HEALTH CARE ADMINISTRATION IN INDIA: A STUDY OF NATIONAL RURAL HEALTH MISSION IN MIZORAM

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LALENGMAWII

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HEALTH CARE ADMINISTRATION IN INDIA: A STUDY OF NATIONAL RURAL HEALTH MISSION IN MIZORAM

BY

LALENGMAWII

Department of Public Administration

Supervisor

Dr. LALTANPUII RALTE

Submitted

In partial fulfillment of the requirement of the Degree of Doctor of Philosophy in Public Administration of Mizoram University, Aizawl.

MIZORAM UNIVERSITY

(A Central University established by an Act of Parliament of India, 2000)

AIZAWL: MIZORAM, PIN- 796004

(A Central University)

Tanhril, Aizawl – 796004, Mizoram

Dr Laltanpuii Ralte

Department of Public Administration

Associate Professor & Supervisor
Mizoram University

Phone: 032331612

Fax: 0389-2331606

CERTIFICATE

This is to certify that the Thesis titled '**HEALTH CARE ADMINISTRATION IN INDIA:A STUDY OF NATIONAL RURAL HEALTH MISSION IN MIZORAM'** submitted by **Ms. Lalengmawii** in partial fulfillment for the award of Degree of Doctor of Philosophy (Ph.D) in the Department of Public Administration, Mizoram University, Aizawl. This Thesis is an original work of his research which has not been used previously and which has not been submitted to any other university for any purpose. It covers the topic of research adequately.

(Dr. LALTANPUII RALTE)

Supervisor

Department of Public Administration

Mizoram University

DECLARATION

MIZORAM UNIVERSITY

JUNE, 2024

I **LALENGMAWII**, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to do the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to the Mizoram University for the Degree of **Doctor of Philosophy in Public Administration.**

LALENGMAWII

Date: Research Scholar

Prof. SRINIBAS PATHI
Head
Department of Public Administration

Dr. LALTANPUII RALTE
Supervisor

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LALENGMAWII

LIST OF ABBREVIATIONS

AHS	:	Annual Health Survey
ANM	:	Auxiliary Nurse Midwife
ARSH	:	Adolescent Reproductive and Sexual Health
ASHA	:	Accredited Social Health Activist
AVBD	:	Association for voluntary blood donation
AWW	:	Anganwadi Worker
BCC	:	Behavior Change Communication-
BPL	:	Below Poverty Line
BPMU	:	Block Programme Management Unit
CEHAT	:	Centre for Enquiry into Health and Allied Themes
CH	:	Child Health
CHC	:	Community Health Care
CSO	:	Central Statistical Office
DC	:	Disease Control
DLHS	:	District Level House Hold Survey
DMO	:	District Malaria Officer
DP	:	Development Partner
DPMU	:	District Programme Management Unit
EAG	:	Empowered Action Group
ECOP	:	Environmental Codes Of Practice
EFC	:	Expected family contribution
EPC	:	Empowered Programme Committee
FAO	:	Food and Agriculture Organization
FRCH	:	Foundation for Research in Community Health
FP	:	Family Planning
FRU	:	First Referral Unit
GoI	:	Government Of India
Govt	:	Government
HMIS	:	Health Management Information System

HPD	:	High Priority District
HR	:	Human Resources
HRD	:	Human Resource Development
HDPE	:	High Density Polyethylene
IDSP	:	Integrated Disease Surveillance Programme
IEC	:	Information Education Communication
IPC	:	Infection Prevention and Control
IVM	:	Integrated Vector Management
JSSK	:	Janani Shishu Suraksha Karyakram
JSY	:	Janani Suraksha Yojana
KTS	:	Kala Azar Technical Support
LLIN	:	Long lasting insecticidal nets
LoU	:	Letter of Undertaking
M&E	:	Monitoring & Evaluation
MAS	:	Mahila Arogya Samiti
MBBS	:	Bachelor of Medicine and Bachelor of Surgery
MCD	:	Municipal Corporation Department
MCH	:	Maternal child Health
MCTS	:	Mother and Child Tracking System
MH	:	Maternal Health
MI	:	Malaria Inspector
MMU	:	Mobile Medical Unit
MOHFW	:	Ministry of Health & Family Welfare
MOIC	:	Medical Officer In charge
MPW	:	Multipurpose Worker
MS	:	Metal Sheet
MSG	:	Mission Steering Group
MTS	:	Malaria Technical Support
NFHS	:	National Family Health Survey
NGO	:	Non-Government Organization
NHSRC	:	National Health Systems Resource Centre

NHM	:	National Health Mission
NHP	:	National Health Policy
NIN	:	National Institute of Nutrition
NICD	:	National Institute for Communicable Diseases
NLEP	:	National Leprosy Eradication Programme
NMHP	:	National Mental Health Programme
NOHP	:	National Oral Health Programme
NPCC	:	National Programme Coordination Committee
NPPCF	:	National Programme for Prevention and Control of Fluorosis
NPPMBI	:	National Programme for Prevention and Management of Burn Injuries
NPCB	:	National Programme for Control of Blindness
NPPC	:	National Programme for Palliative Care
NRHM	:	National Rural Health Mission
NUHM	:	National Urban Health Mission
NVBDCP	:	National Vector Borne Disease Control Programme
OPD	:	Out Patient Department
PFI	:	Private Finance Initiative
PHC	:	Primary Health Center
PIP	:	Program Implementation Plan
PMG	:	Programme Management Group
PRI	:	Panchayati Raj Institution
PPE	:	Personal Protection Equipment
PVC	:	Poly Vinyl Chloride
RBSK	:	Rashtriya Baal Swasthya Karyakram
RCH	:	Reproductive Child Health
RDK	:	Rapid Diagnostic Kit
RMNCH+A	:	Reproductive Maternal Neonatal Child Health + Adolescent
RNTCP	:	Revised National Tuberculosis Control Program
RKS	:	Rogi Kalyan Samiti
ROP	:	Record of Proceedings

SC/ST	:	Scheduled Castes/Scheduled Tribals
SHC	:	Sub Health Centre
SHS	:	State Health Systems
SHSRC	:	State Health Systems Resource Centre
SIHFW	:	State Institute of Health and Family Welfare
SMART	:	Specific, Measurable, Attainable, Relevant, Time Bound
SPMU	:	State Programme Management Unit
SRS	:	Sample Registration System
SSA	:	Sarva Shiksha Abhiyan
TFR	:	Total Fertility Rate
ToR	:	Terms of Reference
UH	:	Urban Health
ULB	:	Urban Local Body
UNICEF	:	United Nations International Children's Emergency Fund
UPHC	:	Urban Primary Health Centre
USAID	:	United States Agency for International Development
VBD	:	Vector Borne Diseases
VHA	:	Veteran Health Administration
VHSNC	:	Village Health Sanitation and Nutrition Committee
WHO	:	World Health Organisation

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PREFACE

Realizing the importance of improving the health conditions of the rural areas, the Government of India has taken initial steps in improving the health conditions of the rural areas by introducing NRHM. The main focus of NRHM is on Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). Although the program was implemented from 2005, the targeted communities are still not aware of the importance and significance of this Mission. So, much research work is yet to be done on the working and implementation of NRHM as a specific part and parcel of the overall National Health Mission with evidence gathered and analyzed through the scope of study incorporated within Kolasib district.

The entire study is divided into seven Chapters.

The first Chapter is introductory which deals with the basic background information of the state, vital information related to socio-demography, climate and a focused description of the meaning and importance of health care in general and specifically to Kolasib district within the ambit of NRHM. It also includes the concept of National Rural Health Mission in India, review of literature, objectives of the present study, research questions, area of the study and method of data collection. It also contains a brief profile of the state of Mizoram as well as Kolasib District within which the present study will be concentrated.

The second Chapter deals with the conceptual study of Healthcare Administration, policies and development in India. It discusses in detail the concept of healthcare administration which includes community based Primary health care, Maternal health, Antenatal care, health education and health promotion. It also includes challenges for health services in developing countries.

The third Chapter traces the origin and historical background of NRHM in India under the sub heading of Health prior to British rule, Health during the British rule and Health in Post-Independent India. It also includes the five main approaches

of NRHM and discusses the objectives, vision, strategies, implementation framework and plan of action, and financing of NRHM.

The fourth Chapter deals with the organizational structure and working of NRHM in Mizoram, introduced by the Central Government. It traces the history of Health Department of Mizoram and their functions according to Government (Allocation of Business) Rules, 1987 and also about the health system conceptual framework for Mizoram;

In the fifth Chapter, an attempt has been made to assess the implementation and monitoring machinery of NRHM by highlighting the fund flow under the NRHM budget and the importance of regular supervision of the Mission activities for its successful implementation.

The sixth Chapter deals with the field finding analysis of NRHM in Kolasib district of Mizoram. It provides results and discussion in relation to the data analysis of the empirical research and its findings. The research questions were formulated to make the objectives of the research to form the major part of this chapter. An analysis of the data received from the respondents has been presented.

The seventh Chapter is a concluding Chapter which has brought out the summary and findings of the study. It has also made some suggestions for the improvement of the organisational set-up of NRHM, the implementation of which would enable the district level machinery to implement the mission in a more effective manner

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CHAPTER - I

INTRODUCTION

I. INTRODUCTION

The term 'Health' is as large and complex as the entire scope of human activities. Health care may be viewed as the provision of a range of health care services by professional, technical, and supportive health work the opening of hospitals or health care centres but more so by their proper administration and management. Health is a vital component as well as a crucial index of social and economic development of a country. Undoubtedly, better health of people, in turn, will lead to better sustainable development. The Constitution of WHO defines health as, 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. Health is no longer considered as merely 'absence of diseases[1].

Health care is the maintenance or improvement of health through the prevention, diagnosis, treatment, amelioration or cure of disease, illness, injury and other physical and health care is delivered by health professionals and allied health fields. Medicine, dentistry, pharmacy, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, athletic training and other health professions are all part of health care. It includes work done in providing primary care, that refers to the work of health professionals who act as a first point of consultation for all patients within the health care system and, tertiary care which is specialised consultative health care usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital as well as in public health.

Providing health care services means the timely use of personal health services to achieve the best possible health outcomes. It cannot be limited to care

[1]C.S.Kanagasabai,(2003): '*Economics of Human Resources Development*'. Rasse Publications, Theni,pp.55.

rendered by or financed out of public expenditure- within the government sector alone but must include incentives and disincentives for self-care and care paid for by private citizens to get over ill health[2]. Health care is one of the basic needs for all of us. Once the primary needs like food and shelter are taken care of, the focus for any government shifts towards providing better health care for its citizens. As per the Indian constitution, health care system in India is primarily run by the states and union territories. Both the states and union territories are responsible for public health and standard of living respectively.

World Health Organization has defined a health system to include all the activities whose primary purpose is to promote, restore or maintain health. The health system is a key to operationalizing any policy approach to address the health needs of a country. Health is the World's largest industry. As such India has to prepare to meet the health care challenges of the new millennium. A few principles are: (a). Health should not be considered in isolation from other socio-economic factors. (b). Sound Health administrative structures may be designed for the implementation of health policy. (c). Ensure basic health services available accessible and acceptable to the people[3].

India has played a pioneering role in conceptualizing and planning for holistic integrated primary health care for all its citizens. It is the second-most populous country in the world and has to change socio-political-demographic and morbidity patterns that have been drawing global attention in recent years. Despite several growth-orientated policies adopted by the government, the widening economic, regional, and gender disparities are posing challenges for the health sector. About 75% of health infrastructure, medical manpower, and other health resources are concentrated in urban areas where 27% of the population lives[4]. Contagious, infectious, and waterborne diseases such as diarrhoea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping

[2]https://www.niti.gov.in/planningcommission.gov.in/docs/reports/genrep/bkpap2020/26_bg2020.pdf

[3] Goel, S.L. (1984). *Public Health Administration.* Sterling Publishers Pvt Ltd.

[4] https://www.Pubmed.nchi.nih.govt>24125926

cough, respiratory infections, pneumonia, and reproductive tract infections dominate the morbidity pattern, especially in rural areas. At the same time, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents, and injuries are also on the rise.

The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), the infant mortality rate (80/1000 live births), and maternal mortality rate (438/100 000 live births) in the rural areas; however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at the macro (national and state) and micro (district and regional) levels in a holistic manner. A paradigm shift from the current 'biomedical model' to a 'sociocultural model', which should bridge the gaps and improve the quality of rural life, is the current need. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative[5].

II. Concept of National Rural Health Mission

The NRHM was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. NRHM is an initiative undertaken by the Government of India to address the health needs of under-served rural areas. Recognising child and maternal health as a critical concern, the Government of India launched the NRHM in 2005 in the country, with a special focus on 18 States which were Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Tripura, Uttarakhand, and Uttar Pradesh. These states were identified by the Government of India as having poor outcome indicators. The idea behind the Mission is to provide universal access to equitable, affordable, and quality health through an integrated approach as well as to bring about institutional

[5]https://www.pubmed.ncbi.nlm.nih.govt/19700794/

changes such as decentralization of the public health system; integration of organizational structures; community participation and ownership of assets; and convergence in services which co-determine health outcomes (e.g. food, nutrition, water and sanitation)[6].

The focus of India's health services right from the early 1950s has been on health care to tackle common health problems of the public in general and the vulnerable groups in particular. At the same time, improvement in the health and nutritional status of the population has been one of the major thrust areas for the social development programmes of the country. Recognizing the importance of health in the process of social and economic development and improving the quality of life of the citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) which has now been renamed as National Health Mission (NHM) covering both the rural as well as urban areas[7]. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene, and safe drinking water. It also aims at mainstreaming the Indian system of medicine to facilitate health care.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integrating organizational structures, optimization of health manpower, decentralization and district management of health programmes community participation and ownership of assets, induction of management and financial personnel into the district health system, and operationalizing community health centres into functional hospitals meeting Indian Public Health Standards in each Rural Development Block of the country[8]. The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women, and children. The NRHM was introduced as a flagship scheme of the United

[6]https://www.cbgaindia.org/wp-content/uploads/2016/04/NRHM.pdf
[7] https://www.health.gov.in
[8] https://www.nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf

Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system[9].

The key goals of NRHM is towards enabling and achieving the stated vision, making the system responsive to the needs of the citizens, and building a broad-based inclusive partnership for realizing the goals of the government which focuses on the survival and well-being of women and children, reducing existing disease burden and ensuring financial protection for households[10]. The NRHM has been developed to bridge the gap in rural health care services through the creation of a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to the district level to improve inter-sectoral convergence, and effective utilization of resources.

Under the NRHM, the Empowered Action Group (EAG) States (Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Odisha and Rajasthan) as well as the North Eastern States, Jammu, Kashmir, and Himachal Pradesh have been given special focus[11]. The thrust of the Mission is on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

By 2013, the considerable success of the Mission prompted the Union Cabinet to set up the National Urban Health Mission (NUHM) on May 1, 2013. Both the NRHM and the NUHM currently exist as Sub-Missions of the National Health Mission (NHM). The NHM, the NRHM, and the NUHM are managed by the

[9] https://www.books.google.co.in.books
[10] https://yourarticlelibrary.com
[11] https://www.nhm.gov.in.index1

Ministry of Health and Family Welfare in close association with the concerned States[12].

