FINDINGS AND EXTENDED SUMMARY

The manner National Rural Health Mission executed and the achievements were key research questions under this research. Now in this chapter answer of how NRHM executed would be presented. Execution of National Rural Health Mission was examined under the purview of qualitative research methods such as case studies and interview however the literature review also contributed to an extent.

The overall execution of National Rural Health Mission thus summarized and presented under different topics such as prescription of action points and timeline, institutional arrangements, merger of societies, identification of key functionaries, programs to be covered, services to be ensured, Human resources management, Financial management mechanisms, Cold chain and routine immunization management, public private partnerships, convergences, development partners, reporting, monitoring and evaluation mechanisms. In this way the entire functioning of National Rural Health Mission could be presented.

Although guidelines relevant to issues as mentioned above were in place despite on the basis of those texts actual situation could not be presented. Thus it was required to investigate those guidelines occurring at the ground levels. And those facets of implementation and execution of National Rural Health Mission investigated through Case studies and Interviews.

A government set up was having their mechanism to generate reports but research scholar since charged not to blindly accept those reports without verifying them fully or partially. The forthcoming findings on execution of National Rural Health Mission were based on reports and data validated by research scholar and according to his personal interpretation of facts and analysis of the situation. Now item wise and stages of implementation would be described hereafter under different sub chapters.
ACTION POINTS AND TIME LINE OF ACTIVITIES

NRHM framework of implementation and Mission documents (MOHFW 2005) had pressed certain action points and timeline of activities but how those action points and time line executed also became essential under this research. Since just on the basis of literatures it was not possible to examine the occurrences of those action points and timeline and herewith those examined by case studies and interviews. On the basis of Literature review, Case studies and Interviews research scholar came to conclusion that proceeding to launch of National Rural Health Mission a sequence of activities were scheduled what termed as action points, prescribed to be accomplished by the respective states in a time bound manner. Thus prescription of timeline was important because National Rural Health Mission was also a time limited program.

Research scholar felt no hesitation in saying that a time line of activities was also prescribed through the Mission documents on National Rural Health Mission and Framework of Implementation of National Rural Health Mission released by the Ministry of health and family welfare, Government of India at the onset of National Rural Health Mission (MOHFW, Framework of Implementation of NRHM, 2005).

It also became evident from interviews with central mission directorate officials that those action points and timeline already communicated to partner states and case study further revealed that almost all states progressed satisfactorily in this regard excepting some delayed here and there. This was one of the most momentous prescriptions and accomplishment for adequate execution of the National Rural Health Mission. Since any obstruction or delay could cause late start of the mission therefore very concerted actions ensured at several levels by key functionaries.

Thus, accomplishment of those action points within the prescribed time line acquired paramount significance mainly because National Rural Health Mission was a time bound program having fixed tenure of 2005-2012. In general, terms it could say that action points were also an indicative of progress of implementation of National Rural Health Mission. Therefore, acquaintance with those action points considered significant under the research. Following action points prescribed to all partner states under:-
7.1.1 Number of health societies constituted and meetings organized:

It was an important action point because it indicated the status of the institutional arrangements under the *National Rural Health Mission* and their functioning as per rule and regulations. The meetings of the governing, executive, or other committees especially program committees required organized accordingly. It was evident from the case studies that state and district health societies were constituted accordingly in all *Empowered Action Group states* and meetings of those societies were organized. The number of meetings organized could be verifiable through *MIS on NRHM* year wise.

7.1.2 Number of meeting of state/ district health mission held:

Meetings of the district health missions were also required being organized on regular intervals. A district health mission was expected to organize its meetings and the number of meetings organized could judge fairness of the implementation of program. Number of members participated and deliberated in the meetings was thus considered significant.

7.1.3 Merger of societies:

It was apparent that different national health programs such as Leprosy eradication, Reproductive and child health programs, Blindness control program, revised national tuberculosis control program, Malaria control program were implemented in the country under the aegis of different –different societies at the State and district levels. It was proposed under the *National Rural Health Mission* to merge all those societies into a single society from the State level to the district level. Although, it was prescribed that the merger of societies would be completed by the year 2006. However research scholar came to know that in some states merger of societies was not completed in the prescribed time and took very long nevertheless ultimately it was accomplished across the country.

7.1.4 Constitution of Rogi Kalyan Samiti:

*Rogi Kalyan Samities* or hospital management societies were required to be constituted and registered as a society for almost all additional, primary, community health centers, first referral units and District Hospitals within the prescribed timeline. It was provisioned under National Rural Health Mission that through Rogi Kalyan Samities each health facilities would be provided funds for emergency situation to make available medicines and other requirements to any patient as need might occur.
7.1.5 Selection and training of Accredited Social Health activists:

The scheme of Accredited Social Health activists was launched for the first time in the country to assist overloaded Auxiliary Nurse and Midwives. This was an important action point, which could tell us about the number of Accredited Social Health activists selected, trained, and provided drug kits. The training on all the seven modules was essential for Accredited Social Health activists. It was required to select and recruit Accredited Social Health activists per 1000 population. Accredited Social Health activists were supposed to be an intermediary between the Auxiliary Nurse and Midwives and Aanganwadi workers.

7.1.6 Village health & sanitation committee (VHSC) and joint accounts:

Each village expected to have constituted Village health & sanitation committee. Now this was one of the most priority areas as their role in selection of Accredited Social Health activists were also important. It was required to open a joint account in the name of Auxiliary Nurse and Midwives and Sarpanch for each health sub centers for respective Village health and sanitation committees. In some states such as Jharkhand it was not constituted due to non election of Panchayat elections for long and thus selection of ASHAs were done by alternative arrangements.

7.1.7 Number of health facilities:

In each state and district, number of health facilities was required to be set up and existing facilities required upgrade accordingly in tune with population norms of Indian public health standards. In true terms it indicated the coverage of health services and on this basis it could say that which state had adequate coverage and which had not?

7.1.8 Status of work force:

Each public health facilities of the country were required to be manned by specialists, paramedics, technicians and supportive staff as per Indian public health standards. Similarly, program management units required setting up at State, Divisional, District, and Block levels. A Program Management Unit constituted of three professionals Program Managers, Accounts Manager, and Data Assistants. Therefore regular auditing of work force existing and required was done under National Rural Health Mission. This was essential to recruit that work force which required urgently. In general, status of work force was reflected through periodical Rural Health Survey data done by mohfw.
7.1.9 Program Implementation Plan and Action plans:

Previous planning was an important aspect of National Rural Health Mission. Generally two kinds of planning were most important such as Program Implementation Plan and Health Action Plan which required prepared at almost every level. The compiled form of those plans formed the basis of funds allocation. However, planning process was very complex and confusing and how much they obeyed by the functionaries as a useful tool was very much doubted. However the customary of preparation of such plan very much existed in all states. Formulation of district level and state level annualized Program Implementation plan and Action plans required accomplished for each financial year. It used to be most important documents for the district and state, which used to be formulated by Program Managers after carefully analyzing the prevalent health requirements and future program of action. It was inclusive of wide ranged information such as work force, population and demography, funds management and requirements and status of programs. Preparation of annualized integrated action plans were considered important because Integrated district health action plan used to be a document containing year wise status of implementation and future program of action.

7.1.10 Mobile medical unit (MMU):

Mobile medical units were expected to be functional in hilly, difficult to reach areas and where there was not adequate growth of the health infrastructure. The number of districts having mobile medical unit would tell about the capacity of health authorities to reach to difficult areas or focused areas on regular intervals.

7.1.11 Health melas:

It was prescribed that health mela would be organized in each block of the country in hard to reach areas and in those areas where medical facilities were not set up or not to be set up in near future. Health mela used to be an important tool for health interventions in left out or high focused areas.

7.1.12 Male sterilization:

Male sterilization was an important tool for population stabilization therefore number of male sterilizations taking place in country would be significant.

7.1.13 Female sterilization:

Female sterilization was also equally important for population stabilization. The currently married women in the reproductive age group were the target group.
7.1.14 Application of PNDT act:

*PNDT or Pre Natal Diagnostics Test act* introduced to maintain the sex ratio in the country. It was observed that certain states were having extremely adverse sex ratio. For example, some northern states were having extremely low number of girl child in comparison to male child and reasons were attributed to the desire to having male child leading to illegal termination of pregnancy. In several part of the country the sex ratio had become extremely unbalanced which bound to pose tremendous demographical turbulences if not checked properly. Since it was noticed that female feticide occurred in large number so this act was supposed to be a great tool in stopping female feticide. The act had several provisions related to prosecution and conviction of persons, doctors, paramedics involved with violation of PNDT act. The number of cases prosecuted under PNDT act would tell about the pace of implementation of PNDT act.

7.1.15 Integrated management of Neonatal and Child Illness or IMNCI:

Each district of the country was expected to develop *IMNCI* or *Integrated management of Neonatal and Child Illness* facilities for modern new borne childcare. It was aimed at reducing the newborn child death rate.

7.1.16 Mainstreaming of AYUSH:

One of main components under the *National Rural Health Mission* was the mainstreaming the traditional system of medicine. *AYUSH* could also known as *Ayurvedic, Unani, Sidha, & Homeopathy* and their specialists required to be posted in each health facilities not below the primary health centre.

7.1.17 Disease related action points:

The status of disease control programs were measured in terms of several action points. It was framed out under the *National Rural Health Mission* that prevalence rates of diseases such as leprosy, vector borne diseases would come down. It also planned to reduce the mortality rates due to diseases and check the occurrence of diseases. In some cases, it was prescribed that certain diseases would be eliminated by the year 2012 or 2015. Therefore, occurrence of diseases and number of cases and deaths due to diseases was one of the most important action points under the *National Rural Health Mission*.

7.1.2 Timeline of activities prescribed

The above action points as prescribed required accomplished in a time bound
manner as a time line clearly prescribed under the *National Rural Health Mission* to implement those action points.

According to the time line of activities it was prescribed that fully trained *Accredited Social Health Activist (ASHA)* for every 1000 population / large isolated habitations would be appointed in fifty percent villages by the year 2007 and 100 percent ASHA would be deployed by the year 2008. *Village Health and Sanitation Committees* was prescribed to be constituted in over 6 lakhs villages and untied grants would be provided. It was prescribed that 30 percent Village health and sanitation committee would be constituted by the year 2007 and 100 percent by the year 2008.

It was suggested that 2 ANMs would be provided in 30 percent HSCs by the year 2007 and 60 percent by the year 2009 and 100 percent by the year 2010. It was suggested that 30 percent PHCs would be strengthened/established with 3 Staff nurses to provide service guarantees as per IPHS by the year 2007 and remaining would be strengthened by the year 2010.

It was prescribed that 30 percent Community health centers would be strengthened or established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS by the year 2007 and 50 percent by the year 2009 and 100 percent by the year 2010. It was also prescribed that 30 percent of 1800 *Taluka/Sub Divisional Hospitals* would be strengthened to provide quality health services by the year 2007 and 50 percent by the year 2009 and 100 percent by the year 2012.

It was prescribed that thirty percent of almost 600 District Hospitals would be strengthened to provide quality health services by the year 2007 and 60 percent by the year 2009 and 100 percent by the year 2012. Further it was prescribed that 50 percent *Rogi Kalyan Samities* would be established in all above block level health facilities by the year 2007 and 100 percent by the year 2009.

It was prescribed that *District Health Action Plan 2005-2012* would be prepared by 50 percent districts of the country by the year 2007 and 100 percent by the year 2012. *Untied grants* would be provided to 50 percent *Village Health and Sanitation Committee, Sub, Primary and Community health Centres* to promote local health action by the year 2007 and 100 percent by the year 2008. Annual maintenance grant would be provided to 50 percent *Sub, Primary and Community health Centres* and one time support to *Rogi Kalyan Samities at Sub Divisional/ District Hospitals* by the year 2007 and 100 percent by the year 2008.
It was also prescribed that fifty percent State and District Health Society would be established and fully functional with requisite management skills by the year 2007 and 100 percent by the year 2008. Systems of community monitoring would be put in place, 50 percent by the year 2007 and 100 percent by the year 2008. Procurement and logistics required being streamlined to ensure availability of drugs and medicines at 50 percent Sub, Primary and Community health Centres by the year 2007 and 100 percent by the year 2008.

Thirty percent Sub, Primary & Community health centers, Sub Divisional Hospitals, District Hospitals would be required to be fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programs, TB, HIV/AIDS, etc by the year 2007, 60 percent by the year 2008, 70 percent by the year 2009 and 100 percent by the year 2012.

Further, thirty percent district health plan would require reflecting the convergence with wider determinants of health like drinking water, sanitation, women’s empowerment, child development, adolescents, school education, and female literacy by the year 2007.

Likewise, sixty percent by the year 2008 and 100 percent by the year 2009, facility and household surveys would require to be carrying out in 50 percent districts of the country by the year 2007 and 100 percent by the year 2008.

In addition, thirty percent annual State and District specific Public Report on Health were required being published by the year 2007, 60 percent by the year 2009 and 100 percent by the year 2010. 30 percent institution-wise assessment of performance against assured service guarantees was needed to be carried out by the year 2008, 60 percent by the year 2009 and 100 percent by the year 2010.

Mobile Medical Units was needed to be provided to thirty percent districts of the country by the year 2007, 60 percent by the year 2008 and 100 percent by the year 2009.

However, it was evident from the case studies and interviews that there were delayed on timeline and which caused late start of the mission in several states and also the performance was not as prescribed which would be discussed later.

In fact under this research the overall performance of the National Rural Health Mission was evaluated in terms of those action points and timeline

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INSTITUTIONAL ARRANGEMENTS

Dedicated Institutions were required to carry forward the mission accordingly in each partner state. Such institutions were required to accept funds and conduct recruitments and manage overall implementation of NRHM on regular terms. Thus, institutional arrangement was one of the most imperative occurrences under the National Rural Health Mission prescribed to be accomplished as early as possible. It became evident from the case studies and interviews that institutional arrangement were made in almost all partner states as suggested through mission documents and framework of implementation of National Rural Health Mission (MOHFW 2005).

Again, those two documents Mission document on NRHM and Framework of Implementation of NRHM worked as guidelines in this process. So much so that draft models of bye laws and memorandum of association of State/ District health societies/ missions, Rogi Kalyan Samities were also provided to all partner states. Institutional arrangement was also required to be accomplished in prescribed time line by all the states as it was the first step soon after the onset of National Rural Health Mission. However, some delay had occurred in some states, which caused late start of the mission. It was evident that Bihar took lead in institutional arrangements whereas in Jharkhand they occurred with marked delay. Also at national level all states were not able to make institutional arrangements within prescribed time limits however with progress of NRHM more and more uniformity in institutional arrangements could be seen.

Institutional arrangement was most needed because of an able-bodied focused establishment was required at diverse levels to carry forward the mission. Institutions were required from state level to district level and further down to sub district levels. It was arranged that there would be state health mission supported by a state health society and on the same pattern, there would be a district health mission supported by a district health society in each state and district of the country or in those states where National Rural Health Mission was implemented. It was also prearranged that all existing societies at the state and district levels related to programs like Reproductive and child health program, Malaria, Blindness control, Revised national tuberculosis control
program, Leprosy control would merge to single State health society at the state level and district health society at the district level. Further new institutions in form of Rogi Kalyan Samiti were required setting up at different levels such as Primary and Community health Centres, first referral units and untied fund required constituted at health sub centre levels. It was further required setting up Village health and sanitation committee and untied funds in each punchayat or HSC of the country.

In addition, Program management units were required making functional at state, division, district, and sub district levels. It was required and expected that Program Management Units consisting of three professionals such as Program managers, Accounts managers, and Data assistants would be associated with State and District health societies. At later stage Divisional Program management Units involving cluster of districts and Block program Management Units were also put in place.

The composition and memberships of National Steering Group, Empowered Program Committees, State health missions, State health societies, District health mission and District health societies were also well defined and articulated to all concerned well in advance. If any how they were not able to get guidelines then in that case they were directed to download from the ministry website www.mohfw.nic.in.

Research scholar would now like to make a brief mention about the memberships, powers and functions of those institutions just because it would be later used to evaluate the functioning of those institutions.

7.2.1 The mission steering group

The Mission Steering Group was associated at the central level or at the apex level and found empowered to approve financial norms in respect of all schemes and components part of National Rural Health Mission. The exercise of delegated powers by the MSG was subject to the condition that a progress report regarding National Rural Health Mission, along with deviation in financial norms, modifications in ongoing schemes and details of new schemes placed before cabinet for information on an annual basis. The Mission steering group was constituted with Prime Minister and other Ministers of Union Council of Ministers including finance minister. The MSG was empowered for financial allocations for National Rural Health Mission as how much amount would be allocated in yearly budgetary provisions at the central levels. They worked on
the feedback provided by the EPC and other Central level organizations and functionaries.

7.2.2 Empowered Program Committee (EPC):

The Empowered Program Committee was also an arrangement mooted at the central level and was given flexibility to change financial norms approved by the MSG within a range of ± 25 percent, with larger variations approved by the MSG. The exercise of delegated powers by the EPC was the subject to the condition that a progress report regarding National Rural Health Mission, along with deviation in financial norms, modifications in ongoing schemes and details of new schemes placed before the cabinet for information on an annual basis.

7.2.3 The state health missions/society:

In each state, a State health mission was to be constituted which was supported by the State health society. It could be mentioned here that though both might appear similar however it was found that State health societies were a legal entity being duly registered with registrar of societies. There were two bodies suggested in a state health mission and society governing and executive. Both bodies were suggested to have different memberships, powers, and responsibilities. Governing body of State health mission was charged with several important responsibilities related to overall administration of the National Rural Health Mission programs. Main responsibilities were inclusive of approving annual state action plan, considering proposals for institutional reforms in health sector, reviewing implementation of the annual action plan, reviewing of status of follow up action on decisions of the state health mission and co-ordination with NGOs/Donors/other agencies/organizations.

Executive committee of the State health society was made responsible towards the governing body. The executive committee was also charged with reviewing the expenditure and implementation, approving proposals from districts, other implementing agencies, executing approved State Action Plan, finalizing working arrangements for intra-sectoral and inter-sectoral co-ordination and most importantly following up action on decisions of the governing body. In general the State health mission was headed by the Chief Minister of the state and Ministers and secretaries of some other departments specially Health and FW, Education, Welfare, HRD were also members. The State health society was headed by an Executive director or State Mission Director usually and IAS officer. The State Program Management Unit was in place to assist the Executive director in implementing and managing programs.
7.2.4 State Program Management Support Unit (SPMSU):

*State Program Management Support Unit* was expected to be set up in each state at the level of state head quarters and recommended to act as the secretariat of the *State Health Mission* as well as the *State Health Society*. It suggested to be headed by an Executive Director/Mission Director; in addition the SPMSU would have experts in the areas of human resources, BCC, M & E, and other technical areas, recruited from the open market.

The *State Program Management Support Unit* was recommended to provide technical support to the State Health Mission through its pool of skilled professionals like MBA, CA, MIS Specialist, and Consultants for RCH and other National Disease Control Programs.

This technical pool under *National Rural Health Mission* used for providing specific program support related to logistics, financial management, MIS, tracking of funds etc.

7.2.5 District health mission/ society:

On the lines of the State Health Mission, every district was required having a *District Health Mission* headed by the Chairperson, *Zilla Parishad* or District Magistrate or Deputy Commissioner. It was required having the Chief Medical Officer as the Mission Director. To support the District Health Mission, in every district an integrated *District Health Society (DHS)* was suggested. The DHS was responsible for planning and managing all health and family welfare Programs in the district, both in the rural as well as urban areas. The DHS also viewed as an addition to the district administration’s capacity, particularly for planning, budgeting, and budget analysis, development of operational policy proposals, and financial management etc. Because it was a legal entity, the DHS required set up its own office, with adequate contingent of staff and experts and evolved its own rules and procedures for hiring the staff and experts both from the market and on deputation from the Government.

7.2.6 Village Health & Sanitation Committees (VHSCS) and untied funds:

*Village Health & Sanitation Committees* required being a multi stakeholder at village level, creating public awareness about the Program, and ensuring community involvement. Those committees expected to analyze the health problems, decide the health priorities, and take appropriate action to overcome the problems. The committees expected to help in managing village health funds in the village. Those committees might utilize to discuss leprosy problem like
stigma and discrimination against persons affected by leprosy and their family members and seeking collaboration from the health services. However Village Health & Sanitation Committees was also discussed in previous chapter.

An untied fund was also established at each health sub centre and provided annual assistance of Rs.10000/- for some remedial and contingency expenditure.

7.2.7 Rogi Kalyan Samities (RKS)/ Hospital management society:

It was already described in earlier chapter that Rogi Kalyan Samiti were required setting up at the levels of District Hospitals, Community health centre, First referral units and Primary Health Centre levels. However, such provisions were also implemented at the health sub centre level in form of untied fund. The main purpose of the Rogi Kalyan Samities was to facilitate patients in case of emergency.

A fund of Rupees 0.5 million and 0.1 million were provided for the district Rogi Kalyan Samiti and block Rogi Kalyan Samiti respectively annually. However it was found that flexi pool funding being in place some facilities were able to receive more funds than the limits prescribed. It was expected that with that fund, patient care get qualitative and lack of emergency medicine or equipments or ambulances covered. At primary health centre and Community health centre Rogi Kalyan Samities were required to be autonomous registered bodies constituted at each level to facilitate in day-to-day management of hospital activities and delivery of quality care to patients. These Samities were having the authority to procure medicines required for emergency conditions. A list of probable heads of expenditure from the funds of Rogi Kalyan Samities was also suggested.

