 percent respondents

respectively from PHC and SHC also reported about GDM test being conducted at their health facilities.

Nearly one-third of respondents said that patients seen by AYUSH MO are reported as AYUSH OPD in the monthly HMIS report of the health facility. It is noted that two-fifths respondents reported that there is no provision of AYUSH OPD services at their health facility. For reporting of family planning services, nearly half of all the respondents reported that apart from regular family planning services, number of acceptors served in family planning camps at their health facilities also reported in HMIS report. Further, 14 percent respondents also mentioned about reporting of number of family planning cases sent from their health facilities to the family planning camps organised at other facilities. As such this is area reporting and may lead to duplication of family planning acceptors.

Nearly half of the respondents said that JSSK services being provided at the health facility are reported, in monthly HMIS report. In actual practice, number of beneficiaries receiving JSSK services is reported only in the monthly consolidated HMIS report of the district. It is noteworthy, that only delivery point health facilities are expected to report about JSSK services. It is seen that among respondents, nearly 45 percent said that data on JSSK services is reported in HMIS, while 75 percent respondents from CHC indicated that JSSK services are reported in HMIS.

Certain health care services which are also provided under different health programmes and also as special services such as pulse-polio drive, measles catch-up rounds, identification of diseases among children under RBSK and treatment of certain disease is also done by RBSK teams. The practices prevailing on reporting of morbidity and its treatment in HMIS is ascertained by asking respondents about reporting of children below age 5 years suffering from diarrhoea and treated by RBSK team. It is seen that only 17 percent respondents said that data about this is reported in both HMIS and RBSK reports. One-third respondents mentioned that it is reported in RBSK report alone while 14 percent said this data is nowhere reported.

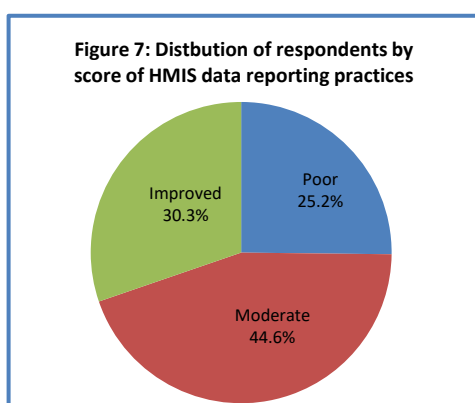
Death is a vital event and as per HMIS guidelines, each event of death is to be reported at the place of occurrence. In earlier studies based on analysis of HMIS data it was found that many health facilities do not report about deaths. HMIS capture data on cause-specific deaths in monthly reports.

It is seen that two-fifths of respondents said that cause of death is ascertained by asking family members of the deceased for reporting in HMIS. Further, one-third of respondents mentioned that cause of death is ascertained on the basis of post-mortem report or verbal autopsy. It is found that majority (85 percent) respondents from SHC ask family members for determining the cause of death for reporting in HMIS. As per Civil Registration System - 2016 report only one-fifth of deaths in India and 18 percent deaths in Chhattisgarh have medically certified cause of death.

Nearly three-fifths of respondents also mentioned that they report number of deaths occurred in an accident in the catchment of their health facility. It is important that accidental deaths are reported properly and completely for designing preventive measures.

It is seen that one-third respondents each mentioned that newborn deaths occurring at SNCU referred by their health facilities are reported in SNCU report and HMIS report of district hospital where SNCU is located. About 17 percent respondents said that it is reported in the HMIS report of the health facility from where the child is referred. Nearly one-fifths of respondents did not respond to the questions related to death reporting.

Study assessed processes of monitoring of HMIS at facility level and in the district. It is found that nearly four-fifths of respondents reported that DEO does the data entry of HMIS of their respective health facility. It is noted that 17 percent respondents do HMIS report verification at their own (Table 7). Nearly one-third respondents reported that supervisor verifies the health facility HMIS reports. Nearly three-fifths of respondents informed that apart from HMIS reports, other reports are also submitted by them from their health facility. It is found that about half of the respondents affirmed the visit of district data officer for monitoring and assessing problems with HMIS data and discussed HMIS reports with them.



Based on the responses of respondents on questions related to practices prevailing for HMIS data reporting at respective health facilities, a joint score is computed by assigning value of '1' if the response matches the right practice of data reporting on individual question and '0' otherwise. The right practice of data reporting has been chosen as per the guidelines on HMIS data reporting.

The total score is obtained by summing of all the values based on 11 questions related to HMIS data reporting practices. The score up to 3 shows poor practices of HMIS data reporting, score 4-5 shows moderately proper practices of data reporting and score above 6 indicate improved data reporting practices. In principle, each and every data item should be reported strictly as per guideline of HMIS data reporting.

It is seen that one-fourth of respondents had a score up to 3, indicating poor understanding and practice of data reporting, 45 percent had moderately proper reporting practice having score of 4 to 5 and about one-third have improved data reporting practice with score of 6 and above (Figure 7). It is observed that older respondents (Age 40+) have poor reporting practices as compared to younger respondents. Among males nearly one-third and among females only one-fifth have poor reporting practices. It is seen that more than one-third (35 percent) females have improved HMIS reporting practices. Among medical officers 37 percent have improved HMIS reporting practices and among other paramedical personnel one-fifth have improved HMIS reporting practices. It is noted that among contractual health personnel 38 percent have improved and 32 percent have moderate HMIS reporting practices. Majority respondents (77 percent) posted at CHC have moderate or improved HMIS reporting practices as compared to 62 percent respondents posted at the DH (Table 7).

Among respondents who have received HMIS training during previous year before survey 40 and 36 percent have moderate and improved HMIS reporting practices respectively. It is noted that only 25 percent among respondents who have not received any training on HMIS have improved HMIS reporting practices. It is found that one-third respondents have improved HMIS reporting practices that have up to five years of work experience. Nearly one-third of respondents having 5 to 10 years of service at present place of posting have improved HMIS reporting practices.

Although majority of respondents have moderate or improved HMIS reporting practices, but necessity of continuous training cannot be ignored. In fact it is extremely important to have round the year training schedule regarding reporting of HMIS across all cadres of health care personnel.

8. Monitoring of HMIS Reporting

Table 8 provides distribution of respondents by processes of HMIS monitoring. Nearly 87 percent respondents mentioned that data entry operator enters the HMIS report in computer, while only 5 percent respondents themselves enter their health facility HMIS reports. Verification of HMIS reports for consistency, completeness and accuracy is important to maintain quality of HMIS data. One-third respondents each said that supervisor or medical officer or AMO/RMA do verification of HMIS reports. Another 22 percent reported that block medical officer verifies the HMIS reports. Majority respondents informed that HMIS reports from their health facilities are submitted timely i.e. on the last day of the month or before 5th of the following month.

Nearly 83 percent said that apart from HMIS reports, other reports are also submitted by them every month. Majority respondents said that data about trainings received by them should be a part of regular HMIS reporting. It is necessary for optimal placement of trained persons at appropriate health facilities.

Majority respondents were not aware that infrastructure data of their health facilities are a part of HMIS reporting. Respondents opined that all types of data reported by them should be discussed during review meetings. This is necessary for tracking performance and service delivery of any health facility.

Nearly half of the respondents mentioned that district data officer or district monitoring and evaluation officer visited their health facility to assess and discuss problems related to HMIS. It is noteworthy that district level officials were lacking in understanding the processes of HMIS monitoring, assessing HMIS data quality and training need of health personnel. District data officer, who is responsible for overall monitoring of HMIS, informed that very few health facilities were visited to monitor the HMIS reporting and data quality. Rechecking, validation, verification of HMIS reports from various health facilities was not done by district data officer. It is understood that district data officer was not adequately trained in HMIS. Study ascertained the processes for HMIS data entry and monitoring at health facility level.

Study observed that HMIS training is not a part of regular training and all levels of health personnel are not involved in HMIS training together. District officials should monitor HMIS reporting and provide adequate support for correct reporting in HMIS.

9. Issues of Training and Reporting in HMIS

Key Programme managers such as Civil Surgeon, DPM, DDO, BMO, and Hospital Consultant were interviewed to assess the issues of HMIS training and reporting in the district. Civil surgeon at DH, Mahasamund asserted that due to administrative workload, HMIS data is not viewed critically for reviewing of services and gaps. For improving maternal and child health care services, assessment of services regarding severe anaemic pregnant women or SAM children is not done. All the key officials have emphasized the paucity of staff for reporting and analysing HMIS on routine basis. The hospital manager at DH informed that only routine checking of HMIS data for monthly reporting is done. It is mainly checked for omission or non-reporting of data items. Civil surgeon informed that no formal training for HMIS monitoring or reviewing based on HMIS has been imparted. It is observed that even during monthly meetings issues related to services provision, availability and supplies of drugs and other consumables are not discussed on the basis of reported HMIS.

Majority of the MOs, BMOs told that they were not adequately trained in HMIS data analysis. The district data officer informed that in district collector's review meeting, data comparison is done in RCH portal data and HMIS reports, which does not match. Since RCH portal capture area reporting and mostly track the completeness of services provided to a beneficiary, whereas, HMIS is facility based reporting of services and provides performance of a health facility in terms of number of services provided. Further, the DPM asserted that the district ranking based on HMIS data is being done by the state. This is crucial for indicating the quality of reported HMIS data and also indicates the progress of the district. However, at times district is put under pressure to improve the performance and improve its ranking, without taking into account the availability of HR and other resources. This leads to improper and erroneous reporting in HMIS.