As per the 12th Plan (2012-2017) Document of the Planning Commission, the flagship programme of NRHM will be strengthened under the umbrella of the National Health Mission. The focus on covering rural areas and rural populations will continue along with the up-scaling of NRHM to include non-communicable diseases and expanding health coverage to urban areas. Accordingly, the Union Cabinet, in May 2013, had approved the launch of the National Urban Health Mission (NUHM) as a Sub-Mission of an overarching National Health Mission (NHM), with NRHM being the other Sub-Mission of the National Health Mission.

The mission's primary goals are to:

i) Enhance everyone's access to and use of high-quality health care;

ii) Decrease infant and maternal mortality;

iii) Universalizing access to public health services with a focus on women's and children's health and universal immunization;

iv) Universalizing access to public services for food and nutrition, sanitation and cleanliness;

v) Maintaining population, gender, and demographic balance;

v) Increasing access to integrated, comprehensive primary health care;

vi) Preventing and managing infectious and non-communicable diseases, particularly locally endemic diseases;

vii) Increasing government funding on health while allowing states and localities more freedom to pool risks through local initiatives;

[12] https://www.mapsofindia.com

viii) Observing a simultaneous decline in the total fertility rate (TFR), the maternal mortality rate (MMR), and the infant mortality rate (IMR)

ix) Promoting healthy lives and revitalising regional health customs are two other goals.

x) Promoting healthy lifestyles[13].

III: Review of Literature

The present scholar has undertaken a review of the following literature about NRHM. Scholars, researchers, and writers enriched the literature through their studies and writings. There is a tremendous increase in the number of publications, books, and periodicals in developed and developing countries. The literature in any field is the foundation upon which all the future work will be built. The review of related literature is an essential aspect of research studies. A summary of the writings of recognized authorities and previous research provides evidence of what is familiar, what is already known, and what is still unknown and untested. Effective research is based upon past knowledge, which helps to eliminate the duplication of what has been done and provides useful hypotheses and suggestions for significant investigations. The Published literature is a good service for the investigators which helps to interpret the significance of its results. Therefore the researcher has reviewed some of the literature on the studies of NRHM in the following –

Abhay T.B. et al (1999), in his article *Effect of home-based neonatal care and management of sepsis on neonatal mortality: field trial in rural India* found that home-based neonatal care, including management of sepsis, is acceptable, feasible, and reduced neonatal and infant mortality by nearly 50% among the malnourished, illiterate, rural study population. This approach would reduce neonatal mortality substantially in developing countries.

[13] https://www.books.google.co.in.books

Aalok Ranjan Chaurasia (2013) in his article *India: Health System Performance* analysed details on the performance of health system of India. He says that population health and its impact on the social and economic production system remains a major development challenge in India even today. In the recent past, India has recorded an impressive economic growth but gains on the economic front do not appear to have been translated in hastening health transition and improvement in the health status of the people. An analysis carried out by the Government of India indicates that, at the current pace, India is likely to miss health related Millennium Development Goals (Government of India, 2014). Although, there has been improvement in the health and mortality situation in the country, yet, the pace of improvement has been substantially slower than what has been planned or expected in the context of social and economic development needs of the country. He further says that the slow pace of health and mortality transition in India has implications for global health and mortality transition as India is the second most populous country in the world. During 2005-10, India accounted for more than 17 per cent of average annual number of deaths in the world (United Nations, 2013). This proportion is the highest among all countries of the world. Obviously, future global health and mortality transition will depend largely upon the pace of health and mortality transition in India.

Anita Raj et al (2010), in his article, *The effect of maternal child marriage on morbidity and mortality of under 5 in India: a cross-sectional study of a nationally representative sample* showed that infant and child malnutrition is significantly more likely among the children born to mothers married as minors than in those born to women married as adults. Also, the study concludes that association between the maternal-child marriage and low infant birth weight as well as infant and child mortality seem to be a consequence of early motherhood, low maternal education, and other indicators of poor maternal health and socioeconomic status factors all significantly linked to an early marriage of girls.

Arun Kumar Sharma (2009) in his article *National Rural Health Mission: Time to take stock* analysed the poor performance of the Indian Public Health System which

has been widely acknowledged. Analysts have attributed this failure to a number of factors, which include almost all the components that make a system functional, that is, infrastructure, human resources, logistics, and participation of the community. However, some attribute this failure primarily to low and declining public investment in healthcare and secondarily to structural and managerial weaknesses in the system. After groping with the challenges for decades, the planners have come up with a comprehensive mission-oriented approach to revamp the rural healthcare delivery system, which was aptly named National Rural Health Mission (NRHM). The mission was launched on 12 April, 2005, to be completed in a time frame of seven years. The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as a healthcare provider. It also recognizes the need to make optimal use of the non-governmental sector to strengthen public health systems and has increased access to medical care for the poor. The core objective of NRHM is to create fully functional health facilities within the public health system. It is expected to provide a certain service guarantee at each level of the healthcare delivery system starting from a Sub-centre (SC) to a District Hospital (DH).

Benerji D. (2005) in his article, *Politics of Rural Health in India* highlights politics of national rural health mission programme initiated by government of India. According to him government has not considered the past experience for implementation of such an important programme throughout the nation. To him, successive government could not successfully implement various health programmes in past and causes of failure in past should have been considered before implementation of national rural health mission so that the promises given by government becomes fulfilled.

Brijesh C Purohit (2016) in his article *Health Care System Efficiency: A Sub-State Level Analysis for Orissa (India)* gave renewed emphasis efficiency in resource utilization in the healthcare sector. This paper explores sub-state level health system efficiency in Orissa, a low-income state in India. They explore the reasons for relative performance of different districts using a frontier estimation technique. There

is a substantial difference in performance between the most efficient district of Jharsuguda and the least efficient district of Balangir, resulting from inadequate utilization of available health care resources. Their study also identifies complimentary of private health care resources and the role of other factors, such as sanitation facilities, village electrification, and rural population growth. Their results suggest a need for better utilization of budgetary resources, both under the state department of health and the National Rural Health Mission, to increase health manpower and improve quality through training and better management resources in order to improve district health systems in Orissa.

Dilip T.R. (2002) in his article *Utilisation of Reproductive and Child Health Care Services: Some Observations from Kerala* found from his study that the preference of public / private sector depends on nature of service in demand. The role of private providers in health care was found to be limited in the case of family planning services, but almost 50 per cent availed delivery care services from the private sector. A majority of women were found to prefer treatment from the private medical service providers if their children were suffering from fever or cough. Class differentials were severe, with the public sector being the major provider of Reproductive and Child Health care services for the poorer sections of society. People with a higher potential to pay preferred the private sector irrespective of the nature of service they required.

Duggal R. (1994) in his article *Health care utilization in India* revealed that India has a plurality of health care systems as well as different systems of medicine. The government and local administrations provide public health care in hospitals and clinics. Public health care in rural areas is concentrated on prevention and promotion services to the detriment of curative services. The rural primary health centers are woefully underutilized because they fail to provide their clients with the desired amount of attention and medication and because they have inconvenient locations and long waiting times. Public hospitals provide 60% of all hospitalizations, while the private sector provides 75% of all routine care. The private sector is composed of an equal number of qualified doctors and unqualified practitioners, with a greater

ratio of unqualified to qualified existing in less developed states. In rural areas, qualified doctors are clustered in areas where government services are available. With a population barely able to meet its nutritional needs, India needs universalization of health care provision to assure equity in health care access and availability instead of a large number of doctors who are profiting from the sicknesses of the poor.

Gandhi, I.C (2002) in his article *Public Health in India: Future Challenges* observed that most of the countries in the world including India and other countries in the South East Asia region have recorded impressive gains in health and development in the 20th century. The green revolution in India has increased the consumption of horticultural produces and leafy vegetables, which has significantly reduced important micro-nutrient malnutrition. Despite overall improvements in control of some communicable diseases, many are still deep rooted in the country and are still the major causes of mortality. Health problems are arising due to rapid urbanization of environmental degradation. The nationwide health infrastructure and the on-going national health programmes have failed to provide adequate and quality health care to meet the need of the population. Study suggests that effective health information system should be established. Good quality and adequate drugs, vaccines and equipment should be manufactured and made available at affordable prices. Balanced development of basic, clinical and problem-oriented health research is encouraged. So in order to meet the challenges of 21st century and to achieve the objectives of National Health Policy 2001, it is necessary that health should be attached higher priority on political and the development agenda.

Glenn Laverack (2006) in his article *Centre for Health and Population Research Improving Health Outcomes through Community Empowerment* reviews the literature on how empowerment can lead to an improvement in the health status of an individual, group, or community. There is a broad body of literature on empowerment, and this review has been designed to identify material, particularly case studies, that can be included within the following 'empowerment domains': Participation; Community-based organizations; Local leadership; Resource

mobilization; Asking 'why'; Assessment of problems; Links with other people and organizations; Role of outside agents; and Programme management. The paper discusses the results of the literature review and provides examples, from both developed and developing countries, of how each of the 'empowerment domains' has led to an improvement in health outcomes. The results of the review should be of interest to the planners and practitioners of health, population and nutrition programmes that have a particular focus on empowerment.

Gokhale M.K. et al (2002) in their article *Infant mortality in India: use of maternal and child health services in relation to literacy* examined that Illiteracy of females had a more detrimental impact on rural than on urban areas. In the event of high female illiteracy, male literacy was beneficial for improving the use of services for reducing infant mortality rate. The micro-level study supported all major findings obtained for the national-level aggregate data. Programmes, like providing free education to girls, will yield long-term health benefits.

Gopinath Reddy et al (2006) in their article *Politics of Pro-Poor Reform in the Health Sector – Primary Healthcare in Tribal Areas of Visakhapatnam* found that poverty is the prime cause for ill health, persistent morbidity and early death among the tribal population of Vishakhapatnam. Lack of access to the right foods and basic healthcare services is the main reason for the marked gap in health indicators between tribal areas and the more developed parts of the state. Tribal suffer disproportionately to their population from communicable diseases like T.B. and Malaria where they account for more than 75 percent of the state's total deaths. The study also finds that the politicization of the health system of appointments and transfers within the health system led to the extremely poor performance of the Public Health Centre and Community Health Worker scheme, resulting to the deteriorating health status of the tribal people. Patterns of use of health facilities are shaped in part by party and political concerns, and the health sector reform policy is influenced by the professional doctor's association in the state, with the overall effect of leaving the private medical market under-regulated and the work of public sector doctors under-monitored.

Guha Mazumdar P. et al (2007) in their article *Indian system of medicine and women's health: a client's perspective* highlighted that for the majority of women's health problems biomedicine is regarded as the first choice, failure of which leads clients to seek treatment from Indian System of Medicine (ISM) as a final resort. Nevertheless, women showed a preference for ISM treatment for certain specific health problems, strongly backed by a belief in their efficacy. Of the predictors that positively influenced women's choice of ISM treatment, 'strong evidenced-based results' was found to be the most important. Women's preference for ISM is dependent on the availability of competent providers.

Julia Hussein et al (2011) in their article *A review of health system infection control measures in developing countries: what can be learned to reduce maternal mortality* highlighted that a functional health system is a necessary part of efforts to achieve maternal mortality reduction in developing countries. Some developing countries have recently experienced increased use of health facilities for labour and delivery care and there is a possibility that this trend could lead to rising rates of puerperal sepsis. This article reviews health system infection control measures pertinent to labour and delivery units in developing country health facilities. Organisational improvements, training, surveillance and continuous quality improvement initiatives, used alone or in combination have been shown to decrease infection rates in some clinical settings. There is limited evidence available on effective infection control measures during labour and delivery and from low resource settings. A health systems approach is necessary to reduce maternal mortality and the occurrence of infections resulting from childbirth. Organisational and behavioural change underpins the success of infection control interventions. A global, targeted initiative could raise awareness of the need for improved infection control measures during childbirth.

Kalaisigamani. J and Sangameshwaran A. (2013) in their article *Health Insurance in India* stated that India is gradually becoming health conscious and this is because youngsters have new ambitions, big dreams and high goals and they have the motivation and drive to make them all come true. Their lives are fast paced and

because of this fact there is an absolute need for health care so that they are able to overcome all the obstacles that might come their way. For this reason, Indians have realized the importance of health insurance India. Owing to this realization, the medical insurance sector is one of the fastest growing segments in India today.

Kaleeswari V and Sridhar T (2012) in their article *Economics of Health and Health Care Issues in India* highlighted that Health is very important for human life. Wealth without health is of no use in our life, life is miserable and painful for an individual with ill health. A sound mind is housed in a healthy body. Though modern man could enjoy all sorts of materialistic comforts in life, thanks to the advancements of science and technology yet he falls often sick due to highly polluted environment in which he lives and works. The country still has enough potential to be a super power in the world. However, a major road block in this regard is the health issue in India. The general health standard of India is extremely bad. Health economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and health care. This paper analyses health economics, health issues and health education, human resources made up of youths not only well educated and skilled but also well-built and robust in health.

Kumar Patra et al (2013) in their article *National Rural Health Mission (NRHM) & Health Status of Odisha: An Economic Analysis* stated that to improve the prevailing situation, the Government of Odisha launched the National Rural Health Mission (NRHM) programme through the state on 17th June 2005. NRHM has completed its six years of journey in Odisha. It becomes necessary to assess the impact of NRHM on the health infrastructure and on the health indicators and to analysed the determinants of health status in the health development of Odisha. The study shows that the health status of study area is very poor and is gradually increasing as a result of the implementation of NRHM and the staple reasons for this tendency are: low income, illiteracy, shortage of doctors, unwillingness doctors to go to remote areas and lack of health care facilities and lack of production of laboratory technicians and radiographers.

Krishna D Rao et al (2014) in their paper entitled *Health systems research in the time of health system reform in India* viewed that research on health systems is an important contributor to improving health system performance. Importantly, research on program and policy implementation can also create a culture of public accountability. In the last decade, significant health system reforms have been implemented in India. These include strengthening the public sector health system through the National Rural Health Mission (NRHM), and expansion of government-sponsored insurance schemes for the poor. This paper provides a situation analysis of health systems research during the reform period

Krishna D. Rao et.al (2006) in their article *Towards Patient-cantered health services in India a scale to measure patient perceptions of quality* found in their study that better staff and physician interpersonal skills, facility infrastructure, and availability of drugs have the largest effect in improving patient satisfaction at public health facilities. Also in their study they concluded that, in India and many developing countries, the excessive emphasis on service coverage and inputs in the provision of health services has ignored the needs of the very people for whom these health services exist. Incorporating patient views into quality assessment offers one way of making health services more responsive to people's needs. It also gives users an opportunity to voice their opinion about their health services. They further stated that while conducting this study, they found many instances in which patients were eager to record their concerns about the services they had received in the hope that some action would be taken. It is likely that the very act involving patients in evaluating their health services will make providers more sensitive and alert to patient needs.