However under case studies it was found that at several places key functionaries entrusted to manage those funds accordingly were not able to transfer full benefits to needed people based upon consideration of their respective situation. In some cases it was also found that amount under RKS was used or diversified for other expenses which were not prescribed under the RKS scheme. This was a well articulated scheme and could be quite effective tool to provide help to people in need with urgent supply of medicine, diagnostics facilities, foods and ambulances. However due to ineffective implementation at several levels the due benefits could not reach to people. Also funds were drawn without adequate resolution of the governing body and meeting of the governing body of RKS also not held regularly at several facilities and in some cases even proceeding registers were not made
available. Thus such malfunction must require corrected which appeared to be a most noble scheme.

The organ gram of the overall institutional arrangements has been constructed; please see Figure-1.

**Figure 1: Institutional arrangements under NRHM**

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National Steering Group

Empowered Program Committee

State Health Society

State Program Management Unit

State Program Committees

Divisional Program Management Unit

District Health Society

District Program Management Unit

District Program Committees

Block Program Management Unit

District Rogi Kalyan Samiti

FRU/CHC/PHC Rogi Kalyan Samiti

Untied funds/ Village health and sanitation committee
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Chapter 7.3

MERGER OF SOCIETIES

Merger of societies under National Rural Health Mission was almost a part of the overall process of institutional arrangements which took place at the state and district levels. Merger of society was another major action points under the National Rural Health Mission. While it was considered as a part of the overall institutional arrangements however it came next or later. It was most like a follow up process after the institutional arrangements were accomplished which marked by setting up of State health mission/ society and District health mission/ society respectively at the state levels and district levels. Thus it could be said that though institutional arrangements took place at different levels including sub district levels however merger of societies took place at state and district levels only. As per the timeline prescribed merger of societies was required to be accomplished within the first year of National Rural Health Mission or as early as it could be possible. National Rural Health Mission, Mission Documents and Framework of implementation had clearly prescribed that each state level and district level health societies were required to get merged with State health society at the state level and district health society at the district level respectively.

Case studies had also confirmed that such merger happened in almost all states excepting delay in some states. Because of this, several health societies mostly related to RCH, TB, Malaria, Leprosy, and Blindness merged like wise to one health society at state level and district level (MOHFW 2005). Figure 2 would demonstrate the merger of societies at the district and state levels. With byelaws and memorandum of district and state health societies, the memorandum of merger in draft format was also provided to eliminate any hurdle in the merger process.

A memorandum of merger was in place and all the liabilities and assets were required being merged. But case studies and interviews had revealed this fact that in some states constitution of state and district health societies were delayed therefore merger of societies also not happened as per timeline and in turn it caused late start of the mission in real terms. At last, the merger completed across the country and erstwhile several health societies for various programs merged to one health society.
Why merger considered important this answered by the case studies and interviews. So many societies at the state and district levels were making it impossible for societies to run accordingly. As one functionary at the state or district levels used to be members of all the respective societies and it was not possible to even organize the required number of meetings of such societies accordingly as such societies were already registered under the Societies registration act and thus meeting was mandatory to be organized at regular intervals. Thus, the idea of merger of societies adopted under National Rural Health Mission was considered a logical action. Research scholar had found that it definitely benefitted the overall management of health programs.

The process of merger was started only after getting the state level and district level health societies registered with the registrar of societies in respective states. After the State and district societies were registered, a meeting of the Governing Body of existing State level societies in the health and family welfare sector was convened to adopt resolution for merger of the societies. Since all earlier societies at both the state level and district level were also registered under the SR Act 21 of 1860, therefore a signed copy of the resolution were also filed with the Registrar of Societies to complete the process of merger. Bihar was one state which had accomplished the merger at the earliest and also got its new health societies registered under S.R. Act 1860. But the same was not the case with Jharkhand and many other states where such mergers were largely delayed however ultimately accomplished across the country.

Figure 2: Merger of societies
Chapter 7.4

KEY FUNCTIONARIES UNDER NRHM

There were certain persons associated with some government, private, local bodies and employees of the State or Central governments to whom responsibilities entrusted to carry forward jobs assigned to them and those persons referred under this research as Key functionaries.

*National Rural Health Mission* was having the services of two kind of work force, first appointed on contractual basis under *National Rural Health Mission* and RCH-II and secondly the regular staff of the respective states and central governments. In addition representatives of local bodies, members of legislative assemblies and parliament also nominated to play their role through the institutional arrangements as described earlier. Sometimes it became quite confusing however it never required getting confused that all staff under the health department though functioned under a same system despite technically they could not term as employed under *National Rural Health Mission*. For example, Civil surgeons / Chief Medical Officers, Medical Officers, Program Officers, Medical and paramedical work force though regular staff of the respective state governments and also they functioned importantly under *National Rural Health Mission* and their contributions were audited as a part of achievements of *National Rural Health Mission* however technically they could not term as employed under NRHM.

Thus the key functionaries under *National Rural Health Mission* could be both the regular staff of state health departments and appointed on contractual basis under *National Rural Health Mission*. In order to strengthen the delivery mechanism under *National Rural Health Mission* it was required to point out key functionaries to whom key responsibilities were assigned. Several personnel inclusive of State Officials, Contractual Staff and medical and paramedical staffs, elected representatives and developmental partners were identified in order to assign them some particular role to each of them. Therefore only following core personnel could be said the core functionaries under the NRHM.

7.4.1 Accredited Social Health Activist (ASHA):
In between auxiliary nurse and midwives on one side and Aanganwadi workers on the other side a new work force was considered essential in order to somewhat ease the burden on auxiliary nurse and midwives. One of the key components of the National Rural Health Mission was to provide every village in the country with a trained female community health activist – ASHA or Accredited Social Health Activist. A specific criterion for selection of Accredited Social Health Activists also prescribed in the Accredited Social Health Activists guidelines. One Accredited Social Health Activists prescribed per 1000 population in the country. Accredited Social Health Activists required chosen through a rigorous process of selection involving various community groups, self-help groups, Aanganwadi Institutions, the Block Nodal officer, District Nodal officer, the Village Health Committee and the Gram Sabha.

Accredited Social Health Activists were the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. Accredited Social Health Activists would be a health activist in the community who would create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She also worked as a depot holder for essential provisions made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet, Chloroquine, Disposable Delivery Kits, Oral Pills, and Condoms. Accredited Social Health Activists were eligible to get compensation, traveling and daily allowances to attend training sessions.

7.4.2 Auxiliary Nurse Midwife (ANM):

One Auxiliary Nurse Midwife was required per 3000 and 5000 population in hilly and plane area to operate each health sub centre. However a second post was also recommended and provided to some HSCs in the country under NRHM. An Auxiliary Nurse Midwife was supposed to discharge all functions were prescribed for her and ensure all services required at health sub centre. The roles of Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activists also integrated. The Auxiliary Nurse Midwife was supposed to hold weekly/fortnightly meeting with Accredited Social Health Activists, and provide on-job training by discussing the activities undertaken during the week/fortnight and provide guidance in case Accredited Social Health Activists encounters any problem. Auxiliary Nurse Midwife would also act as resource persons for the initial and periodic training and ensure that during the training. Auxiliary Nurse Midwife was supposed to guide Accredited Social Health Activists in bringing
the beneficiary to the outreach session. She would utilize Accredited Social Health Activists in motivating the pregnant women for coming to the Sub-Centre for initial check-ups and take Accredited Social Health Activists help in bringing married couples to Sub Centres and motivating pregnant women for taking full medical services.

7.4.3 Aanganwadi Worker (AWW):

Aanganwadi Workers, however not directly appointed under National Rural Health Mission as they appointed under Integrated Child Health Scheme and expected to take care of level of nutrition for mother and children. After convergence of both health and nutrition program under NRHM Aanganwadi Worker became a major functionary under National Rural Health Mission at the village level. The responsibilities of Aanganwadi Worker were supposed to guide Accredited Social Health Activists in performing their roles and work in close proximity with ASHA and ANM. Aanganwadi Worker was expected to guide Accredited Social Health Activists in performing activities such as organizing health and nutrition day at the Aanganwadi centre and orientating women on health related issues such as importance of nutritious food, personal hygiene, and care during pregnancy, importance of immunization etc. Aanganwadi worker was also a depot holder for drug kits and found issuing it to Accredited Social Health Activists. The replacement of consumed drugs were also done through Aanganwadi Worker. Accredited Social Health Activists was expected to support the Aanganwadi Worker in mobilizing pregnant and lactating women and infants for nutrition supplement. She was also likely to take initiative for bringing the beneficiaries from the village on specific days of immunization, health check-ups/health days to Aanganwadi Workers. Therefore the role of AWWs under NRHM became so important especially considering one aspect of organizing health and nutrition days in AWC on regular intervals. Research scholar had also found special immunization sessions being organized at several AWCs during case studies.

7.4.4 Punchayati raj representatives:

In India, one Panchayat was set up per 5000-10000 population. The representatives of Panchayat such as Mukhya, Sarpanch, Panch and others were elected through elections held every five years. The role of Panchayat in National Rural Health Mission was made most crucial. Panchayat representatives such as Mukhya/ Sarpanch were most recognized functionaries under the National Rural Health Mission and their role was most crucial in Village Health and Sanitation Committees. They were largely responsible for
selection of Accredited Social Health Activists as per prescribed norms. Further they were required to take part in the planning process at the panchayat or HSC level in close cooperation with respective ANM, AWW and ASHA. However case studies found that in several states especially in Jharkhand due to non organization of panchayat election their role to select ASHA was given to non governmental organizations.

7.4.5 Non- Government Organizations representatives:

In each state several Mother NGO, Service NGO & Field NGO were recognized by the Ministry of health and family welfare, Government of India. Such NGOs were assigned and assisted directly by the ministry to carry forward some key tasks related to health and family welfare including National Rural Health Mission.

7.4.6 Chairperson of Zilla Parishad:

Every district mission or society was required being headed by the elected head of the Zilla Parishad. However, in several states their role was found given to respective District Magistrates or Deputy Commissioners. In some states such situation happened due to non organization of local and urban body’s elections. However in those states where election was held and Zilla Parishad Chairperson were elected it appeared quite illogical to research scholar because considering the superiority of democratic institutions over administrative arrangements how provisions violated which was deeply recommended by frame work of implementation of NRHM.

7.4.7 District administration representatives:

The role of District Magistrates, Deputy Commissioners and Deputy Development Commissioners were most crucial under National Rural Health Mission. In addition, other district level government officials related to Integrated Child Health Scheme, Education, AYUSH, Panchayati raj, Welfare was also most crucial under NRHM as it was found under case studies that they were nominated to the District level health mission or society as members in many states. Case studies had further found that in several states District magistrates or Deputy Commissioners were heading the district level mission and society whereas it was required to be headed by chairman of the respective Zilla Parishads.

7.4.8 Chief Medical Officer (CMO):
The role of Chief medical officer was most important under the *National Rural Health Mission*. A CMO was supposed to be the mission director at the district level. They were the chairperson of the executive committee of the District health society and chief executive officer of the Governing body. Research scholar had found that in some states, CMO was also referred as *Civil Surgeons* especially in Bihar and Jharkhand.

### 7.4.9 Deputy Chief Medical Officer (Dy. CMO):

CMO or *Civil Surgeon* was assisted by ACMO however under *National Rural Health Mission* posts of Dy. CMO were proposed to work as program officers at the district levels. Each Dy. CMO was required to head the concerned program committee at the district level for a particular disease. A Dy. CMO also worked as District program Manager in some cases especially in those cases where they were not appointed. Nevertheless, it was under case studies it was found that the post and rank of Dy. CMO was not recognized in several states. However research scholar had found that in Bihar and Jharkhand state posts of Dy. CMO not created for long and they worked in previous manner.

### 7.4.10 State/ Divisional/ District/ Block Program/ Accounts Managers:

One program manager and accounts manager was required in each state/ division/ district and block program management unit. It was found that program management units were set up in almost all states at different levels and they were provided with the services of Program manager, Account Manager and data Assistant in majority of districts and blocks of the country. Those work force deployed has assisted the State health society in carrying out all its daily-to-daily activities. They were required to report to the respective mission directors at the state and district levels. The role of program managers was considered so important and they required being ready with every bit of information about his territory and it required in order to prepare health plans and give presentation over the performance. All those work force were also appointed on contractual basis and state health societies or district health societies were authorized to appoint them and extend the terms of contract.

### 7.4.11 Data assistants/ experts:

Data assistants were also recruited on large numbers to extend their services at the respective program management units at different levels. They were computer experts and supposed to assist in dissemination of timely reports and prepare various reporting formats, plan and review reports. They were also supposed to maintain HMIS through regular inputs.
7.4.12 Hospital Manager:

Hospital managers were recruited for each first referral units, community health centers and district hospitals. Their roles were different from Program managers as they were specified with management of daily functioning of the hospitals. Thus they came having a background of study in the field of management although preference was given to candidates having specialization in hospital management.

7.4.12 MAMTA and E-MAMTA: In some states this scheme was implemented as an innovative idea.

Figure 3: NRHM key functionaries at different levels.
Chapter 7.5

Programs Under National Rural Health Mission

It could be quite confusing for general people to identify which program covered under National Rural Health Mission or which not and so much so that even some functionaries at different levels appeared quite confused and provided different versions. With the case studies, it became evident that some states were found implementing their own health programs and also National Rural Health Mission programs were named differently in different states. This was unique because one National Program could not required name differently in different states. However, it happened in several states i.e. accredited social health activists program was named as SAHIYA in Jharkhand and MITANNI in Chhattisgarh. Similarly, Janani Suraksha Yojna named MMJSY or Mukhya Mantri Janani Suraksha Yojna in Jharkhand.

In some cases, states also started new programs with the funds being available under National Rural Health Mission as was like an umbrella for all the existing and new health programs in the country. The erstwhile disease control programs were included within the purview of National Rural Health Mission. After the merger of societies at state and district levels a separate program committees within the purviews of concerned state and district health societies incorporated to tackle different disease control programs. However several innovations were enlisted in different CRMs reports and directory of innovations published by DFID. Though it was not possible to verify each and every programs being implemented in different states due to paucity of resources however, on the basis of ‘Mission documents on NRHM’ and ‘MIS on NRHM’ and case studies it could be said that following programs were largely implemented under the aegis of National Rural Health Mission:-

7.5.1 Reproductive & Child Health Program (RCH-II)

Reproductive and child health program or RCH was the major component of the National Rural Health Mission. After yielding failures of RCH-I different strategies related to management and financial management was made-up and extended to RCH-II, which ultimately also extended to National Rural Health Mission. The RCH-II, a flagship program of the Government of India on reproductive and Child Health, was launched in April 2005 under National Rural Health Mission. This program was reoriented and revitalized to give a
pro-outcome and pro-poor focus. It aimed at reducing the Maternal Mortality Ratio, the Infant Mortality Rate, and Total Fertility Rate. RCH-II evolved a shared vision and a common program encompassing the entire Family Welfare Sector, lending a strong focus on results, especially improving the use of RCH services by the poorest and the underserved populations. RCH-II also allowed states to have greater flexibility in programming and use of allocated funds. As a result, larger portions of funds targeted towards the poor. At the same time, use of innovative approaches and enhancing the participation of the private and the NGO sector were hallmarks of this program (MOHFW 2005).

RCH-II was also not a single program but was an amalgamation of several programs aimed at child and maternal care. RCH flexi pool were provisioned to plan and implemented throughout the country, which promoted innovative ideas. RCH program was found intermingled with following:-

7.5.1.1 Routine Immunization:

*Extending* cover to all mother and child was the main aim and objective of the universal immunization program conducted in the country. Immunization coverage in India was one of the lowest in the world. Therefore measures were in place under *National Rural Health Mission* to increase immunization coverage. Special immunization sessions planned and implemented at micro levels. Cold chain management corrected at different levels and work force adequately trained and deployed. Special catch up round executed in some states to cover dropouts.

7.5.1.2 Maternal Health Activities under RCH-II:

Reproductive and child health program also targeted the reduction of maternal mortality which in India remained significantly higher. Based on the official estimates of Registrar General of India (RGI-SRS), the Maternal Mortality Ratio (MMR) for India had declined from 398 in 1997-98 to 254 per 100,000 live births in 2004-06.

About two-thirds of maternal deaths occurred in a handful of states – Bihar and Jharkhand, Orissa, Madhya Pradesh and Chhattisgarh, Rajasthan, Uttar Pradesh and Uttarakhal and in Assam. RCH-II/NRHM had envisioned to minimize the regional variations in reproductive health and to provide assured, equitable and responsive service delivery by setting of national targets for reduction of maternal mortality and improving service delivery.

7.5.1.3 Janani Suraksha Yojna:
Janani Suraksha Yojna (JSY) was a safe maternity interference under the National Rural Health Mission implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Janani Suraksha Yojna implemented in whole country. The scheme focused on the poor pregnant woman belonging to below the poverty line with special dispensation for states having low institutional delivery rate namely, the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Orissa, Rajasthan and Jammu and Kashmir, While these states were classified as low performing statures, the remaining states have been named as High performing States. Besides the maternal care, the scheme provides cash assistance to all eligible mothers for delivery care.

However research scholar found this scheme highly beneficial despite it required raising the financial limit also it required monitoring the scheme vigorously as several malpractices reported from several states.

7.5.1.4 Integrated Management of Neonatal and Childhood Illness:

Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy was one of the main interventions under the RCH. The strategy encompassed a range of interventions to prevent and manage the commonest major childhood illnesses, which cause death i.e. neonatal illnesses, Acute Respiratory Infections, Diarrhea, Measles, Malaria, and Malnutrition. It focused on preventive, primitive, and curative aspects, i.e. it gave a holistic outlook to the program. The Child survival strategy of IMNCI was introduced in 219 districts of the country and 90401 health persons were trained on IMNCI as per MIS on NRHM (MOHFW 2011).

7.5.1.5 Pre Service IMNCI:

Pre Service IMNCI had been accepted an important strategy to scale up IMNCI by GOI and had been included in the curriculum of 79 Medical colleges of the country. Four thousand students were already trained. This would help in providing the much-required trained (IMNCI) work force in the public and the private sector (MOHFW 2011).

7.5.1.6 Facility Based New Born Care (FBNC):

As more and more sick children screened and detected at the peripheries through IMNCI and referred to the health facilities, care of sick newborn and child at health facilities assumes priority. Building up the capacity of the
Medical Officer at these facilities to handle such cases thus became important. 146 SNBCUs were set up to address sick newborn care at facilities.

7.5.1.7 Home Based New Born Care (HBNC):

The Government of India had approved the implementation of home based newborn care although this was Norway government initiative called Indo Norway Initiative (NIPI) which focused the five high focus states covered. Under this joint initiative, the HBNC was implemented. It also incorporated into the ASHA training and duties. For home based care of the newborn, a skill-based task, and materials to enhance the skills of the ASHAs was initiated (NIPI 2011).

In addition, a course module developed by WHO headquarters had been field tested in UP, found useful and shall be adapted to suit Indian conditions and the material were shared with the states.

7.5.1.8 Management of malnutrition:

To effectively tackle the huge burden of malnourished children in the country, nutrition rehabilitation centers were set up. Malnourished children admitted at those centers, nurtured back to normalcy through the provision of hot cooked high calorie dense foods using locally available food materials. 582 nutritional rehabilitation centers were established to address malnutrition among children. Community based guidelines for management of malnutrition developed to supplement the facility-based guidelines. There were some provisions also for stunted children but on this issue it was said that situation would only improve with improvement in the income level of the family and nation.

7.5.2 Revised National TB Control Program (RNTCP)

Revised National TB Control Program had been another major program brought within the purview of National Rural Health Mission. The Revised National TB Control Program, based on the internationally recommended Directly Observed Treatment Short course (DOTS) strategy was launched in 1997 and expanded across the country in a phased manner (RNTCP 2011).

The program had consistently maintained the treatment success rate more than 85 percent and case detection rate close to the global target of 70 percent.

Quality assured diagnostic facilities were available through more than 12,500 laboratories across the country. Over 2500 NGOs, 19500 private practitioners and 150 corporate were involved in Revised National TB Control Program
services. 267 medical colleges (including private colleges) were involved in Revised National TB Control Program. The media were agency hired to support the IEC activities at the national level. Communication facilitators appointed by the states to support the IEC activities at the district level.

Due to successful implementation of Revised National TB Control Program, prevalence of all forms of TB brought down from 5860 per million populations (1990) to 2830 per million populations in 2007 and TB mortality in the country reduced from over 420 per million in 1990 to 280 per million in 2007 as mentioned in WHO global report 2009. Repeat population surveys indicated an annual decline in prevalence of disease by 12 percent.

7.5.3 National Vector Borne Disease Control Program

Vector borne diseases, viz., Malaria, Filaria, Kalazar, Japanese Encephalitis (JE), Dengue, and Chikungunya were major public health concerns, which obstructed socio-economic development (NVBDCP 2011).

The National Health Policy (2002) had set the goals for reduction of mortality because of malaria and other vector borne diseases by 50 percent by the year 2010; elimination of Kalazar by the year 2010 and elimination of Lymphatic Filariasis (LF) by the year 2015.

Under the aegis of vector borne disease control program several programs implemented and some those might mention here by the research scholar:-

7.5.3.1 Malaria control program: Control of malaria was one of the major components under vector borne diseases control program. The occurrence of malaria was widespread in the country. Over the years, with the efforts of the Govt. of India and State Governments, the incidence of malaria brought down to below 2 million annually whereas reported deaths are around 1600 annually. Under this program treatments besides control measures such as spray of DDT, health camps, and distribution of medicated nets were found organized in the infected areas.