During discussions it was pointed out that many health care providers of the health facilities in the periphery are not fully acquainted with the new HMIS reporting formats. Proper guidelines were provided but most of the health care providers are not familiar with certain medical terminologies and procedure to pinpoint the morbid conditions among patients. This has reflected in the zeros and blanks data items reported in HMIS facility level reports. During discussions it was pointed out that routine checking of HMIS reports submitted by the health facilities are done by the DEOs or PADA for consistency errors. It was observed that many health facilities do not keep an office copy of the submitted HMIS

report and most of these reports are not properly checked and verified by supervisor and concerned medical officers at periphery level health facilities. During field visit to some of the health facilities, services availability, training and HMIS reporting were observed and HMIS reports were checked for consistency and completeness.

Issues emerged during discussions with the service providers of health facilities are given below -

UPHC, Nayapura

- MO of UPHC is attached from CHC, Tumgaon. But quite often his duty is scheduled at CHC. MO post could not be filled on contractual basis for UPHC. AMO was thus posted in place of MO.
- There are five SSKs, covering 30 wards of Mahasamund town, attached to the UPHC. SSK-wise data is sent to CHC, Tumgaon for reporting in HMIS.
- Data entry of HMIS report is done by DEO posted at CMHO office, Office copy of the HMIS report is retained at UPHC.
- SSK-wise reporting format and HMIS need synchronization to match data items.
- In HMIS report, number of lab tests done is reported as '12' in all months.
- Instead of condom pieces, number of condom packet distributed from PHC is reported in HMIS.

CHC Tumgaon

- Tumgaon outreach services are reported by SHC Tumgaon in HMIS.
- Tumgaon has no specialist. Only MBBS MO is posted at CHC. It has no BSU.
- OGTT test is reported in HMIS report in every month in 2018-19. However, it is not done.
- AYUSH services are not given since December, 2018. AYUSH MO resigned.
- Number of in-patient is reported is same as number of in-patient treated in emergency.
- Irregular reporting of in-patient head count at mid night.
- CHC has no NRC and SNCU, data on services provided or children admitted in NRC/SNCU is reported as zero, instead of 'blank'.

SHC Tumgaon

- Hindi translated HMIS format is being used.
- ANM fills-up the HMIS report and PADA enters the data in HMIS portal
- Total number of lab test reported as zero. but Hb tests are being reported in HMIS.
- No deaths are reported in any month. Data items are left 'blank'.
- Pregnancy testing kits used reported zero. But ANC registration are reported.
- There are translation errors in the HMIS format and ANM not able to understand it properly. For example –

8.1.1.a RDT Conducted for Malaria – RDT आयोजित मलेरिया के लिए

8.1.1 Acute Flaccid Paralysis (AFP) - तीव्र झिल्लीदार पक्षाघात

15.3.3.c Pregnant women screened positive for HIV - HIV के लिए सकारात्मक संख्या

15.3.3.c Number confirmed positive at ICTC – ICTC पर सकारात्मक पुष्टी (In PHC format)

PHC Patewa

- In Infrastructure MIS bed occupancy reported > 60%, Building area as 'blank' however, as per records available it is 31000 ft²
- In monthly HMIS reporting of IUCD insertion total (01) is less than PPIUCD (26)
- In all 72 deliveries were reported since April, 2018 and all were reported as discharged within 24 hours.
- Death reporting is zero in December, 2018. PHC does not report deaths occurring in the PHC village. It is reported by SHC, Patewa and that too only death of local resident. All outside deaths are ignored for reporting in HMIS both by PHC and SHC.

SHC, Chirko

- Pregnant women tested for Hb, Blood Pressure checked reported as zero (ANM informed about non-availability of testing solution for Haemoglobinometer), Number of pregnancy testing kits used reported as 'Blank' (ANM reported non-availability of pregnancy testing kits since long)
- Wrong Hindi translation of 12.6.14 Number of Adolescent / Adult deaths due to Causes Not known – कारणों की वजह से अप्राकृतिक / वयस्क मृत्यु की संख्या ज्ञात नहीं है. This needs to be corrected as - अज्ञात कारणों से हुई किशोरों / वयस्क मृत्युओं की संख्या
- Weekly pills strips (5.11) distributed is reported as - 18 in December, 2018 only.

- Calcium supply is not available, but ANM purchased and supplied.

SHC Bonda

- Total Hb test (10.1.1) and RD kit test for Malaria (8.1.1.a) – blank
- ANM informed that IUCD 380A is not available, although it is easy to insert. IUCD 375 is available but insertion is not convenient and she needs more training on IUCD 375.
- ANM reported that many women in the area not able to properly breastfeed. But just to show our performance we have to report 100% breastfeeding. This needs more in-depth study.
- Few medicines are not supplied in sufficient quantities and some times remain out of stock at Jan Aushadhi Kendra.
- Some medicines are supplied in excess quantities which are not required at all or very few is needed.
- ANM asserted that feedback on HMIS report is not given at all.
- Due to short supply of HIV kits, only ANC HIV test is done. Non-ANC and male cases are not tested for HIV. There are high risk groups which needs HIV testing.

PHC Patsendri

- Health Wednesday is organized for children, SAM mother and all other patients.
- Lab technician is not posted so patient load is less. Patients are aware and insist on lab testing for any fever.
- There are 13 SHCs in the catchments of PHC. Mostly delivery and NCD patients are referred to PHC. As per the symptoms, patients are referred to higher facilities. No investigation is done for NCD.
- Immunization is not done at PHC.

SHC, Kenduwa

- It is HWC designated SHC. Renovation as per requirement is in progress. It has very old building with only one room. ANM resides at SHC.
- In HMIS report – No reporting of ANC calcium since September' 2018
- Many data items which should be either zero or non-zero values are reported as blank. Such as Hb<7 and all Hb<11, Syphilis test zero/blank, Number of LBW birth, Condom pieces distributed, All pregnancy complications, Rotavirus vaccination, Childhood diseases (M7) and Death Reporting

- Deaths occurred at SHC is only recorded and provided death certificate. Any other household death certification is done by Gram Panchayat.
- Although death register is maintained, but deaths are not reported in HMIS.

SHC, Singhanpur

- SHC earlier using English language HMIS format. But new bilingual format is being used since January, 2019.
- In November' 2018 report – Hb<11, <48hrs discharge are blank
- Pre-term corticosteroid is reported '1' but pre term labour is reported 'zero'.
- Number of newborn weighed < 205 kg is same as number of live births. Meaning all the births are LBW.
- Delivery at SHC are 16, but BCG is only 6
- Vit.K birth dose – zero
- RDT kit for Malaria used – blank
- Deaths reporting – blank
- HIV screening at SHC is zero, ICTC confirmed cases are 19
- OPD cases for Diabetes (22), Hypertension (33), Stroke (3), Paralysis (4), Mental illness (3), Epilepsy (1), Eye (13), Dental (24). This needs further verification.
- Short supply of OP, CC and Pregnancy testing kits was reported by ANM.
- Mitnin refers diarrhoea, pneumonia cases to SHC and they are reported in HMIS.
- ANM takes meeting of mitnin for dropout cases of immunization, and for avoiding home delivery by promptly sending to SHC.
- ANM informed about problems in RCH Portal entry – connectivity, network problem and software problem.
- ANM suggested that all other reports should be incorporated in HMIS. Multiple reporting of same data in different formats need to be stopped.
- ANM informed about problems in ascertaining causes of death from family members. In case of IDR and MDR, family members don't cooperate. More sensitization to community and ASHAs for ascertaining cause of death is needed.

PHC, Baroli

- There are nine personnel posted at PHC. Eleven types of test are done at PHC for all

patients. This PHC is close to Orissa boarder and patients from nearby villages from Orissa come for delivery and other services.

- In September' 2018 HMIS reporting discrepancies were observed – ANC registration, Pregnant women tested for Syphilis, Home deliveries, Newborn weighted at birth, IUCD, Ophthalmic OPD, Other OPD are all reported as blank.
- Staff nurse informed that PPIUCD training is given but due to less number of cases, she has less confidence in PPIUCD insertion.
- Staff informed that there are many LBW newborns, so Vit.K should be supplied.
- Neonatal complication cases are referred to DH, which is very far. NBSU is needed at PHC. Neonatal deaths are very high in the area and patients prefer to go to DH.
- PHC staffs are motivated and cooperative.

SHC, M.K.Bahra

- ANM maintain a rough register for HMIS reports as office copy. The register has incomplete entries. No HMIS entries in the register for November, December, 2018
- Discrepancies in HMIS reports observed are – All ANC registration, ANC 4 check-ups, four times Hb testing, Hb<11, ANC Syphilis test reported are all same figures.
- Every month same number of institutional deliveries is reported.
- CC and OP reported same in every month.
- Vit K administered is 'blank'.
- SAM check-up reported as blank since October – 2018.
- OPD cases is always in round figure such as 200, 300, etc.
- Only total IUCD reported, PPIUCD is blank.
- Death reporting is blank.
- BCG, Penta, OPV, Measles, booster dose are all same within each month
- ANM suggested that HMIS should allow reporting of non-available services at SHC. Demand for equipment, medicines should also be a part of HMIS.
- ANM informed that PNC services given to women who delivery outside the SHC area is not reported in HMIS, however, all PNC services are given.
- Only normal IUCD is provided, PPIUCD trained but do not give services.
- Services given by mitanin are not reported in HMIS.

SHC, Khallari

- This is a delivery point. Khallari village also has a functional PHC with few staffs.
- HMIS format is in Hindi language. ANM using it since 2018. ANM has neatly filled-up the format
- HMIS Discrepancies observed are – All ANC registration, pregnant women given 180 IFA and 360 calcium are all equal – supplies are irregular.
- Pregnant women tested for Syphilis is blank
- OPD either blank or zero
- All ANC registration are in first-trimester.
- VHND conducted zero in December, 2018.
- ANM insisted that she provides vaccination services at PHC and at AWW. However, service provided at AWC is reported in HMIS of SHC. Even birth does is given at PHC although delivery is done at SHC. This shows low performance in SHC
- OPD general is not reported or recorded for HMIS reporting. Separate OPD report is sent to block
- WIFS services are provided but not reported in HMIS since no data item in HMIS.
- Only institutional deaths are recorded and reported in HMIS.
- Antibiotics and Calcium is irregular supply.
- Catheter is supplied but it has no use at SHC.
- No or short supply of basic medicines such as PCM etc.