Lewando Hundt et al (2012) in their article *The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan* found in their study that there are issues of accessibility in terms of distance, and of acceptability in relation to the lack of local and female staff, lack of cultural competencies and poor communication. Also they found that provision of accessible acceptable health care in rural areas poses a challenge to health care

providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area.

Mand MTE Huymen et al (2005) in their article *The health implications of globalization by framing a conceptual framework* developed the framework by first identifying the main determinants of population health and the main features of the globalization process. As for globalization, they have identified (the need for) global governance structures, global markets, global communication and diffusion of information, global mobility, cross-cultural interaction, and global environmental change as the important features. In this paper, globalization is perceived as an overarching process in which simultaneously many different processes take place in many social domains. In addition, the conceptual framework is embedded in a holistic approach towards population health. The resulting conceptual model explicitly visualizes that globalization effects the institutional, economic, social-cultural and ecological determinants of population health, and that the globalization process mainly operates at the contextual level, while influencing health through its more distal and proximal determinants. The developed framework provides valuable insights in how to organize the complexity involved in studying the health effects resulting from globalization.

Meenakshi Gautham et al (2011) in their article *First we go to the small doctor: First contact for curative health care sought by rural communities in Andhra Pradesh & Orissa, India* found that most rural persons seek first level of curative healthcare close to home, and pay for a composite convenient service of consulting –cum-dispensing of medicines. Non Degree Allopathic Practitioners (NDAPs) fill a huge demand for primary curative care which the public system does not satisfy and are de facto first level access in most cases.

Michael Pagano P (2016) in his book, *Health Communication* emphasized the need for maintaining of good and healthy relationship with patients, peers and colleagues as cornerstone of effective utilization health care services. The study described the theories and abilities needed by all healthcare providers like nurse medicine professional, physiotherapist, pharmacist, dentist, physician and opticians. It

incorporates recommendations for specific multimedia, suggestions for class discussion and interactive case studies to provide a rich and multi-perspective learning experience for gaining optimal expertise in effective health communication. It teaches about the behavioural aspect of healthcare service providers in diverse healthcare context and assesses its efficacy.

Mukherjee and Karmakar (2008) in their article *Untreated Morbidity and demand for healthcare in India: An Analysis of NSS Data* studied the problem of poor health outcomes in India from the demand side, and using the unit level data from the 60th round of the National Sample Survey analyses the determinants of not accessing medical care. The authors investigated the health-seeking behaviour of the respondents of the survey, and explored three avenues through which health and human development outcomes may be related-demographic characteristics, education level of the head of the household and expenditure group. The intra-family relationship, as well as the level of education of the head of the household, exerts considerable influence on health-seeking behaviour. This analysis is confined to persons who have reported being ill within 15 days of the survey but have not sought either public or private professional medical services. There are systematic variations in accessing healthcare between rural and urban areas, as well as between males and females in each sector. While in the rural areas, the demand for healthcare increases significantly with the education level of the head of the household, in the urban areas the evidence is mixed. Richer economic sections constitute a larger proportion of sick persons who do not access medical care, especially in urban areas. Paradoxically, among poor households, which cite financial reasons for not accessing healthcare, women are less likely to be discriminated in rural than urban areas. In this study, educational qualification has also taken as an important parameter to assess the stakeholders' knowledge and understanding the analysis of Health System of their own state. In Mizoram the majority of people are educated and they know something about theadministrative system on which the present health care system is functioning.

Nandan D. (2010) in his article, *National Rural Health Mission: Turning into reality* mentioned that on 12 April 2005, the Government of India took a major welfare initiative by launching National Rural Health Mission (NRHM) in 18 states with weak public health indicators and infrastructure and extended it across the entire country. What constituted the conceptual build-up to this mission was a spectrum of systemic deficiencies in the health system. According to him, the NRHM employed five main approaches while addressing these issues - communitization, flexible financing, improved management through capacity building, monitoring progress against standards, and innovations in human resource management, which became the mainstay. On the other hand, untied funds are making things somewhat easier for the peripheral health facilities, while overcoming small day-to-day problems. One of the success stories being attributed to NRHM is a huge increase in institutional deliveries.

Nath, L.M. (1994) in his article *Health care in rural areas* highlighted that in rural areas where the government centres are particularly desolate, the community has chosen to erect its own health care system of private practitioners of all sorts and qualifications. Even in rural areas where a comprehensive health service is provided, with each household visited regularly by health workers, people depend upon practitioners of various types. Upon analysis, it was discovered that the reason for using this multiplicity of practitioners had nothing to do with the level of satisfaction with the government service or with the accessibility of the services. Rather, when ill, the people make a diagnosis and then go to the proper place for treatment. If, for instance, they believe their malady was caused by the evil eye, they consult a magico-religious practitioner. These various types of practitioners flourish in areas with the best primary health care because they fulfil a need not met by the primary health care staff.

Nirupam Bajpai (2010) in his article, *Improving Access and Efficiency in Public Health Services: Mid-Term Evaluation of India's National Rural Health Mission (English)* presents a systematic mid-term evaluation of the processes of the National Rural Health Mission (NRHM), India’s biggest rural health programme. Data from

District Level Health Surveys (DLHS), National Family Health Surveys (NFHS), and Sample Registration System (SRS) as well as primary data collected from field surveys and interviews with health functionaries have been utilized for undertaking empirical analysis in the study. It discusses the challenges and successes of the Mission with the help of extensive field observations, data analysis and inputs from experts on health and nutrition sectors focusing on maternal, new born and child health issues and chronic diseases. The book draws from data collected in field visits in the three states of Madhya Pradesh, Uttar Pradesh, and Rajasthan. After assessing the NRHM processes and progress achieved so far, it discusses important ground realities, identifies the gaps and bottlenecks in the implementation of the Mission, and recommends corrective actions.

Peter Berman and Ricardo Bitran (2011) in their article *Health Systems Analysis for Better Health System Strengthening* identifies key elements of health systems analysis and situates them in a logical framework supported by a wide range of data and methods and a sizable global literature. Health systems analysis includes evidence on health system inputs, processes, and outputs and the analysis of how these combine to produce the outcomes. Health systems analysis proposes causes of poor health system performance and suggests how reform policies and strengthening strategies can improve performance. It contributes to implementation and evaluation. Health systems analysis should be an integral part of good practice in health system strengthening efforts, including planning, policy development, monitoring, and evaluation. Health systems analysis can be conceived in a coherent and logical fashion and can be practiced and improved.

Park J E (2002) in his book *Text Book of Preventive and social Medicine* highlighted that there is vast inequality in health care provisions between various social sectors. The health care expenditure is continuously increasing. Due to low government expenditure, the out-of pocket expenditure takes away a significant portion of individuals' income. It has its own impact on the patient, the patient's family and the economy.

Partha D et al (2002) in their article *Determinants of child immunization in four less developed states of North India* showed that children are more likely to receive immunization if their parents are a couple, with the father literate and the mother with at least a middle-school-education level who received antenatal care or delivered in an institutional environment.

Rajasekhar D and Sasikala (2013) in their article *An Impact of Stress Management on Employed Women* stated that today's women are in a state of transition caught between the illusory safety of traditional role on one hand and the challenge to realize their potential outside on the other hand. Women have a lot of balancing to do between home and workplace, and balancing between social and personal requirements. The major issues are maternity, menopause, parenthood, gender roles, conditions at home and workplace, familial and social support, often blight women's lives in the long run. Stress is the reactions people have, to excessive pressures or other types of demand placed on them. Stress make a person more susceptible to disease, which then aggravates any existing illness or chronic condition such as heart disease, depression, ulcers, irritable bowel disease, diabetics, the common cold, urinary tract infections. Depression, only one type of stress reaction, is predicted to be the leading occupational disease of the 21st century, responsible for more days lost than any other single factor.

Rajna P.N. et al (1998) in their *article Impact of maternal education and health services on child mortality in Uttar Pradesh, India* shows through their study on the effect of maternal education on child mortality that education has direct as well as indirect effects through antenatal care and family formation patterns on neonatal mortality. Maternal education also has a substantial effect on later childhood mortality. While improving maternal education is a means of reducing childhood mortality, an immediate reduction in childhood mortality is feasible even under existing social conditions by enhancing accessibility to maternal and child health services and safe drinking water.

Ramila Bisht et al (2000) in their article, *Championship Management for Healthcare Organizations* highlighted that the national and transnational health care systems are

rapidly evolving with current processes of globalisation. A structured scoping exercise was conducted to identify relevant literature using the lens of India – a rising power with a rapidly expanding healthcare economy. A five step search and analysis method was employed in order to capture as wide a range of material as possible. Via electronic bibliographic databases, websites and hand searches conducted in India, relevant articles, books and reports were identified. These were classified according to topic area, publication date, disciplinary perspective, genre, and theoretical and methodological approaches. Topic areas were identified initially through an inductive approach, then rationalised into seven broad themes. Transnational consumption of health services; the transnational healthcare workforce; the production, consumption and trade in specific health-related commodities, and transnational diffusion of ideas and knowledge have all received attention from social scientists in work related to India. This survey of India-related work suggests a young and expanding literature. The field would benefit from further cross-fertilisation between disciplines and greater application of explanatory theory. Literatures around stem cell research and health related commodities provide some excellent examples of illuminating social science. Future research agendas on health systems issues need to include innovative empirical work that captures the dynamics of transnational processes and that links macro-level change to fine-grained observations of social life.

Ravendra K. et al (2010) in their article *New born Care among Tribes of Central India Experiences from Micro Level Studies* demonstrates that utilization of maternal and child health services is very poor among the tribes of central India. Clinically acceptable maternal and new born care practices for delivery, cord cutting and care, bathing of mother and new born and skin massage are uncommon. Therefore, new born remain at high risk of hypothermia, sepsis and other infections. Supplementary feeding practices and delay in breastfeeding are very common, although colostrum is less frequently discarded. Malnutrition is a severe problem among tribes and many tribal children and women are severely malnourished as well as anaemic.

Raje V.N (2014) in his book *Health Education and Community Pharmacy* discussed about evolution of healthcare industry in India. He also recognized different institutions that paved the way for healthcare industries in the country. These institutions deliver healthcare services, finance healthcare services and manufacture products which are being utilized in these services. This study also discussed about 28 the innovative efforts to raise the capital for the development of healthcare sectors

Rajendra Pratap Gupta (2016) in his book *Healthcare Reforms in India* laid down the comprehensive methods need to be followed to attain excellence in healthcare industry. According to him practice oriented healthcare organizations can gain a competitive edge through superior operations. He opined that there will be huge benefits if the entire healthcare industry is aligned with the parameters. The study precisely depicts that how negotiation to be made between various prospective of clinicians and administrators by offering a uniform platform so that competitive advantage can be enjoyed. He also identified various tools that will aid in bringing solutions to the problems and improve the healthcare facilities

Ray S.K. et al (2011) in their article *An assessment of rural health care delivery system in some areas of west Bengal – An overview* found in their study that large no of patients did not avail any services when they fall sick especially in the tribal district where distance, poor knowledge about the availability of the services and non-availability of the medicine in addition to the cost of treatment and transport. Utilization of government health facilities was around 38% followed by unqualified Practitioners and Private Practitioners. Referral was mostly by self or by close relatives / families. Also attention is required with respect to the cleanliness of the premises, safe drinking water, face-lift of PHCs and SCs, clean toilet with privacy. Also they concluded that an attempt should be made to improve utilization by cordial behaviour, providing more time for patient care by the doctor, and staff, explain their prescription and report, reducing time for registration.

Sharad D. Iyengar et al (2009) in his article *Comparison of Domiciliary and Institutional Delivery care Practices in Rural Rajasthan, India* examined that several factors had contributed to maternal mortality. Lack of skilled attendance and

immediate postpartum care were major factors contributing to deaths. Improved access to emergency obstetric care facilities in rural areas and steps to eliminate costs at public hospitals would be crucial to prevent pregnancy-related deaths. Although the high prevalence of health conditions and diseases, including TB and anaemia, are identifiable as direct or indirect causes of death, important societal and health systems factors constrain women from accessing quality health services. If reduction in maternal mortality is to become a reality, women in rural regions will require more efficient access to high-quality delivery and emergency services at an affordable cost.

Sisira Sarma (2009) in his article *Demand for Outpatient Healthcare: Empirical Findings from Rural India* studied the Demand for Outpatient Healthcare in Rural India. The main objective of the study was to examine the role of monetary and non-monetary price, income, and a variety of individual- and household-specific characteristics on the demand for healthcare in rural India. The study found that contrary to many earlier studies on the demand for healthcare in developing countries, prices and income were statistically significant determinants of the choice of healthcare provider by individuals in rural India. Demand for healthcare was found to be price and income inelastic, corroborating the findings from other developing countries. Distance to formal healthcare facilities negatively affected the demand for outpatient healthcare, an effect that was mitigated as access to transportation improved. Age, sex, healthy days, educational status of the household members and the number of children and adults living in the household also affected the choice of healthcare provider in rural India. After controlling for a number of socio-demographic factors, it was found that prices, income and distance are statistically significant determinants of the provider chosen by individuals; nevertheless, the demand for healthcare is price and income inelastic in rural India.

Srivastava R.K. et al (2009) in their article *Assessment of utilization of RCH services and client satisfaction at different levels of health facilities in Varanasi District* revealed that the utilization of RCH services in the government facilities was higher among the backward classes than the general category; and higher the level of

education the lower was the utilization of the government services. Also the users were not satisfied with the services provided by the governmental health facilities especially with the behaviour of medical officer and health workers and non-satisfaction was highest among SC category. Also authors concluded that all the health facilities need to be made functional according to the Indian Public Health Standards (IPHS) of National Rural Health Mission (NRHM).

Subhashini R. (2012) in his article *National health policy, the need of the hour: an analysis in Indian perspective* formulate a renewed national health policy, which should enable to strive towards achieving the concept of 'healthcare for all' conceptualized by the World Health Organization (WHO) through health insurance scheme. The purpose of this paper is to identify and discuss the various gaps affecting the health care systems and to evolve strategic issues in health care in India through an exploratory survey on as well as waiting and finally cost of medicine they can afford.

Susmita Bharati et al (2007) in their article *Obstetric care practice in Birbhum District; West Bengal, India* showed in their study that the status of literacy of mothers and standard of living of the family are of prime importance in improving the obstetric health care practices. The study indicates that the educated women with high standards of living have an emphasized role in the practice of more maternal health care. The study shows that rural antenatal care is still mostly based on Indian traditional system. It is the women who need to be educated and must be made aware about the importance of the health care for ensuring healthy pregnancy and safe delivery.

Vikash Bajpai and Anup Saraya (2012) in their article *NRBM the Panacea for Rural Health in India: a critique* highlighted the reason for failure of government to fulfil objectives of national rural health mission. According to them government could not fulfil its objective of rural health care in last seven years of implementation of national rural health mission in India. Deficit in infrastructure and manpower in government health care sector is major cause of problem of health for them. Rather

private health care institutions are growing in India. According to them, government should change its strategy to implement the programme properly.