7.5.3.2 Filaria control program: In pursuit to achieve the goal of elimination of Lymphatic Filariasis by the year 2015, Govt. of India in 2004, launched the campaign of Annual Mass Administration (MDA) with single dose of Diethyl Carbamazine Citrate (DEC) tablets to all individuals living at risk of filariasis excluding pregnant women, children below 2 years of age and seriously ill persons.
Mass Drug Administration (MDA) observed in 18 States. Total population targeted in all the 20 State was 599 million out of which about 516 million populations was eligible for Drug Delivery

7.5.3.3 Kala Azar control: With the efforts of then union health Minister Dr. C.P.Thakur being himself a renowned medical practitioner and a research scholar in the field of Kalazar, it included in the central list of vector borne diseases control program. Elimination of Kalazar by the year 2010 was also envisaged as national health policy goal. Kalazar was reported endemic in 4 states viz. Bihar, West Bengal, Jharkhand and Uttar Pradesh besides sporadic occurrence in a few other areas.

7.5.3.4 Japanese Encephalitis (JE/AES): JE reported mainly from Andhra Pradesh, Assam, Goa, Haryana, Karnataka, Kerala, Maharashtra, Tamil Nadu, Uttar Pradesh, and West Bengal. Govt. of India had initiated JE vaccination program for children between 1 and 15 years of age as an integral component of Universal immunization program with single dose live attenuated JE vaccine.

7.5.3.5 Dengue/Dengue Hemorrhagic Fever: Dengue had become a major problem in some part of country. It had affected national capital region of Delhi very badly. Each year soon after monsoon season, it emerged. As there was no specific treatment for Dengue, the emphasis was on avoidance of mosquito breeding conditions in homes, workplaces and minimizing the man-mosquito contact.

7.5.3.6 Chikungunya: It re-emerged in the country during 2006 in epidemic form after a quiescence of about three decades. Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Madhya Pradesh, Gujarat, Kerala, Andaman and Nicobar Islands, National Capital Territory of Delhi, Rajasthan, Pondicherry, Goa, Orissa, West Bengal, Lakshadweep, and Uttar Pradesh affected. Government of India continuously monitored the situation and emphasized for implementation of strategic action plan by the states. Central government had identified 13 apex referral laboratories for advanced diagnosis and regular surveillance of Dengue and Chikungunya fever cases and 137 sentinel surveillance hospitals for pro-active surveillance. National Institute of Virology, Pune entrusted to supply test kits to these institutes.

7.5.4 National Program for Control of Blindness (NPCB)
**National Program for Control of Blindness** was launched in the year 1976 as a 100 percent centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3 percent by 2020. Rapid survey on avoidable blindness conducted under **National Program for Control of Blindness** during 2006-07 showed reduction in the prevalence rate of blindness from 1.1 percent (2001-02) to 1 percent (2006-07).

The scheme had been formulated with the view to achieve ultimate goal to eliminate avoidable blindness from the country which was in consonance with the action plan of World Health Organization. National Rural Health Mission it adopted and included in the national disease control program.

Free supply of spectacles to children, school eye test camps, IOL and Cornea operations were some of activities implemented under NPCB (NPCB 2011).

### 7.5.5 National Leprosy Eradication Program (NLEP)

India was among a handful of countries which used to be in the watch list. Some major achievements was witnessed in India and almost thirty-two states including union territories had achieved leprosy elimination status and only three states such as Bihar, Chhattisgarh, and Dadra & Nagar Haveli were yet to achieve full elimination (NLEP 2011).

### 7.5.6 Integrated Disease Surveillance Project (IDSP)

**Integrated Disease Surveillance Project** launched in November 2004 being intended to detect early warning signals of impending outbreaks and helped to initiate an effective response in a timely manner (IDSP 2011). **Integrated Disease Surveillance Project** had also started a pilot project for strengthening community based disease surveillance in three states (Maharashtra, Orissa, and Karnataka).

Seven infectious disease hospitals were sanctioned one each in four metros besides one each in Bangalore, Ahmadabad, and Hyderabad given funds for strengthening reporting from ID Hospitals.

**Integrated Disease Surveillance Project** was supporting activities related to Avian Influenza under **Integrated Disease Surveillance Project** with total outlay of 2085 million for three years (2006-09) for Human Component. A networking model developed with 10 laboratories and additionally ICMR with its four branch laboratories.

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111
Chapter 7.6

MANDATORY SERVICES FOR HEALTH FACILITIES

The Indian public health system was found suffering from both the quality and adequacy and lack of quality of services had caused tremendous trust deficit among the population and they used to be deviated towards private medical sector for medical services (Upadhyay 2011). Indian public health sector was further found suffering due to lack of work force, logistics and infrastructure as all those three components required being available simultaneously at all places for adequacy. The coverage of health facilities was never corresponded to the population. It was required to establish new health facilities according to population and strengthen or upgrade the existing health facilities in order to make them ready to deliver. Ministry of health and family welfare had thus prescribed standards of services to deliver by each health facilities; it was further made a policy for minimum number of services delivered by each health facilities and requirements of work force, logistics, and infrastructure for each level of health facilities. It was in form of document, which known as ‘Indian Public Health Standards’ or ‘IPHIS’ (IPHS 2006 & 2010). In fact government of India had diluted the provisions of Indian Bureau of Standards considering later too expensive to implement.

The draft Indian public health standard was put forward for each public health facilities in the country from Health Sub Centre to Primary Health Centre, Community Health Centres, First Referral Units and District Hospitals. For each health centre a separate draft format was released first time in the year 2006 and the second revised format was released in the year 2010. The norms of Indian Public Health standards were adopted under NRHM considering the Bureau of Indian Standards as most expensive; however this move was criticized by several quarters. However the content in this chapter was based largely upon the study of all the draft formats of Indian Public Health standards and case study.

Thus, Indian Public Health standards had formed the basis for establishing new health facilities and upgrading of new health facilities in the country based on population under the National Rural Health Mission. It was found that under National Rural Health Mission a minimum standard of services, which could be available at any public health facilities, was formulated, and prescribed. Provisions and norms for minimum services were spelled out in form of Indian Public Health standards for varied levels of health facilities ranging from HSCs
to DHs. It was almost made mandatory for health administration to mobilize their resources available under NRHM in order to enable minimum services in tune of *Indian Public Health standards*. National Rural Health Mission had incorporated provisions of *Indian Public Health standards* for upgradation and setting up of new health facilities.

The health services ensured at different levels summarized as follows:

**7.6.1 At Health Sub Centres (HSCs)**

*Indian Public Health standards* had suggested one Health Sub-Centre (HSC) established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. The minimum services required to be made available at each Health Sub-Centre were also prescribed which to be of Antenatal care, intra natal care and postnatal care.

Further under the category antenatal care services like early registration of all pregnancies, minimum three antenatal check-ups and further associated services like general examination such as height, weight, blood pressure, anemia, abdominal examination, breast examination, folic acid supplementation in first trimester, Iron & Folic Acid Supplementation from 12 weeks, injection tetanus toxoid, treatment of anemia were included. Minimum laboratory investigations like hemoglobin estimation, urine for albumin and sugar, and referral to primary health centre for blood grouping was also made mandatory.

Identification of high-risk pregnancies, appropriate and prompt referral was required taken up by each health sub-centre. Similarly, each Health Sub-Centre was required to take up Malaria prophylaxis in malaria endemic zones as per the guidelines of *National Vector Borne Disease Control Program*.

Intra natal care was included of promotion of institutional deliveries, skilled attendance at home deliveries and appropriate and prompt referral. Whereas the postnatal care was inclusive of a minimum of 2 postpartum home visits, first within 48 hours of delivery, 2nd within 7 to 10 days, Initiation of early breastfeeding within half-hour of birth, Counseling on diet & rest, hygiene, contraception, essential newborn care, infant and young child feeding.

Besides natal care, provisions of child health inclusive of essential newborn care inclusive of maintaining the body temperature, preventing hypothermia, maintaining the airway and breathing, the baby breastfed by the mother within half-an-hour, taking care of the cord, and eyes, as per the guidelines for
antenatal care and skilled attendance at birth by Auxiliary nurse and midwives and Lady health visitors.

Services at HSCs were also included promotion of exclusive breast-feeding for 6 months, full immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI, Vitamin A prophylaxis to the children as per guidelines and also prevention and control of childhood diseases like malnutrition, infections, ARI, Diarrhea, Fever, etc.

It was prescribed that each health sub-centre would ensure family planning and contraception services inclusive of Education, Motivation and counseling to adopt appropriate family planning methods, Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions, Follow up services to the Eligible couples adopting permanent methods (Tubectomy / Vasectomy), Counseling and appropriate referral for safe abortion services (MTP) for those in need.

Adolescent health care provisions like education, motivation, and referrals ensured. Assistance to school health services was inclusive of assistance to school health activities. The disease surveillance was inclusive of Control of local endemic diseases such as Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics. The water quality monitoring activities were involved with disinfection of water sources, testing of water quality using Rapid Test (Bacteriological) and promotion of sanitation including use of toilets and appropriate garbage disposal. Every auxiliary nurse and midwife required conducting field visits on regular intervals for community needs assessment like health requirement of the area required assessed at the Health Sub-Centre level.

The curative services inclusive of treatment for minor ailments such as fever, diarrhea, worm infestation, and first aid, appropriate - prompt referral, organizing health day at Aanganwadi Centre at least once in a month. The training of traditional birth attendants or Dai and accredited health activists, community health volunteers, Monitoring of water quality in the villages, keeping watch over unusual health events and coordinated services also required to be facilitated at each health sub centre of the country.

Besides all of these a health sub centre must require to implement all national health programs in the country such as National AIDS Control Program which mainly inclusive of Information Education and Communication activities to enhance awareness and preventive measures, Counseling and referral, Condom
promotion & distribution, help and guide patients with HIV/AIDS receiving anti retro therapy with focus on adherence.

The National Vector Borne Disease Control Program at this level was involved with prevention of breeding places of vectors through Information Education and Communication, community mobilization, collection of blood smears from all fever cases, supply of anti malarial drugs and follow-up of patients on treatment are the activities that are required at the sub centre level. Rapid test kits for malaria used in sub-centers wherever such provision made. Assistance were required from health sub centers to integrated vector control activities in relation to Malaria, Filarial, Japanese encephalitis, Dengue, Kalazar etc. as prevalent in specific areas and record keeping and reporting the same.

The National Leprosy Eradication Program was required to include referring the suspect cases of leprosy to primary health centre, provision of multi drug therapy to diagnosed patients of leprosy at sub centre, accompanied with documentation & follow-up.

Facility for portable drinking water was ensured for patients taking supervised treatment. Each health sub centre required educating public about sign, symptoms, & complication of leprosy and availability of multi drug therapy at Government Institutions.

The Integrated Disease Surveillance Projects expected mainly involve with weekly reporting of information for Syndrome Surveillance in prescribed format to be reported to Primary Health Centre on every Monday. High level of alertness was required for any unusual health event and appropriate action.

The Revised National Tuberculosis Control Program was inclusive of referral of suspected symptomatic cases to the Primary Health Centre or microscopy centre. Provision of directly observed treatment scheme at sub centre and proper documentation and follow-up were expected. Adequate drinking water ensured for taking the tablets.

The National Blindness Control Program was involved with Information Education and Communication as the major activity to help identify cases of blindness and refer suspected cataract cases to the Primary and community health centre.

The Non-communicable Disease and Cancer Control Programs was involved with Information Education and Communication to sensitize the community about prevention of cancers and other Non-communicable Disease, early
detection through awareness regarding warning signs and appropriate and prompt referral of suspect cases.

7.6.2 At Primary Health Centres (PHCs)

*Indian Public Health Standards, IPHS* had clearly prescribed that there would be one Primary Health Centre or PHC per 30000 population in plains and 20000 population in hilly areas. IPHS had made every primary health centre to ensure delivery of services like outpatient and inpatient department. Each PHC made to have six beds at least with outpatient department and inpatient department facilities. Outpatient department made to run four hours in morning and 2 hours in afternoon or evening. One doctor for each 40 patients was provisioned. An inpatient department must have 6 beds and made to run 24 hours emergency services with appropriate management of injuries and accident. First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions, referral services, In-patient services were ensured at each primary health centre which further required delivering antenatal care on the pattern prescribed for a primary health centre almost ahead in quantity to health sub centre level.

The intra-natal care at primary health centre was inclusive of promotion of institutional deliveries, assisted vaginal deliveries including forceps / vacuum delivery whenever required, manual removal of placenta, appropriate and prompt referral for cases needing specialist care, management of pregnancy induced hypertension including referral, pre-referral management in obstetric emergencies that need expert assistance. It was also required to deliver postnatal care. Every primary health centre made to ensure newborn care inclusive of facilities and care for neonatal resuscitation, management of neonatal hypothermia / jaundice.

Each primary health centre made to provide services for Management of Reproductive Tract Infections or Sexually Transmitted Infections, which included health education for prevention of reproductive tract infections or sexually transmitted infections and treatment of reproductive tract infections or sexually transmitted infections.

Under the school health program regular checkups, appropriate treatment including deworming, referral and follow-ups were required. Adolescent were required to counseled and motivated for life style education, counseling, appropriate treatment.
Under the Disease Surveillance and Control of Epidemics program alertness to detect unusual health events and take appropriate remedial measures, Disinfection of water sources, testing of water quality, promotion of sanitation including use of toilets and appropriate garbage disposal were prescribed.

Each primary health centre were required extending basic laboratory services such as routine urine, stool, blood tests, bleeding time, clotting time, and diagnosis of reproductive tract infections or sexually transmitted diseases with wet mounting, grams stain.

Further, primary health centre also made to sputum testing for tuberculosis, Blood smear examination for malaria parasite, Rapid tests for pregnancy & malaria, RPR test for Syphilis & YAWS surveillance, Rapid diagnostic tests for Typhoid, Rapid test kit for fecal contamination of water, Estimation of chlorine level of water using ortho toludine reagent.

Almost one fifth primary health centre in the country was made to extend AYUSH services as per local people’s preference. The rehabilitation and disability prevention, detection, intervention and referral were also mandatory for each primary health centre.

The surgical procedures like vasectomy, tubectomy, including laparoscopic tubectomy, medical termination of pregnancy, hydro colostomy and cataract surgeries as a camp/fixed day approach were expected to be carried out in a primary health centre having facilities of operation theatres were also required at each primary health centre.

7.6.3 At Sub District Hospitals

Sub-district or Sub-divisional hospitals were below the district and above the block level or primary health centre hospitals and made to act as First Referral Units. All subdivision hospitals were made to cater about 0.5-0.6 million people. In bigger districts, the sub-district hospitals expected to fill the gap between the block level hospitals and the district hospitals.

There were about 1200 such hospitals in the country with a varying strength of number of beds ranging from 50 to 100 beds or more. The Government of India was strongly committed to strengthen the health sector for improving the availability, accessibility of affordable quality health services to the people. In order to improve the quality and accountability of health services a set of standards were there for all health service institutions including sub-district
hospitals. It was ensured that services of a FRU or sub divisional hospital would be marked ahead in comparison of PHC.

Consultation services such as General Medicine, General Surgery, Obstetrics and gynecology, Pediatrics, Emergency, Critical care, Anesthesia, Ophthalmology, Eye-Nose-Throat, Dermatology and Venerology (Skin & VD) Reproductive Tract Infections or Sexually Transmitted Infections, Orthopedics, Dental care, AYUSH were ensured.

Diagnostic and other Para clinical services like Lab, X-ray, Ultrasound, Electrocardiogram, Blood transfusion, and storage, Physiotherapy were also ensured.

Support and ancillary services like medico legal, postmortem, ambulance services, dietary services, laundry services, security services, housekeeping and sanitation, waste management, office management, counseling services for domestic violence, gender violence, adolescents, gender and socially sensitive, finance, inventory management were also ensured.

Minimum services ensured at first referral units could display as Figure-4.

**Figure 4: Mandatory services prescribed at CHCs/FRUs**

- **Consultancy services**
  - General medicine
  - General surgery
  - Obstetrics and gynecology
  - Anesthesia
  - ENT
  - Dermatology
  - Ophthalmology
  - Virology
  - Orthopedics
  - Dental
  - AYUSH
  - Emergency and critical care

- **Diagnostic services**
  - Pathological
  - ECG
  - Ultrasound
  - X-Ray
  - Laboratory
  - Blood transfusion and storage
  - Physiotherapy

- **Support services**
  - Medico legal
  - RTI
  - Laundry
  - Security
  - Waste management
  - Inventory management
  - Dietary
  - Counseling
  - Ambulatory
  - Kitchen

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Chapter 7.7

HUMAN RESOURCES MANAGEMENT

Human resources management was an emerging or emerged field of management, which dealt with personnel management, industrial relations, labor laws, organization behavior etc. Human Resource Management (HRM) term used to describe formal systems devised for the management of people (James A.F. Stoner, R. Edward Freeman and Daniel R. Gilbert, JR., 2007).

Human resources, when pertaining to health care, defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention (Saiyadain 2009). As arguably the most important of the health system inputs, the performance and the benefits the system could deliver depended largely upon the knowledge, skills, and motivation of those individuals responsible for delivering health services. As well as the balance between the human and physical resources, it was also essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success (Bach 2000).

Due to their obvious and important differences, it was imperative that human capital handled and managed very differently from physical capital. In fact, the human resources management under National Rural Health Mission was extremely complex, and it merited further examination and study. In a public sector program like National Rural Health Mission, Human resources or HR practices developed in order to find the appropriate balance of workforce supply and the ability of those practitioners to practice effectively and efficiently (Deoki Nandan 2007).

Human Resources Management (HRM) was one of the fundamental apparatus of National Rural Health Mission and used to be decisive for any concern and so the case was with NRHM. One of the basic requirements of modern day HRM was that it must carry speed and had to remain highly associated with the objectives of the concern (Mavalankar 2002).

The core HRM strategy under National Rural Health Mission was rightly found associated with top level or at central level which was rightly done because it was widely observed that any HR policy had better chance to succeed if they remained associated with top level of management. The fixation of
qualification, salary, and allowances were done at the central level but the recruitments process were found to be both centralized as well as diversified. HRM implemented in most diversified manner at state, district, or sub district levels. The HRM under NRHM was not applicable in the case of permanent staff and it was only made to cover personnel recruited under NRHM. Disciplinary actions procedures were also different for two set of staff contractual and permanent. Contractual staff were recruited and provided contract through respective health society. Therefore it was definitely a case that employees were not recruited by the permanent structure such as any government department especially health and family welfare.

Since economic liberalization started in the early 1990s India had witnessed several innovations in HRM practices but most of such practices were so far limited to private sector. Nevertheless, during the investigation it established that a public sector program like National Rural Health Mission also influenced by those innovative HRM practices performed by private sector. Perhaps this could be a reason that National Rural Health Mission was not having any well-documented or disclosed policy related to HR actions and personnel practices at least that was not found by the research scholar. Personnel practices also found applied differently in different states. Allowances leave and benefits provided according to respective state government rules. The HR policy under National Rural Health Mission appeared to be ‘hire and fire’ or best suited to the occasion.

HR actions and personnel practices such as recruitments, training, and payment of salary-allowances were highly decentralized. Although there was no any documented policy for HR Management, under the National Rural Health Mission despite the HR policy under NRHM was found to be most compatible with the set objectives and certain uniformity across the country was visible.

The execution of a large developmental program like National Rural Health Mission could not be possible without adequate and workable HR policy. HR policy under the National Rural Health Mission was thus very much required not in hypothetical or undisclosed manner but more on well documented manner and it must require having all the qualities of modern day HRM. The several deficiencies observed by the research scholar under NRHM were mostly due to lack of well documented HR policy and procedures involved. Therefore confusions persisted and different functionaries implemented personnel practices as they might suit them. This was certainly not good. It also resulted in large scale out ward migration of health work force which was considered not good for the public health system (Johnson 2007).
The HRM for *National Rural Health Mission* was found performing fewer than two major restraints. One was the lack of work force for the public health sector in India and second was the capacity of the country to produce work force in limited period. The capacity of the country to produce work force for public health had fallen distinctly short. This was the obvious reason that all kind of work force required for the public health could not be recruited and deployed also it could not going to happen in near future despite all funds being available.

The HR policy under *National Rural Health Mission* definitely deviated a lot from most of the other public sector concerns in India. The HR policy under *National Rural Health Mission* was definitely flexible according to the situation. The highlights of the visible HR policies under the *National Rural Health Mission* could be paradigm shift in selection, recruitments, and terms of employment offered to employees. The lack of work force in the health sector was evident and this lead to provisioning likes contractual appointments and multi skilling. Multi skilling, orientation and skill advancement training for medical, and paramedics were some of the highlights of the HR policy practiced under *National Rural Health Mission*.

*National Rural Health Mission* was most like a project based, time bound program, and standardized version of human resources management approach could be not useful. Therefore, lot of deviation and causalties found to be involved in the HR practices under the *National Rural Health Mission*. One of the basic requirements of the modern HR practices was that it must carry speed. The speed could be significant factor for any time bound project like *National Rural Health Mission*. In time bound programs the ultimate objectives of the program acquired significance but it never justifiable to ignore the requirements and expectations of work force in action. One of basic requirement of HR policy for a time bound program used to be the accomplishment of HR actions on time failing which desired objectives not realized. It was evident that country’s public health system was plagued by tremendous deficiencies most importantly inadequacy of skilled work force. Success of *National Rural Health Mission* was highly dependable on the availability of skilled doctors, nurses and paramedics or technicians. Thus, human resources policy for the *National Rural Health Mission* was visibly influenced by a situation, which may termed as high demand but low supply of work force. The supply side of work force under *National Rural Health Mission* could be reason that *National Rural Health Mission* failed to create adequacy in public health.