During discussions with various services providers it was noted that there is a need to orient all the health personnel in new HMIS reporting format. It is reported that there are confusing directives regarding reporting of birth and BCG, NCD services, death reporting, vaccination in outreach sessions etc. It was informed that during review meetings, ratio of number of BCG and measles is matched for each SHC. This indicator always misleads the officials since BCG given to children born in institution is not reported by SHCs. There are no proper guidelines for reporting of 180 IFA and 360 Calcium tablets given during ANC and PNC. Further there is a conflict on reported data on delivery, live births and BCG particularly at SHCs and PHCs.

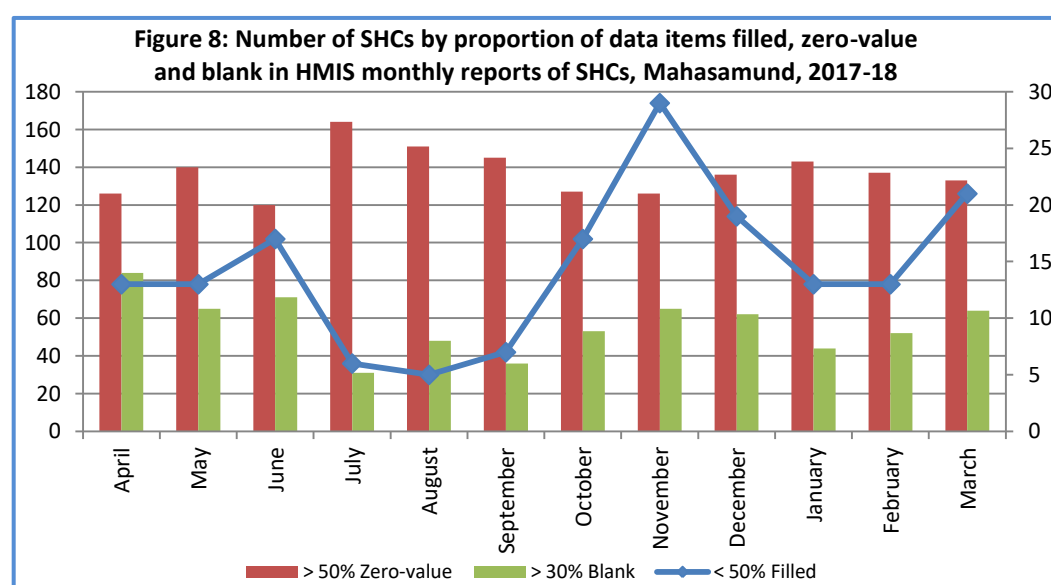
Infrastructure MIS is never verified for correctness of reported data. There are no supplies of medicines as per requirement. There is not EDL specific to the SHC.

It is noted that HMIS reporting need through review at periphery level. All the health personnel should be oriented about HMIS reporting.

10. Status of HMIS Reporting at Facility Level

Level of data reporting in HMIS monthly reports provides valuable information about the issues related to training and practices of data reporting at health facility level. In new HMIS monthly reporting, SHCs report 179 data items, PHCs report 284 data items, CHC report 297 data items and DH report 305 data items. In HMIS monthly district consolidated report 368 data items are reported.

Figure 8 shows that during 2017-18 number of SHCs have increased from 13 to 21 that had reported less than 50 percent of data items in HMIS monthly report. This shows that out of 222 SHCs in the Mahasamund districts, 21 SHCs have been reporting on less than 50 percent of data items in monthly HMIS reports.

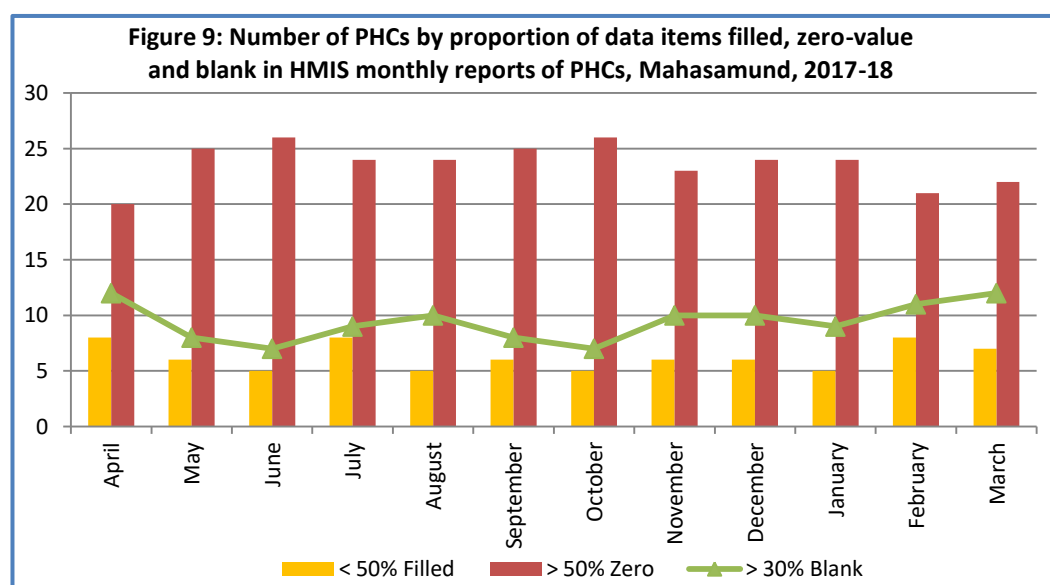


Further it is seen that out of the total data items reported in the monthly HMIS report, more than 140 SHCs have reported zero-values in more than half of the data items. Further around 60 SHCs have reported more than 30 percent of all the data items as blank.

It is observed that majority of the SHCs are not reporting deaths and other critical data in HMIS reports and leaving the data items 'blank' meaning services are not available at the SHC. It is noteworthy, that data items pertaining to vital events cannot be a blank-value since it is countable and exclusive to the health facility where vital event has occurred.

Out of 222 SHCs in the district, 50 SHCs had reported more than 50 percent of all the data items as zero-value in all the months during 2017-18. Analysis also shows that 10 SHCs had reported more than 30 percent data items as 'blank' throughout the year 2017-18. Further, the analysis pertaining to the 31 SHCs visited during the field survey shows that during 2017-18 majority of the these health facilities had reported data on more than 70 percent data items, but out of the reported data majority are zero-values, indicating services are not provided. Proportion of data items reported as 'blank' was less than 20 percent for majority of health facilities (Table 9).

HMIS monthly data reporting at PHCs show that out of 36 PHCs in the district, nearly 20 to 26 PHCs had reported more than 50 percent data items as zero-value (Figure 9). During 2017-18, 5 to 10 PHCs had reported data in less than 50 percent data items in the monthly HMIS reports. About one third of all the PHCs also reported more than 30 percent data items as 'blank' in monthly HMIS report. This shows that more than two-thirds of all the PHCs have not reported any services during 2017-18.



It is seen that out of 36 PHCs in the district one private institution equivalent to a PHC has reported average 15 data items in each month. This PHC is situated in Saraipali block. Analysis revealed that 16 PHCs Junwani Khurd, Khallari, Khamhariya, Komakhan, Mungaser, Tendukona, Jhalap, Khatti, Sirpur, Bamhani, Bhithidih, Pirda, Saldih, Baloda, Patsendri, Singhoda had reported more than half of data items as zero-value throughout the year. Further, it is noted that PHC, Sinodha, PHC, Patewa and UPHC Nayapara had reported

more than 30 percent of data items as 'blank' in monthly HMIS report in all the months during 2017-18.

It is noted that PHCs - Bamhani, Bhithidih and Singhoda had filled more than 80 percent of data items in all the months in 2017-18. PHC Singhoda has reported more than 90 percent non-blank data items throughout the year depicting more than availability of more than 90 percent of services.

It is found that out of 12 visited PHCs in the district majority data items were reported as zero-values in the HMIS monthly reports (Table 10). This shows that for most of the services there were no beneficiaries visited the PHCs.

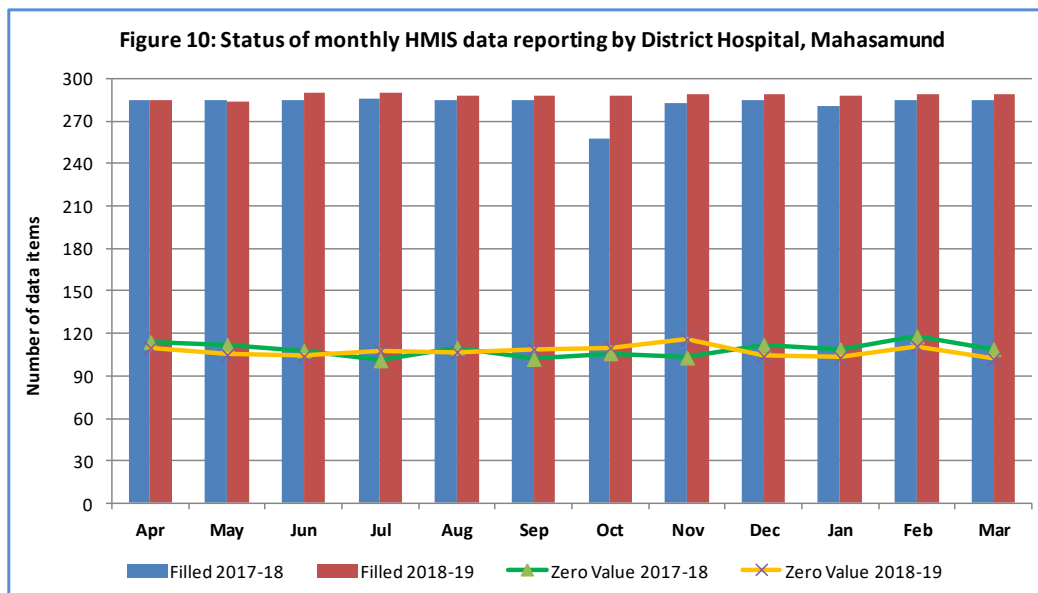
There are five CHCs in the district and three private institutions equivalent to the CHC are also reporting monthly HMIS reports. It is observed that out of 297 data items, on an average more than 200 data items were reported by five CHCs in 2017-18 (Table 11). CHC Tumgaon had reported average 251 data items [(Min: 165 (June); Max: 292 (Sept.,Nov.))] in the monthly HMIS report. CHC Pithora had reported on an average 181 data items [Min: 98 (June); Max: 273 (March)] in the monthly reports during 2017-18.