William Joe et al (2008) in their article *Health Inequality in India: Evidence from NFHS-3* utilized the National Family Heath Survey-3 data and presented an empirical assessment of the income-related health inequality in India. It undertakes state-level analysis of inequities in child health by employing the widely accepted measures of the concentration curves and concentration indices. As the key indicators for child health, it employs the information available on under-five mortalities, immunization status and nutritional performance (stunting and underweight) of the child population of the different states. It found that the poorer sections of the population are plagued with ill health whether in the quest for child survival or due to anxieties pertaining to child nutrition. Further, an attempt is made to comprehend the relationship between income inequality and the health status in the Indian context. The analysis reveals that the degree of health inequalities escalates when the rising average income levels of the population is accompanied by rising income inequalities. The income-poor sections have different needs and therefore, planning and intervention necessitates understanding of the sources of inequality and recognition of the vulnerable groups to arrive at efficient resource allocation and policy decisions.

Zakir Husain (2011) in his article *Health of the National Rural Health Mission* stated that the National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. With the completion period drawing to a close in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website, this paper attempts a desk review of the progress of the mission with respect to its core strategies - provisioning of health services to households through Accredited Social Health Activists (ASHA), strengthening rural public health facilities, enhancing

capacity of panchayats to control and manage provisioning of health services and positioning of an effective health management information system.

Commendable though they are in their respective works, none of the above works has dealt with the working of National Rural Health Mission, population health and its impact on the social and economic production system, economic growth and its impact on health improvement and there is limited emphasis on preventive healthcare. There is a lack of focus on promoting preventive measures such as health education, awareness campaigns, and immunization programmes. This can lead to a higher burden of preventable diseases in rural areas in Mizoram; hence the present study has been taken up.

IV: Statement of the problem

The majority of India's population live in rural areas and one of the foremost agenda in the development process is the improvement of the rural areas in all aspects, including the health conditions. Realising the importance of improving the health conditions of the rural areas, the Government of India has taken initial steps in improving the health conditions of the rural areas by introducing NRHM. The main focus of NRHM is on Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). NRHM suggest that IMR and MMR determine the overall health condition of a specific community or county as they represent the health status of the community as well as the status and standard of health programs, services, facilities and infrastructures, policies, governance's and investments.

IMR and MMR are the influencing factors which drives all the projects and activities under the National Rural Health Missions based on the annual Program Implementation Plans prepared by the different states with the bulk of its program and budget mandated towards the then Reproductive Child Health (RCH) into the newly termed Reproductive, Maternal, Neonatal, Child, Health, Adolescent Plus (RMNCH+) along the saying 'from womb to tomb' as the new National Health Policy since 2013-14 had incorporated urban health, non-communicable diseases (NCD), geriatrics within its functions and mandate.

NHRM stresses on universal access to public health services such as women's health, child health, drinking water, sanitation and hygiene, nutrition and universal immunization, prevention and control of communicable and non-communicable diseases and its main goal and objectives is reduction of infant mortality and maternal mortality. Inspite of the benefits that local communities can acquire through this Mission there is lack of awareness, especially among the rural population. What the urban areas treat as a common disease could become fatal or a highly challenging medical problem for the rural areas because of negligence and ignorance of the importance of going to the hospital immediately and, most importantly, because of lack of taking proper treatment at the initial stage which by the technical definition of the NRHM guiding principles of 'efficient system' includes early and correct diagnosis and appropriate treatment at the right time, which consists of referral, linkages and networking within the health system and chain of referral.

It is in this background that the study had been undertaken with a focus on IMR and MMR in the district of Kolasib. The study determined the gaps in governance and administrative machinery in Mizoram which are the causal factors for understanding National Rural Health Mission and its implementation.

V: Scope of the study

This study concentrates on the implementation, functions, issues and problems of NRHM in Mizoram with special focus on Kolasib District. Although the program was implemented from 2005, the targeted communities are still not aware of the importance and significance of this Mission. So, much research work is yet to be done on the working and implementation of NRHM as a specific part and parcel of the overall National Health Mission with evidence gathered and analysed through the scope of study incorporated within Kolasib district. The study covered the period from the period of its implementation i.e. 2005-2006 Financial year till the present day i.e. 31st March 2021.

The study comprised of the various indicators of NRHM programmes, targets and achievement made since its implementation and the issues and relevant challenges including bottlenecks found along the process of the study. However, it

will not incorporate all parameters of the empirical data from the National Health Mission due to the degree of their relevance to the study and plausible indication in the objective of the study findings.

VI: Objectives of the study

The objectives of the study are:

(1) To study the background and origin of implementation of NRHM in India in general and in Mizoram in particular

(2) To understand the implementation and monitoring process and mechanism of the mission in Mizoram

(3) To assess the benefits of the mission in terms of improvement in public health alleviation.

(4) To find out the shortcomings and the problems faced in the process of implementation of NRHM in Mizoram from a public health administration perspective.

(5) To understand the implications and make suitable suggestions for the effective performance of NRHM.

VII: Research Questions

The study has attempted to answer the following research questions:

(1) What are the basic components of NRHM implemented in Mizoram?

(2) What are the administrative structures and mechanism involved in the process of implementation of NRHM?

(3) What are the measures adopted for improving the health of the people?

(4) What are the major challenges faced in the implementation of the NRHM?

(5) What measures can be taken to improve the implementation of the NRHM?

VII: Methodology

The study had adopted mixed method. Field study and data collection were done through key informant interviews, questionnaire structured format which are descriptive in nature on one hand, while the district specific data related to NRHM which are empirical in nature are acquired through the different annually prepared Program Implementation Plan (PIP) and the Monitoring Information System maintained by the District Program Management Unit (DPMU) as well as the State Program Management Unit (SPMU).

Purposive stratified random sampling method was used to represent the respondents/beneficiaries, community workers, employees of NRHM as well as public and other health personnel from NGO or private. Secondary data were collected from different sources such as books, magazines, articles and journals, PIPs, HMIS etc. as mentioned in the previous segments.

VIII: Chapterization

The entire study is divided into seven Chapters.

The first Chapter is introductory which deals with the basic background information of the state, vital information related to socio-demography, climate and a focused description of the meaning and importance of health care in general and specifically to Kolasib district within the ambit of NRHM. It also includes the concept of National Rural Health Mission in India, review of literature, objectives of the present study, research questions, area of the study and method of data collection. It also contains a brief profile of the state of Mizoram as well as Kolasib District within which the present study will be concentrated.

The second Chapter deals with the conceptual study of Health care Administration, policies and development in India. It discusses in detail the concept of health care administration which includes community based Primary health care, Maternal health, Antenatal care, health education and health promotion. It also includes challenges for health services in developing countries.

The third Chapter traces the origin and historical background of NRHM in India under the sub heading of Health prior to British rule, Health during the British rule and Health in Post-Independent India. It also includes the five main approaches of NRHM and discusses the objectives, vision, strategies, implementation framework and plan of action, and financing of NRHM.

The fourth Chapter deals with the organizational structure and working of NRHM in Mizoram, introduced by the Central Government. It traces the history of Health Department of Mizoram and their functions according to Government (Allocation of Business) Rules, 1987 and also about the health system conceptual framework for Mizoram;

In the fifth Chapter, an attempt has been made to assess the implementation and monitoring machinery of NRHM by highlighting the fund flow under the NRHM budget and the importance of regular supervision of the Mission activities for its successful implementation.

The sixth Chapter deals with the field finding analysis of NRHM in Kolasib district of Mizoram. It provides results and discussion in relation to the data analysis of the empirical research and its findings. The research questions were developed to make the objectives of the research to form the major part of this chapter. An analysis of the data received from the respondents has been presented.

The seventh Chapter is a concluding Chapter which has brought out the summary and findings of the study. It has also made some suggestions for the improvement of the organizational set-up of NRHM, the implementation of which would enable the district level machinery to implement the mission in a more effective manner.

IX: Relevance of NRHM:

Till date, the importance of addressing the needs of important public administrative reforms or study within the context of public health has seemed to be inadequately addressed as assessed through the first interaction with the key officials

of the Health department at the hypothetical stage of this study. From the front line workers to the Ministers in charge including the top bureaucrats and technocrats, the realities on the ground is quite different from what are seen in the reports and publications. Public Health being one of the most critical element of development and progress and, NRHM/ NHM being the driving seat for this crucial sector of the society and government at large has not undergone any positive quantum leap even within the last two decades and, given the importance of public administration within the ambit of public health, it is imperative that unless and until an in-depth study or analysis and a pathway is established the 'status quo' of the program can neutralize even such an ambitious and expeditious investment quite far away from its original goals and objectives.

X: Importance of NRHM:

In rural areas, it is very important to note that-

i) Infectious diseases continue to be a major cause of death and disease.

ii) Such infectious diseases are preventable in many cases.

iii) The major cause of disease and death continues to be malnutrition.

iv) Women continue to have greater rates of morbidity and mortality than men.

v) Neglect of the girl child, as well as her poor health and nutritional status, are all too common.

vi) The prevalence of underweight children under the age of three years in rural areas is 24 per cent, compared to 21 per cent in urban areas, which is equally alarming[14].

It is evident that the health situation in rural areas continues to be far from satisfactory, and it results in major draw-back in developmental work. The National Rural Health Mission (NRHM) is the key instrument of intervention by the Central

[14] https://www.yourarticlelibrary.com/nrhm/national-rural-health-mission-nrhm-aims-components-and-importance/66677

Government. The goal is to establish a fully functional, community owned, decentralized health delivery system.

CHAPTER – II

HEALTH CARE ADMINISTRATION: A CONCEPTUAL STUDY

I Health and Health care

Health and health care need to be distinguished from each other because the former is frequently incorrectly seen as a direct function of the latter. Health is not the mere absence of disease. Good health confers on a person or group's freedom from illness - and the ability to realize one's potential. Health is, thus, best understood as the indispensable basis for defining a person's sense of well-being. The health of populations is a distinct key issue in public policy discourse in every mature society, often determining the deployment of a huge society. They include its cultural understanding of ill health and well-being, the extent of socio-economic disparities, the reach of health services and quality and costs of care, and current biomedical understanding of health and illness[15].

Health care covers not merely medical care, but also all aspects of preventive care too. It is the maintenance or improvement of health through prevention, diagnosis, treatment, amelioration, or cure of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields. Medicine, dentistry, pharmacy, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, athletic training and other health professions are all part of health care. It includes work done in providing primary care, that refers to the work of health professionals who act as a first point of consultation for all patients within the health care system and, tertiary care which is specialized consultative health care usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital as well as in public health.

Providing health care services means the timely use of personal health services to achieve the best possible health outcomes. It cannot be limited to care rendered by

[15]http:// www.niti.gov.in/planningcommission.gov.in/docs/reports/genrep/bkpap2020/26_bg2020.pdf

or financed out of public expenditure - within the government sector alone but must include incentives and disincentives for self-care and care paid for by private citizens to get over ill health. Where, as in India, private fund expenditure dominates the cost of financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot, therefore, be left to be regulated solely by the invisible hand of the market and cannot be established on considerations of utility-maximizing conduct alone[16].

II Health care administration

Health care administration is the management of all the non-clinical functions involved in operating a healthcare facility, from day-to-day operations to staffing to budgeting and finance to long-term strategic planning to ensure the success of the health care provider or system. One can think of health care administration as the process of managing and handling every aspect of the business side of delivering healthcare services. Health care administration represents an essential component of the healthcare industry, ensuring the efficient and coordinated delivery of health services, and the effective management of hospitals and other health care facilities. In addition to working for hospitals and clinics, healthcare administrators are also often found working for consulting firms, bio-pharmaceutical companies, and insurance companies. It is a field related to leadership, management, and administration of public health systems, hospitals, and hospital networks.

Health care informatics and health care management are the part of health care administration degree program. Health administration is under the supervision of a group of individuals called health administrators. Health care administration is a profession that deals with the provision of leadership, guidance and management in health systems. With many health facilities putting professionals with advanced degrees in health care administration into top leadership positions, the pressure to deliver quality services is increasing. A hospital administrator's main objective is to create a work environment that treats patients in the most effective and financially

[16] https://www.en.wikipedia.org/wiki/Health_care

responsible way possible. Health care administration involves understanding that ignoring diversity and providing culturally incongruent nursing care can adversely affect patient outcomes and jeopardize patient safety. They work toward helping doctors and nurses learn to appreciate and overcome issues stemming from cultural diversity, such as language barriers. To achieve this, the hospital administration sets its sights on improving diversity awareness through creating working environments that embrace diversity among health care employees and promote multicultural workplace harmony[17].

The responsibilities of health care administration professionals differ from facility to facility. In a large hospital system, a health care administrator may oversee a specific department. In contrast, a health care administrator who works for a small private medical practice might handle the entire facility's administrative needs.

Professionals who work in health administration may handle any or all of the following tasks:

i) Coordinate staff schedules

ii) Create short- and long-term goals

iii) Develop and approve facility policies related to HR and operations

iv) Find ways to streamline operations and reduce expenses

v) Liaison with doctors, nurses, and lab personnel

vi) Manage non-medical staff

vii) Department budgets

viii) Monitor regulatory compliance

ix) Oversee general operations and facilities management

[17] https://www.healthcareadministrationedu.org/what-is-health-and-medical-administration/

x) Oversee marketing

xi) Recruit, train, and mentor new staff

xii) Represent the facility at board meetings

xiii) Track facilities and service use

xiv) Track and analyze patient outcomes

Health care administration has become a fundamental approach to introduce healthcare professionals to the main responsibilities at various ranges of scopes and enable them to manage their healthcare facilities in an effective way. This requires more understanding of the growing and changing health care industry, besides focusing on building more critical and analytical thinking and getting in line with all external and internal factors-

i) Health care administration is about the future leaders of the twenty-first century who take into consideration the combination of business knowledge, technical knowledge, hospitality knowledge, and health care knowledge, to lead and successfully manage their health care organization[18].

ii) Health care administration addresses a large scope of settings and services, ranging from a single physician office to polyclinics, network of hospitals, home care, nursing home, hospice care, continuing or long-term care.

iii) Health care administration is about connecting the dots between what has been learned, applying the acquired knowledge on the job itself. It is about complying with local, state and federal laws and regulations, creating an ethical dynamics environment, setting standards of care at every diagnostic or therapeutic procedure, and integrating technological enhancements. Moreover, health care administration emphasizes on the enhancement of building capacities through the professional development of health care providers, who are responsible for providing

[18] https://www.noodle.com/articles/what-is-healthcare-administration

the best quality of care, to ultimately attain efficient and effective health care services, by avoiding misuse, overuse, and underuse of the resources.

iv) To function as health care facility of any kind whether a solo practice or group practice, small hospital or a big hospital, two groups of personnel are required; the clinical personnel and the administrative one. Clinical personnel include those individuals who are trained to work directly with the care of patients within the health care facility in order to provide diagnostics, preventive, and therapeutic care; such as physicians, nurses, therapists, and technicians. Whereas the administrative personnel are those non- clinical staff members who are complementing the provision of health care, by providing non-clinical services such as Admission department, Medical records department, Marketing department, Financial department and other departments related to administrative work.

v) All health care administrators should be aware of the current and future challenges facing the health care industry, to be well prepared to handle wide range of aspects related to the business in healthcare. Such challenges are determined by technological innovations, organizational behaviour, compliance strategies, health care financing, health information management, human resource management, the physical environment, and facility management.

vi) Since the needs for health care services have been expanding over the recent decades, the way the individuals are using the resources available (Utilization) has also changed. For example, the expansion of preventive medicine services and techniques have a dramatically prolonged the lifespan of patients. Early detection of diseases followed by proper and instant interventions helped the individuals avoid invasive tertiary health care and post complications.

vii) The utilization of health care services can be increased or decreased by diverse scope of factors such as demographic changes, public awareness, technology, changes in consumer preferences, new diseases, new discoveries in medicine, introducing non- traditional healthcare services such as ambulatory care, and changes in the practice pattern (invasive vs. non- invasive procedures).

viii) The table 2.1 shows factors that decrease or increase health services utilization[19].