It could be found that the human resources responsibilities were generally divided into three major areas of management and those were staffing,
employee compensation, and defining-designing work. Essentially, the purpose of HRM for National Rural Health Mission was to maximize the productivity by optimizing the effectiveness of its diversified human resources.

Some important HR actions under National Rural Health Mission were as follows:-

7.7.1 Estimating requirement of work force at various levels

The kind and count of work force, which was required to deliver various health services at different levels, were found being duly acknowledged in form of Indian Public health standards or IPHS. It was evident that huge gap persisted in the work force availability as per IPHS. National Rural Health Mission had tried to minimize the gap by recruiting wide ranged man power in different states across the country at various levels. The process of calculation of deficient work force was a part of overall gap analysis called as facility surveys which was done accordingly to the IPHS (MOHFW 2006). The gaps as identified were expressed in numerical values. Gaps existed in both the number of health facilities and work force as per IPHS. Research scholar had accomplished own gap analysis and measured the gaps in terms of number of facilities required and existing and number of work force required and existing.

It was found by the research scholar that at national level there was some mistake in this calculation therefore correct figures could not be shown by MIS on NRHM and RHS 2010. In fact they just considered rural population whereas NRHM was also found being implemented in urban areas also to some extent. Also the decadal growth rate of population was not considered by the authorities.

One of the biggest HR challenges under the National Rural Health Mission was to appoint and train over 0.8 million female health workers (ASHAs). However it was found that though ASHA selected yet they could not able to get all the modules of training which were prescribed for them.

About 7 percent health sub centers had lacked an ANM (shortfall of 11200) and 50 percent did not have a male health worker. The National Rural Health Mission therefore envisaged the provision of an additional ANM at each sub-centre. Almost 143000 additional ANMs were required to operate the existing sub centers. Almost 22000 new sub centers needed to be established as per the 2001 population norms; thereby increasing the number of an additional 44000 ANMs was required. Thus, taking altogether, the country was in urgent need of about 200000 ANMs.
All the existing almost 23200 Primary Health Centres being scaled up to provide 24x7x365 service deliveries in a phased manner with the primary aim of improving institutional delivery. At the Primary Health Centres, against the availability of one staff nurse, it proposed to provide three staff nurses to ensure round-the-clock services. Outpatient services strengthened through postings/appointments of AYUSH doctors, over and above the medical officers posted at the Primary Health Centres. Nearly 700 Primary Health Centres were currently without doctors. To enable Primary Health Centres to provide 24x7x365 hours service delivery, an additional 24000 doctors needed besides 46000 nurses.

The National Rural Health Mission was aiming at ensuring a functional 30-bedded rural hospital at the Community Health Centre (usually located at the Block headquarters) level and seeks to scale the CHCs up to the Indian Public Health Standards (IPHS) to provide round-the-clock hospital services with specialist facilities. The work force requirements for every Community Health Centres required met through provision of seven specialists (against four at present) and nine staff nurses. An additional 3500 Community Health Centres were required to meet the as per 2001 population norms the number would grow further the moment it would be calculated on 2011 census including urban population as done by the research scholar and mentioned in tables 25 & 26.

7.7.2 Recruitment

After gap, analysis next could be the recruitment process. Nevertheless it was noticed that gap analysis was a continuous process and so the recruitments. The recruitment process under National Rural Health Mission was also unique because it was both centralized and diversified on the same pattern of overall HR Management. Sizeable amount of the recruitments done by the state level society whereas district health societies were also involved in recruitment of some key personnel such as staff for Program Management Units, Hospital managers, Lab technicians, health supervisors. Usually advertisements published in different newspapers and posted on various websites of the State level and district level societies seeking job applications from eligible candidates (Delhi 2009).

Services of recruiting agencies such as SAMS and Feedback venture were also availed in some cases. Hiring of recruitments agencies such as SAMS, Feedback venture, and others were ensured for recruitment against the key positions in a situation where specialized qualifications were required. Services of recruiting
agencies were mostly availed by central agencies and in some cases; state health societies also ensured their services. In such cases advertisement published in newspapers and candidates were asked to submit online applications or submit resumes by e-mail.

A vacancy advertisement by the Delhi *National Rural Health Mission* examined during January 2010 (Delhi 2009). The advertisements reflected that reservation quota was fully obeyed in the recruitments. The situation was similar almost throughout the country. It could be noted that fixed salary were offered without any provisions of HRA, PF/GPF etc. Throughout the country, the recruitments were done on almost similar pattern with some differences in salary offered, experiences, and qualifications desirable. At several places, applications also accepted online. Especially *SAMS* and Feedback ventures accepted application online largely. In Bihar and Jharkhand the state level health society also arranged recruitment process which had put extra burden on the functionaries.

The approach of recruitments was also varied from level to level and from state to state. Written tests, computer ability tests, and interviews were organized in order to shortlist candidates before final selection. List of successful candidates were provided to authorities by private agencies, which in turn invited candidates to join as soon as possible. Several district health societies were found inviting application for various posts such as technicians, supervisors, block program managers, hospital managers etc. Each district health society had to publish different advertisements and conduct separate selection procedures.

### 7.7.3 Training

One of the major components to assess the HR policy of any organization used to be its training design and thus every organization and its performance could be judged according to kind of training it provided to its work force and training plan it had. Training under the *National Rural Health Mission* was one of the most challenging HR function. Providing training under *National Rural Health Mission* was one of the major areas of intervention for the HR policies and it was found that *National Rural Health Mission* was having a well-documented training strategy (MOHFW 2007).

The nature, kind and diversity of the training required under *National Rural Health Mission* was so extensive that it was an uphill task in enabling adequate training to all kind of staff. Health care delivery system under *National Rural Health Mission* was prone to changes with advancement in technology or
methods. It was required to keep pace with the advancement in medical technology. Creation of infrastructure, supply of logistics and training on new methods were required repeatedly under the *National Rural Health Mission*.

The major focus of *National Rural Health Mission* was to provide all primitive, preventive, and curative services needed by the people in an integrated approach, so that services provided through a single window. In order to achieve this, it was imperative that Health, Family Welfare, and AYUSH programs effectively integrated and delivered through an effectively functioning primary health care infrastructure. *National Rural Health Mission* also envisaged convergence of services with relevant ministries / departments like Women & Child Development, Rural Development (Drinking Water/Sanitation) and Education. It also recognized that community and *Panchayati Raj* Institutions had a major responsibility in planning, monitoring and assisting service providers as also in awareness building and improving utilization of available facilities.

In order to rapidly orienting all the stakeholders, MOHFW decided to bring out a concise document outlining training strategy for service providers at district and below. This document was useful for state and central officials and policy makers to understand the training for effective integrated Health, Family Welfare and AYUSH service delivery at sub district levels. The National Training Strategy was to ensure integrated training programs to encompass the vast training needs and the expanded trainee universe, address the issues of planning and operationalisation of health facilities, synchrony of supplies, gender, and quality issues, and fund flow mechanism of all trainings.

In some cases, training also provided after placements but in certain cases training provided to working staff with a view to promote their functional abilities. Similarly, training types, requirements, size of training, location of training, details of trainers etc also mentioned in the guidelines and strategies for national training released by the central mission.

It was found that numerous training programs were implemented at several levels and so much so that it was quite usual that there was hardly any month in which no any training program was organized at the district level. Training under NRHM was more like a routine and every kind of staff were provided training at some stage during his employment. However it was not so that training was always sufficient and adequate. There were several instances that performance of work force not found as expected due to lack of training.
7.7.4 Personnel practices

The basic personnel responsibilities associated with human resource management under National Rural Health Mission found to be inclusive of Job analysis, staffing, organization and utilization of work force, measurement, and appraisal of work force performance, implementation of reward systems for employees, professional development of workers and maintenance of work force.

Job analysis was found consisted of determining the nature and responsibilities of various employment positions. This could encompass determination of the skills and experiences necessary to adequately perform in a position. Job analysis was the cornerstone of HRM practices under National Rural Health Mission because it provided valid information about jobs that was used to hire and promote people, establish wages, determine training needs, and make other important HRM decisions.

Staffing, meanwhile, was the actual process of managing the flow of personnel into, within, and out. Once the recruiting part of the staffing process was completed and selection accomplished through job postings, interviews, reference checks, testing, and other tools.

Organization, utilization, and maintenance of work force, were another key function of HRM under the National Rural Health Mission. This involved designing an organizational framework that could make maximum use of an enterprise's human resources and establishing systems of communication that help the organization operate in a unified manner. Other responsibilities in this area included were safety and health and staff-management relations. Human resource maintenance activities related to safety and health usually entailed compliance with existing state health department’s rules that protect employees from sufferings. Those regulations handed down from central agencies to state agencies, further up to district, and sub district agencies.

Performance appraisal was the practice of assessing employee job performance and providing feedback to those employees about both positive and negative aspects of their performance. Performance measurements were very important for both the organization and the individual, for they were the primary data used in determining performance. If any individual find to keep performing adversely they served show cause notices leading to termination and dismissal from the service. Situation were definitely created for failing
employees to leave the job however such practices were limited to some developed states only.

Reward systems, was typically managed at the micro level. There were some post such as ANMs, ASHAs, and AWWs who expected certain incentives based on their performances. Therefore, it maintained a systematic vigil to record the performances of such health employees in a selected geographical area and within a timeframe.

Employee development and retention, was another vital responsibility of HR policies. HRM was responsible for researching an organization's training needs, and for initiating and evaluating employee development programs designed to address those needs. These training programs ranged from orientation programs, which designed to acclimate new hires to the National Rural Health Mission long term and short-term objectives, to ambitious education programs intended to familiarize employees with a new developments in specified areas of health.

7.7.5 HRM constraints

HRM functioning under National Rural Health Mission was having some major constraints and it was found that HRM under National Rural Health Mission were though marred by those constraints however no any corrective measures could be ensured. Some of the constraints identified under this research could be summarized as hereafter:-

7.7.5.1 Lack of medical and paramedical work force:

The country was facing tremendous scarcity of medical and paramedical staff. It was not so that only developing were faced with such problems but most of the developed countries also faced such problem but the situation in developing countries especially in a country like India the situation acquired a most crucial aspect. It was estimated that country was in urgent need of about 0.6 million doctors and 0.9 million paramedical. It was extremely impossible to fill this gap because it would take considerable time and investment (Trivedi, 2010).

7.7.5.2 Private practice by government doctors:

Private practice by government doctors and paramedics, technicians were most common in some states. It was so prevalent in Bihar and Jharkhand that almost all doctors were having their clinics and nursing homes, pathological centres. The issue of government doctors doing private practice was another major
issue. Andhra reported in particular quoting a case from Nalgonda states that “this has become a vested interest in the public health provider, not to operationalise emergency obstetric care and further to make the matter worse the ANMs and ASHAs under the MO in charge may become agents for taking the C-section cases to the private clinics being run by them and earn some extra bucks.” Certainly there were numerous demands that private practice by government doctors must be banned in this country.

7.7.5.3 Transfer and posting of doctors and paramedics:

The issue of a lack of a transfer and posting policy impeding workforce management and workforce morale were reported from many states. Transfer procedure required to involve counseling and transparency wherein the list of vacancies put in the public domain and doctors could put in their requests for their posting to the place of their choice. During case studies it was also found that more and more doctors were posted at big towns or facilities located near to big towns or district head quarters.

7.7.5.4 Cadre conflicts:

Now we aware with above facts that huge workforce required to be hired under the NRHM. One of the major shifts in public health scenario under NRHM especially in the field of HR was noticed in form of hiring and engaging large number of employees on contract basis. It created two kinds of staff and cadre system within the single government system. One was permanent staff of the government and other was contractual staff. They were also differently paid. The permanent staff paid a structured salary whereas contractual staff paid fixed salary. They were supposed to accomplish almost similar kind of job. In most cases medical, management, nurses, paramedics, technicians and IT experts were extended limited period of contracts ranging from 2-5 years. Certainly, this had caused cadre conflicts, as there could be no similar salary and services terms for similar kind of work.

7.7.5.5 The size of work force:

The variation of size, distribution, and composition within a state’s health care workforce was of great concern. For example, the number of health workers available in a state was a key indicator of that state's capacity to provide delivery and interventions. Factors to consider when determining the demand for health services in a particular state was required to be inclusive of cultural, socio-demographic characteristics and economic factors.
7.7.5.6 Work force training:

Workforce training was another important issue. It was essential that human resources personnel consider the composition of the health workforce in terms of both skill categories and training levels. New options for the education and in-service training of health care workers were required to ensure that the workforce was aware of and prepared to meet a particular state's present and future needs. A properly trained and competent workforce was essential to any successful health care system.

7.7.5.7 The migration of work force:

The migration of health care workers was an issue that rose when examining state’s health care systems. Research had outlined that the movement of health care professionals closely followed the migration pattern of all professionals in that the internal movement of the workforce to urban areas was common to all states. It was noticed that there was utmost willingness to get stationed in some urban areas where better power, transport and other amenities were available. Lot of persuasion was practiced regarding persuasion of authorities to get posted on desired locations. Workforce mobility could create additional imbalances that required better workforce planning, attention to issues of pay and other rewards and improved overall management of the workforce. In addition to salary incentives, it was required to use other strategies such as housing, infrastructure, and opportunities for job rotation to recruit and retain health professionals, since many health workers underpaid, poorly motivated and very dissatisfied. The migration and de motivation of health workers in the manner as described were an important human resources issue that required be carefully measuring and monitoring.

7.7.5.8 State’s level of income:

Another issue that rose when examining HRM under National Rural Health Mission was a state's level of economic development. There was evidence of a significant positive correlation between the level of economic development in a state and its number of human resources for health. States with higher gross domestic product (GDP) and per capita spend more on health care than states with lower GDP and they tended to have larger health workforces.

7.7.5.9 Socio-demographic:

Socio-demographic elements such as age distribution of the population also played a key role in a country's health care system. An elderly population led
to an increase in demand for health services and health personnel. An elderly population within the health care system itself also had important propositions such as additional training of younger workers would be required to fill the positions of the large number of health care workers that would retire. This situation was typically observed in Kerala.

7.7.5.10 Cultural and geographical:

It was found essential that cultural and geographical factors must be considered while implementing HRM under NRHM. Geographical factors such as climate or topography used to influence the ability to deliver health services; the cultural and political values of a particular state could also affect the demand and supply of human resources for health. Such provisions could be found under the IPHS.

7.7.5.7 Leave and traveling rules:

Leave and traveling rules for employees were practiced as per different patterns. At central level central government rules were applied whereas at state level state specific rules were applied in most cases. Therefore, there was not uniformity.

7.7.6 Impacts of HRM on National Rural Health Mission

It was both useful and important to explore the impact of human resources on health sector. Some special arrangement mooted to challenge those constraints, which could be summarized as follows:-.

7.7.6.1 Outsourcing and private public partnerships:

Several human resources initiatives were well employed in an attempt to increase efficiency. For example, outsourcing of services was used to convert fixed labour expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts, and internal contracting were also examples of measures employed largely under the National Rural Health Mission. Under public private partnerships at various places diagnostics and institutional services were outsourced whereas it could be argued that instead of developing its own and authentic institutional set up full of varied kind of work force and logistics to deliver key health care services why shift was towards privatization in the name of public private partnership. This issue ignored or compromised under National Rural Health Mission. It was general apprehension that careless or reckless outsourcing and
privatization could cost grave for the country’s health care system as it could never able to develop.

7.7.6.2 Gender equity and fairness:

*National Rural Health Mission* did not discriminate against women however key personnel such as ANMs, AWWS and ASHAs all being women. Besides, it could be also seen that in almost 60 percent PHC there was a woman doctors at least. Therefore, it could see that *National Rural Health Mission* was one of the programs where gender bias never existed in theory at least. At mental level, gender bias may exist, which were more individual in nature. Large number of women employed in capacity of managers, administrative and supervisory positions.

Many human resources initiatives under *National Rural Health Mission* were also included attempts to increase equity or fairness. Strategies aimed at promoting equity in relation to needs required more systematic planning of health services. Some of those strategies were included the introduction of financial protection mechanisms, the targeting of specific needs and groups, and re-deployment services. One of the goals of human resource professionals under *National Rural Health Mission* must be to use these and other measures to increase equity.

7.7.6.3 Improving workforce skills for service delivery:

Improving workforce skills required a systematic program of in service training. Training programs was almost completely linked to the national health programs and even within those it was divided into IMNCl, SBA, adolescent and reproductive health, training in IUD insertion, training for different types of sterilization surgery and for safe abortion etc, each of which was proceeding independently of the other.

There was no way of even measuring how many facilities now had all these skills in place and were using it and the training institutions were not charged with ensuring that each facility had the requisite skills in place. There were efforts to build up district and regional training Centres and State institutes of health and family welfare, but they were limited to transmitting, as unchanged as possible those above packages to a fixed number of persons every year with little certainty of what became of it after they had left the training hall. Beyond those fixed RCH and RNTCP type, training packages no other dimension of the IPHS specified service packages were addressed.
7.7.6.4 Numeric adequacy and the skill mix:

One major step undertaken by the National Rural Health Mission had been to increase the total number of posts by firming up IPHS norms of how many posts needed at each level and offering to fund them for contractual appointment. There was a condition attached that funding for contractual appointments would flow only if there were corresponding efforts to fill up regular posts by the state government.

7.7.6.5 Multi-skilling:

Multi-skilling was one major option for getting the skill mix required within the available human resource of the department. There were three areas where such multi-skilling was encouraged under the National Rural Health Mission. One was in paramedical especially for laboratory technicians and for curative clinical skills and first aid skills in pharmacists and other paramedical posted in remote areas. This taken up in two states, Tripura and Chhattisgarh, and in the latter progress was slow. In Tripura, all Supervisors had received multi-skill training (MOHFW, Common Review Mission Reports, 2007, 2009).

7.7.6.5.1 Multi-skilling of nurses:

The specific proposal in this regard had been for the creation of nurse practitioners, in a context where there were no women doctors and often no doctors at all. Some functions like RTI management needed women doctors and indeed, in all functions this was welcome. Counseling, adolescent clinics, regular follow up in non-communicable disease, were other functions that nurses could perform. This was in the program implementation plan of number of states but only Andhra Pradesh and to a limited extent; West Bengal had begun working on this (MOHFW 2007, 2009).

7.7.6.5.2 Multi-skilling of specialists:

For specialist skills which were needed for emergency obstetric care the area where the most visible advance could be made. It was most needed in those states where number of specialists was low. This scheme was successfully implemented in Gujarat. Chhattisgarh too had shown that it could be done. Most other states had started up those courses. One aspect was that in many states a fair number of medical officers were providing surgical and anesthetist skills and they were under pressures to stop doing so. (MOHFW, Common Review Mission Reports, 2007, 2009).

7.7.6.5.3 Improving Workforce performance:
Pooling of resources at block level considered a way of getting the right skill mix both at the Primary health centre and at the Community health centre but there very few instances could see of it practiced.

7.7.6.5.4 Use of modern tool and techniques:

_National Rural Health Mission_ had witnessed a significant impact on the broad approach of various HR actions. Recruitments tests conducted online with use of sophisticated desktops and laptops. New technologies were broadly used, particularly in the areas of electronic communication and information dissemination and retrieval, had dramatically altered the landscape. Satellite communications, computers and networking systems, fax machines, and other devices had all facilitated change in the ways in which employees interacted with each other and their head quarters.

Telecommuting, for instance, had become a very popular option for many employees, and HRM professionals had to develop new guidelines for this emerging subset of employees. Proper management of human resources was critical in providing a high quality of health care. A refocus on human resources management under _National Rural Health Mission_ and more research needed to develop new policies. Effective human resources management strategies greatly needed to achieve better outcomes from and access to health care.

CRM 2007 had mentioned that the central challenge of the _National Rural Health Mission_ was to find definitive answers to the old questions about ensuring adequate recruitment for the public health system and adequate functionality of those recruited. Breaking a vicious cycle where poor performance of the workforce had justified poor attention to solving the fundamental problems of human resource development, the _National Rural Health Mission_ laid downs a minimum human resource requirement for each facility level and follows up to ensure that states agree to a road map to close these gaps. The most important outcome of this was the dramatic increase in the number of nursing and allied staff brought into the system. Contractual appointment routed to immediately fill gaps as well as ensure local residency, incentives, and innovation to find staff to work in hitherto underserved areas and the use of multi-skilling and multi-tasking options were examples of other innovations that seek to find new solutions to old problems (MOHFW, Common Review Mission Reports, 2007, 2009).

It was quite in practice those days to evaluate HR Administration of any
Organization against certain parameter such as personnel administration including HR policies, hiring processes and employee contracts, personnel files, performance appraisal, conflict resolution, and assuring compliance with labor laws. The research scholar had evaluated the HR administration under NRHM against those parameters. In the Table 10 the contents and findings against those parameters had been summarized. Therefore you may please see in table 10.

It was found that substantial work was required to up-date HRM processes and policies. Not all staff had job descriptions or accurate job descriptions. Other policies also required a fresh look such as the organizations’ performance appraisal systems. In some cases, there had not been sufficient training for supervisors and employees.