It is seen that in monthly HMIS reports of all the CHCs, nearly half of all the reported data items were zero-value. Out of 297 data items, on an average 116 data items were reported 'blank' by CHC Pithora. An average of 70 data items were reported 'blank', majority pertaining to health events – deaths, morbidity and critical illness including NCDs by the CHCs. HMIS monthly reporting of private health facilities was observed as irregular. Only 38 percent of data items were filled by Sewa Sadan in Pithora block and nearly 85 percent of filled data were zero-value.

District hospital, Mahasamund is the only FRU in the district. It is expected to report data on majority of services, health and vital events under HMIS. The data reporting of DH revealed that during 2017-18 and 2018-19 number of data items filled and data reported as zero-value in HMIS monthly report remained unchanged (Figure 10). The DH had reported on nearly 280 data items out of 305 data items in HMIS monthly reports.

It is seen that out of filled data items, nearly one-third data items were reported as zero-values. This shows that HMIS reporting at DH in the newly introduced HMIS reporting formats has streamlined quantitatively in terms number of data items reported.

This improvement should be percolated to other periphery level health facilities, especially at PHCs and SHCs, where no separate data personnel are available and ANM and MPWs have to take responsibility of HMIS reporting.



Monthly district consolidated HMIS report helps in monitoring of health programmes and performance of health services at the district level. The monthly district consolidated report is generated by consolidating monthly HMIS reports of all the health facilities of the district. Any omission, under-reporting, non-reporting at health facility level HMIS reports is reflected in the monthly consolidated report of the district. This report encompasses all the data items reported in each level of health facility right from SHCs to DH. Some of the data items pertaining to specific programmes such as RBSK, JSSK, JSY etc. are reported directly as consolidated data items, which are not part of individual health facility level HMIS reports.

The analysis of data reporting in monthly consolidated report shows that out of 368 data items, on an average 286 (77 percent) data items in every month were filled during 2017-18. This proportion has increased by 17 percent point and 94 percent of data items (346 data items) were filled in 2018-19. This has been a major improvement in HMIS data reporting. However it is noted that from 2017-18 to 2018-19, number of data items reported as non-zero value has decreased from 71 percent to 67 percent. Ideally, district consolidated report should not have any zero-value data items, since majority health care services, health and vital events are reported under all the levels of health facilities.

In Mahasamund district, majority SHCs and PHCs had reported zero-values in monthly HMIS reports and few of them had also reported majority data items as blank. This reflects that more orientation of periphery level health personnel is required. Best practices of HMIS reporting at higher health facilities such as CHC and DH should be discussed with the periphery level health personnel to enhance HMIS reporting quality.

11. Summary and Conclusion

The present study highlights the status of training and practices prevailing about HMIS data reporting in Mahasamund district of Chhattisgarh. Study covered 175 respondents from 49 health facilities from the district using self-administered interview questionnaire. Study also analyzed data reporting of monthly HMIS reports of all the health facilities in terms of completeness. It also provides status of training of health personnel reported in district quarterly HMIS reports and information provided by the district.

The new HMIS format introduced in 2017 requires proper training on new data definitions, source of data and coverage of reporting of data items. In the revised monthly HMIS reporting formats, data on morbidity and mortality is to be recorded and reported in the catchments area of PHCs and SHCs. At higher facility level, only services given at health facility or health /vital events occurred at health facility is required to be reported. It was observed that district has no mechanism for proper record keeping and reporting of health personnel and programme management unit personnel trained in HMIS. State programme management unit need to ensure proper reporting of quarterly HMIS report by the districts. District should also keep track of trained personnel and its reporting in district HMIS quarterly reports. While many districts either not reporting data at all or reporting erratic data in quarterly HMIS reports, very few districts have reported data on number of trained personnel for all the quarters of the year. It was observed that majority districts have trained MIS/Data personnel during 2016-17. However, in the light of revised HMIS reporting formats, more MIS/Data personnel should have been trained in HMIS. In Basna and Pithora blocks of Mahasamund districts, very few service providers have been trained in HMIS during 2017-18. Quality of HMIS data reporting has direct bearing on training of health personnel about data reporting.

Study found that only half of respondents have received any training during 2018 in the district and nearly all of them have not been given training of 2 days' duration. It is necessary to engage health care providers in HMIS reporting providing them tools to analyze their reported data. This ensures ownership of reported data. HMIS is a computer intensive data reporting system. Study observed that only 27 percent respondents are trained in data entry using computer/tablet.

Key concepts, processes of data reporting, compilation, and usefulness of HMIS is known to very few respondents. Only half of all the respondents were aware about key features of HMIS web-portal, where HMIS data is uploaded or entered. One in every ten respondents did not know about HMIS web-portal. Only two-thirds of respondents were aware that different HMIS formats are there for different types of health facilities. Except monthly HMIS reporting formats, majority respondents were not aware about other reporting formats in HMIS. Only two-thirds of respondents from DH and CHCs have seen monthly HMIS reporting formats.

Study ascertained practices of HMIS data reporting and services being provided at the health facilities from respondents. In all more than half of respondents have fair practices of HMIS reporting with respect to various kinds of services provided at the health facilities. It was observed that majority health care providers have no idea about reporting of vital events particularly data on number of deaths by cause. A joint score computed to ascertain right practices of HMIS reporting shows that one-fourth of respondents have poor HMIS reporting practice, while two-fifths have moderately proper reporting practices and one-third respondents have improved HMIS reporting practices. It is noteworthy, that this score is based on only few dimensions of HMIS data reporting and majority respondents do not practice basic checks, verification and validation before HMIS data reporting. District data officer often do not take necessary visits to health facilities for assessing completeness and verification of HMIS data reporting.

The study has found that in Mahasamund district, not all the data items are reported in monthly HMIS reports at facility level. During 2017-18, nearly 10 percent of 222 SHCs had reported less than half of the data in monthly HMIS formats. Majority SHCs are reporting zero-values in majority data items meaning no services are given at the SHCs. Among PHCs, nearly one-third had reported less than half of all the data items in monthly HMIS reports

during 2017-18. Similarly for CHCs, nearly half of all the data items are reported at zero-value in monthly HMIS reports. On an average, 70 data items out of 297 data items have been reported as blank by CHCs.

The study revealed that majority services providers were not trained continuously to improve HMIS reporting at health facility level. There is little scope for monitoring and supervision of HMIS reporting practices at health facility level, since many programme management units at block level have no dedicated person for HMIS data assessment. Study also found that, HMIS data is never discussed to identify service gaps and infrastructure availability at health facility level. Respondents argued that there is no mechanism for two-way feedback on HMIS data and issues in reporting of HMIS.

Study suggests following steps to improve HMIS data reporting practices at health facility level.

- State should provide detailed data definition guidelines to each health facility in the form of handbook for HMIS data reporting in local language.
- State need to ensure that each SHC and PHC should have at least one person well trained in HMIS data reporting. This should be done by providing hands-on training each month during monthly review meeting.
- State should provide support of resolving problems in HMIS data reporting through designing FAQs for different types of health facilities.
- All the data items in HMIS which are common to all the health facilities should be focused to ensure correct reporting. For example – reporting of health events such as OPD/IPD, morbidity conditions and vital events such as births and deaths need to be checked for completeness.
- All the service providers should be given thorough understanding about HMIS reporting at all levels. They should be given adequate information about annual infrastructure MIS, quarterly district headquarter MIS, district monthly consolidated MIS, facility level monthly MIS and interrelation between all the HMIS reporting formats.
- Each health facility should be promoted to display monthly data of key service delivery indicators from HMIS. This will allow service providers to understand their own performance and they will be able to relate the performance of health facility with available resources and skills.

- Health facilities should be provided support to present their data on key health parameters and services available during review meetings. This will also help in promoting best practices to understand HMIS data reporting.
- Critical care services and identified key health issues through HMIS data reporting should be compared with other data sources to inform health facilities and thus helping them in identifying pros and cons in services.
- Health care providers who have adequate understanding of HMIS data should be encouraged to provide training to other health personnel.
- District data officer and other PMU officers should monitor the utilization of HMIS data in planning and improvement in health care delivery.