Table 2.1: Factors that decrease or increase health services utilization

Factors that may Decrease Healt Services Utilization	Factors that may Increase Health Service Utilization
1. Decreased supply (e.g., hospita closures, large numbers of physician retiring).	1.Increased supply (ambulatory surger centres, assisted living
2. Public health / sanitation advances (e.g., quality standards for food and water distribution). Better understanding of the risk factors of diseases and prevention initiatives (e.g., smoking prevention programs, cholesterol lowering drugs).	2. Growing elderly population: - More functional limitations associated with aging. - More illness associated with aging. - More deaths among increased number of elders.
3. Discovery / the implementation c treatments that cures or eliminate diseases.	3. New procedures and technologies (e.g hip replacement, stent insertion, MRI).
4. Consensus documents or guideline that recommend decrease of utilization.	4. Consensus documents or guidelines tha recommend increase of utilization.
5. Shifts to other sites of care may cause decline in utilization in the original sites: As technology allows shifts (e.g., ambulatory care) as alternatives sites of care become available (e.g., assisted living).	5. New disease entities (e.g., HIV / AIDS, bio terrorism).
6. Payer pressure to reduce costs.	6. New drugs, expanded use of existing drugs Increased health insurance coverage.
7. Changes in consumer preferences (e.g., home birthing, more self-care, alternative medicine).	7. Consumer / employee pressures for more comprehensive insurance coverage. Changes in practice patterns (e.g., more aggressive treatment of the elderly). Changes in consumer preferences and demand (e.g., cosmetic surgery, hip and knee replacement, direct marketing of drugs

[19] http://www.ebsedu.org/blog/operational-aspect-healthcare-facility/

The role of a health care administrator is essential in managing any health care facility. Health care administrators should structure and execute a cohesive strategic plan by analyzing data and identifying the trends of improvements to maintain a well-designed process that is easy to follow and improve. This will ultimately ensure both efficient and effective delivery of health care services. The former is related to the best use of resources by minimizing the waste of time, energy and costs. The latter is related to achieving best-desired outcome addressed by patient's improved health status and patient satisfaction.

Four criteria may be suggested for a just health care system as ideal –

i) Firstly, universal access and access to an adequate level, and access without excessive burden.

ii) Secondly, fair distribution of financial costs for access and fair distribution of burden in rationing care and capacity and a constant search for improvement to a more just system.

iii) Thirdly, training provides for competence empathy, accountability, the pursuit of quality care, and cost-effective use of the results of relevant research.

iv) Last but not the least; special attention should be given to vulnerable groups such as children, women, the disabled, and the aged.

Health care is viewed as the provision of a range of health care services by professional, technical, and supportive health workers, within-patient, out-patient, and home health facilities. The development of health care facilities is influenced not only by the opening of hospitals or healthcare centres, but more so by their proper administration and management. Health care has been defined by the WHO as 'A programme that should make available to the individual and thereby to the community, all facilities and allied sciences necessary to promote and maintain the health of mind and body'. Health care remains one of the most important human endeavours to improve the quality of life. The main objective of any health care system is to facilitate the achievement of optimal level of health to the community through the delivery of services of appropriate quality and quantity. Increasing the

availability, accessibility, and awareness about the services and technological advances for the management of health problems, raising expectations of the people, and the ever-escalating cost of health care are some of the challenges that the health care systems have to cope with. Health care delivery systems will have to gear up to take up necessary preventive, curative, promote, and rehabilitative health care for the population. The challenge of building rural health services, the state's responsibility in providing these, and training paramedical personnel to carry out limited curative and preventive responsibilities were part of India's development thinking before and after independence. The rising expectations of health care users mean that the way the services are organized and delivered will become significant. It is, therefore, essential to understanding how best to organize and deliver health care services[20].

The concept of a health centre was first brought by Lord Dawson in England in 1920. As early as 1928 Govt. of Mysore established the first health unit in the country at Mandya (in Karnataka). The establishment of health centres at Nazafgarh, Singur, Poonamallie, Trivandrum, Lucknow, and other places in collaboration with the Rockefeller Foundation and Govt. of India between 1931 and 1939 was an important landmark in the history of the health care delivery system.

Community-based primary health care is the mainstay of health care delivery to persons in developing countries. In these countries, primary care must be accessible to the vast majority of the population as poor access to primary health care is associated with adverse pregnancy outcomes, infant mortality, and decreased vaccination coverage. Inaccessibility of health care facilities may also affect adherence to treatment regimes. Access to health services in the developing world is poor, but it gets significantly worse in rural areas[21].

World Health Organization (2009) in its study on increasing access to health workers in remote and rural health areas found that there is more of a problem of geographical mal-distribution rather than a lack of physicians. The movements of health workers in general, such as turnover rates, absenteeism, unemployment, or

[20] http:// www.docplayer.net/89414832-Ugc-university-grants-commission-journal-no-48996.html
[21] http:// www.who.int/news-room/feature-stories/detail/primary-health-care-around-the-world-delivering-health-services-to-people-where-they-need-it

dual employment correlate with the factors influencing the choices and decisions of health workers to practice in remote and rural areas and the categories of interventions that could respond to those factors. The deepest concerns of health workers when it comes to practicing in remote and rural areas are those related to the socio-economic environment, such as working and living conditions, access to education for children, availability of employment for spouses, insecurity, and work overload[22].

Finding strategies to make health services in developing nations more customer-focused is a major challenge. Assessment of patient perspectives gives users a voice, which, if given systematic attention, offers the potential to make services more responsive to people's needs and expectations, important components of making health systems more effective. Indifferent treatment of patients and inadequate provision of medicines and supplies are common. Studies have revealed that user perceptions of quality are susceptible to health care consumption, a long-standing issue for many developing nations.Because of these factors, evaluating the quality of healthcare increasingly heavily relies on patient views of health services. The limited user perception studies that have been done in developing nations have demonstrated that patients are capable of evaluating structural, procedural, and outcome measures of quality. Due to the growing need for patient-centered care, which is expected to result in better patient outcomes and ongoing use of treatment, research has focused on patient perceptions of quality. Provider assurance, discipline, communication, and responsiveness were all linked to patient satisfaction. The measurement of perceived quality is further justified by the significant impact that these perceptions have on developing countries, where quality is one of the primary concerns to be addressed under the present health care reforms. For these reasons, patient perceptions of health services are now an important part of quality assessment in health care. The few studies on user perceptions conducted in developing countries have shown that patients can evaluate structural, process, and outcome measures of quality. Patient perceptions of quality have been a focus of research due to the increasing need to provide patient-centred care, with the expectation that such care would lead to better

[22] Ibid

patient outcomes and continued use of care. Patient satisfaction was associated with providers' responsiveness, assurance, communication, and discipline. In developing countries, where quality is one of the major challenges to be met under the current health care reforms, the measurement of perceived quality is also justified by the powerful influence that these perceptions have on utilization of services. Surprisingly, little research has been done on patients perceptions of quality in India.[23].

Previous research has demonstrated a relationship between patient's satisfaction is related to age, health status, and education.When compared to their peers, older patients are typically more satisfied with their healthcare services, while highly educated individuals are typically less so.Another important consideration is one's state of health. Patients with better general health had higher levels of satisfaction. Real and perceived waiting times have also been demonstrated to have an impact on patients' satisfaction. Patient-centeredness is another facet of quality; the extent to which patients are involved in decision-making as well as their level of engagement are directly related to their level of satisfaction. The amount of time patients spend with their doctor is also highly correlated with overall satisfaction. Receiving information has an impact on overall patient satisfaction.

In the developing country, access to quality health care is limited and people depend on providers who have limited training or supervision, often from the private sector.A number of studies have suggested that improving the quality of services can increase utilization in low-income countries, but public providers often lack the resources and systems to encourage high-quality services. The poor may prefer private and unqualified providers because they may be more accessible, affordable and responsive to their needs, even if the technical quality of care is questionable. The outcome is that many people's health conditions are inappropriately treated. Many students have been made in developed and developing country health delivery systems to try assess whether health services met acceptable levels of quality.

[23] https:// www. Jstor.org/stable/45127241/

Different methods have been used in developed and developing countries health delivery systems to try to assess whether health services meet acceptable levels of quality. These include record review or audits, interviews with health care providers, written and oral exams, focus groups and interviews with patients, and direct observation of the delivery of the services. Although these methods are used frequently, there has been little empirical research on their validity in measuring the quality of health worker's performance in delivering primary health care services.

III Maternal and Child healthcare

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health, and even death. Most maternal deaths and pregnancy complications can be prevented by quality ante-natal, care during the delivery period and postnatal care.

Antenatal care is the 'care before birth' to promote the well-being of mother and foetus, and is essential to reduce maternal morbidity and mortality, low-weight births, and perinatal mortality. However, the content and quality of antenatal care and the availability of effective referral and essential obstetric care are important for antenatal care to be effective.

Antenatal care is generally aimed at producing a healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with several interventions that may be vital to their health and well-being and that of their infants. The antenatal care period also provides a forum to supply information that may positively influence maternal and child outcomes. Thus, it has been suggested that antenatal care could play a role in reducing the maternal mortality rate and that it could ensure that pregnant women deliver with the assistance of a skilled attendant. Most maternal deaths and pregnancy complications can be prevented by quality antenatal, natal, and post-natal care.

IV Maternal and Child Health Care Services delivery

In recent years, developing countries influenced by finding on developed countries, have become increasingly interested in assessing the quality of their health care. Outcomes have received emphasis as a measure of quality.Assessing outcomes has merit as an indicator of the effectiveness of different interventions as part of a monitoring system directed to improving the quality of care. Quality assessment studies usually measure one of three types of outcomes: medical outcomes, costs, and client satisfaction. For the last mentioned, clients are asked to assess not their status after care but their satisfaction with the services delivered.

Most maternal deaths are avoidable, as the health care solutions to prevent or manage complications are well-known. All women need access to prenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. All births must be attended by skilled health professionals, as timely management and treatment can make the difference between life and death.

Health care services are not reaching their programme goals because of poor utilization. Provision and utilization can only be brought into balance if there is an understanding of people's health-seeking behaviour and the felt needs of communities.

V Health education and health promotion

Health education is widely promoted in primary care, but there have been few rigorous evaluations of its impact, especially in developing countries. The efficacy of health education interventions should be examined before being widely deployed because the effectiveness of those that rely solely on giving people to bring about a change in health behaviour is improved. Alternative strategies for health promotion in poor nations, such as interactions within families, peer groups, or communities, may be more successful but are more expensive and challenging to put into practise on a wide scale.

According to Alma Ata's proclamation of 1978, the rational approach to health promotion, the information was given by health workers during clinic-based or community-based contacts that will bring about a change in health behaviour and is an integrated part of primary health strategies. In practice, opportunities for one-to-one health education are given low priority by busy health-workers. Health education and information is critical for ensuring people's participation in rural health service.

VI Social marketing of health programmes for public health

Social marketing, the use of marketing to design and implements programmes to promote socially behaviour change, has grown in popularity and usage within the public health community.Social marketing is the use of marketing principles to design and implement programmes that promote socially beneficial behaviour change. Contrary to the marketing of consumer goods, social marketing does not deal with material products, but with 'behaviour', e,g. immunization for infants or children. This 'product' has a basic benefit (i.e. reduction of health risks in the long run), which is, however, difficult to convey. Therefore, the intended change in behaviour has to be related to a further reward which consists of symbolic goods, e.g. social appreciation or a better body feeling. Social marketing uses commercial marketing strategies to change individual and organizational behaviour and policies.. It has been effective on a population level across a wide range of public health and health care domain.

CHAPTER III

NRHM IN INDIA: BACKGROUND

Health is of vital importance for the improvement and development of a nation. The term 'health' should not only be understood as the mere absence of illness and diseases. It is, in fact, a state of complete and harmonious functioning of the body and the mind, mental, physical and social well-being that enables an individual to fully explore his potentiality and talent and allow him to enjoy and take advantage of the opportunities available to him as a person and as a citizen of a nation and also to fulfil his obligations and responsibilities in the family, in the society and in the nation. . Health is, thus, best understood as the indispensable basis for defining a person's sense of well-being. Good health of people is not only a desirable goal, but also an essential investment in human resources. It is very difficult to define and conceptualize health. The widely accepted and popular definition of health is given by World Health Organization (WHO). According to it 'Health is a fundamental human right inclusive of physical, mental and social well-being and not merely absence of disease or infirmity[24].

I Indian Health Scenerio

When it comes to the idea and planning of providing all of its residents with comprehensive, integrated primary health care, India has led the way. As the second most populous country in the world, it must alter the socio-political-demographic and morbidity patterns that have captured the attention of the globe in recent years. The government has implemented a number of growth-oriented initiatives, but the health sector is facing challenges due to the growing economic, regional, and gender inequities. Approximately two-thirds of the population resides in metropolitan regions, which are home to 75% of the health infrastructure, medical personnel, and other health services.

[24] K. Park, Parks Text Book of Preventive and Social Medicine, Banarsidas Biianot,2007, Jabalpur, pp 12-15

When it comes to designing and implementing comprehensive, integrated primary health care for all of its people, India has led the way. The nation, which is the second most populous in the world, has to alter the socio-political-demographic and morbidity patterns that have garnered attention from around the world lately. The health sector is facing issues due to growing economic, regional, and gender imbalances, even with the government implementing various growth-oriented programs. In urban areas, where 27% of the population resides, there is a concentration of around 75% of health infrastructure, medical personnel, and other health resources. Particularly in rural areas, infectious, waterborne, and contagious diseases like pneumonia, whooping cough, worm infestations, diarrhoea, amoebiasis, typhoid, infectious hepatitis, measles, malaria, and tuberculosis predominate in terms of morbidity patterns. At the same time, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents, and injuries are also on the rise.

There is still great cause for concern regarding the health of Indians, particularly with regard to the rural population. Though significant progress has been made over time, this is still evident in rural regions as evidenced by the life expectancy of 63 years, the infant mortality rate of 80/1000 live births, and the maternal mortality rate of 438/100 000 live births. The issue of rural health must be approached holistically at all levels, from the macro (national and state) to the micro (district and regional), in order to ameliorate the current state of affairs. There is currently a need for a paradigm change from the existing "biomedical model" to a "sociocultural model," which should close the gaps and enhance rural living conditions. A redesigned National Health Policy that tackles the current disparities, mainly for rural health, is imperative[25].