NRHM had a HRM budget, sometimes adequate, sometimes not, used almost exclusively to support HRM staff salaries and not necessarily for other activities. In each state health, society there was staff assigned to the HRM. Some state health societies felt they minimally staffed in this area. The HRM units could not said to be well structured as very few HR Managers were available. Day-to-day operations were occurring through the HR unit at each state health society.

In general, this study revealed that human resource management under National Rural Health Mission was guided by several overriding principles. Human resource management functions appeared ideally positioned near the theoretic centre of the National Rural Health Mission with access to all areas of the mission. HRM structures under National Rural Health Mission were extremely diversified and powers were shifted from macro level to micro level organizations such as central mission steering group to state health missions to district health missions. Although the most of the HR policies were planned at the central level but they executed in diversified manner. In nutshell, it said that there unified approach in planning and diversified approach was practiced in execution of HR policies under the National Rural Health Mission. Under National Rural Health Mission the HR administration was mostly integrated to state and district level institutions.

To end with research scholar could say that it required tackling all those deficiencies such as migration of work force, maintenance of proper personnel data and files, access of personnel data and files, employee’s evaluation and incentivization, and more HR budget and more HR Specialists.

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134
Financial management under National Rural Health Mission was one of the most challenging tasks, which merited accomplished in most transparent and professional manner. India had a history of unsatisfactory financial management for the public health specially the financial management under RCH-I had established the need for specialized financial practices at different levels. The problem not only due to numerous cases of siphoning away the funds but also lack of transparency and proper utilization of funds. The fund management was also marred due to lack of management and accounts professional in the system.

Since National Rural Health Mission had ensured the services of management and accounts professionals at various levels which had eased the financial management to an extent. The main approach for financial management under the National Rural Health Mission was inclusive of Funds allocation, Funds disbursements, Funds utilization, and Submission of utilization certificates. All these approaches and components required accomplished in time bound manner (SIHFW 2009).

Research scholar had found that there was urgent end on adequate finance management under NRHM which was not felt earlier due to lacked investments in the public health sector. The thrust on adequate financial management was required because more funds were invested in the public health sector. The capacity of the public health system to absorb additional funds allocation was also not satisfactory.

Country had witnessed bad financial management records. The main hurdles at initial stages such as many divisions in MOHFW were found involved in fund transfer and too many budget heads had resulted in fund transfer delayed and protracted at all levels. Financial and administrative powers were concentrated at the top in almost all States/Districts, Undue dependence on revenue administration at the cost of health administration and low absorption capacity within the system. There was also no skill set within the system for financial management and the reporting structure was in disarray. Proper accounting systems were not in place and financial management conferences was unheard of (S.P.Yadav 2009).
Previously financial management even at central government level was restricted to sending funds and waiting for utilization certificates. To end this, financial management group (FMG) was constituted. Key features of FMG were the concept of flexi pool, single nodal for point of release, accounting, and collection of utilization and audit reports. Under the FMG, personnel trained to accounts related issues. Funds provided under different heads and required to be expending on the prescribed norms. Such FMG was incorporated after the failures of RCH-I and suggest means for RCH-II and extended to cover *National Rural Health Mission* (MOHFW 2005).

Double accounting systems was introduced under NRHM from the National level to State level and further up to district, and sub district levels. With accounts professional in position at all level had made things easier but such professionals also depended upon the timely disbursement and submission of utilization reports by the authorities.

One of the central pillars of the corrected architecture of the health sector was that the *National Rural Health Mission* had intended to achieve was improved public health sector financial management. *National Rural Health Mission* had strategized to address this dimension. One was the creation of the integrated district and state health societies as measure of horizontal integration and convergence, better governance and participatory decision-making. The second in the induction of a number of contractual staff with management skills – program management, data management and financial management. A third was the building up of the state level institutions.

There were several steps taken in order to improve financial management. One major step forward was the use of e-transfer for funds up to the districts as it had eliminated the time being usually consumed in transfer of funds marred by delay or even loss or damage of checks/draft or bills. The other step was the increase in accounting staff under contractual appointment at the state, district, and block levels. The financial powers were delegated adequately to the districts, in charge medical officer and various committees. The main components of financial management under *National Rural Health Mission* were coordination among different agencies, establishments of new procedures for accounting and ensuring that institutions function accordingly to financial management group guidelines.

Accounting under *National Rural Health Mission* found to be involved with the process of recording the financial transactions in a systematic manner and preparing summarized reports. The accounting process under *National Rural
Health Mission was inclusive of identification of transaction, recording, classifying, summarizing, analyzing, and reporting the transaction. The accounting tools used under National Rural Health Mission was Ledger book, Assets books, Cashbooks, Bankbooks, Credit vouchers, Debit vouchers, Sales books, Purchase books, Receipts, Bills.

National Rural Health Mission could be a framework which could encompass all interventions for health care as well as those for wider determinants of health care. The financing through the National Rural Health Mission budget head had provided the much-needed funds to the district level to facilitate better health outcome.

7.8.1 Accounting and finance practices under NRHM

7.8.1.1 Concurrent audit:

Concurrent audit was introduced under National Rural Health Mission to make house under order. The concurrent audit practiced under National Rural Health Mission which involved of handholding at the local level at monthly/Quarterly periodicity to make book keeping qualitatively better resulting in better statutory audit compliance.

7.8.1.2 State budgetary support to institutions:

National Rural Health Mission launched to supplement the funds available from State budget and not replace it. Reserve Bank of India data showed that the health budget in almost all states enhanced at satisfactory levels (RBI 2010). However, it was required to monitor that most of fund not go towards salary and allowances, institution level patient-centric funds replenished and maintained at optimal level and the waiver of user charges being compensated by hike in State budgetary support to affected institutions?

7.8.1.3 Management of treasury route fund:

Treasury route funds were largely aimed to meet salaries of ANMs and Family welfare bureaus. In many states, timely payment of salaries had been a constant problem leading to demoralization of perhaps the most important health functionaries. The main reasons were identified as delay in sending allocations from GOI, delayed allocation by the Finance Dept. of the State Govt. to Department of health and FW, delayed allocation of funds by the Department of health & family welfare to the Directorate of Health and FW and delayed release of funds from the Directorate to the field.
7.8.1.4 Banking:

It was conceptualized under National Rural Health Mission that banks would be used as a partner for providing value added services rather than a banker in the traditional sense and expected to be pro-actively involved in fund-flow. Many States had started e-transfer of funds to their districts; however, full potential of e banking was still to be fully realized. Sub district level transfers had remained the weakest link. It was realized that there would be tie-ups at district level with the District Health Society banker on one side and the lead Bank & Grameen Bank on the other side for faster fund transfer to sub-District levels (FMG 2011).

7.8.2 Flexible financing:

The flexi pool financing approach was adopted for the first time under NRHM/RCH-II. The central strategy of this support was the provision of untied funds to village health and sanitation committee, sub-centre, primary health centre, community health centre and district hospital. Even the strategy of providing a resource envelope to each district and state, which the district/state had to use against an approved plan that it had developed, was an unprecedented level of financing flexibility.

Financial packages for demand side finance and various forms of risk pooling where money followed the patient were also major strategies declared by the National Rural Health Mission. The Janani Suraksha Yojna was one major, almost overwhelming example of the demand side financing option, so much, so that in many places the National Rural Health Mission identified with it. However, the challenge of the National Rural Health Mission able to build more comprehensive packages that ensured allocate efficiencies within the public health system and that addressed equity concerns for the entire range of curative care needs.

7.8.3 Basis of funds flow under NRHM:

A tentative budgetary envelope was usually communicated to all states in the beginning of the year (March/April). The States were required to submit a National Rural Health Mission Program Implementation Plan (PIP) for a financial Year in advance with complete projections of funds required to implement the PIP. The PIPs was likely to be appraised and approved by National Program Coordination Committee of the MOHFW.
GFR provisions were practiced for fund release according to which the first tranche (to the extent of 75 percent of PIP) was released on submission of utilization certificates on a provisional basis for the funds released during the previous year to a State/Union territory. The unspent balance might take into account. The balance 25 percent of the approved budget under the PIP was made to be released after the receipt of audited statements and audited utilization certificates for the previous financial year.

Fund Release for RCH flexible pool and mission flexible pool was required done by *National Rural Health Mission* finance division. All utilization certificates pertaining to NRHM/RCH flexible pool were required to be sent to the director (NRHM-Finance). Fund released for immunization and other NDCPs required done by the concerned program divisions themselves. Utilization certificates for those programs required directly sent to the concerned program divisions.

**7.8.4 Funds flow under NRHM**

Funds flow under the *National Rural Health Mission* was based upon the micro plans, program Implementations Plans (PIPs) and district health action plans which submitted by states and districts annually in advance. The funds were routed through two ways- direct funds transfer from the central mission directorate to the state health societies and state treasuries. Generally, state treasuries funds utilized to provide salary to administrative, medical, and paramedical staff and to meet other expenditures. While funds flow under *National Rural Health Mission* were utilized for salary to contractual staffs and upgradation of infrastructure, logistics and to meet expenses such as planning, training.

**7.8.4.1 Treasury Route:**

Under this route expenses such as salaries of the posts of Auxiliary Nurse Midwife (ANMs) & LHV, training of ANMs, support to family welfare bureau at state and district levels etc were likely to meet.

**7.8.4.2 Society route:**

Under this route expenses such as expenses for Program implementation, salaries for the contractual employees hired for strengthening of Program implementation under the mission were met.

**7.8.4.3 Mechanism of funds transfer:**
Funds under *National Rural Health Mission* to States were transferred electronically through Real Time Gross Settlement within 24-48 hours. For which states were communicated different codes.

### 7.8.5 Financial monitoring reports (FMRs):

Financial reporting format specifically developed under the *National Rural Health Mission*. It was an almost 10 pages format, which contained almost information about opening balance, fund received, funds utilized and unspent balance. On examination of the format, it appeared that in general *National Rural Health Mission* financial format was inclusive of RCH flexi pool, *National Rural Health Mission* flexi pool, SRI. Respectively the 14, 28 and 3 heads of expenditure were countable under those three segments. The FMR under *National Rural Health Mission* was inclusive of entire gamut of the *National Rural Health Mission* activities and inclusive of purchases, salary, allowances, program management cost under different headings. The cycle of FMR was practiced monthly, quarterly, and yearly in most cases. Statements of funds position, bank statement positions were required submitted quarterly and monthly respectively whereas FMR were required submitted quarterly. It was also mandatory to submit annualized audit report by September of the following year and a consolidated audit report for the Society.

### 7.8.6 Flow of financial reports:

The financial management report usually originated from health sub centre level by ANMs. ANMs usually submitted reports related to expenses incurred out of untied funds and other funds. She used to rout her reports to the district health society directly or through concerned medical officer in charge of Primary Health Centre. Medical officer in charge of Primary Health Centre also required submitting financial management report to their district health society. Community health centre and first referral units or other Sub district facilities required to submit their reports to district health society. District health society routed their reports to the state health society and from there they used to be sending to the MOHFW/ Director finance (NRHM).

### 7.8.7 NRHM financial management software:

Web enabled software developed under the *National Rural Health Mission* for financial management. However, its success was not adequate similar to *Routine Immunization Management System*. Non-availability of broadband, electric supply at different levels restricted its proper usage. The software was simple to
use and synchronize data with single click despite it not made fully functional yet across the country however some reports obtained from current year.

7.8.8 Financial management group (FMG) under NRHM:

Financial management group came into being after RCH-I. It was in place under RCH-II and extended to National Rural Health Mission. Key features of financial management group were to single window for funds release and receipt of utilization certificates, flexible financing. The key functions of financial management group were analysis of financial situation of states, training of professionals and study of funds utilization and generation of FMIS.

Research scholar found it was not easy to say that everything was so smooth with financial management under National Rural Health Mission as several challenges and drawbacks were evident during the investigation. There was a dire need to track the fund flow from the district downward as large portions of funds devolved to blocks and below. Under National Rural Health Mission, funds devolved for Janani Suraksha Yojna (JSY), Rogi Kalyan Samities, Untied funds which required strictly monitored. In addition funds released for training also required vigorously monitored.

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Chapter 7.9

ROUTINE IMMUNIZATION AND COLD CHAIN MANAGEMENT

Research scholar could say that routine immunization was the key strategy under the National Rural Health Mission for protecting children from various diseases and lowering the morbidity and mortality among the children. Polio, Measles, Diphtheria, Tetanus, Pertussis, and TB were six diseases, which could be averted by proper vaccination in children. Better immunization system was certainly indicative of a prudent primary health care system. Success on the front of immunization in form of rapid growth of coverage from every part of the country could be an indicative of success of NRHM/ RCH-II programs.

What research scholar able to know from his commonsense that immunization usually could be referred as a process of inducing immunity by stimulating immune systems through antigens. Ensuring routine immunization in the country was a major component of the National Rural Health Mission, which covered under the RCH-II programs. It was a huge exercise and sustainable involving thousands of medical, paramedical, technicians and volunteers in the each and every part of the country.

Implementation of routine immunization in just a vast and diversified country was not easy and also it was not easy to make it successful. It required efforts and planning. The supply chain of vaccines from the factory to the consumer required maintained adequately. The provision for maintaining vaccines at prescribed temperature all the time from factory to state headquartered and further down to district, sub district and peripheral level required being done properly. This process was termed as cold chain management. It consisted of massive deployment of hardware and logistics at all places. The coverage of routine immunization under the National Rural Health Mission had registered phenomenal increase. The increase was more visible in high focus states.

There were several components of routine immunization process:-

7.9.1 Deployment of work force:

Deployment of work force at all places was first process under the immunization process. It observed that ANMs with vaccines, syringes, cold
boxes, hub cutters and other logistics deployed in each sub centre. Special sessions also planned for the hard to reach areas, which supervised by a medical officer. Lady health visitors, alternate vaccine carriers, and NGOs also participated in this endeavor.

7.9.2 Micro planning:

It was a crucial exercise usually implemented at several levels. It included calculation of targets and requirement of logistics according to the target. The process for micro planning usually started at the sub centre level by the ANMs. Micro plans were also prepared and monitored for urban areas. There was a formula for estimation of number of pregnant women, number of children, number of vials of vaccines, syringes and other logistics.

7.9.3 Demand and supply of logistics:

At state level there used to be a sufficient storage of vaccines and logistics as they required transferred to every district. From districts they transferred to primary health centers and from there to health sub centers or other peripheral health centers. Telephonic linkage established in case of emergency shortages of vaccines or logistics.

7.9.4 Maintenance of cold chain:

A system of transporting and storing vaccines at recommended temperature from point of manufacture to the point of use referred as cold chain management. Cold chain required maintained at different levels. At state depot cold chain was maintained through large walk in fridges were used being capable of storing huge quantity of vaccines. At district or regional level, cold chains maintained by using ILR 300 liter capacity fridges, Deep fridges and solar fridges. At primary health centre level cold chain found largely maintained by using ILR, DF or solar fridges. At HSC, cold chain maintained by ANMs by using cold boxes and vaccine carriers.

7.9.5 Maintaining immunization schedule

In India, different immunization schedules were maintained and there was no uniformity. Under National Rural Health Mission also different immunization schedule maintained in different states, as some vaccines were included in some state where it was not included in other states (MOHFW 2005). In addition, the immunization schedule approved by Indian Association of Pediatrics observed by almost all private service providers. At international level different
immunization schedule observed in different countries. In India, generally following immunization schedule maintained:

7.9.5.1 DPT Vaccine:

This vaccine contained *Diphtheria and tetanus toxoid* usually prevention against three disease *pertussis, diphtheria and tetanus*. 0.5 ml of the vaccine usually administered deep intramuscular, /generally anterior-lateral aspect of thigh, between 6-8 weeks after birth. Usually three does required administered maintaining a gap of 4-8 weeks. Booster also administered. It had some side effects in form of fever and local pain. It stored in lower compartment of the fridge and kept on room temperature.

7.9.5.2 Oral Polio Vaccine (OPV):

It contained *Sabin attenuated polio virus strain* concentration per dose of Type 1: 106 TCID50’, Type 2 105 TCID 50; Type 3:10 TCID505.5. Ideal age of Initiating primary vaccination was 6 week after the birth. However at birth OPV-0 usually also delivered followed by 3 doses at 4 to 8 weeks interval. Two boosters: Two, at 1.5 years and between 4-5 years were also administered. Two drops administered orally. Generally, it was having no side effects and stored at the temperature 2-4 degree Celsius in the uppermost compartment of the fridge.

7.9.5.3 Measles vaccine:

It Contained *1000 TCID 50 live attenuated measles virus (Schwarz)* grow in chick embryo cells. It delivered at the Ideal age of 9 months. 0.5 ml administered subcutaneous in the upper arm or anterior-lateral aspect of thigh. Single dose administered and no boosters recommended. Mild fever & rash might appear after 5-7 days. It was stored at 2 - 8 C in the upper most compartment of refrigerator when not in use. It kept on ice during immunization session.

7.9.5.4 Typhoid Vaccine:

It contained *Salmonella typhus 1000 million heats killed phenolized or acetone killed (AKD) bacteria* per ml. Ideal age of Initiating Primary vaccination was 2 years. Two doses administered 4 weeks apart. Boosters recommended every 3 years. It was administered subcutaneous generally anterior lateral aspect of thigh. It was stored in lowermost compartment of fridge it kept at room temperature during immunization sessions.

7.9.5.5 MMR Vaccine:
It contained I) 1000 TCID -50 live attenuated measles virus (Schwarz) Grown on click embryo cells. II) 5000 TCID 50 live attenuated mumps (Urabe AM-9) cultured in embryonic hen egg iii) 1000 TCID 50 live attenuated rubella (Wistar RA/3M) cultured on human diploid cells. Ideal age of initiating primary vaccination was within 15-18 months. Single dose of 0.5 ml administered subcutaneous at upper arm or anterior lateral aspect of thigh with no boosters. It required to be stored at 2 – 8 degree Celsius in upper compartment of fridge (with diluents).During Immunization session it kept on ice.

7.9.5.6 BCG Vaccine:

It contained Freeze-dried live attenuated Chalmette Guerin strain of bovine Mycobacterium tuberculosis, 0.1 to 0.4 million viable bacilli per dose. Ideal age of initiating primary vaccination was at birth or at earliest contact. Single dose of 0.1 ml was administered intra dermal in left upper arm at deltoid insertion. No booster was required. It was stored at +2 to +8 C in the middle compartment of refrigerator.

7.9.5.7 Vitamin A:

1 ml of dose orally administered with measles vaccine at the age of 9 months, and then 1 dose administered every six month up to age of 5 years.

7.9.5.8 TT-I and TT- II:

TT- I was required administered to pregnant women during early pregnancy. 0.5 ml of vaccine administered intramuscular in the upper arm while TT- II was required administered 4 weeks after the TT-I.

7.9.5.9 TT booster:

If pregnancy occurred within three years of last TT vaccination in that case a booster dose of TT administered.

7.9.6 Care of adverse effects of immunization, AEFIs

Minimizing AEFIs was one of the key aspects of the immunization process. To minimize AEFIs certain precautions required maintained at all levels. It included proper maintenance of cold chain equipments and keeping at least 90 percent of the cold chain equipments functional always. Vaccines must monitor before its administration and there could no reuse of syringes.

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PUBLIC PRIVATE PARTNERSHIPS

Public private partnership or PPP was highly focused under successive health and population policies of India. However, there could be a difference between privatization and public private partnerships. The full privatization of public health facilities was not pursued so far under NRHM although greater focus on PPP was definitely laid. Several PPP arrangements such as Primary Healthcare Center Adoption, Management was pressed on one side while on other side Build, Own, and Operate Diagnostic Centers was proposed and in addition Hospital Private Finance Initiative was also mooted through several policy documents (Anouj Mehta, 2010).

There was a most favorable situation for PPPs in India and provided they fitted to local circumstances, they clearly had the potential to drastically change the healthcare landscape in India. PPPs could survive only if the interests of all stakeholders were taken into account. This means detailing specific roles, rights and responsibilities, establishing clear standards, providing training for public sector managers, active dissemination of information, and constantly refining the process to make the system more efficient. The public sector had to lead by example, and be willing to redefine itself and work with the private sector. The latter must in turn be willing to work with the public sector to improve mutual cooperation and understanding (CII & KPMG, 2009).

PPP was considered highly beneficial in certain areas specially infrastructure development, Management and operation of healthcare facilities for technical efficiency, operational economy and quality, Capacity building for formal, informal and continuing education of professional, Para-professional and ancillary staff engaged in the delivery of healthcare, Creation of voluntary as well as mandated third-party financing mechanisms, Establishment of national and regional IT backbones and health data repositories for ready access to clinical information, and finally Development of a maintenance and supply chain for ready availability of serviceable equipment and appliances, and medical supplies and sundries at the point of care (CII & KPMG, 2009).

Starting from the Bhore Committee report in 1946 there had been an increasing emphasis on the state providing healthcare services through a three-tiered approach in India. However, despite those efforts and despite many
healthcare and family welfare plans and programmes made since then, health outcomes in India had remained closer to those in sub-Saharan Africa than in industrialised nations among which India would like to be counted. Public-private partnerships must aim to harness the large pool of private sector healthcare resources and draw them into the process of nation building (Das, 2007).

Sonalini Khetrapal had highlighted a role for Public-private partnerships in the insurance sector especially implementation of Rastriya Swasthya Bima Yojna (RSBY) (Khetrapal 2010).