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Table 1: District-wise number of personnel trained in HMIS, Chhattisgarh

District	2017-18					2016-17				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Balod	5	5			10	5	5	4	5	19
Baloda Bazar		12	22		34	45				45
Balrampur			1		1					0
Bastar	7	7	4		18	6	6	7	6	25
Bemetra	24	4	24		52	4			24	28
Bijapur	1				1			1		1
Bilaspur	5	3	3		11	7	7	5	5	24
Dantewada	24	26	44		94		2	23	21	46
Dhamtari	26	12			38	3	4		3	10
Durg	3	3	3		9	3	3	3	3	12
Gariyaband					0			5	4	9
Janjgir Champa					0		1	9		10
Jashpur	7	7	7		21	8	8	7	5	28
Kanker					0		35	19		54
Kawardha		3	5		8	4	4	4	4	16
Kondagaon	1		2		3		30	40	40	110
Korba		41			41	5	5			10
Koriya	1	1	1		3		5	5	40	50
Mahasamund	40				40	4		4	30	38
Mungeli	8	7	7		22	3	3	3	2	11
Narayanpur	2	2			4	2	1	1	1	5
Raigarh	9	18	18		45	9	9	9	9	36
Raipur	4	4			8	4	4	4	4	16
Rajnandgaon					0			51	34	85
Sukma					0			17	16	33
Surajpur	6	6	6		18		6	6	6	18
Surguja	3	3	3		9	4	6	4	6	20

Source: Compiled from quarterly MIS reports, HMIS, Chhattisgarh, <http://nrhm-mis.nic.in>

Table 2: Number of health personnel trained in HMIS at district level during 2017-18 in Mahasamund

Designation of Health Personnel	Number
Block Program Manager	2
RMNCHA Counsellor	3
District Account Manager/ District accounts assistant	2
District Training Coordinator	2
District Data Manager/ District data assistant	4
Data Manager (IDSP)	2
Block Data Manager	9
PHC level accountant-cum-data assistant	42
Data Entry operator	11
Assistant Grade - 3	6
Other	41

Table 3: Percentage distribution of respondents by background characteristics

Background characteristics		N = 175	Percent
Age (Years)	<=25	12	6.9
	26-30	49	28.0
	31-35	46	26.3
	36-40	26	14.9
	>=41	42	24.0
	<i>Mean</i>	26.5	
Gender	Female	92	52.6
	Male	83	47.4
Education	up to 12 th	43	24.6
	Graduate	44	25.1
	Medical graduate	18	10.3
	Post graduate	47	26.9
	Clinical diploma	23	13.1
Designation	Medical officer	8	4.6
	Rural health organizer/MPW	66	37.7
	Staff nurse	27	15.4
	Other paramedical	47	26.9
	Non-paramedical	10	5.7
	Other	17	9.7
Type of Post	Regular	125	71.4
	Contractual	50	28.6
Place of posting	District hospital	29	16.6
	Community health centre	59	33.7
	Primary health centre	36	20.6
	Urban primary health centre	3	1.7
	Sub health centre	48	27.4
Other work is also assigned	Yes	42	24.0
	No	133	76.0
Work Experience on current post (Years)	<= 5	58	33.1
	5-10	75	42.9
	>=10	42	24.0
	<i>Mean</i>	9.2	
Duration of service at place of current posting (Years)	<= 5	58	33.1
	5-10	65	37.1
	>=10	52	29.7
	<i>Mean</i>	9.2	

Table 4: Percentage distribution of respondents by status of HMIS training

		N=175	Percent
Training on HMIS given during last 1 year	Yes	83	47.4
	No	90	51.4
	No response	2	1.1
Any HMIS training of more than 2 days given	Yes	8	4.6
	No	166	94.9
	No response	1	.6
Any of your colleague is trained in HMIS	Yes	121	69.1
	No	41	23.4
	No response	13	7.4
Trained in data entry using computer or tablet	Yes	48	27.4
	No	121	69.1
	No response	6	3.4

Table 5: Percentage distribution of respondents by HMIS awareness

		N=175	Percent
When HMIS was introduced	2000	5	2.9
	2005	1	0.6
	2008	77	44.0
	2013	51	29.1
	2011	1	0.6
	No Response	40	22.9
HMIS formats are different for different types of health institutions	Yes	109	62.3
	No	41	23.4
	No Response	25	14.3
Any changes are made in HMIS formats	Yes	120	68.6
	No	19	10.9
	No Response	36	20.6
Shown HMIS formats	Yes	153	87.4
	No	11	6.3
	No Response	11	6.3
What do you know about HMIS web portal	HMIS report of all rural health facilities of the country can be seen	12	6.9
	HMIS report of all DH of the country can be seen	1	0.6
	HMIS report of all health facilities of previous 5 years can be seen	25	14.3
	All above	96	54.9
	No information about this	21	12.0
	No response	20	11.4
HMIS formats seen*	Annual format of health facility	16	11.2
	District quarterly format	1	0.7
	Monthly format of health facility	116	81.1
	District monthly format	16	11.2
	No Response	32	18.3

* Multiple response

Table 6: Percentage distribution of respondents by practices prevailing in HMIS reporting

		N=175	Percentage
Guidelines for preparing HMIS report of your health facility is provided	Yes	140	80.0
	No	23	13.1
	No Response	12	6.9
Reporting of children age <5 suffering from diarrhoea treated by RBSK team is done as	HMIS report of health centre	26	14.9
	RBSK team report	55	31.4
	Both HMIS and RBSK report	30	17.1
	Do not report	24	13.7
	No Response	40	22.9
Basis of reporting of number of pregnant women with Hb<11gm in HMIS	Based on check-up by doctor	34	19.4
	Only through check-up when Sahli apparatus not available	1	0.6
	By checking through Sahli or other method	114	65.1
	Report all pregnant women who ever had anaemia	17	9.7
	No Response	9	5.1
Reason of death is ascertained	Based on PM report	22	12.6
	Based on verbal autopsy	14	8.0
	Any of above	27	15.4
	By asking family members of the deceased	72	41.1
	Based on emergency documents	1	0.6
	No Response	40	22.9
Basis of reporting of total OPD attendance	No. of all patients visiting health facility	163	93.1
	No Response	12	6.9
Newborn death in SNCU referred by health facility is reported in	SNCU report	50	28.6
	HMIS report of the DH	51	29.1
	HMIS report of health centre from where child was referred	30	17.1
	SNCU not functional	2	1.1
	In both SNCU and HMIS report of DH	7	4.0
	No Response	35	20.0
Report deaths occurred in an accident in your health centre area in HMIS	Yes	103	58.9
	No	47	26.9
	No Response	25	14.3
GDM test for pregnant women is done at your health facility	Yes	122	69.7
	No	22	12.6
	No Response	31	17.7
AYUSH OPD in HMIS report indicates	Patients seen by AYUSH MO	55	31.4
	Patients who are given AYUSH treatment	13	7.4
	No AYUSH services given in OPD	81	46.3
	Not possible to report AYUSH OPD	4	2.3
	No AYUSH MO Available	1	0.6
	No Response	21	12.0

Table 6: Percentage distribution of respondents by practices prevailing in HMIS reporting

		N=175	Percentage
Basis of reporting of number of pregnancy testing kits used in HMIS	Based on ANC registration	23	13.1
	Number of kits used	133	76.0
	Number reported by ASHA	4	2.3
	Difficult to keep record	4	2.3
	No Response	11	6.3
Reporting of FP cases in camps at health facility	Yes	81	46.3
	No	24	13.7
	No camp but report FP cases sent from health centre	24	13.7
	No camps so do not report	26	14.9
	No Response	20	11.4
Reporting of JSSK services provided at health facility	Yes	94	53.7
	No	53	30.3
	No Response	28	16.0

Table 7: Percentage distribution of respondents by practices prevailing on HMIS monitoring

		N=175	Percentage
Usually who enters HMIS report of your health centre in computer	Self	9	5.1
	DEO	152	86.9
	Other colleague	1	0.6
	PADA from CHC	2	1.1
	No response	11	6.3
Who verifies HMIS report of your health facility*	Self verification	26	17.1
	Supervisor	47	30.9
	MO or RMA	45	29.6
	BMO	34	22.4
	Civil Surgeon	2	1.3
	Hospital Consultant	5	3.3
	No response	23	13.1
Due date of sending monthly HMIS report of your health centre	Last date of the month	86	49.1
	up to 5th of following month	78	44.6
	Between 5th and 10th of following month	4	2.3
	No response	7	4.0
Do you submit any other report apart from HMIS every month	Yes	146	83.4
	No	22	12.6
	No response	7	4.0
District M&EO visited health centre to assess and discuss problems related to HMIS report	Yes	98	56.0
	No	62	35.4
	No response	15	8.6

* Multiple Responses

Table 8: Percentage distribution of respondents by HMIS reporting practices					
Respondent's Background		N	Poor	Moderate	Improved
Age (Years)	<=25	12	25.0	41.7	33.3
	26-30	49	22.4	42.9	34.7
	31-35	46	26.1	43.5	30.4
	36-40	26	23.1	46.2	30.8
	>=41	42	26.8	48.8	24.4
Gender	Female	92	20.7	43.5	35.9
	Male	83	29.3	46.3	24.4
Designation	MO	8	37.5	25.0	37.5
	RHO	66	24.2	48.5	27.3
	Staff Nurse	27	22.2	44.4	33.3
	Other Paramedical	47	28.3	50.0	21.7
	Non-Paramedical	10	40.0	10.0	50.0
	Other	17	5.9	47.1	47.1
Type of Post	Regular	125	22.6	50.0	27.4
	Contractual	50	30.0	32.0	38.0
Place of Current Posting	DH	29	37.9	34.5	27.6
	CHC	59	22.4	41.4	36.2
	PHC	39	20.5	46.2	33.3
	SHC	48	22.9	54.2	22.9
Work Experience (Years)	<= 5	58	32.8	34.5	32.8
	5-10	75	22.7	48.0	29.3
	>=10	42	17.1	53.7	29.3
Tenure of Work (Years)	<= 5	58	31.0	37.9	31.0
	5-10	65	20.0	47.7	32.3
	>=10	52	23.5	49.0	27.5
HMIS training during last 1 year	Yes	83	24.1	39.8	36.1
	No	90	24.7	50.6	24.7
District MEO visited health facility	Yes	98	20.6	48.5	30.9
	No	62	24.2	43.5	32.3