[37]https://www.pubmed.ncbi.nlm.nih.govt/19700794/

II Health prior to British rule

Hospices in India have existed from the ancient times. Even during the time of Buddha in 6th century BC, there were a number of the hospitals to look after the handicapped and the poor. At the time of Buddha, the most outstanding hospitals in India were those built by King Ashoka (273–232 BC). The books written by the Arabian and European travelers in around AD 600, reveals that the study of medicine in India was in its bloom. The enthusiasm of the native vaidyas for the investigation of the Indian flora loosened for want of encouragement. Physical and mental ingredients of positive health were a genuine concern of people in the Vedic period. Lord Buddha himself took very acute interest in supporting the science of medicine. However, Indian surgery a setback during this period because of the doctrine of Ahimsa. Lord Buddha used to attend to himself as to look after the sick was treated as a noble cause throughout this period. During the course of his travel for propagating Buddhism, Buddha created Buddhist Viharas (monasteries) in different places, and in all the Viharas, care of the sick and medical education was given special attention. Emperor Ashoka established many hospitals throughout the country. With the advent of Muslim rule from the 10^{th} century onwards, Middle East physicians trained created their impact.The main impact was curative approach. Emperor Akbar (1555–1605), during his period, encouraged the amalgamation of the Unani and Ayurvedic systems. The m achievement was the translation of medical texts in Arabic, then into Persian and later into Urdu.

III Health during the British rule

The invasion of India by foreigners in the 10th century AD brought with them their own physicians called Hakims. With the arrival of European missionaries in the 16th century, the practice of Allopathic system of medicine started in India. It was during the British rule that there was improvements in the construction of hospitals and organized medical training was started in the 19th century. It was the French and the British who later established the first hospitals 1664 and 1668, respectively, while the Portuguese first brought modern medicine to India.

In Calcutta, the first medical school in India was started , followed by Madras in 1846. Along with the spread of British rule over India, local governments encouraged establishment of dispensaries at subdivision and district level. At provincial levels the hospitals were converted into teaching hospitals attached to medical colleges. In 1885, there were 1250 hospitals and dispensaries in British India . In 1943, the Government of India appointed a Committee called the Health Survey and Development Committee headed by Sir Joseph Bhore and having nineteen other members. This is the only authentic record depicting hospital development and health care system in pre-independence India, that is, before 1947. The report was submitted in 1946. The report recommended upgrading of medical care in a various forms, such as medical relief in the form at thr village level, secondary health centres at the sub-division level (Taluka level), and district hospitals at district headquarters, with all the specialist services. Bhore Committee had stated in their report that the health service should be available to all citizens, irrespective of their ability to pay for it and it should be complete medical service, domiciliary and institutional, in which all the facilities required for the treatment and prevention of disease as well as the promotion of positive health are provided. The efforts of health administrations at earlier stages were directed towards the alleviation of suffering and rehabilitation of the sick. The idea of prevention came later, partly as a result of the observation were often communicated from a patient to those in close association with him. The concept of the sick and infection control started. The development of modern sciences brought to the forefront the importance of specific organisms as the causative agents for individual diseases. The importance of

environmental hygiene was felt and the coordinated effort of prevention, treatment, and rehabilitation brought out more desired results.. The then Government took certain steps which are important landmarks in the history of health administration in India. They are as follows:

i) The appointment of Royal Commission to enquire into the health of the Indian Army in 1859.

ii) The report of Plague Commission in 1904 following the outbreak of plague in 1896.

iii) Reforms introduced by Government of India Act for Health, 1919.

iv) Reforms introduced by Government of India Act for Health, 1935.

The above reports and Acts created top posts of various categories in the central and state governments, respectively. The Government of India Act of 1919 gave statutory sanction to decentralize the health administration, including medical administration, hospital administration, etc.The Act of 1935 further passed larger autonomy to provincial legislatures.The Centre further passed some legislation, such as the Quarantine Act 1825, the Vaccination Act 1880, the Medical Act 1886, the Epidemic Diseases Act 1897, the Indian Factories Act 1911, the Poisons Act 1919, the Indian Red Cross Act 1922, the Dangerous Drugs Act 1930, the Indian Port Health Rules 1938, the Indian Air Craft Public Health Rules, etc.to streamline health administration.

IV Health in Post-Independent India

After remaining under foreign domination for more than 150 years, India became an independent nation in 1947. The economic, social, religious, and political exploitation during the period of foreign domination was beyond comprehension. While independence brought delights and joy on the one hand, it also faced problems like population explosion, retarded economic development, mass illiteracy, and multilingual problems, etc. The Government of India set up the Planning Commission in 1950 to prepare a plan for the most effective and balanced utilization

of the country's resources. Health being a state subject led to every state having its own plan.Since health is a state concern, each state has its own strategy. However, the main thrust of the Centre was to start the Community Development Programme and National Extension Movement. The Community Development Programme pledged itself toward self-help. The concept of democratic decentralization adopted by the government theoretically shifted the responsibility for health to the people themselves, through the Panchayati Raj system, In actual practice it was a failure, except for the opening of 725 Primary Health Centers and some effect on control of communicable disease. In course of time, when the government found that recommendations of Bhore Committee (1946) were too ambitious, it set up the Health Survey and Planning Committee, popularly known as Mudaliar Committee, in 1959. This Committee was set up with the following aims:

i) To assess the progress in the field of medical relief and public health service since the submission of the Bhore Committee report.

ii) To review the progress of First and Second Five Year (Health Projects).

iii) To formulate recommendations for the future plan of health Department in the country.

The Health Survey and Planning Committee submitted its report in 1961. This report was submitted some fifteen years after the Bhore Committee and ten years after the introduction of programmed systematic development in the form of Five Year Plans. The result of systematic approach towards health care development programme has paid dividends in the field of control of epidemic diseases like the plague, cholera, malaria, and the eradication of smallpox, a methodical approach to health care development programmes has paid off. India has achieved many spectacular results in the field of health since independence[26].

The current health policy and systems have evolved from the Report on the Health Survey and Development Committee, commonly referred to as the Bhore

[26] S.A Tabish, (2000). Historical Development of Health Care in India. In book: Hospital &Health Services Administration: Principles & Practice pp.23-28

Committee Report, 1946 under the chairmanship of Sir Joseph Bhore, the Indian government resolved to focus health care delivery services on rural people which has been a landmark report for India[27]. The Report gave importance to social orientation of health care services community participation in public health care delivery mechanisms. The principles on which the current public health care systems were started from the recommendation for a three tiered health care system to provide preventative and curative health care in rural and urban areas, placing health workers on government payrolls and limiting the need for the private practitioners to make certain that access to primary care is independent of individual socio economic conditions. But a simultaneous evolution of the private health care systems with a constant and gradual expansion of private health care services is a result of lack of capacity of public health systems to provide access to quality care[28].

The first National Health Policy of India (NHP) was formulated in 1983 with the main objective of provision of primary health care to all by 2000 while the first national population programme was declared in 1951[29]. The NHP highlighted the setting up of a system of primary health care services through health volunteers and simple technologies creating a well-established referral systems and an integrated system of special facilities. The NHP 2002 further built on the NHP 1983, with an objective of providing health services to the general public through decentralization, use of private sector and increasing public expenditure on health care overall[30] It also stressed on the growing use of non-allopathic form of medicines such as ayurveda, unani, and siddha, and a need for strengthening decision-making processes at decentralized state level.

The areas of governance and operations of health system in India have been divided between the union and state governments owing to India's federalized system of government. It is the responsibility of the Union Ministry of Health &

[27] Ma S, Sood, N.A (2008), Comparison of the Health Systems in China and India. Rand Corporation: CA, USA.
[28] Peters DH, Rao K.S, Fryatt, R. (2003). Lumping and splitting: the health policy agenda in India. *Health Policy Plan 18*(3):pp 249–260. DOI: 10.1093/heapol/czg031
[29] Ministry of Health and Family Welfare(1983) National Health Policy https://www.nhp.gov.in/ sites/ default /files/pdf/ nhp1983.pdf
[30] https://www.nhp.gov.in/sites/default/files/pdf/nhp1983.pdf

Family Welfare to implement the various programmes on a national level in the areas of health and family welfare, prevention and control of major communicable diseases, promotion of traditional and indigenous systems of medicine, and setting standards and guidelines that state governments can adapt. The Ministry helps the states in the prevention and control of the spread of seasonal disease outbreaks and epidemics through technical assistance.As health comes under the state subject, the areas of public health, hospitals, sanitation and so on comes under the purview of the state. But, the areas which have wider ramification at the national level like family welfare and population control, medical education, the prevention of food adulteration, and quality control in manufacture of drugs, are administered jointly by the union and the state government[31]. India has both public and private health care service providers but most of the private health care providers are concentrated in urban areas providing secondary and tertiary health care services. The public health care infrastructure in rural areas has been developed as a three-tier system based on the population norms.

Over the last few years, India has recorded substantial progress in improving the lifespan at birth along with reduction of infant and maternal mortality. But, a high proportion of the population living in rural areas continues to suffer and die from preventive diseases; pregnancy and child birth related problems as well as malnutrition. The country is facing arising pitfalls and challenges in addition to the old unresolved problems and due to the high cost of private sector health care, the rural public health care system is in a bad shape which leads to pauperization of poor households. Non-communicable diseases like cancer, psychological illness, cardio-vascular diseases, and blindness and tobacco use related ailments have imposed the chronic diseases burden on the already over-stretched health care system in the country. The large disparity across India places the burden of these conditions mostly on the poor and on women, scheduled castes and tribes especially those who live in the rural areas of the country. Public spending on health in India is amid the lowest in the world but its proportion of private spending on health is one of the highest.

[31] MOHFW. Annual Report 2012-2013

Persistent malnutrition, high levels of anaemia among children and women, low age of marriage and at first child birth, inadequate safe drinking water round the year in many villages, over-crowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Therefore, the country has to deal with multiple health crises, rising costs of health care and mounting expectations of the people. The challenge of quality health services in remote rural regions has to be met with a sense of urgency. Given the scope and magnitude of the problem, it is no longer enough to concentrate on narrowly defined projects. The critical need is to transform the public health system into an accountable, accessible and affordable system of quality services.

National Rural Health Mission (NRHM) is a mission of the Ministry of Health and Family Welfare (MH&FW), New Delhi. From the beginning of the post-independence period, MH&FW has planned and promoted a large number of activities at the national level to improve the standards of public health in India, with emphasis on preventive, promotive and curative aspects of health. However, the 21st Century is marked by a paradigm shift in health when a more aggressive, mission mode, approach to health is adopted. In the field of health two important things has taken place in India in the year 2000 itself. For the first time, Indian government announced the National Population Policy (known as NPP 2000), and India became one signatory among the 191 UN Member States to commit to Millennium Development Goals (MDG). The NPP 2000 had the following objectives:

i) Address the unmet demands for fundamental infrastructure, commodities, and services, supplies and infrastructure.

ii) Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 per cent for both boys and girls.

iii) Reduce infant mortality rate to below 30 per 1000 live births.

iv) Reduce maternal mortality ratio to below 100 per 100,000 live births.

v) Achieve complete immunisation of children against all vaccine preventable diseases.

vi) Delayed marriage for girls, not earlier than the age 18 preferably after 20 years of age.

vii) Achieve 80 per cent of institutional deliveries and 100 per cent of deliveries by trained persons.

viii) Achieve universal access to information/counselling, and services for fertility regulation and contraception with a wide basket of choices. Achieve 100 per cent registration of births, deaths, marriage and pregnancy.

ix) Combat the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.

x) Prevent and control communicable diseases.

xi) Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

xii) Promote vigorously the small family norm to achieve replacement levels of TRF.

xiii) Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centred programme.

Under MDG, there are eight goals that must be achieved by 2015 which overlap with the stated objectives of NPP and they are-

i) To eradicate extreme poverty and hunger;

ii) To achieve universal primary education;

iii) To promote gender equality and empower women;

iv) To reduce child mortality;

v) To improve maternal health;

vi) To combat HIV/AIDS, malaria, and other diseases;

vii) To ensure environmental sustainability; and

viii) To develop a global partnership for development.

In 2002 India announced the National Health Policy. This policy reflects the concern of MDGs. The NHP - 2002 may be called the forerunner of NRHM which was to start from 2005, The Twelfth Five Year Plan 2012–2017 and the Eleventh Five Year Plan 2007–2012 shows similar concerns with fast and inclusive growth, focusing on the lagging sectors and population.[32]

Under NHM, health interventions/ initiatives are regularly designed and implemented to address the healthcare needs of the country. A list of interventions currently being implemented under NHM to reduce IMR and MMR and the steps taken by the Government under the National Health Mission (NHM) to accelerate the pace of reduction in maternal mortality and infant mortality were-

i) Promotion of institutional deliveries through Janani Suraksha Yojana.

ii) Capacity building of health care providers in basic and comprehensive obstetric care.

[32] A.K.Sharma, Sociological Critique of the National Rural Health Mission: Issues and Priorities. pp289

iii) Operationalization of Sub-Centres, Primary Health Centres, Community Health Centres and District Hospitals for providing 24x7 basic and comprehensive obstetric care services.

iv) Name Based Web enabled Tracking of Pregnant Women to ensure antenatal, intranatal and postnatal care.

v) Mother and Child Protection Card in collaboration with the Ministry of Women and Child Development to monitor service delivery for mothers and children.

vi) Antenatal, Intranatal and Postnatal care including Iron and Folic Acid supplementation to pregnant & lactating women for prevention and treatment of anaemia.

vii) Village Health and Nutrition Days in rural areas as an outreach activity, for provision of maternal and child health services.

viii) Health and nutrition education to promote dietary diversification, inclusion of iron and foliate rich food as well as food items that promote iron absorption.

ix) Janani Shishu Suraksha Karyakaram (JSSK) entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick infants accessing public health institutions for treatment.

x) To sharpen the focus on the low performing districts, 184 High Priority Districts (HPDs) have been prioritized for Reproductive Maternal Newborn Child Health+ Adolescent (RMNCH+A) interventions for achieving improved maternal and child health outcomes.

xi) Emphasis on facility based newborn care at different levels to reduce child morbidity and mortality: Setting up of facilities for care of sick newborn such as

Special New Born Care Units (SNCUs), Newborn Stabilization Units (NBSUs) and Newborn Care Corners (NBCCs) at different levels is a thrust area under NHM.

xii) Capacity building of health care providers: Various training's are being conducted under NHM to train doctors, nurses and ANMs for essential newborn care, early diagnosis and case management of common ailments of children. These trainings are on Navjaat Shishu, Suraksha Karyakram (NSSK), Integrated Management of Neonatal and Childhood Illnesses (IMNCI), Facility Based Newborn Care (FBNC), Infant and Young Child Feeding practices (IYCF), etc.

xiii) India Newborn Action Plan (INAP) has been launched with an aim to reduce neonatal mortality and stillbirths.

xiv) Newer interventions to reduce newborn mortality- Vitamin K injection at birth, Antenatal steroids for preterm labour, kangaroo mother care and gentamicin injection to young infants in cases of suspected sepsis.