7.10.1 Defining Public Private Partnership in health sector

It was obvious that public health sector in India was marred not only by deficiencies such as investments, work force or logistics but it was also due to lack of new technologies in the medical science and deficient management. The public private partnerships in the public health sector of the country were resulted mainly due to poor management of affairs and malpractices due to poor monitoring in the areas such as education, training, investments, and management (Mukhopadhyay 2010). However research scholar could see no harm in public private partnerships yet it required evaluating the necessity logically and fruitfully.

The PPP in health sector was a global phenomenon and therefore it rightly provisioned under the National Rural Health Mission for adequate Public Private Partnership. It estimated that contribution of private health sector in India was almost 87 percent. It was also clear that private health sector had grown in India and they were capable in delivering excellent health services. However, access to such services not extended to almost 70 percent of the Indian population. Public health sector largely affected due to lack of investments, work force and infrastructure and logistics. It was not possible for the government to provide all kind of facilities in public health sector without cooperation from private health stakeholders. Therefore, the idea of public private partnership mooted under the National Rural Health Mission to facilitate some special provision through involving private players, which could not be possible through public sector players. There were certain areas where role of private sector considered important. The current shift towards Public Private Partnership under National Rural Health Mission could be also attributed to globalization, epidemiological and demographic transition, World Trade Organization, patents, TRIPS and other related developments in order to harness the potentiality of information technology in future management of
health care, to address the digital divide, reaching out to the unreached etc (Thakur, 2007). Private parties would only come provided they see some financial gains however some charitable organizations could also come up despite research scholar could not find PPP happening under NRHM on any massive scale.

Public Private Partnership was considered a central feature of global health landscape. The partnerships, however, was clearly required improved system of institutional governance. A system was required being established with public sector agencies to ensure that the greatest possible importance attached to protecting the public's interest. There were different forms and models of public private partnerships found existing world over and also in India, and it was also required understanding the meaning of it in local and global perspectives and what considered under NRHM. The public private partnership was defined by different organization in various forms.

World Health Organization had defined Public Private Partnership as “means to bring together a set of actors for the common goal of improving the health of the population based on the mutually agreeable roles and principles”.

Balgescu and Young had defined Public Private Partnership as “A form of agreement that entailed reciprocal obligations and mutual accountability, voluntary or contractual relationships, the sharing of investment and operational risks, and joint responsibility for design and execution”.

According to En.wikipedia.org “Public private partnership means that both parties have agreed to work together in implementing a program and that each party has a clear role and say in how that implementation happens”.

Public private partnership was a variation of privatization in which elements of a service previously run solely by the public sector or provided through a partnership between the government and one or more private sector companies. According to London School of Hygiene and Tropical Medicine “Unlike a full private scheme, in which the new venture was expected to function like any other private business, the government continued to participate in some way.

Most commonly used definition in the health arena proposed by Kent Buse and Gill Walt. They considered Public Private Partnership as a collaborative relationship, which transcended national boundaries and brings together at least three parties, among them a corporation (and/or industry association),
and an inter government organization, so as to achieve a shared health-creating
goal on the basis of a mutually agreed division of labour”.

### 7.10.2 History of health related Public Private Partnership

*Public Private Partnership* at an individual project level was not new. During
the 1980s, political and economic disruptions in many areas of the world led to
a reassessment of the basis of the reliance on the public sector for health care.
Both national governments and global economic organizations began to shift
to an increasing reliance on the private sector for improvement in health and
welfare systems. The restructuring of the British National Health Service
under Prime Minister *Margaret Thatcher* and the restructuring of Mexican
health care system as a part of the international response to its economic crises
were examples of the movement towards privatization and increased reliance
on market forces that became increasingly widespread (Prasad J., 2007).

In November 2002, the WHO centre for Health Development in Kobe (Japan)
convened the Global Symposium on Health and Welfare systems
development, in which the participants stressed *public private partnership* as a
strategy to improve the health and welfare services in developing countries. In
the year 2003, the WHO centre for Health Development asked Stanford
University researchers to assist in the development of a research protocol to
evaluate the effectiveness of *public private partnership* model.

William Hsiao of Harvard University had published the effects of those
marketization efforts in the health care systems in four countries. He had
called for a collaborative effort by public and private sectors to confront the
health care challenges of developing countries. Around the same time, *Hsiao*
had published his analysis, perceptions about the role of private sector in
providing health and welfare services were rapidly shifting. Instead of
adopting a pure privatization model, increased emphasis placed on
establishing partnerships between the public sector and various organizations
in the private sector. The term *Public Private Partnership* became common
and typically referred to by its acronym. In one of the articles published in
2000 and 2001 suggested that the challenges of the myriad unmet health needs
of the developing nations met with by *public private partnership*.

An Editorial in BMJ had referred *public private partnership* as “essential” for
getting vaccines and new medicines to world's poorest nations. The
enthusiasm for a *public private partnership* approach to global health
problems arose in response to convergence of a number of forces during the

149
mid and late 1990s. First, the growing scepticism had directed at a private sector approach. Second force was a growing pattern of collaboration in the US between the Govt., private universities, and private pharmaceutical companies etc. as initiated by the Bayh-Doyle Act. Third force was the decision by the Rockefeller Foundation, the Bill and Melinda Gates Foundation, etc. to rely on public private partnership model to address the growing worldwide crises of HIV/AIDS, Malaria, Tuberculosis and other major diseases.

Public private partnership used to bring outside resources to bear on areas of local need. Public private partnership contributed by ensuring sustainability of programs by enhancing the skills and capacities of local organizations, and by increasing the public's access to unique expertise and core competencies of the private sector. Facilitating scale up proven, cost-effective interventions through private sector networks and associations, Expanding the reach of interventions by accessing target populations in their through workplace programs and sharing program costs and promoting synergy in programs etc were some other modalities.

7.10.3 The need of Public Private Partnership:

Public Private Partnership (PPP) had become almost integral to health sector worldwide. Public Private Partnership had become a most common loom to health care problems. Several Public Private Partnerships were functional in the fields of HIV/AIDS, malaria, TB and other diseases. Due to shortage of public sector health systems the poor forced to seek services from private sector, under immense economic constraint. Partnership with the private sector had emerged as a new avenue of reforms resulting from resource constraints for the public sector by various Governments across the world (Mukhopadhyay, 2007).

India had one of the highest levels of private-out of pocket financing to the tune of 87 percent in the world. Hospitalization or Chronic illness often leads to liquidation of assets, or indebtedness. It was estimated that more than 40 percent of hospitalized people had borrowed money or sell assets to cover expenses and 35 percent of hospitalized Indians had fallen below the poverty line in one year. The inequalities in the health system had further aggravated by the fact that public spending on health had remained stagnant at around 1 percent of GDP (0.9 percent), against the global average of 5.5 percent. Even the public subsidy on health did not benefit the poor. The poorest 20 percent of population had benefited only 10 percent of the public (State) subsidy on
health care, while richest quintile (20 percent) had benefitted to the tune of 34 percent of the subsidies. On the other hand, the private health sector in India had grown remarkably. At independence, the private sector in India had only 8 percent of health care facilities but now it estimated that 93 percent of all hospitals, 64 percent of beds, 80-85 percent of doctors, 80 percent of outpatients and 57 percent of inpatients are in the private sector. Hence, the possibility of a Public Private Partnership in the health sector required explored and implement adequately to meet the growing health care needs of the population (Banerjee, 2007).

Therefore, the NRHM incorporated several mechanisms and modules for public private partnerships. The module of Public Private Partnership varied from training to education and from treatment to rehabilitation. It was highly believed that through strategic Public Private Partnership some core objectives of the health requirements would meet.

7.10.4 Type of Public Private Partnerships

The database of the Initiative on Public Private Partnership for Health of the Global Forum for Health Research had listed 91 International partnership arrangements in the health sector, which called Public Private Partnership. Of these, 76 focused on infectious diseases prevention and control, (AIDS, Tuberculosis, Malaria), 4 on Reproductive health issues, 3 on nutritional deficiencies and the rest had focused on other issues (health policy and research, etc.). Several classifications proposed to conceptualize and categorized Public Private Partnership, which based on the terms of the constituent membership or nature of the constituent membership or nature of activity.

Based on the definitions and the characteristics of the public and private sectors, it could be stated that Public Private Partnership arrangements were fostered either when Govt. and Inter Government agencies interfaced with the for-profit private sector to tap into resources, or the non-profit private sector for technical expertise or outreach. Transnational partnerships were involved a visible role of the for-profit sector. Those usually involved larger partnerships and a complex grouping; depending upon their structure, they may bring together several government, local and international NGOs, research institutions, and UN agencies in transnational programs, often involving the non-profit sector. Such partnerships could be owned by the public sector and have private sector participants such as in the case of Global Alliance for Vaccine Initiative, Roll Back Malaria, Stop Tuberculosis partnership, Safe
Injections, Global Network, etc. On the other end of the spectrum, there were examples of individual Government forming partnerships with the for profit private sector. There were also examples of situations when a government had partner with an NGO with a particular technical strength, technical or outreach related. In certain cases, the NGOs seek support from corporate partners at National and International level. Partnerships in the health sector could be for various purposes. Many of such partnerships had positively contributed to health outcomes in the past; developing technologies for tropical diseases, surveillance and screening strategies, etc.

7.10.5 Public Private Partnership models under NRHM:

Under National Rural Health Mission, several models of Public Private Partnership were noticeable at several places in the country. In some cases diagnostic, care inclusive of pathological tests was arranged under the Public Private Partnership. At micro level, Public Private Partnership was most visible in Janani Suraksha Yojna whereby several memorandum of understanding were done with private nursing homes for safe delivery and maternal care. So far, Public Private Partnership was most visible in supportive services such as drinking water, sanitation, arrangements of food and medicines and shelter of patient’s family, ambulance services etc. Research scholar had also found that Public Private Partnership under NRHM was different than Public Private Partnership in health services.

At Patna in the premises of precious Patna medical college and hospital or PMCH the TATA ward, the HATHUA ward were an established model of Public Private Partnership in health sector. However the functioning of HATHUA ward was different than TATA ward. TATA ward was operated by private concerns whereas HATHUA ward though developed by individual and fully transferred to government.

Similar experiences could be witnessed at several places in the country. Several institutions for medical education and training were came up and proposed under Public Private Partnership. Public Private Partnership was not new in Indian health sector but under NRHM, it given a definite and structured impetus. Public Private Partnership related programs formulated to develop Public Private Partnerships in the areas of medical education, training, research, medicine supply, logistics supply, creation of infrastructure etc. Some models as identified by scholar were in following manner:-

Without realizing or expecting, any return:
Under this category, there several examples in the country whereby some cash or kind contributions made to certain health installations. There were ample examples that how even infrastructure such as building, lab, auditoriums, lighting arrangements, drinking water facilities, food supply, free medicines, free residential arrangements for patient’s family etc. were done by the private parties. In most cases such work done with a view of philanthropy without realizing any charges. In some cases wards, auditoriums, OTs, teaching classes constructed by private parties in the name of their family members. Such partnership was most old in India.

**With realization of charges for services:**

In this category, there were several partnerships, which aimed the realizing certain charges from beneficiaries in order to maintain the running costs.

**Partnership for paid services:**

In this category, also there were arrangements with private parties to provide services, which could not, provided by the public health installations. In such cases, full charges or costs realized from the beneficiaries.

**8.10.6 Some other examples of PPP in health sector in India**

Common Review Mission Reports had also described some PPP examples implemented in different states. In addition KPMG report on public private partnerships had also identified some models in different states especially in health insurance sector (KPMG, 2009) the Yashashwini health scheme in Karnataka, Arogya Raksha Scheme in Andhra Pradesh, Telemedicine initiative by Narayan Hrudalaya in Karnataka, Contracting in Sawai man Singh hospital Jaipur, Uttaranchal Mobile Hospital and research centre, PHCs in Gumballi and Sugganahalli in Karnataka, Emergency ambulance services in Tamil Nadu, Urban Slum Health care project in Andhra Pradesh, Rajiv Gandhi Super Hospital in Raichur in Karnataka, and Community health insurance scheme in Karnataka could be some examples of PPP in health sector of India.

**7.10.7 Pre-requisites for evolving effective Public Private Partnership**

There were utmost care required in forging public private partnership and it was must that services would be provided at low cost (Björkman, 2006). At least following issues needed to be taken care prior to venturing for Public Private Partnership:-
a. The health system required to avoid profit oriented *Public Private Partnership* because it would increase burden on public in long run.

b. The necessity and limitations required analyzed carefully.

c. *Public Private Partnership* must not promote just because one has some target to create more and more *Public Private Partnership*.

d. The background, motives, and objectives of the private party required considered carefully.

e. There was a need to have explicit, transparent, and adequate mechanisms, which could ensure involvement of all stakeholders in the process Co-ordination across various departments within the govt. & various implementing agencies.

7.10.8 Problems associated with Public Private Partnership:

There could be certain stake also which required attention. Therefore, issues required accurately examined prior to venturing for any form of *Public Private Partnership*. It was required to examine that *Public Private Partnership* not done with profit care and it done only in case if required urgently. *Public Private Partnership* required moving to remote areas and villages and it not required centred in big cities and big hospitals.

There could be no excuse if any public property utilized for private gains. In certain cases, there were complaints about *Public Private Partnership* also especially related to quality compromise, suppression of facts and lack of transparency. There was few available data about the success or problem of using a *Public Private Partnership* approach to improve the delivery of health and welfare services. Further research on effectiveness of *Public Private Partnership* needed before substantial resources invested in the expansion of *Public Private Partnership* efforts.

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Research scholar at this point would like to differentiate little bit between public private partnerships and convergences under National Rural Health Mission as they sometimes assumed drastic similarity. In the previous chapter, public private partnerships were described and though the both could appear similar however qualitatively they were distinctly aloof and apart. The motives might be the betterment of the public health system nevertheless convergences were aimed to unite all efforts of different governmental and non-government agencies which were having mandate for promotion of public health. In the process of accomplishment of such motives, they required working in synchronized manner.

On 11 May 2000 the then Prime Minister Atal Bihari Bajpayee had announced the formation of the National Population Commission with him as the Chairman and the Deputy Chairman Planning Commission as Vice Chairman. Chief Ministers of all states, Ministers of the related Central Ministries, secretaries of the concerned Departments, eminent physicians, demographers and the representatives of the civil society were Members of the Commission (Panigrahi, 2005). The Commission had several mandates and one among them was to promote synergy between health’s, educational environmental and developmental programs so as to hasten population stabilization and further to promote inter sectoral coordination in planning and implementation of the programs through different sectors and agencies in centre and the states. Involvement of Punchayati Raj Institutions in ensuring inter-sectoral coordination and community participation in planning, monitoring, and management of the program considered crucial (Randhawa, 2005). Assisting the states in supervising the functioning of health care related infrastructure and work force such as Sub-Centres (SCs), Primary Health Centres (PHCs) and Aanganwadi was another idea, which mooted under framework of NRHM (MOHFW, 2005).

Convergence was required for the health sector, as it found necessary. It had already described earlier that health was dependent on several factors commonly referred to as ‘health determinants’. Some important health
determinants such as nutrition, sanitation, drinking water, health infrastructure, and coverage, environment dealt by different agencies under different departments. Even at the functional level, no coordination existed among various such agencies, departments, and functionaries. The matter related to health dealt under the Ministry of health and family welfare, similarly nutrition, education, sanitation, municipalities, Punchayati raj etc. covered under different departments/ agencies such as ministry of HRD, Women and child development, rural development, urban development respectively. No doubt that that some synergies required among them on certain core issues related to health. However research scholar could not find such convergences fruitful and workable if every department and functionaries at different level would not take their duty seriously.

Under National Rural Health Mission the need of coordination and agreement among such varied departments were not only recognized but given a shape. This coordination executed among agencies falling both within and outside the framework of health department. This broader coordination or arrangement could be termed as convergence. Hence two types of convergences occurred under the National Rural Health Mission first within the health sector and secondly with different other departments which commonly referred to as sectoral and intersectoral convergence respectively.

The levels of convergences spread from top to bottom. All such convergences also reflected in form of institutional arrangements done at different levels. Sectoral convergences marked by the merger of societies, single nodal functionaries for health and intersectoral convergences were mostly in form of integration of some program and functionaries of different departments.

Research scholar could see that how functionaries related to different specific work such as education, urban development, women, and child development, rural development made members of various committees under National Rural Health Mission. However in holistic terms it was not possible to measure the outcome and effects of such convergences under the current research though it was required to measure actual effects and impacts of such convergences because it would tell about the real distinction between the concept, theory of convergence and their impacts, usefulness.

It also spelt out in detail to ensure coordination of activities of workers of different departments such as health, family welfare, ICDS Social Welfare, and Education etc. functioning at village, block, and district levels. The Departments whose activities found to have close linkages with Family
Welfare Programs were the Department of Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture.

Inter-sectoral coordination among those departments emphasized for sectors such as Railways and Industry should make necessary provisions providing Family Welfare Services to the workers and their families. All those Departments required trying to involve their extension workers in propagating IEC messages pertaining to reproductive and child health care to the population with whom they work. Concerned Central and state departments like Department of Women & Child Development, Human Resources Development, Rural Development etc. to take steps to improve the status of girl child and of women, improving female literacy and employment, raising the age at marriage, generating more income in rural areas.

Convergences under National Rural Health Mission practiced at almost every level. We must know that convergences required managing both the health and health indicators simultaneously. Several different departments of the government made to function in synchronization and the phenomenon could be termed as convergence.

7.11.1 Intersectoral convergence with education department:

It Included health, nutrition and population related educational material in the curriculum for formal and non-formal education. As a part of socially useful productive work involved with school teachers and children in Class V or above was in growth monitoring, immunization and related activities in the village at least once a month. Some awareness camps involving school teachers and students could be seen by the research scholar in addition some special nutrition supplementation drive initiated in several schools. Some health camps also organized in several schools including eye camps but it required to make such a routine rather an exception.

7.11.2 Intersectoral convergence with Women and Child Development:

It included involvement of Aanganwadi workers in execution of local events such as births, deaths, identification of pregnant women and in recording of birth weights. Utilization of Aanganwadi worker also found crucial in improving coverage of massive dose Vitamin-A in children and improving compliance of Iron-folic acid medication in pregnant women. They also identified undernourished pregnant & lactating women and children below 5 years to ensure that those vulnerable populations got benefitted of the food
supplementation programs under ICDS. Coordination with members of Punchayati Raj Institutions and agricultural extension workers to promote growing of adequate quantities of green leafy vegetables, herbs and condiments and ensure that those were supplied to Aanganwadi on a regular basis so that food supplements had also the vitamin and mineral contents. However research scholar could found any specific convergence with agriculture department at any level.

Following areas of convergence with DWCD could be identifiable:

7.11.2.1 Women and children’s health:

Mobilization of women, adolescents, children, and provision of a package of quality health education and services at the village level was expected to be ensured.

7.11.2.2 Women’s empowerment, gender, and equity:

Involvement of community based women’s groups was expected to ensure that social and related determinants of health including gender and equity addressed. Those included prevention of early child marriages, implementation of the PNDT Act, including awareness and action against girl child elimination, leading to distorted sex ratios, domestic violence, and mobilization of resources through collective action for health and other emergencies.

7.11.2.3 Convergence among the functionaries:

Convergence between the functionaries of both departments for nutrition, health, and women’s empowerment was considered necessary. They included Joint formulation of behavior change communication strategies, materials, and messages, operational strategies for joint planning at village, block and district levels, development of joint management information system including common indicators, identification of functional areas for training of staff including joint training.

Convergence with all departments that influenced outcomes of wider determinants of health was considered necessary for improved health indicators. District level Zilla Parishad framework was to allow convergent action of all departments under one umbrella. State and National level framework was to allow more flexibility and more untied financial resources to districts for them to forge solidarity of diverse departments. Bringing development functionaries of several departments under the control of the district was expected to facilitate greater co-ordination.
7.11.3 Intersectoral convergence with Rural Development Department:

With the cooperation from *Punchayati Raj* Institutions, several issues were required contemplation. Although it was suggested that the *Jawahar Rojgar Yojna* funds would be utilized for construction and maintenance of Primary health care institutions specially sub-Centres and PHCs, Rural Water Supply, and Sanitation. Further it was also expected of providing access to safe drinking water and sanitary disposal of wastes in primary health care institutions. Although how much such happened could not be ascertained fully as research scholar could not find any such incidence.

7.11.4 Levels of convergences:

Convergences occurred under *National Rural Health Mission* at different levels as investigated by the case studies. It observed among several functionaries at different levels and given a structure in form of an organizational setup. Thus, the convergences under *National Rural Health Mission* well reflected in form of composition of institutional structures at different level.

At the national level such convergences occurred between the Ministry of Education, Rural development, *Punchayati Raj*, Department of women and child development, Development partners, Planning commission, NGOs and Foreign agencies were done and given an institutional shape. In Mission, steering groups and empowered program committee’s representatives of such stakeholders made members.

At the state levels, the *intersectoral* convergence occurred with all such departments as the pattern of national level.

At the district level convergence was noticeable among the functionaries of different departments and programs such as District education officer, District welfare officer, District Program officer, District development officer. At the block levels coordination existed among BDOs, CDPOs, *Pramukhs, Mahilla mandals*, NGOs.

At the village level coordination was definitely noticeable among ANMs, ASHAs, AWWs, PRI and NGOs. Institutional arrangements like Village health committee were inclusive almost of such stakeholders. Out of all such convergences, the convergence with the Department of Child and Women Development was most visible as it could find special immunization sessions being held at Aanganwadi Centres and Nutritional Camps Organized in
collaboration of public health centres. In monthly meetings at district levels presence of Child Development program Officers were easily noticeable. In addition several programs were involved with ASHA, AWW and ANM.