Table 9: Average number of data items reported in monthly HMIS reports by SHCs covered in the study, Mahasamund, 2017-18

Block	SHC	Average number of data items			Number of data items Filled		Number of data items with Zero Value		Number of data item Blank	
		Filled	Zero Value	Blank	Min	Max	Min	Max	Min	Max
Bagbahra	Khallari	128	67	51	118 (Jun)	133 (Aug)	59 (Jan)	75 (Oct)	46 (Aug)	61 (Jun)
Bagbahra	M.K. Bahra	144	96	35	119 (Apr)	153 (Aug)	69 (May)	117 (Apr)	26 (Aug)	60 (Apr)
Bagbahra	Tendukona	154	114	25	154 (Apr)	154 (Apr)	105 (Aug)	119 (May)	25 (Apr)	25 (Apr)
Basna	Bade Temri	154	97	26	95 (May)	179 (Dec)	67 (May)	119 (Apr)	0 (Dec)	84 (May)
Basna	Baroli	121	66	58	105 (Jan)	129 (Oct)	50 (Jan)	78 (Oct)	50 (Oct)	74 (Jan)
Basna	Bhukel	156	92	23	101 (May)	179 (Dec)	60 (May)	108 (Apr)	0 (Dec)	78 (May)
Basna	Gadpatni	155	99	24	95 (Apr)	179 (Aug)	63 (Apr)	123 (Jul)	0 (Aug)	84 (Apr)
Basna	Habekata	165	107	14	131 (May)	177 (Jul)	81 (Jun)	124 (May)	2 (Jul)	48 (May)
Basna	Kharora	149	97	30	87 (May)	179 (Dec)	54 (May)	118 (Aug)	0 (Dec)	92 (May)
Basna	Mohka	158	101	21	96 (May)	179 (Dec)	62 (May)	122 (Oct)	0 (Dec)	83 (May)
Basna	Singhanpur	156	91	23	76 (Apr)	179 (Dec)	35 (Apr)	108 (Oct)	0 (Dec)	103 (Apr)
Mahasamund	Chirko	98	52	81	73 (Jun)	177 (May)	36 (Jun)	130 (Jul)	2 (May)	106 (Jun)
Mahasamund	Thumsa	97	57	82	76 (Jun)	177 (May)	37 (Jan)	136 (Oct)	2 (May)	103 (Jun)
Mahasamund	Tumgaon	95	52	84	29 (Feb)	172 (May)	0 (Oct)	119 (Jul)	7 (May)	150 (Feb)
Pithora	Ansula	175	117	4	174 (Oct)	176 (May)	104 (May)	125 (May)	3 (May)	5 (Oct)
Pithora	Bhithidih	175	117	4	167 (Nov)	177 (Apr)	106 (Nov)	124 (Aug)	2 (Apr)	12 (Nov)
Pithora	Chhibarra	162	100	17	155 (Nov)	178 (May)	91 (Oct)	122 (Jul)	1 (May)	24 (Nov)
Pithora	Dhanora	158	108	21	132 (May)	177 (Apr)	91 (May)	128 (Oct)	2 (Apr)	47 (May)
Pithora	Durugpali	160	103	19	155 (Nov)	177 (May)	92 (Aug)	121 (May)	2 (May)	24 (Nov)
Pithora	Gadbeda	162	104	18	154 (Nov)	179 (Apr)	91 (Dec)	121 (Sep)	0 (Apr)	25 (Nov)
Pithora	Gopalpur	175	116	4	173 (Apr)	178 (May)	107 (Dec)	128 (Sep)	1 (May)	6 (Apr)
Pithora	Jamhar	158	104	21	139 (Apr)	177 (May)	86 (Apr)	122 (Oct)	2 (May)	40 (Apr)
Pithora	Memra	176	113	3	174 (Jun)	179 (Oct)	102 (Jul)	119 (Apr)	0 (Oct)	5 (Jun)
Pithora	Mudipar	160	101	19	141 (Sep)	177 (May)	90 (Sep)	119 (Jun)	2 (May)	38 (Sep)
Pithora	Sarkada	149	101	31	19 (Apr)	177 (Jun)	7 (Apr)	134 (May)	2 (Jun)	160 (Apr)
Pithora	Sonasilli	150	94	29	35 (May)	179 (Jun)	19 (May)	117 (Aug)	0 (Jun)	144 (May)
Pithora	Teka	165	106	14	138 (Dec)	175 (Jun)	76 (Dec)	123 (Sep)	4 (Jun)	41 (Dec)
Saraipali	Bilaigarh	153	94	26	89 (May)	171 (Sep)	50 (May)	108 (Oct)	8 (Sep)	90 (May)
Saraipali	Bonda	164	94	15	158 (Apr)	173 (Dec)	86 (Sep)	105 (Jun)	6 (Dec)	21 (Apr)
Saraipali	Kedua	163	98	16	156 (Apr)	173 (Dec)	92 (Sep)	103 (Jun)	6 (Dec)	23 (Apr)
Saraipali	Sirboda	171	113	8	158 (Apr)	176 (Jun)	103 (Jan)	121 (Oct)	3 (Jun)	21 (Apr)

Table 10: Average number of data items reported in monthly HMIS reports by visited PHCs, Mahasamund, 2017-18

Block	PHC	Average number of data items			Data items Filled		Data items with Zero Value		Data item Blank	
		Filled	Zero	Blank	Min	Max	Min	Max	Min	Max
Bagbahra	Khallari	221	171	63	205 (Jul)	230 (Nov)	163 (Jun)	186 (Apr)	54 (Nov)	79 (Jul)
Bagbahra	Khamhariya	234	205	50	207 (Sep)	249 (Jun)	172 (Sep)	233 (Feb)	35 (Jun)	77 (Sep)
Bagbahra	Mungaser	217	194	67	190 (Dec)	248 (Sep)	172 (Dec)	227 (Nov)	36 (Sep)	94 (Dec)
Bagbahra	Tendukona	206	185	78	202 (Oct)	209 (Apr)	177 (Jul)	194 (Apr)	75 (Apr)	82 (Oct)
Basna	Baroli	133	91	151	27 (May)	215 (Jun)	10 (May)	167 (Jun)	69 (Jun)	257 (May)
Mahasamund	Garhsivni	102	86	182	17 (Jan)	266 (Oct)	0 (Nov)	250 (May)	18 (Oct)	267 (Jan)
Mahasamund	Nayapara*	86	26	198	48 (Jul)	129 (Apr)	2 (Aug)	98 (Apr)	155 (Apr)	236 (Jul)
Mahasamund	Patewa	168	101	116	107 (Jun)	195 (Jan)	55 (Jun)	123 (Jan)	89 (Jan)	177 (Jun)
Pithora	Bhithidih	278	232	6	253 (Sep)	282 (May)	226 (Jul)	237 (Oct)	2 (May)	31 (Sep)
Saraipali	Baloda	238	207	46	188 (Jul)	276 (Apr)	171 (Aug)	231 (Apr)	8 (Apr)	96 (Jul)
Saraipali	Patsendri	250	206	34	217 (Apr)	270 (Dec)	179 (Apr)	234 (Dec)	14 (Dec)	67 (Apr)
Saraipali	Toshgaon	148	118	136	52 (Mar)	262 (Sep)	31 (Aug)	221 (Sep)	22 (Sep)	232 (Mar)

* UPHC

Table 11: Average number of data items reported in monthly HMIS reports by CHCs, Mahasamund, 2017-18

Block	CHC	Number of data items			Data items Filled		Data items as zero-value		Data items as Blank	
		Filled	Zero	blank	Min	Max	Min	Max	Min	Max
Bagbahra	Bagbahra	232	173	40	0 (Oct)	262 (Jan)	0 (Oct)	203 (Dec)	0 (Oct)	83 (Feb)
Basna	Basna	223	155	75	158 (May)	269 (Mar)	91 (May)	202 (Mar)	28 (Mar)	139 (May)
Mahasamund	Tumgaon	251	157	46	165 (Jun)	292 (Nov)	59 (Jul)	196 (Nov)	5 (Sep)	132 (Jun)
Pithora	Pithora	181	108	116	98 (Jun)	273 (Mar)	37 (Jun)	177 (Nov)	24 (Mar)	199 (Jun)
Saraipali	Saraipali	224	132	73	187 (Sep)	274 (Apr)	100 (Oct)	178 (Jun)	23 (Apr)	110 (Sep)
Basna	Private	231	219	66	222 (Apr)	269 (Jan)	211 (Apr)	256 (Jan)	28 (Jan)	75 (Apr)
Mahasamund	Private	17	6	280	2 (Aug)	39 (Oct)	0 (Aug)	28 (Oct)	258 (Oct)	295 (Aug)
Pithora	Hospitals									
	Seva	113	96	184	38 (Dec)	255 (Aug)	27 (Dec)	205 (Aug)	42 (Aug)	259 (Dec)
	Bhawan									

Photographs of Health facilities visited in Mahasamund (Chhattisgarh)