xv) Home Based New Born Care (HBNC): Home based newborn care through ASHAs has been initiated to improve new born practices at the community level and early detection and referral of sick new born babies.

xvi) Intensified Diarrhoea Control Fortnight (IDCF) to be observed in July-August 2015 focusing on ORS and Zinc distribution for management of diarrhoea and feeding practices.

xvii) Integrated Action Plan for Pneumonia and Diarrhoea (IAPPD) launched in four states with highest infant mortality (UP, MP, Bihar and Rajasthan)

xviii) Management of Malnutrition: Nutritional Rehabilitation Centres (NRCs) have been established for management of severe acute malnutrition in children.

xix) Appropriate Infant and Young Child Feeding practices are being promoted in convergence with Ministry of Woman and Child Development.

xx) Universal Immunization Programme (UIP): Vaccination protects children against many life threatening diseases such as Tuberculosis, Diphtheria, Pertussis, Polio, Tetanus, Hepatitis B and Measles. Infants are thus immunized against seven vaccine preventable diseases every year. The Government of India supports the vaccine programme by supply of vaccines and syringes, cold chain equipment and provision of operational costs.

xxi) Mission Indradhanush has been launched in 201 high focus districts to fully immunize more than 89 lakh children who are either not vaccinated or partially vaccinated; those that have not been covered during the rounds of routine immunization for various reasons. They will be fully immunized against seven life-threatening but vaccine preventable diseases which include diphtheria, whooping cough, tetanus, polio, tuberculosis, measles and hepatitis-B. In addition, vaccination against Japanese Encephalitis and Haemophilus influenza type B will be provided in selected districts/states of the country. Pregnant women will also be immunized against tetanus.

xxii) Mother and Child Tracking System (MCTS): A name based Mother and Child Tracking System has been put in place which is web based to ensure registration and tracking of all pregnant women and new born babies so that provision of regular and complete services to them can be ensured.

xxiii) Rashtriya Bal Swasthya Karyakram (RBSK) for health screening and early intervention services has been launched to provide comprehensive care to all the children in the age group of 0-18 years in the community. The purpose of these services is to improve the overall quality of life of children through early detection of birth defects, diseases, deficiencies, development delays including disability.

xxiv) Under National Iron Plus Initiative (NIPI), through life cycle approach, age and dose specific IFA supplementation programme is being implemented for the prevention of anaemia among the vulnerable age groups like under-5 children, children of 6 – 10 years of age group, adolescents, pregnant & lactating women and

women in reproductive age along with treatment of anaemic children and pregnant mothers at health facilities.

The Government of India is making efforts to provide health services to all the states across the nation by enforcing numerous programmes for achieving the target of 'Health for All' since the post independent periods. For improving the status of health, the then Honourable Prime Minister Manmohan Singh launched NRHM on 12th April, 2005 throughout the country. Therefore, Public Health being a state subject under the Constitution of India, NRHM has made considerable efforts towards providing both financial as well as know how assistance to states for eliminating the gaps existing in case of health infrastructure and workforce. Although the mission was implemented in all the thirty five states and Union Territories, special focus has been given on 18 states including eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan), eight North Eastern States (Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura) and the hilly states of Himachal Pradesh and Jammu & Kashmir. All the existing sectors relating to Reproductive and Child Health (RCH), National Program for TB, Malaria, and Blindness and Integrated Disease Surveillance were integrated into one unified mission NRHM .including eight Empowered Action Group (EAG) States, the North-Eastern States, Jammu & Kashmir and Himachal Pradesh. The Union Cabinet vide its decision dated 1st May 2013, has approved the launching of National Urban Health Mission (NUHM) as a sub-mission of an over-arching National Health Mission (NHM) with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

After giving approval to launch a NUHM as a sub-mission under the over-arching NHM by the Union Cabinet, the following proposals have been approved:

i) One Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population.

ii) One Urban Community Centre(U-CHC) for five to six U-PHC's in big cities.

iii) One Auxiliary Nursing Midwifes(ANM) for 10,000 populations.

iv) One Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households.

The purposes of NUHM is for the improvement of the health status of the urban population in general and in particularly for the slum dwellers and other vulnerable sections of the society by means of facilitating reasonable access to quality health care through a revamped primary public health care system, targeted services and involvement of the community and with the active participation of the urban local bodies. The funding pattern of the Center-State is 75:25 except for the North Eastern states and other special category states of Jammu and Kashmir, Himachal Pradesh and Uttarakhand for whom the funding pattern is 90:10[33].

The main objectives of the NRHM include reduction in child and maternal mortality, universal access for nutrition, water and sanitation prevention and control of communicable and non-communicable diseases, access to integrated comprehensive primary health care, population stabilization, revitalize local health traditions and mainstreaming AYUSH and creation of healthy life style. For the improvement and promotion of the availability of public health care services, the mission has given emphasis on core strategies like decentralizatio of village and district level health planning and management through involvement of Panchayati Raj institutions (PRI), appointing ASHAs for facilitating the access to health services, strengthening public health delivery services at primary and secondary level, improving management capacity to organize health system and services, improving intersectoral coordination as well as improving public private partnership (PPP) to meet national public health goals and lastly, providing social insurance to raise the health security for poor.

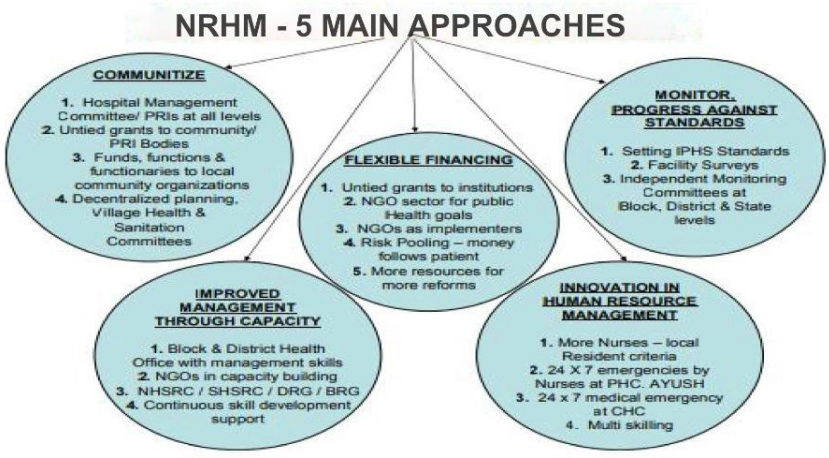
[33] https//www.upnrhm.gov.in

V: Implementation Framework and Plan of Action for NRHM

The crucial features in order to achieve the goals of the mission include making the public health delivery system completely fuctional and responsible to the community, human resources management, community invovement, decentralization, rigorous monitiring and evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators in achieving the mission's goals. Other important factors include human resource management, community involvement, decentralization, rigorous monitoring and evaluation against standards, and decentralization.

The diagrammatic representation of the five main approaches of NRHM is Illustrated in diagram 3.1:

Diagram 3.1: Five main approaches of NRHM



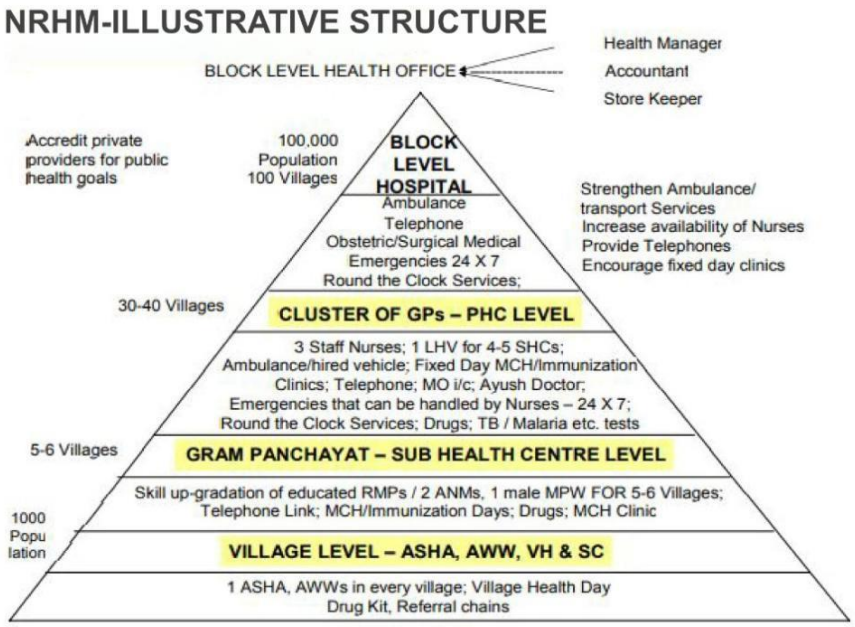
Source: *NRHM: Framework for Implementation 2005-2012*

Improving the Public Health Delivery

Given the status of public health infrastructure in the country, particularly in the EAG and the North Eastern States, it is possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing the current infrastructure and fresh construction or renovation wherever required. The mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The mission provide priority to both these aspects.

A generic public health delivery system envisioned under NRHM from the village to the block level is illustrated in diagram 3.2

Diagram 3:2 Public Health Delivery System



Source*: NRHM: Framework for Implementation 2005-2012*

Public Health Infrastructure

The Central Government has so far supported only the construction/ upgradation of sub-centres. Due to lack of financial conditions, the States are not provided sufficient funds for construction / up-gradation of Primary Health Centre (PHC)/Community Health Centre (CHC)/District Hospitals etc. As a result, health infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33% of the total NRHM outlay in case of high focus States and 25% in case of non-high focus States. NRHM also provides for upgradation of District Hospitals.

In the first Cabinet approval, provision had been made for setting up of Indian Public Health Standards (IPHS) only for Community Health Centres (CHCs)/ Primary Health Centre (PHCs). The Mission now provides for IPHS at all levels i.e., sub-centres PHC/CHC and district hospitals.

As per the original Cabinet approval in 4th January 2005, untied grants were to be made available only to sub-centres. However, the Mission today proposes provisions for untied funds at PHC/CHC/district levels. A provision for funds for taking up innovative schemes at district/State/Central level has also been implemented.

Having Rogi Kalyan Samitis for managing health facilities has already been approved by the Cabinet. Now funds would be released as untied funds to these Samitis as 100% grant by Government of India (GOI) during 2006-07, while it would be in the ratio 2: 2: 6 with regard to State / Internal / GOI from 11th Plan onwards.

The Mission also seeks to ensure the availability of requisite equipment and drugs at all the public health care facilities. Procurement of equipment drugs would be progressively decentralized and a road map prepared.

It has been proposed to improve outreach activities in un-served and under-served areas specifically in the areas inhabited by vulnerable sections through

provision of Mobile Medical Units (MMU) in every district under this proposal. The Mobile Medical Units (MMU) would also cover Anganwadi centres[34]

Improving Availability of Critical Manpower

The issue of availability of critical manpower in rural areas is proposed to be addressed through initiatives like introduction of a trained volunteer community health worker (ASHA) in every village of the 18 high focus states, Additional Auxiliary Nurse and Midwife (ANM) at each sub-center, three staff nurses at the Primary Health Centers (PHC) to make them operational round the clock and additional specialists and paramedical staff at the Community Health Centers(CHC). The condition of local residency is proposed to ensure that the staffs stay at their place of posting. In the North-East, keeping in view the difficulty in availing services of doctors and specialists, the emphasis is on recruitment, training and upgradation of locally recruited ANMs/nurses/midwives/paramedics. It is also proposed to supplement the availability of critical manpower across the States through contractual appointments/local level engagement of medical and paramedical manpower upgrading and multi-skilling of the existing medical personnel.

Innovations

Public private participation in service provision, franchise of service providers, licensing and training of Rural Medical Practitioners (RMPs), rationalization of existing manpower are few of the innovations/options already explored. Stringent monitoring at all levels, involvement of the PRIs and monitoring by the Rogi Kalyan Salmitis should ensure the presence of doctors and paramedics in the rural areas. Besides this, compulsory posting of doctors in the rural areas, better cadre management personnel policies are expected to help in improving manpower availability.

[34] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001. pp 6.

Capacity Building

In order to provide managerial support for tracking funds and monitoring activities under the Mission, provision has been made for setting up Programme Management Units at the State/District level. More than five hundred (500) professionals have already been recruited. The successful implementation of the Mission require health sector reforms and development of human resources. Capacity building at all levels is a huge challenge under National Rural Health Mission (NRHM). In order to achieve technical support to the Mission for this objective, National Health System Resource Center (NHSRC) at the Central level and State Health System Resource Center (SHSRC) at the State level have been set up with an annual corpus support of Rupees Fifteen (15) crore and Rupees One crore at the Central and State levels, respectively. The NRHM also emphasizes the setting up of fully functional Block and District level Health Management Systems. As under NRHM, 70% of the resources would be utilized at the block and below block levels and 20% at the district level. Given the large army of ASHAs, ANMs, nurses, and rural medication practitioners, continuous skill development is needed. Strengthening nursing institution, linking medical colleges for providing skill development support to rural health workers, involving the voluntary sector skill development are few key interventions that are taken up.[35]

To make the health facilities more accountable, their control would be gradually shifted to the PRIs and civSil society.The Sub-centres are proposed to be placed exclusively under the control of the Panchayat. The PHCs and CHCs are also to be managed by the Panchayat Block Samitis (PBS) and Rogi Kalyan Samitis (RKS).

[35] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001. pp 7.

Community Health Workers

As per the approval of the Cabinet's dated 4th January 2005, one female Accredited Social Health Activist (ASHA) is to be provided for every village with a population of 1000 (with provision for relaxation in the eight EAG States, Jammu & Kashmir, and Assam) in each of the high focus states. She would be the link between the community and the health faculty and would be the first person to call for any health related demand. Now under the Mission, it is proposed to have ASHAs in all the 18 high focus states. Besides, based on the recommendations of the Committee of Secretaries (COS) in its meeting held on 20.10.2005, it is also proposed to support ASHAs in tribal districts of all remaining districts as well, it would be possible for them to do so under RCH II, ASHA along with Anganwadi workers (AWW), the Auxiliary Nurse Midwife (ANM), Self Help Groups, and community-based organizations through combine organization of monthly Village Health, Nutrition and Sanitation Day at the Anganwadi centres would be expected to bring about perceptible changes in the health status of the community[36].

Convergent Action on Other Determinants of Health

The PRIs and large range of community-based organizations like Self-Help Groups, Schools, Water, Health Nutrition and Sanitation Committees, Mahila Samakhya Groups, and Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. Schools and anganwadis would form the base of these activities. NRHM provides for School Health Check-up and School Health Education to be worked out in consultation with the States. Convergence of programmes would be at the village and facility levels.

[36] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001. pp 7.