7.11.5 Rationale and actions towards convergences

Ministry of Health & Family Welfare (MOHFW) had a large number of schemes to support states in a range of health sector interventions. Many of those programs pertained to disease specific disease control programs. Many others were related to programs for Family Welfare. Special programs were also initiated as per need for diseases like TB, Malaria, Filarial, HIV AIDS etc. While the disease specific focus had helped in providing concerted attention to the issue, the weak or absent integration with other health programs had often led to lack of coordination and convergent action.

All central programs had worked on the assumption that there was a credible and functional public health system at all levels in all parts of the country. In practice, in many parts of the country, the public health system had not been in a satisfactory state. The challenge of National Rural Health Mission, therefore, was to strengthen the public health institutions like Health Sub Centres, Primary Health Centres, Community Health Centres, Sub Divisional and District Hospitals. This expected to have positive consequences for all health programs. Whether it was HIV/AIDS, TB, Malaria or any other disease, National Rural Health Mission attempted to bring all of them within the umbrella of a Village/District/State Health Plan so that preventive, primitive and curative aspects were well integrated at all levels.

The intention of convergence within the Health Department was also to reorganize human resources in a more effective and efficient way under the umbrella of the common District Health Society. Such integration within the Health Department could make available more human resources with the same financial allocations. It expected to promote more effective interventions be in place for health care. To help the States achieve inter sectoral convergence; appropriate guidelines were issued to the districts (Mohan R., 2011).

The pandemic of HIV/AIDS required convergent action within the health system. By involving health facilities in the program at all stages, it was likely to help early detection, effective surveillance, and timely intervention wherever required. The National Aids Control Organization had presence only from district level upwards. The NRHM enabled the National Aids Control Organization to provide necessary investment and supported to the program at
district and sub district levels. While National Aids Control Organization provided Counselors at CHCs and PHCs as also testing kits as a part of the National Aids Control Program – III, it could also help to integrate training on HIV/AIDS to Medical Officers, ANMs, Para medicals, and lab technicians. Common programs for condom promotion and IEC also planned (Pathnayak, 2011).

National Rural Health Mission sought to improve outreach of health services for common people through convergent action involving all health sector interventions. The indicators of health depended as much on drinking water, female literacy, nutrition, early childhood development, sanitation, women’s empowerment etc. as they did on hospitals and functional health systems.

Realizing the importance of wider determinants of health, National Rural Health Mission sought to adopt a convergent approach for intervention under the umbrella of the district plan. The Aanganwadi Centre under the ICDS at the village level could be the principal hub for health action. Likewise, wherever village committees effectively constituted for drinking water, sanitation, ICDS etc. National Rural Health Mission could attempt to move towards one common Village Health Committee covering all these activities. Punchayati Raj institutions could be fully involved in this convergent approach so that the gains of integrated action reflected in District Plans. While substantial spending in each of these sectors could be by the concerned Department, the Village Health Plan/District Plan could provide an opportunity for some catalytic resources for convergent action. National Rural Health Mission household surveys through ASHA, AWW could target availability of drinking water, firewood, livelihood, sanitation and other issues in order to allow a framework for effective convergent action in the Village Health Plans.

The MOHFW had constituted inter- departmental committee on convergence with the Mission Director as Chairman. This Committee reported to the Empowered Program Committee. Convergence also envisaged at the level of the MSG, which had representation of all the concerned ministries. Similar mechanisms were available at the State level. Convergence with the Department of Women and Child Development and with AYUSH clearly outlined and shared with States. Necessary guidelines on inter sectoral convergence were issued by the ministry.

The success of convergent action could depend on the quality of the district planning process. The District Health Action Plans could reflect integrated action in all section that determine good health – drinking water, sanitation,
women’s empowerment, adolescent health, education, female literacy, early child development, nutrition, gender and social equality. At the time of appraisal of District Health Plan, care taken to ensure that the entire range of wider determinants of health taken care of in the approach to convergent action.

Support of non-governmental organizations was considered critical for the success of *National Rural Health Mission*. With the mother NGO program scheme, 400 MNGOs covering nearly 300 districts were appointed. Their services utilized under the RCH-II program. Programs such as Disease control programs, RCH-II, Routine immunization, Pulse polio, and *Janani Suraksha Yojna* made use of partnerships of variety of NGOs (Kukreja, 2011).

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DEVELOPMENTAL PARTNERS

The three terms *Public Private Partnership, Convergence, and developmental partners* would appear similar however they were distinctly apart and aloof from each other in terms of their respective mandates. *Developmental partners* under this research were meant with only those large organizations which had their programs sponsored by any major world agencies or any developed countries. Several *Developmental partners* were already engaged in the field of public health in India yet partnerships with them considered crucial under *National Rural Health Mission*. Implementation of a major developmental program like *NRHM, RCH-II*, or disease control programs could not be possible without international cooperation. It must remember that one of the core foundations of the *National Rural Health Mission* besides *sectoral and intersectoral convergences* was national-international partnerships and public private partnerships. Though the roles of various developmental partners not limited only to health sector and on this basis research scholar would say that attachment of *developmental partners* with *National Rural Health Mission* was different from *Public Private Partnerships* and *Convergences*. Therefore, it was required to put some light on *developmental partners* with their respective roles and now that would be described in this chapter.

It was investigated that several international agencies were involved in one or another manner with the implementation of *National Rural Health Mission* and its other health programs. Such international partners were termed as *Developmental partners of National Rural Health Mission* under this research. The role of developmental partners were most crucial as they varied from providing know how, technical supports as well as assistance in monitoring, training and supply of materials and logistics. They usually charged with international charter and their individual mission statements. Under *National Rural Health Mission*, several renowned world agencies seemed cooperating in planning, implementation, monitoring, and evaluation of several health programs in different parts of the country. More often, they also started their own programs and provided cash or kind assistances to the government health facilities. Some important *developmental partners* working in India and involved with implementation of NRHM/RCH-II programs could be as identified and summarized hereafter:-
7.12.1 The international advisory panel (IAP)

It was found by the research scholar that there was an international advisory panel, which at one point of time was led by Prof. Jeffery Sachs, Director of Centre on Globalization and Sustainable Development, Earth Institute of Columbia University, New York (MOHFW, International Advisory Panel (IAP)). This panel was simultaneously set up with onset of National Rural Health Mission. The first meeting of Honorable Health Minister with the International Advisory Panel led by Prof. Jeffrey Sachs held on 3 August 2006. In this meeting, IAP had discussed several health sector issues on National Rural Health Mission. Thereafter the second meeting was held on 7 August 2007 and in addition several issues relating to progress under National Rural Health Mission were discussed in detail and points came out of the meeting.

Research scholar could not find how and why such international advisory panel made as not any authentic documents made available also no definite idea about the functioning and implications of that body could be traced also different versions available and it was difficult for the scholar to pick any one.

7.12.1 World health organization (WHO)

World health organization was one of the main organizations under United Nations, which initiated actions for health care in global perspectives. So far the World health organization had emerged as a prominent international organization which analyzed, formulated action plans and coordinated with governments all over the world for health situation improvements, since its constitution in the year 1948 (WHO, 2010).

With the assistance of World health organization Leprosy eradication program in India had witnessed access to diagnosis and treatment services, which had increased, particularly for the poorest, cutting leprosy cases in half between 1993 and 2000. In 2001, India had remained one of the last eight countries to have cases of leprosy. India had accounted for two-thirds of cases of leprosy around the world with close to 400,000 new cases diagnosed each year. The prevalence of leprosy in India had reduced from 5.3 to 1.3 per 10,000 people during the course of the project. Over two million people with symptoms suggestive of leprosy were examined and over 1.2 million people with the disease were treated. Leprosy services were integrated within the general health care system for long-term sustainability. The program had used a full range of elimination techniques including skin camps in high prevalence areas, school education programs and surveys, and utilization of a variety of health workers to identify and initiate treatment of cases. The project had decentralized leprosy
control activities to the states and integrated leprosy control into general health services in local clinics. India was required to continue to fund the National Leprosy Eradication Program and focus on eliminating leprosy as a public health problem from each of the Indian States and Union Territories with the ultimate goal of eradication.

Remarkable progress was made in controlling the spread of tuberculosis - a leading cause of illness and death in adults in India. Tuberculosis was a dreaded disease causing the deaths of hundreds of thousands every year due to the lack of access to treatment. Around one billion people in India were having access to treatment with 730 million living in areas covered by the World Bank financed project. The TB death rates had been reduced 7-fold with 100,000 lives saved each year. The project had involved over 550 NGOs, more than 2,000 private practitioners, and over 80 corporate houses. More than 31,000 community volunteers had provided assistance under the program. Free diagnostic and treatment services provided through public or non-public institutions, the project had ensured availability of TB diagnosis and treatment to all citizens regardless of their economic status. The program had been effective in developing a wide network of community volunteers, which had greatly boosted the effectiveness of TB control efforts. The World Bank a leading partner in India had also addressed cataract blindness with a special focus on women and those living in tribal and remote areas.

7.12.2 Department for International Development (DFID)

Department for International Development was set up in 1997 in UK with the ambition of fighting world poverty as its topmost priority. This had marked a turning point for Britain’s aid program, which until then had mainly involved economic development. In its manifesto, the government elected in May 1997 had pledged to create a new department for international development headed by a cabinet minister. Among its key objectives, Department for International Development had set out to make global development a national priority and promote it to audiences in the UK and overseas, while fostering a new ‘aid relationship’ with governments of developing countries. In the autumn of 1997, Department for International Development had published its first white paper with the focus on eliminating world poverty. Three other white papers, issued in 2000, 2006, and 2009 had reinforced the first white paper’s message. Two acts of parliament had since helped to put development higher on the national agenda (DFID, 2011).
The International Development Act 2002 had clarified the purpose of aid spending as poverty reduction; while International Development (Reporting and Transparency) Act 2006 had defined Department for International Development annual reporting to Parliament through its Annual Report. The 1960 white paper had recognized the best way to lift poorer nations out of poverty was through economic development. Department of Technical Cooperation was set up in 1961 to deal with the technical side of the aid program. It had brought together the expertise on colonial development previously spread across several government departments. Ministry of Overseas Development was created in 1964, and headed by Minister of Overseas Development. The 1965 white paper had stated that UK had moral duty for development and development is in the nation’s long-term interest. In 1970 Ministry of Overseas Development was dissolved. Its work was carried out by the Overseas Development Administration a functional wing of the Foreign and Commonwealth Office. In 1974, the government had announced that the Ministry of Overseas Development was once again to be a separate ministry, as the Ministry of Overseas Development, under its own minister. In November 1979, the ministry again became the Overseas Development Administration, a functional wing of the Foreign and Commonwealth Office (DFID, About DFID, 2011).

However, the role of DFID under NRHM could be identified by the research scholar as a facilitator in implementation and monitoring of the program. It had published a directory of innovation in different states under National Rural Health Mission. Certainly they also involved in administrative reforms in several states of the country.

7.12.3 United Nations Children Education Fund or UNICEF

United Nations Children Education Fund had sought to complement government-led programs to achieve development goals, and guided by the convention on the Rights of the Child and other international and regional commitments. The overall goal of United Nations Children Education Fund in India was to advance the fulfillment of the rights of all women and children to survival, development, participation, and protection by reducing social inequalities based on gender, caste, ethnicity, or region (UNICEF, 2010).

United Nations Children Education Fund work was mostly centered on children from neonatal stages to adolescence. There was also a special focus on social inclusion in all these programs, keeping in mind the fact that the eleventh-five-year plan had emphasized on ‘inclusive growth’ and recognized social exclusion and inequality as a constraint to the achievement of MDG goals. United Nations
**Children Education Fund** had worked closely with government flagship schemes including NRHM to strengthen their capacity to deliver quality services to all its citizens.

In health sector precisely the **United Nations Children Education Fund** in addition to reducing infant mortality rates (IMR), the Reproductive and Child Health Program had also aimed to reduce maternal mortality rates (MMR) from 301 to 100 per 100,000 live births. The main interventions had also revolved around enhancing child survival and maternal care.

The Child Development and Nutrition program of **United Nations Children Education Fund** had stressed on the nutritional status of the mother along with the child. **United Nations Children Education Fund** focused on providing technical know-how to enhance **Integrated Child Development Schemes** functioning and delivery by supporting training of the field-level workers on the one hand and by conducting a nationwide awareness campaign on the issue with the purpose of influencing policy. Child, environment, improving freshwater availability, its management, conservation and equitable allocation, as well as access to sanitation and adoption of critical hygiene practices were also some illustrative areas where **United Nations Children Education Fund** was active.

With **The Children and AIDS Program** **United Nations Children Education Fund** sought to reduce vulnerabilities, slow down the rate of new infections and mitigate the impact of HIV/AIDS among children 0-18 years old; in addition, the emphasis in the area of prevention was on the most at risk and especially vulnerable young people up to the age of 24 (UNICEF, HIV Aids Programs in India, 2010).

Therefore the research scholar could say that **United Nations Children Education Fund** had addressed wide ranged health issues including health determinants.

**7.12.3 US AID**

**US AID** was a United States initiatives world over and in India they found committed to working in partnership to reach India’s development goal of halving poverty by 2015. **US AID** had worked in India in area such as economic growth, health, disaster management, energy and environment, opportunity and equity. Ensuring the good health of over 1 billion people was an enormous challenge for India. **US AID** had made considerable contributions to reducing the transmission and impact of HIV/AIDS, unintended pregnancies and child
mortality. An intensive effort to further improve nutrition and health care for women and children, including newborns, was underway (USAID, 2010).

In Muslim communities with persistent polio, US AID had worked with faith-based organizations to battle misconceptions about the polio vaccine, creating community support and ensuring that children immunized. US Aid’s programs in the 1990s also focused on economic liberalization and the global issues of population growth, HIV/AIDS, climate change, and the status of women. US AID supported financial reforms at the state and national levels (USAID, USAID HIV/ Aids Commitments in India, 2010).

Research scholar could say that US Aid had continued working in India in the field of health and precisely in the field of HIV/Aids and Reproductive Child Health its role was quite visible in some parts of the country.

7.12.4 CARE

CARE was active in the country in almost every backward-tribal districts of India. With the inception of Integrated Nutrition and Healthcare Project in 1996, CARE had shifted focus from food distribution to putting health and nutrition on the public agenda.

CARE had regularly partner with the Government of India on nationwide reforms. Together, they had designed a child development training program which was now compulsory for staff in all 1.4 million maternal and child healthcare centers, across India. Their work had also impacted right to food initiatives, nutrition and health days, Home Visit campaigns, and breastfeeding and immunization practices, within the most vulnerable and marginalized communities. CARE and the Government of India were currently planning the development of a national research centre on nutrition. CARE India had strived for lasting transformation in the lives of women, girls and the most marginalized by fostering inclusion and collective action, enhancing community resilience and breaking systemic barriers. For 5 million women, girls and the most marginalized to exercise greater choice in personal and public spheres to advance their capabilities and position by 2012. CARE India had strived for lasting transformation in the lives of women, they had sought a society, which celebrates diversity, where rights secured, citizenship realized, and human potential fulfilled for all (CARE, 2010).

7.12.5 European Union or EU
In the 1990s almost 30 European countries had formed a union which called as European Union. They had set EURO as their common form of currency and mobilized their international philanthropy and development aids through European Union (WIKIPEDIA, 2010). European Union was a most trusted and significant partner under the National Rural Health Mission seen contributing to logistics, know how about public health.

7.12.6 Joint initiatives with countries:

Research scholar had found that several limited initiatives under National Rural Health Mission were also implemented in some states. Norway, Germany, Japan Netherlands also found implementing some programs (MOHFW, 2009).

To end this chapter research scholar could say that National Rural Health Mission had sought partnership with both governmental and non-governmental health care providers at international level however their functioning required comprehensive appraisal as the nature of work they implemented and manner and amount showed as expenditure was not fully justifiable and transparent. However their involvement definitely promoted overall management as training to staff in some manner. Ultimately it could say that international developmental partners support were so crucial for the National Rural Health Mission as it also provided technical and other know how. However such partnership could not just a show piece or taken in order to please some developed countries who wanted to get engaged with India anyhow.

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PLANNING PROCESS UNDER NRHM

Research scholar had found that one of the key strategies adopted under *National Rural Health Mission* was diversified planning process, which mostly centralized at the district levels. A handsome amount allocated for preparation of work plans, orientation training and training of resources persons and stakeholders in the planning process. Thus, most of planning process initiated and held by district level functionaries of the *National Rural Health Mission* with adequate and compulsory inputs from several stakeholders at the sub district levels. Although research scholar had observed that those work plans turned more customary and routine, however, the need and requirement of such plans on periodical basis was a huge exercise which kept professionals busy.

District Health Plans were prepared by an aggregation and consolidation of village and block health plans. This required setting up of planning teams and committees at various levels such as habitation or village level, *Gram Panchayat* or Health Sub Centre level, Primary Health Centre and Community Health Centre level, and District level.

However the overall planning process suggested and practiced was not similar. At Health Sub Centre, Primary Health Centre, Community Health Centre levels, broadly representative committees required to perform both planning and ongoing monitoring functions. A similar committee at district level required to involve in reviewing plans, based on drafting by the specialized district planning team. The monitoring and planning committee at the state level required supported by a state health-planning cell and a similar cell was required at the state and national level which expected to provide support as needed. Besides large-scale consultations, planning teams had to conduct household surveys, help select ASHAs, organize training for community groups and health functionaries. NGOs were also required a role to play in the entire planning process. Orientation of planning team and contractual engagement of professionals as per need was required to be the starting point for the planning process. Village health plans were likely to take time and therefore district, block and cluster level consultation to form the basis for initial district plans.

The initial plans could be adhoc and for a year it proposed. Ideally a planning process was required to be started by the ANMs and village punchayat
collectively. The perspective plans were based on village health plan. Even then, block became the key level for development of decentralized plans. Village level health and sanitation committee was responsible for the village health plans. ASHA, the Aanganwadi Sevika, the Panchayat representative, the Self help group leader, the PTA/MTA Secretary and local community based organization representative were supposed to be key persons responsible for the household survey, the village health register and the village health plan. However how much happened according to prescribed norms could not be ascertained. The health need of a village panchayat was reflected in plans but functionaries at this level were not so trained to put forward a formidable and workable health plan. Therefore it was usually practiced that district level functionaries especially district program management units usually prepared the entire plan and it could not be ascertained that how much contributions came from other stake holders.

The *gram panchayat* level health plans comprising a group of villages required to be worked on at the Sub health centre level. The *Panchayat Pradhan*, ANM, MPW, Village Health & Sanitation Committee representatives were responsible for the village *panchayat* health plan. They were also considered responsible for over view and support for the household survey, preparation of village health registers and preparation of village health plans- the *gram panchayat* or health sub centre level were expected to organize activities like health camps to facilitate the planning process.

The primary health centre were expected to lead the cluster level planning process sometime additional primary health centers also included in this endeavor. In general, almost 1-4 clusters were expected in a block. The primary health centre health monitoring and planning committee was expected to facilitate planning inputs of *panchayat* representatives, along with other inputs from the community to formulate a broad plan. In this context, the Medical Officer in charge of the primary health centre expected to work in close coordination with the *Pradhan* of the Gram *Panchayat* covered in that cluster. The Cluster could be responsible for over viewing the work of *Gram Panchayat* and for organizing surveys and activities through the health sub centre.

The block level or community health centre level monitoring and planning committee was expected to review the block health plan. The block pramukh and the block medical officer, Block Development Officer, Child development program officer or CDPO, NGOs or community based organization representative; head of the community health centre level *Rogi Kalyan Samiti* required considered as key members of such team. Additional social
mobilization professionals and planning resource persons expected to be contracted at the block level to develop a good resource team at that level.

The block level health mission team required to finalize the block Health Plans. The block health teams also made to supervise household and health facility surveys. They expected to organize public hearings and health camps in order to make the planning process intensive.

District health mission required having a health monitoring and planning committee responsible of providing overall guidance and support to the planning process. A draft plan as formulated by the district health team was required presented for discussion to the broader committee. After relevant discussion and modifications in the committee the district plan could be finally streamlined by the district health team.

The district planning team was responsible for household surveys and health facility surveys. They could also facilitate organization of health camps and public hearings in order to make the planning process activity intensive. The Zilla Parishad Adhyaksha, District Medical Officer, District Magistrate could be key functionaries of the district team.

The state level health mission was required to have a state health monitoring and planning committee to give overall guidance to the planning process. The state resource centre or planning cell might propose the draft plans to the committee. After relevant discussion, the state resource centre or planning cell could finally streamline the plans as part of its resource support. The resource centre or planning cell required to supervise the work of all the district health missions by scrutinizing and providing feedback on the plans so that adequate quality of plans and processes ensured. The state resource centre also entitled to finalize survey formats and formats for preparation of plans at various levels. It made to finalize with guidance and directives from the ministry, the criteria for prioritization and indication of resources likely to be available for each Block and convey those to the district these details as also help develop the financial norms in conformity with these guidelines and on the basis of inputs from blocks and districts.