Discussion with Civil Surgeon and Health Personnel at DH



Visit to UPHC – Nayapara, Mahasamund



Well maintained PHC, Patewa



Visit to SHC, Chirko



Respondent filling questionnaire at SHC, Bonda

उप स्वास्थ्य केन्द्र की प्रमुख संकेतिकांक 2018-19	
क्र.सं.	संकेतिकांक
1	कुल जनसंख्या (अनुसूची 1)
2	कुल जनसंख्या (अनुसूची 2)
3	कुल जनसंख्या (अनुसूची 3)
4	कुल जनसंख्या (अनुसूची 4)
5	कुल जनसंख्या (अनुसूची 5)
6	कुल जनसंख्या (अनुसूची 6)
7	कुल जनसंख्या (अनुसूची 7)
8	कुल जनसंख्या (अनुसूची 8)
9	कुल जनसंख्या (अनुसूची 9)
10	कुल जनसंख्या (अनुसूची 10)
11	कुल जनसंख्या (अनुसूची 11)
12	कुल जनसंख्या (अनुसूची 12)
13	कुल जनसंख्या (अनुसूची 13)
14	कुल जनसंख्या (अनुसूची 14)
15	कुल जनसंख्या (अनुसूची 15)
16	कुल जनसंख्या (अनुसूची 16)
17	कुल जनसंख्या (अनुसूची 17)
18	कुल जनसंख्या (अनुसूची 18)
19	कुल जनसंख्या (अनुसूची 19)
20	कुल जनसंख्या (अनुसूची 20)
21	कुल जनसंख्या (अनुसूची 21)
22	कुल जनसंख्या (अनुसूची 22)
23	कुल जनसंख्या (अनुसूची 23)
24	कुल जनसंख्या (अनुसूची 24)
25	कुल जनसंख्या (अनुसूची 25)
26	कुल जनसंख्या (अनुसूची 26)
27	कुल जनसंख्या (अनुसूची 27)
28	कुल जनसंख्या (अनुसूची 28)
29	कुल जनसंख्या (अनुसूची 29)
30	कुल जनसंख्या (अनुसूची 30)
31	कुल जनसंख्या (अनुसूची 31)
32	कुल जनसंख्या (अनुसूची 32)
33	कुल जनसंख्या (अनुसूची 33)
34	कुल जनसंख्या (अनुसूची 34)
35	कुल जनसंख्या (अनुसूची 35)
36	कुल जनसंख्या (अनुसूची 36)
37	कुल जनसंख्या (अनुसूची 37)
38	कुल जनसंख्या (अनुसूची 38)
39	कुल जनसंख्या (अनुसूची 39)
40	कुल जनसंख्या (अनुसूची 40)
41	कुल जनसंख्या (अनुसूची 41)
42	कुल जनसंख्या (अनुसूची 42)
43	कुल जनसंख्या (अनुसूची 43)
44	कुल जनसंख्या (अनुसूची 44)
45	कुल जनसंख्या (अनुसूची 45)
46	कुल जनसंख्या (अनुसूची 46)
47	कुल जनसंख्या (अनुसूची 47)
48	कुल जनसंख्या (अनुसूची 48)
49	कुल जनसंख्या (अनुसूची 49)
50	कुल जनसंख्या (अनुसूची 50)

SHC, Bonda key indicators 2018-19 displayed



Visit to SHC, Bonda



In-Patient ward at PHC, Baroli

Photographs of Health facilities visited in Mahasamund (Chhattisgarh)



Respondents at PHC, Baroli



Respondents gathered for monthly meeting at SHC, Singhpur



Labour room at SHC, MK Bahra



Visit to SHC, MK Bahra



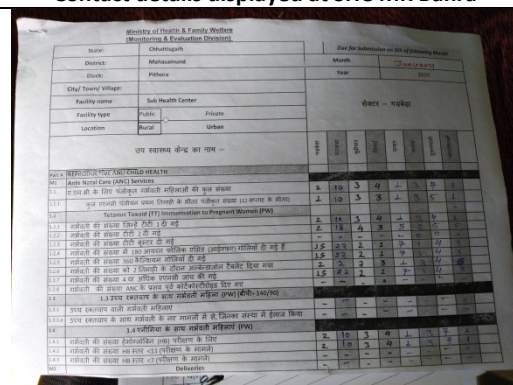
Medicine distribution counter at PHC, Khallari



Contact details displayed at SHC MK Bahra



Respondents gathered for monthly meeting at PHC, Bhithidihi



Collective HMIS monthly report of SHCs of sector Gadbeda

Block-wise list of health facilities covered in the study				
Block	DH	CHC	PHC	SHC
Bagbahra	DH	Bagbahra	Khallari Khamhariya Mungaser Tendukona	Khallari M.K. Bahra Tendukona
Basna		Basna	Baroli	Bade Temri Baroli Bhukel Gadpatni Habekata Kharora Mohka Singhanpur
Mahasamund (Tumgaon)		Tumgaon	Nayapara (UPHC) Garhsivni Patewa	Chirko Thumsa Tumgaon
Pithora		Pithora	Bhithidih	Ansula Bhithidih Chhibarra Dhanora Durugpali Gadbeda Gopalpur Jamhar Memra Mudipar Sarkada Sonasilli Teka
Saraipali		Saraipali	Baloda Patsendri Toshgaon	Bilaigarh Bonda Kedua Sirboda

जनसंख्या अनुसंधान केंद्र
Population Research Centre
डॉ. हरीसिंह गौर विश्वविद्यालय, सागर (म.प्र.)
Dr. Harisingh Gour Vishwavidyalaya, Sagar (M.P.)

HMIS प्रशिक्षण तथा क्रियान्वयन का अध्ययन - 2019

जनसंख्या अनुसंधान केन्द्र (स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार द्वारा स्थापित) द्वारा यह शोध अध्ययन, HMIS के प्रशिक्षण एवं डाटा रिपोर्टिंग की विभिन्न पद्धतियों तथा HMIS के क्रियान्वयन के आयामों को जानने के लिए किया जा रहा है। इसका मुख्य उद्देश्य HMIS रिपोर्टिंग के नये प्रपत्रों के बारे में के स्वास्थ्य सेवा प्रदाताओं की जानकारी, विभिन्न आंकड़ों की रिपोर्टिंग की पद्धतियों को समझना तथा स्वास्थ्य केन्द्र स्तर पर ऐसे कारणों का पता लगाना है जो HMIS के क्रियान्वयन को प्रभावित कर सकते हैं। इस शोध के निष्कर्षों के आधार पर HMIS प्रशिक्षण को भी सुदृढ़ करने में मदद हो सकेगी। इस शोध प्रश्नावली में आपसे विशेषतः HMIS के बारे में प्रशिक्षण तथा आपके स्वास्थ्य केंद्र पर HMIS रिपोर्टिंग के विभिन्न आयामों के बारे में जानकारी पूछी गई है। आपके द्वारा दी गई जानकारी के आधार पर HMIS को और अधिक प्रभावी बनाने में मदद मिलेगी। आपके द्वारा दी गई व्यक्तिगत जानकारी, टिप्पणियों को गोपनीय रखा जावेगा तथा इनका उपयोग केवल शोध कार्य के लिए ही किया जावेगा। यदि आप जानकारी देने हेतु सहमत हैं तो प्रश्नावली भरना आरंभ करें। इसमें 20-30 मिनट का समय लगेगा।

प्रश्नावली भरने हेतु निर्देश -

1. प्रश्नावली में कुल 40 प्रश्न हैं।
2. प्रश्नों के सामने जानकारी देने के लिए खाली स्थान दिया गया है। प्रश्नों के सामने उत्तर के रूप में कुछ विकल्प दिए गए हैं। आपकी जानकारी के अनुसार उचित विकल्प के क्रमांक पर गोला बनाएं।
3. यदि किसी प्रश्न से संबंधित कोई अन्य जानकारी आप देना चाहते हैं तो उसे अंतिम पेज पर अंकित करें।

Sr. क्र.		Code Category कोड	Skip
भाग – 1 सामान्य जानकारी			
1.	Name नाम		
2.	Designation पदनाम		
3.	Age आयु	_____	
4.	Gender लिंग	1. महिला 2. पुरुष	
5.	Type of Post पद का प्रकार	1. नियमित 2. संविदा	
6.	Where are you working presently? वर्तमान में किस संस्था पर कार्यरत है?	1. जिला चिकित्सालय 2. सिविल अस्पताल 3. सामुदायिक स्वास्थ्य केंद्र _____ 4. प्राथमिक स्वास्थ्य केंद्र _____ 5. शहरी प्राथ.स्वास्थ्य केंद्र _____ 6. उप स्वास्थ्य केंद्र _____	
7.	Education शैक्षणिक स्तर	_____	
8.	How long you are working on this post? इस पद पर कितने वर्षों से कार्य कर रहे हैं?	_____	
9.	How long you are working at your health facility? आपकी स्वास्थ्य संस्था में कितने समय से कार्य कर रहे हैं?	_____ माह _____ वर्ष	
10.	Whether other work is also assigned to you? क्या आपको अपने पद के अतिरिक्त कोई और काम दिया गया है?	1. हां 2. नहीं	
भाग – 2 HMIS प्रशिक्षण			
11.	Whether any training on HMIS given during last 1 year? पिछले 1 वर्ष में HMIS का कोई प्रशिक्षण दिया गया?	1. हां 2. नहीं	
12.	Any HMIS training of more than 2 days is given to you? क्या आपको 2 दिन से अधिक अवधि का HMIS प्रशिक्षण दिया गया है?	1. हां 2. नहीं	
13.	Does any of your colleague is trained in HMIS? क्या आपके स्वास्थ्य केंद्र के किसी सहकर्मी ने HMIS का प्रशिक्षण लिया है?	1. हां 2. नहीं	
14.	When HMIS was introduced? HMIS कब से आरंभ किया गया है?	1. वर्ष 2000 से 2. वर्ष 2005 से 3. वर्ष 2008 से 4. वर्ष 2013 से	
15.	Whether HMIS formats are different for different types of health institutions? क्या अलग-अलग स्वास्थ्य संस्था / केंद्र के लिए अलग-अलग HMIS फॉर्म / प्रपत्र होते हैं?	1. हां 2. नहीं	
16.	Whether any changes are made in HMIS formats? क्या HMIS फॉर्म / प्रपत्र में कोई बदलाव किया गया है?	1. हां 2. नहीं	
17.	Whether you have been shown HMIS formats? क्या आपको HMIS फॉर्म / प्रपत्र दिखाये गये हैं?	1. हां 2. नहीं	
18.	Are you trained in data entry using computer / tablet? क्या आप कम्प्यूटर / टेबलेट द्वारा डाटा एंट्री में प्रशिक्षित हैं?	1. हां 2. नहीं	
19.	Have you seen these HMIS formats during training or later? क्या आपने प्रशिक्षण के समय या बाद में निम्न HMIS फॉर्म / प्रपत्र देखे हैं? (जो प्रपत्र देखा है उसे ✓ से अंकित करें)	a. आपके स्वास्थ्य केंद्र का वार्षिक प्रपत्र b. जिला त्रैमासिक प्रपत्र c. आपके स्वास्थ्य केंद्र का मासिक प्रपत्र d. जिला मासिक प्रपत्र	

Sr. क्र.		Code Category कोड	Skip
20.	Who should prepare HMIS report of health facility? आपकी स्वास्थ्य संस्था की HMIS रिपोर्ट किसे बनाना चाहिये?	1. स्वास्थ्य सेवा प्रदाता को 2. सुपरवाइजर को 3. डाटा एंट्री ऑपरेटर को 4. बी.पी.एम. को 5. मेडिकल ऑफिसर को	
21.	Whether any information or data related to your trainings be reported in HMIS? क्या आपके द्वारा लिए गए सभी प्रशिक्षणों की जानकारी HMIS रिपोर्ट में भेजना चाहिए?	1. हां 2. नहीं	
22.	Whether information about infrastructure of your health centre is reported in HMIS? क्या आपके स्वास्थ्य केंद्र में उपलब्ध संसाधनों की जानकारी HMIS रिपोर्ट में भेजना चाहिए?	1. हां 2. नहीं	
23.	What do you know about HMIS web portal? HMIS वेब साइट / पोर्टल के बारे में आप क्या जानते हैं?	1. इसमें देश के सभी ग्रामीण स्वास्थ्य केंद्रों की HMIS रिपोर्ट देखी जा सकती है 2. इसमें देश के सभी जिला अस्पतालों की HMIS रिपोर्ट देखी जा सकती है? 3. इसमें सभी स्वास्थ्य केंद्रों की विगत पांच वर्षों के प्रत्येक माह की HMIS रिपोर्ट देखी जा सकती है? 4. उपरोक्त सभी 5. इसके बारे में कोई जानकारी नहीं है	
भाग – 3 HMIS क्रियान्वयन			
24.	Whether any guidelines are provided for preparing HMIS report of your health facility? क्या आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट बनाने के लिए कोई दिशानिर्देश दिए गए हैं?	1. हां 2. नहीं	
25.	Where do you report children age <5 suffering from diarrhoea treated by RBSK team in villages in your health centre area? आपके स्वास्थ्य केंद्र के अंतर्गत आने वाले क्षेत्र में RBSK टीम द्वारा 5 वर्ष से कम उम्र के दस्त से पीड़ित बच्चों का उपचार करने पर इसे कहाँ रिपोर्ट करते हैं?	1. स्वास्थ्य केंद्र की HMIS रिपोर्ट में 2. RBSK टीम की रिपोर्ट में 3. दोनों रिपोर्ट में 4. रिपोर्ट नहीं देते हैं	
26.	On what basis at your health centre report number of pregnant women with Hb<11gm in HMIS? आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट में खून की कमी वाली (Hb<11 gm) गर्भवती महिलाओं की संख्या किस आधार दी जाती है?	1. डॉक्टर के द्वारा जाँच के आधार पर 2. सहली उपकरण उपलब्ध न होने पर केवल जाँच के आधार पर 3. सहली उपकरण या अन्य विधि से खून की जाँच करने पर 4. सभी गर्भवती महिलाओं की संख्या जिनको कभी खून की कमी रही हो	
27.	For reporting number of deaths in HMIS, how reason of death is ascertained? HMIS में मृत्यु की संख्या को रिपोर्ट करने के लिए मृत्यु के कारणों का पता कैसे लगाते हैं?	1. पोस्टमार्टम की रिपोर्ट के आधार पर 2. वर्बल ऑटोप्सी के आधार पर 3. उपरोक्त दोनों में से कोई भी 4. मृतक के परिवार के सदस्यों से पूछ कर	
28.	On what basis your health centre report total OPD attendance? आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट में कुल ओ.पी.डी. में कौन से संख्या दी जाती है?	1. स्वास्थ्य केंद्र में इलाज / जाँच के लिए आने वाले सभी मरीजों की संख्या 2. महिलाएं और बच्चों को छोड़कर अन्य सभी मरीजों की संख्या 3. ओ.पी.डी. में मरीज नहीं आते हैं 4. ओ.पी.डी. की संख्या रिपोर्ट नहीं करते हैं	

Sr. क्र.		Code Category कोड	Skip
29.	Do you report deaths occurred in an accident in your health centre area in HMIS? क्या आप अपने स्वास्थ्य केंद्र के क्षेत्र में घटित दुर्घटना में मृतकों की संख्या को HMIS में रिपोर्ट करते हैं?	1. हां 2. नहीं	
30.	Whether GDM test for pregnant women is done at your health facility? क्या आपके स्वास्थ्य केंद्र पर गर्भवती महिलाओं की जी.डी.एम. जाँच की जाती है?	1. हां 2. नहीं	
31.	In case of death of a newborn referred to SNCU due to any complication from your health facility, where the death of the child is reported? आपके स्वास्थ्य केंद्र से किसी नवजात शिशु को गंभीर जटिलता के कारण SNCU को रेफर किया गया। नवजात शिशु की SNCU में मृत्यु होने की स्थिति में इस नवजात की मृत्यु को कहाँ रिपोर्ट किया जाता है?	1. SNCU की रिपोर्ट में 2. जिला अस्पताल की HMIS रिपोर्ट में 3. स्वास्थ्य केंद्र की HMIS रिपोर्ट में जहाँ से नवजात को रेफर किया गया 4. कहीं रिपोर्ट करना आवश्यक नहीं	
32.	In HMIS report of your health facility, what does AYUSH OPD represent? आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट में आयुष ओ.पी.डी. की जानकारी किस आधार पर दी जाती है?	1. आयुष डॉक्टर द्वारा देखे गए मरीजों की संख्या के अनुसार 2. मरीजों की संख्या जिन्हें आयुष उपचार दिया गया है? 3. ओ.पी.डी. में आयुष सेवाएँ उपलब्ध नहीं हैं 4. आयुष ओ.पी.डी. की जानकारी देना संभव नहीं है	
33.	Whether number of family planning operations done in a camp at your health centre is reported in HMIS? क्या आपके स्वास्थ्य केंद्र पर आयोजित परिवार नियोजन ऑपरेशन शिविर में किये गए परिवार नियोजन ऑपरेशन की संख्या को HMIS में रिपोर्ट किया जाता है?	1. हां 2. नहीं 3. शिविर आयोजित नहीं होते हैं किन्तु परिवार नियोजन हेतु स्वास्थ्य केंद्र से भेजे गए केसेस की संख्या को HMIS में रिपोर्ट करते हैं 4. शिविर आयोजित नहीं होते हैं इसलिए HMIS में रिपोर्ट नहीं करते हैं	
34.	On what basis, number of pregnancy testing kits used is reported in HMIS report of your health centre? आपके स्वास्थ्य केंद्र पर उपयोग में लाई गई गर्भावस्था टेस्ट किट की संख्या को किस आधार पर HMIS में रिपोर्ट किया जाता है?	1. ए.एन.सी. पंजीयन की संख्या के आधार पर 2. उपयोग की गई किट की संख्या के रिकॉर्ड के आधार पर 3. आशा कार्यकर्ता के द्वारा बताई गई संख्या के आधार पर 4. इसका रिकॉर्ड रखना कठिन है	
35.	Whether services provided under JSSK reported in HMIS from your health centre? क्या आपके स्वास्थ्य केंद्र द्वारा जननी शिशु सुरक्षा योजना के अंतर्गत दी गई सेवाओं को HMIS में रिपोर्ट किया जाता है?	1. हां 2. नहीं	
36.	Usually who enters HMIS report of your health centre in computer? आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट को कंप्यूटर में एंट्री कौन करता है?	1. स्वयं करते हैं 2. डाटा एंट्री ऑपरेटर 3. अन्य सहकर्मी 4. पता नहीं	
37.	Who verifies HMIS report of your health facility? आपके स्वास्थ्य केंद्र की HMIS रिपोर्ट को कौन सत्यापित करता है?	1. स्वयं सत्यापन करते हैं 2. सुपरवाइजर 3. मेडिकल ऑफिसर 4. बी.एम.ओ.	
38.	What is the due date of sending monthly HMIS report of your health centre? आपके स्वास्थ्य केंद्र की मासिक HMIS रिपोर्ट	1. प्रत्येक माह की अंतिम तिथि 2. आगामी माह की 5 तारीख तक	

Sr. क्र.		Code Category कोड	Skip
	भेजने की निर्धारित तिथि क्या है?	3. आगामी माह की 5 से 10 तारीख तक 4. कोई अन्य तारीख	
39.	Do you submit any other report apart from HMIS every month? क्या प्रत्येक माह HMIS रिपोर्ट के अलावा कोई अन्य रिपोर्ट भी आपके स्वास्थ्य केंद्र से भेजी जाती है?	1. हां 2. नहीं	
40.	Whether district M&E officer visited your health centre to assess and discuss problems related to HMIS report? क्या जिला डाटा अधिकारी ने आपके स्वास्थ्य केंद्र आकर HMIS रिपोर्ट के बारे में समस्याओं को देखा और चर्चा की?	1. हां 2. नहीं	

दिनांक _____

समय _____

उत्तरदाता के हस्ताक्षर _____