7.13.1 The annual work plans and perspective plans

National Rural Health Mission had a seven-year period (2005-2012). The perspective plan could be a 7-year plan outlining the year wise resource and activity needs of the district. The annual plan based on resource availability and a prioritization exercise. As far as possible, states expected to let districts know
by the October each year about the resources likely to be available in the coming financial year. The district required disaggregating likely budget availability based on needs at village/cluster/block levels by November. The Village, Gram Panchayat, Cluster, & Block Plans could come to district based on a prioritization exercise. The district health mission or society could recommend the annual work plan and budgets and the perspective plan to the state level health mission.

7.13.2 Essential requirements for preparation of health Plans

Constitution of planning team and committees with clearly demarcated responsibility at each level was necessary. Engagement of professionals on contract at State, District, and Block level urgently to meet planning needs was ensured. It required advance preparation of training modules for planning teams, and finalization of survey format for household survey, Family Health Cards, Village Health Register, mapping of non-governmental providers, and Health facility surveys. Survey of non-governmental health providers to assess their possible role in the District Health Plan was also requisite.

Organization of large-scale activities like health camps, Public hearings was essential to make the planning process activity intensive. Involvement of Women’s groups and Community based organizations in planning activity emphasized. Release of untied grants to health sub centre facilitated activities done in advance. Recruitment and relevant training of ASHAs/ANMs also required accomplishment. Orientation of existing health department functionaries on new ways of working was duly endurable. The intention was to use the household and facility surveys to construct a base line and to make annual plan for each health facility with a clear assessment of financial and human resources and clear commitments of service guarantees.

Based on literatures and assessment of the ground situation the planning process under National Rural Health Mission defined as presenting an outline of the circumstances and need of intervention for a particular geographical area. Planning process under National Rural Health Mission found to be multidirectional and moved both ways from top to bottom and bottom to top. Several types of planning process were evident under National Rural Health Mission at various levels, which usually involved with several key functionaries.

The central administrators provided the format and guidelines but all key functionaries at every level provided adequate training to fill that format and
prepare a plan of action for that particular area. In general, any plan used to be inclusive of several issues such as work force, disease prevalence, and logistics.

It had become usual in several government departments that planning for programs done at the centralized level and which was executed all over the country. The occurrence of problems and conceptualization of remedies by formulating any specific program would not have universal usefulness because severe diversity persisted in the country in manner of sociology, demography, geography, culture, and traditions. Therefore, country was in need to adopt a planning process at the micro level and it was required to sanction those plans, which came up from the bottom. It observed that programs planned at the central level when reached to implementation stage most often they suffered from deficiencies resulting in inadequate implementation of the program and benefiting none. Huge amount of money and energy wasted in this manner. Therefore it was required a two way planning process which flow from both direction top to bottom and bottom to top simultaneously. A correct planning process expected to start from the bottom or community level. The agricultural, household, livelihood, health, and education needs at community level or micro level required analyzed carefully and then specific interventions in form of plan or program required formulated. Such plan or program required approved for providing financial assistance. However, in most programs, planning process did not involve community or other stakeholders at the micro level and without analyzing the requirements and usefulness at the micro level programs get formulated at the central level. If need analysis, objectivity, mode of implementation and role of stake holders would not properly articulated then any plan or program would have extremely remote chances of getting successful. Nevertheless, unlike several other programs it provisioned under the National Rural Health Mission that planning done at the district and sub district levels.

To promote the planning process at the micro level a team of professionals coming from development, management, accounts and IT were deployed at district and block levels. They were part of the program management units, which used to perform planning and collect information on status of any program in their respective area of work.

This research had observed that several kinds of planning were done at different levels under the National Rural Health Mission. One of the most important planning was the 'health action plans'. It was prepared at the district levels by ensuring the contributions from all concerned including medical, paramedical, technician, ANMs, ASHAs, AWWs, and PRIs. District health action plan
complete in all manner used to be sent to the concerned state health societies from where it was sent to the national level in consolidated manner what was known as State Action Plan. Some other kinds of plans related to various disease control and immunization programs were also done on regular intervals. For example, micro plans were prepared for the routine immunization, which included targets and requirements of logistics in a particular geographical area. Such micro plans were prepared at the Sub centre level by ANM then sent to District level through PHC and then finally get compiled at the state and central government levels. Following types of planning generally practiced under NRHM:–

7.13.3 District health action plan (DHAP):

The District Health Action Plan was usually prepared as a joint effort under the chairmanship of District magistrates/Deputy Commissioner of the district, Civil Surgeon, Assistant Chief medical Officer, all program officers and the State level team formed for District Health Action Plan as well as the Block Development Officers, Child Development Program Officers, Medical Officer In-Charge, District Program Officers, ANMs, AWWs and community representatives as a result of a participatory processes. After completion the District Health Action Plan, a meeting usually organized by Civil Surgeon with all MOIC of the block and all program officer. Then discussed and displayed prepared District Health Action Plan. If any comment came from participants it usually added then finalized. The field staffs of the department too had played a significant role. District officials used to provide technical assistance in estimation and drafting of various components of this plan. After a thorough situational analysis of district health scenario District Health Action Plan gets prepared. It usually contained health care needs of rural poor especially women and children, the teams had analyzed the coverage of poor women and children with preventive and primitive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus also been given on current availability of health care infrastructure in pucib/NGO/private sector, availability of wide range of providers. District Health Action Plan evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

7.13.4 Program implementation plan (PIP):
The Program Implementation Plan was in form of mainly a detailed plan of future course of action for the year. A format prescribed to prepare Program Implementation Plan, which contained executive through which an overview of the Program Implementation Plan usually presented. Program Implementation Plan used to contain vision of the State for health sector, progress of the state since launch of National Rural Health Mission in important indicators including IMR, MMR, TFR, disease prevalence, Human Resources, Infrastructures, etc. Goals set for the year and strategies to achieve the goals. New initiatives and innovations of the State in various areas may also find mention in this part. Differential planning and financing for the identified backward districts elaborated. A summary of budget as per the broad functional head were also a significant part of the Program Implementation Plan. According to guidelines, a Program Implementation Plan could be structured and presented in the prescribed format.

Chapter -1 was expected to contain outcome analysis of Program Implementation Plan for the previous years. In this chapter, physical and financial outcomes in respect of various parameters of the PIP for the preceding years required indicated. For this, a format also prescribed.

In Chapter-2 Policy and Systemic, reforms in strategic areas were required mention. Lack of systems approach expected to result in serious gaps that affect service delivery. For instance, investments in FRUs largely nullified if there was an irrational deployment of doctors trained in EMOC and LSAS and there was a sub optimal maximum utilization of HR, equipments & facility up gradation. Similarly, the promise of free institutional deliveries remains unkept if drugs and consumables are not available. The experience so far was that the States had addressed these criticalities in an uneven manner and to a varying extent. Therefore, in this Chapter, the States required clearly describe the policies and systems that the States had put in place and proposed, if any, with timelines in respect of several management imperatives.

In chapter-3, almost thirty-one conditions were prescribed before the states required complying. Failure to demonstrate strong evidence of progress on conditionality expected to affect release of funds under National Rural Health Mission. In addition to the conditions mentioned, States were also required to comply with some other conditionality pertaining to disease control programs.

The chapter-4 contained the performance achievements of different Schemes/Programs like RCH Flexi Pool, National Rural Health Mission Flexi
pool, Immunization, Disease Control Programs and Inter-sectoral Convergence.

The chapter-5 consisted information related to Monitoring and evaluation.

In Chapter-6, the budget section through which detailed expenditure expected and amount requested was presented. This formed the basis of funds allocation under National Rural Health Mission to states.

In chapter-7 in order to get a complete picture of the resources available for the health sector, the states required to clearly indicate the resources available from the state Government and from other sources for the health Sector and the details of the activities for which these funds utilized. Amount received or likely received from each source and the activities for which it utilized along with outcomes of the same indicated in this chapter. Resources made available in BE and RE and amount spent in the last financial year indicated.

In chapter-8, the States/UTs were required to give a prioritized list of projects based on felt needs that taken up if additional resources become available from the Government of India. The additional projects could be of any type, e.g., construction projects, HR requirements, training needs, disease control efforts.

**7.13.5 Micro plan for routine immunization:**

Usually micro plan for the routine immunization used to be prepared at four levels starting from HSC level to PHC level and from PHC level to district level and further at state level. The micro plan was presented for each year. For special immunization sessions and catch up rounds specific micro plans were also prepared in prescribed formats. Usually concerned functionaries provided training to prepare a micro plan. The basis of micro plan used to be the population of the area. On this basis micro plan were given final shape for which a formula was also prescribed to perform calculation of logistics.

**7.13.5 Levels and stakeholders of planning process**

**7.13.5.1 At the Health Sub Centre or Village Panchayat level:**

At HSC level micro plan for immunization were prepared by ANMs. Special immunizations sessions, nutritional days required mention by the ANM in association of ASHA & AWW in micro plan. They were used to prepare their own plan after conducting survey or need analysis.
7.13.5.2 At the Primary Health Centre or Block level:

At PHC level planning for health mela, routine immunization, and organization of special immunization sessions usually done by concerned MOIC and block program management units were mostly involved in the planning process.

7.13.5.3 At the district levels:

At district the district program management unit in consultation with the state level consultants, CMO, and respective MOICs of PHC, elected people representatives, PRIs etc, were expected to do levels planning. Planning at district levels were mainly involved of preparation of health action plan, preparation of micro plan, and program implementation plan.

7.13.5.4 At the state level:

All plans coming to the concerned state health society were given a shape of PIP or program implementation plan, which sent to central *National Rural Health Mission* directorates for approval.

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Chapter 7.14

REPORTING, MONITORING AND EVALUATION

Reporting, monitoring, supervision and evaluation were found to be another essential requirement under the National Rural Health Mission. Generation of reports, supervision of the work, evaluation of progress and achievements were mandatory under National Rural Health Mission and built in a system. Reports generated monthly, quarterly and annual basis in most cases. However, in some cases especially in case of catch up rounds for immunization reports required to be generated on daily basis. Such reports usually included work done report and also financial reports.

Generation and submission of reports was found mandatory and time bound action under National Rural Health Mission. Each facility was required to submit different kinds of reporting formats according to prescribed timeline as already a time limit for submission of reports by each health facilities were prescribed which required following strictly. Functionaries also identified to whom responsibilities entrusted for submission of reports and supervision of work done. In addition, time-to-time different individuals, agencies and teams from outside or belonging to developmental partners also assigned responsibilities to monitor and evaluate the progress made by different states. Continuous assessment and evaluation of the program was important to keep focused and do the necessary course corrections swiftly. States required proposing an amount from National Rural Health Mission Flexi pool for evaluation and assessment of activities and components like ASHA, VHSCs, RKS, etc. Reputed medical, Public Health, Management and Research Institutes were also identified for such evaluation/assessments, finalized in consultation with Government of India.

There was monitoring and evaluation division functional under National Rural Health Mission at the central level. The division had released several formats for submission of reports from states, districts and sub district levels. The reports generally submitted on monthly basis by each health facility. However, annual reports were most important document, which required submitted by all districts and states annually. Different formats used for different facilities such as HSC, PHC, CHC, FRU, and DH. In addition, financial report formats or FMR was also different for each level.
The state format required information against almost 234 heads, which divided into parts and sub parts. Part A required information on demography of the state. Part B aimed to seek information from the eligible couple survey register. Part C was related to certain indicators, Part D was on urban health infrastructure. Part E was related to general health infrastructure in the state. Part F was to seek information of human resources available to state. Part G was related to accreditation as per Indian public health standards. Part H aimed to seek information on Training.

Similarly, the district format also required information against almost 170 heads, which also divided into parts and sub parts. Again, Part A required information on demography of the state, Part B aimed to seek information from the eligible couple survey register, Part C related to certain indicators, and Part D was about urban health infrastructure. Part E related to general health infrastructure in the state. Part F was to seek information of human resources available to state. Part G relates to accreditation as per Indian public health standards. There was no Part H required for the districts.

Reports realized from states and districts directly by the Central Monitoring Divisions. This enabled cross-examination of the data. Sometimes some serious discrepancies were also reported time to time in the data provided by the state and district situated in that particular state, which required dedicated efforts for sorting them out.

7.14.1 Eligible couple survey, supervision, & monitoring

Eligible Couple Survey was continuing since 1995 in all rural and urban slums and usually updated in the month of April of each year. The format with 44 columns and each column seek information on age, education, youngest child, delivery, infant/maternal death, immunization status, current pregnancy status, current contraceptive use, unmet need. In some states the Crude birth rate or CBR, the Infant mortality rate or IMR, the maternal mortality rate, or MMR & Couple protection rate or CPR also calculated based on Eligible Couple Survey. The information of Blindness, T. B., and Leprosy also collected during EC survey. At PHC level it was monitored by lady health visitor which used to physically verify 10 percent of total eligible couples. The medical officer in charge used physically verifies 5 percent of total eligible couples verified by supervisory staff. At Block level, the primary health centre medical officer in charge was sole responsible for timely conduct of eligible couple’s survey and its quality. At District, level Chief Medical Officer was responsible for conduct of timely survey. RCH Officer would also physically verify the survey. The
statistical staff posted at district & block level required to physically verify and monitor the eligible couple’s survey in their respective areas.

7.14.2 Service delivery registers, records and reports

Service delivery records maintained in service delivery registers for each village. Information of eligible couple survey transformed in service delivery register, having 16 tables like contraceptives, current users & unmet need, ANC services, Immunization Birth & Death registration, regarding diseases such as Tetanus Cases, IEC activities on reproductive tract infections and sexually transmitted infections & Dai training. Several kinds of reports generated under National Rural Health Mission. Some reports were done since prior to National Rural Health Mission also. There were several specific reporting formats used at different levels. Following forms used to submit reports such as Annual Action Plan, Annual PIP, Reports in National Rural Health Mission Format, Financial management reports, and Utilization certificates. Besides that daily and weekly progress of sterilization and sterilization camps, weekly report of sterilization progress, primary health centre wise quarterly progress report of family welfare Programs, Camp wise monthly progress report of sterilization, Annual report of FW according to age, caste, parity etc. were also required. Besides, above formats specific National Rural Health Mission formats also introduced under National Rural Health Mission. Such formats were inclusive of all the health programs, immunization, RCH, and family welfare activities at different levels. Different National Rural Health Mission formats used level to level. Different Financial formats also used at different levels.

7.14.3 Data monitoring and validation

Different personnel at different levels did the data monitoring and validation. The Monitoring & Validation Exercise required done in every month in every district. The reports relating to services of maternal & child health and family planning validated. The services validated through cross check by team consisting of medical officer, lady health visitor, and lady supervisor of women and child department. Records & physically verification verified the reported information. The availability, accessibility, utilization, & coverage of services analyzed.

7.14.4 Community based monitoring

Community based monitoring was specially done under National Rural Health Mission. Self-monitoring tool and social map done through people based monitoring committee. Monitoring also performed through Gram Sabha. Social
audit also conducted by various NGOs and Community organizations, Self Help Groups.

7.14.5 HMIS:

The establishment of computer based health management information system in the central and state health departments done to facilitate reliable and cost effective mechanism for better decision-making, monitoring, planning, and implementation for effective service delivery.

7.14.6 Reporting mechanism and flow of reports

In the last sub chapter, we learnt about the planning process under National Rural Health Mission. The planning process started both ways from bottom to apex and vice versa. Nevertheless, flow of reports especially work done report started from bottom to top. Health sub centre was the place from where almost every report under National Rural Health Mission usually started it long journey. It was required to submit reports, which substantiated with records. Therefore, there were dual responsibilities for functionaries such as preparation or reports and maintenance of records for future references. Reports under National Rural Health Mission used to travel from bottom to top. In fact, it actually traveled from health sub centre to primary health centre, additional primary health centre to primary health centre and from primary health centre to District head quarters, and from District head quarters to the State head quarters and from State head quarters to Central level. Information then published on HMIS and respective websites of the respective state and district websites for easy sharing and evaluation.

Reports flow chart under National Rural Health Mission displayed in Figure-5; therefore, you could please see Figure-5.

7.14.7 The Common review missions (CRMs)

The Common Review Mission or CRM was set up as part of the Mission Steering Group’s mandate of review and concurrent evaluation. So far three CRMs were constituted which conducted its appraisal. Based on terms of reference set out, the CRM mandated to identify the constraints faced and to make recommendations on the areas that needed strengthening and course correction.

The Common Review Mission generally consisted of members belonging to central, state government officials, public health experts. They usually provided orientation briefing by the various divisions at the ministry in Delhi,
prior to break up in more than dozen teams and each team assigned different tasks for assessment and evaluation of performance of separate states. Then team used to visit states as assigned to them. They had conversation, presentation with the state level officials and then conduct field visits to see the ground realities. A field visit was done by isolation priority areas and visits of district level facilities and sub centre, PHC or CHC/FRU level facilities also arranged accordingly. The team used to collect information in a format. Also at the state level team get divided in several groups and sub groups. Each group assigned different program or place to visit. In one state teams used to spent at least 8-10 days. Finally, the common review mission teams used to present their observations and findings to the host state department heads and National Rural Health Mission facilitation teams for their feedback.

7.14.8 Community Monitoring Framework

The basic change that National Rural Health Mission wished to bring about in the monitoring framework was to involve local communities in planning and implementing programs with a structure that allowed them to assess progress against decided standards. While external institutions also assessed progress, they did so, on benchmarks that agreed with local communities and health institutions. The intention was to move towards a community based monitoring framework that continuous assessment of planning and implementation of National Rural Health Mission.

It was expected that community based monitoring could provide regular and systematic information about community needs feedback according to the locally developed measure for monitoring as well as key indicators, enable the community and community-based organizations to become equal partners in the planning process. In addition it could increase the community sense of involvement and participation to improve responsive functioning of the public health system and used for validating the data collected by the ANM, Aanganwadi worker and other functionaries of the public health system.

7.14.9 Primary health centre monitoring and planning committee

Such committee had functioned at primary health centres having role and responsibilities assigned. According to the ‘Framework for implementation of NRHM’ 30 percent, members could be representatives of Panchayat Institutions. Similarly, 20 percent members could be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages.
Further 20 percent members could be representatives from nongovernmental organizations / Community based organizations and People’s organizations working on community health and health rights in the area covered by the primary health centre. Lastly the 30 percent members could be representatives of the health and nutrition care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the primary health centre area. The chairperson of the primary health centre committee could be one of the Panchayat representatives, preferably a Panchayat Samiti member belonging to the primary health centre coverage area. The executive chairperson could be the Medical officer of the PHC. The secretary of the PHC committee could be one of the nongovernmental organizations/ community based organizations representatives. The secretary of the Primary health centre committee could be one of the nongovernmental organizations/ community based organizations representatives.

7.14.10 District monitoring and planning committee

It was recommended that the district committee would have the following broad pattern of representation, including members from Panchayati Raj Institutions, health care service providers and civil society. 30 percent members could be representatives of the Zilla Parishad. 25 percent members could be district health officials, including the District Health Officer / Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals. 15 percent members could be non-official representatives of block committees, with annual rotation to enable successive representation from all blocks. 20 percent members could be representatives from nongovernmental organizations/ community based organizations and People’s organizations working on health rights and regularly involved in facilitating Community based monitoring at other levels in the district 10 percent members could be representatives of Rogi Kalyan Samities or hospital management committees in the district. The chairperson of the District committee could be one of the Zilla Parishad representatives, preferably convener, or member of the Zilla Parishad Health committee. The executive chairperson could be the Chief Medical Officer or any other officer of equivalent designation.

7.14.11 State Health Monitoring and Planning Committee

The main role of the state committee was to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes. This committee could review and contribute to the development of the State
health plan, including the plan for implementation of *National Rural Health Mission* at the state level; the committee could suggest and review priorities and overall programmatic design of the State health plan.

Key issues arising from various district health committees, which cannot be resolved at that level especially relating to budgetary allocations, recruitment policy, programmatic design etc could discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, discussed. The purpose was also to institute a health rights redresses mechanism at all levels of the health system, which could take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports, Operational sing and assessing the progress made in implementing the recommendations of the National Human Rights Commission, to actualize the Right to health care at the state level. The committee could take proactive role to share any related information received from GOI and share achievements at different levels. 30 percent of total members could be elected representatives, belonging to the State legislative body or Conveners of Health committees of *Zilla Parishad* of selected districts by rotation. 15 percent could be non-official members of district committees, by rotation from various districts belonging to different regions of the state. Twenty percent members could be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring. Twenty-five percent members could belong to State Health Department: Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services along with technical experts from the State Health System Resource Centre / planning cell. Ten percent members could be officials belonging to other related departments and programs such as Women and Child Development, Water and Sanitation, Rural development. The Chairperson could be one of the elected members while executive chairperson could the Secretary Health and Family Welfare. The secretary could be one of the NGO coalition representatives.

The research scholar based upon aforesaid deliberation could say that with such a huge institutionalized arrangement for monitoring and reporting the *National Rural Health Mission* was one of the most monitored and supervised program in the country.
Figure 5: Flow chart of reports under NRHM
Chapter 7.15

THE NRHM LOGO

For conveyance of such a major developmental program, certain logo and title words were most required. *National Rural Health Mission* logo could be easily traced on almost each circulation, documents, posters, reports, and advertisements.

Four colors were used in the logo; the overall background was in red color. The texts *National Rural Health Mission* was depicted in both *Nagari* and *Roman* scripts in black color. In between the logo, a family, which included a mother-father and daughter, were faced towards a rising sun. The rising sun was in yellow color whereas family was depicted using white color. The family and the sun depicted in white and yellow colors respectively in red colored background.

The logo of *National Rural Health Mission* is displayed as **Figure-6**.

**Figure 6: NRHM Logo**