Decentralization

As the indicators of health depend much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach foe interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. The District Health Action Plan is the main instrument for planning, Inter-sectoral convergence, implementation and monitoring of the activities under the Mission. Rather than funds being allocated to the states for implementing programmes designed and approved at the GOI level, the states are encouraged to prepare their perspective and annual plan which in turn would be based on the district plans. Even though village is envisaged the primary unit for planning, looking at the extensive capacity building required before it would be in a position to take up the exercise, the Mission did not insist on the village plans at least during the first two years. The District Health Mission under the Zilla Parishad gets the district plan prepared covering health as the determinants of health. Household and Facility Surveys would define the baseline. Periodic surveys are therefore taken up on an annual basis to tract the improvements in the facilities as well as in the reduction in health indicators. The District Plans are then collated into a State Plan which is appraised and approved by the Mission at the national level. As far as the other determinants of health are concerned, the funds for them continue to flow through the existing channels but the District Plan brings out the convergent action being taken at the district level. NRHM recognizes that the delegations of financial and administrative powers at various levels are necessary for the successful implementation of the decentralized plans

Mainstreaming of AYUSH

Provisions has been made for state specific proposal for mainstreaming AYUSH, including appointment of AYUSH doctors/paramedics on contractual basis, providing AYUSH Wings in PHCs and CHCs. As envisaged under NRHM vision and goals, effort is being made to integrate AYUSH in primary health delivery

Flexible Financing

The programmes under the erstwhile Departments of Health and Family Welfare and Department of AYUSH were not being run in an integrated manner. As a result the transfer of funds to the states under different budget heads at different points of time vertically hampered flexibility. It also led to duplication of efforts and thereby wastage of scarce resources. For improved delivery, the Mission attempts to bring the schemes of the Ministry of Health and Family Welfare within the overarching umbrella of NRHM as approved by the Cabinet, Therefore, under the Implementation Framework, from the Eleventh plan onwards, it was proposed to have a single budget head for the activities under the Mission. This was meant to provide the States much needed flexibility to direct the fund to those areas where they are needed the most. However, a minimum amount is earmarked for various disease control programmes to ensure that the national objectives and commitments are met. The funds under the NRHM budget head flows through the integrated health society at the state and the district levels. The norms under which the funds are allocated by the center to the states and by the states to districts have been clearly spelt out in the Implementation Framework

Normative Framework

The District Health Action Plans are prepared based on a normative framework. The cost norms have been derived from three sources which are -

i) Firstly, the existing norms of the schemes brought under the umbrella of the NRHM.

ii) Secondly, the norms developed by NCMH and,

iii) Thirdly, the norms developed and approved as new interventions under NRHM.

Pro-People Partnerships with the Voluntary Sector

Investments by volunteer organizations are critical for tha success of NRHM. The Mission provides partnership with the voluntary groups/organizations for advocacy, building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, and working together with community organizations. It is proposed to provide friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols and training and upgradation of skills of non-government health providers. The five percent (5%) of the total NRHM outlay is proposed to be resource allocation to voluntary organizations on the basis of approved guidelines and norms[37].

Reducing IMR/MMR/TFR and the Disease Burden

Reproductive and Child Health Programme (RCH-II) was launched in 2005 as a part of Mission as the principal vehicle for reducing IMR, MMR, and TFR as envisaged in the original Cabinet note, Upgradation of Community Health Centers at First Referral Units (FRUs) for dealing with Emergency Obstetric Care, 24x7 delivery services at Primary Health Centers (PHCs), operationalization of Sub-Centres multi-skilling of doctors, contractual appointments of Medical Officers (MOs) and Assistant Medical Officers (AMOs), training of Medical Officers in Anaesthetic Skills, training of Doctors/ANMs/Nurses as Skilled Birth Attendants (SBA) permitting ANMs to administer certain drugs in emergency, partnership with voluntary arganizations, RCH camps, accreditation of non-profit organizations, the Information, Education & Communication (IEC) activities are the major inventions in reducing MMR. For reducing neo-natal mortality, programme for Integrated Management of Childhood Illness (IMNCI) is being extended to the community and facility levels. Activities of ASHAs, Anganwadi workers and ANMs, inspirations of continuing Education Centres and SHG groups at the village level with focus on both preventive and promotional aspects of health care accelerated immunization programme, advocacy on age of marriage/ against sex selection, spacing of births,

[37] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001 pp 9.

institutional delivery, breast feeding, meeting unmet demands for contraception, besides providing a range of RCH services are to have impact on reducing the health indicators. Efforts are being made to integrate HIV AIDS programme with the RCH at the district and sub-district levels. Convergence of disease control programmes, integration of services, combined awareness generation, education advocacy at community and facility levels, taking care of preventive, promotive and curative health care are expected to bring down IMR/MMR/TFR and the disease burden as stated.

Risk Pooling and the Pool

The Mission recognizes that in order to reduce the out-of-pocket expenditure of the rural poor, there is an imperative need for setting up effective risk pooling systems as already envisaged. State specific, community oriented innovative and flexible insurance policies need to be developed and disseminated. While the first priority of the Mission is to put the enabling public health infrastructure in place, various innovative models would be pilot tested to assess their utility.

Financing of NRHM

The National Commission on Macroeconomics and Health (NCMH) has worked out an additional requirements of non-recurring expenditure of Rs. 33811 crores per year and additional recurring expenses of Rs. 41006 crores at current prices for delivering functional health care in the public domain. This outlay which is shared by the Centre and States pushes the expenditure on public health care to nearly 3% of GDP. As some of the elements included in this computation of fund requirement relate to activities which are not strictly covered under the NRHM (like setting up of medical colleges etc.) and if allocations to be made on such activities are excluded then the additional capital and recurring requirements come to Rs. 30,000 crores and Rs. 36,000 crores per annum respectively over and above the current allocations. It may, however, be mentioned that with growth in GDP, in order to maintain the same percentage level of health expenditure vis-a-vis GDP, the expenditure would have to go up in the same proportion.

In order to step up the expenditure on public health, the states also have to very significantly increase the allocation for the health sector in their budgets since they contribute almost 4/5 of the current total expenditure. The EFC has agreed that under the NRHM, 100% grant is provided to the states during 10th Plan which was phased downwards to 85% in the 11th and and 75% in the 12th Plan respectively[38].

The Vision of the Mission

i) To provide effective healthcare to rural residents across the nation, with a special emphasis on 18 states with subpar infrastructure and/or public health indicators. Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal, and Uttar Pradesh are among the 18 states with a special focus on them.

i) To increase public spending health from 0.9% of GDP to 2-3% of GDP with improved arrangements for local financing and risk pooling.

ii) To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country .

iii) To revitalize local health traditions and mainstream AYUSH into the public health system.

iv) Effective integration of health concerns through decentralized management at the district with determination of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.

v) Address inter states and inter districts disparities.

vi) Time-bound goals report publicly on progress.

[38] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001. pp 56-97

vii) To increase access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary healthcare. [39].

Strategies of the Mission:

i) To meet the health services goals included, strengthening management capacity to monitor

ii) To meet the human resource included, reviewing and developing comprehensive Human Resource Policy and involving private sector for producing necessary trained human resources

iii) To meet health information goals included, review of data reporting and use mechanisms, establishing a central data repository, implementing a performance management system in the form of a score-card, capacity building of senior managers and integration of Health Management Information Systems with decision making process.

iv) To meet the strategies of health financing goals included, increasing the state outlay as percentage of Gross State Domestic Product, taking stock of the current expenditure pattern and aligning it to estimated burden of disease and ensuring financial inclusiveness in health care programmes.

v) To meet governance goals included, developing a comprehensive health policy, operationalizing community based organizations, encouraging innovation, improving community participation and capacity building of leaders through leadership development programmes.

vi) To meet medical technology goals included, increasing financial outlay for drugs, strengthening drug procurement and developing drug policy, service delivery, implementing specialized health service packages, accreditation of health facilities to improve quality and establishing a healthy systems performance management unit.

[39] National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation. 2005-2012.Ministry of Health and Family Welfare Government of India, Nirman Bhawan. New Delhi-110001. pp 14

VI Conceptual review of NRHM in the administration of welfare activities

In India, the Ministry of Health and Family Welfare under the NRHM launched several initiatives for the improvement of health in the country. A brief conceptual review of NRHM in the administration of welfare activities may be discussed under-

i) Kayakalp: Kayakalp is a national initiative launched by the Ministry of Health and Family Welfare under Swachh Bharat Abhiyan in 2015, to inculcate the practice of hygiene, sanitation, effective waste management and infection control in public health facilities. It also includes recognition with Certificate of Commendation and Cash Awards of such public healthcare facilities that show extraordinary performance and compliance to protocols.

According to Harsh Vardhan, the former Union Cabinet Minister, Health and Family Welfare, the scheme, which saw the participation of 716 District Hospitals and central government institutions in its first year has spread to 26,172 public health facilities now. In the last year 2019-20, number of Kayakalp facilities has increased to 7,615.

ii) Janani Suraksha Yojana (JSY)]:Janani Suraksha Yojana (JSY) is a safe motherhood campaign under the National Rural Health Mission (NRHM). This scheme is for strengthening Maternal and Child Health Services wherein incentives are paid to all the pregnant women of both urban and rural areas for deliveries in public institutions. Incentives are given to all patients irrespective of their BPL status, so as to facilitate public institutional deliveries

As regards achievement, JSY has been a success both in terms of number of mothers covered under the scheme and the expenditure incurred. The number of beneficiaries has increased from a modest figure of 7.39 lakhs in 2005-06 to 106.48 lakhs beneficiaries in 2013-14. Also, the utilization of funds has increased from 38 crores in 2005-06 to 1762.82 crores in 2013-14. The scheme is considered to

be one of the major contributory factors towards increased utilization of public health facilities by the pregnant women for delivery care services[40]

iii) Rashtriya Bal Swasthya Karyakram (RBSK): The National Rural Health Mission is launching a new initiative of Rashtriya Bal Swasthya Karyakram to provide comprehensive care to all the children in the community. The objective of this initiative is to improve the overall quality of life of children through early detection of birth defects, diseases, deficiencies, development delays and disability. The high burden of these childhood ill health contributes significantly to child mortality, morbidity and out of pocket expenditure of the poor families.

As reported by States/UTs, 157.35 crore children have been screened, 10.11 crore children have been identified with selected health conditions and 4.73 crore children have been provided secondary/tertiary care from FY 2013-14 till FY 2022-23 under RBSK[41].

iv) Rashtriya Kishor Swasthya Karyakram (RKSK): In order to ensure holistic development of adolescent population, the Ministry of Health and Family Welfare launched Rashtriya Kishor Swasthya Karyakram (RKSK) on 7th January 2014 to reach out to adolescents of male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups The programme expands the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

Adolescent often do not have the autonomy or the agency to make their own decision. RKSK takes cognizance of this and involves parents and community. The focus is on reorganizing the existing public health system in order to meet the service needs of adolescents.The programme expands the scope of adolescent health programming in India - from being limited to sexual and

[40] Press Information Bureau, Government of India, Ministry of Health and Family Welfare
[41] Press Information Bureau, Government of India, Ministry of Health and Family Welfare

reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse[42].

v) Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA): has been launched by the Ministry of Health and Family Welfare in 2016 to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month. PMSMA follows a systematic approach for engagement with private sector which include motivating private practitioners to volunteer for the campaign, developing strategies for generating awareness and appealing to the private sector to participate in the Abhiyan at government health facilities.

PMSMA 'I Pledge For 9'Achievers Awards' have been devised to celebrate individual and team achievements, identify and recognize excellence in performance in PMSMA at various levels and focus on awarding government teams and private sector doctors who have volunteered for the programme[43].

Table: 3.1 Time Line for NRHM Activities

	Activity	**Phasing and time line**	**Outcome Monitoring**
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.	50% by 2007 100% by 2008	Quarterly Progress Report
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	Quarterly Progress Report
3	2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009	Annual Facility Surveys

[42] National Health Mission, Ministry of Health &Family Welfare, Government of India
[43] Ministry of Health &Family Welfare, Government of India

		100% by 2010	External assessments
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 50% by 2010 100% by 2012	Annual Facility Surveys. External assessments.
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	Annual Facility Surveys. External assessments.
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	Appraisal process. External assessment.
10	Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress reports.
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress Reports.
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	Independent assessment.
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008.	Independent assessment.
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	50% by 2007 100% by 2008.	External assessment.
15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/	30% by	Annual

	District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HOV/AIDS, etc.	2007 50% by 2008 70% by 2009 100% by 2012.	Facility Surveys. Independent assessments.
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	Appraisal process. Independent assessment.
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	Independent assessment.
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009	Quarterly Progress Report.

***Source: NRHM: Framework for Implementation 2005-20*)**

VII. Achievements of Timeline for NRHM activities in India

The National Rural health Mission (NRHM) was launched to provide accessible, affordable, accountable and effective primary healthcare facilities, especially to the poor and vulnerable sections of the population. The targets and achievements of the National Rural Health Mission (NRHM) are given as follows.

Certain targets as envisaged in 2005 at the launch of NRHM have not been achieved. This is because public health is a State subject and there have been issues of lack of capacities and human resource shortage in certain States and general under-funding for health sector.

In terms of population for the selection of ASHAs, majority of the states have one ASHA for 1,000 population or less. The ASHA programme has expanded at the grass root level to cover all the high focus states except Himachal Pradesh and Jammu and Kashmir, and is now being expanded to cover the entire nation. The ASHA has emerged as an enthusiastic community health worker whose effectiveness and live contact with the public health system is sustained through the JSY and her role in the village health and nutrition day/ immunization session. Most states are working towards improving their support systems, quality and frequency of training, regularizing payments, refilling drug kits, providing for special referral support and expanding the incentive package.

The dimensions of community participation like the Village Health and Sanitation Committee, Sub Centre, PHC, and CHC are showing good potential and is given untied funds to promote local health action but in many states it is too early to comment as they are only in the take-off stage. There is a scope for increasing the participation of NGOs in the ASHA programme and in strengthening other community processes.

The increased utilization of PHC is not uniform across all facilities in all states. In some states, all of them high focus, despite an overall increase, the increase at PHC level (the facilities meant to follow the norms of one per 30,000 population), is modest or absent. And in a few of the states, increases in service even at the sub-center level have been compromised by the focus on developing CHC or block PHC (i.e. with the norm of one per lakh population)

Rogi Kalyan Samitis/Hospital Development Societies are in place in all the districts, divisional and block hospitals and in most of the PHCs. These societies are functional and are an effective vehicle for untied funds and to some extent for improved facility level management and this has substantially contributed to improving quality of services.

Though there have been significant improvements in infrastructure, drugs, diagnostics, sanitation and hygiene, dietary arrangements etc in the high focus states,

the rapid increase in utilization, especially the rise of institutional deliveries tends to outpace the relatively much slower rate of expansion of infrastructure, human resources and supplies.

Regarding Mobile Medical Units provided to each district of the country - as of December 2014, there were about 1301 operational MMUs in 368 districts across the country. Besides the Government initiatives, there is a good variety of MMUs currently being implemented by charitable organizations or NGOs too.

VII. Achievements Of National Rural Health Mission (NRHM) in India

The National Rural Health Mission (NRHM) was launched to provide accessible, affordable, accountable and effective primary healthcare facilities, especially to the poor and vulnerable sections of the population. The targets and achievements of the National Rural Health Mission (NRHM) are given below. Certain targets as envisaged in 2005 at the launch of NRHM have not been achieved. This is because public health is a State subject and there have been issues of lack of capacities and human resource shortage in certain States and general under-funding for health sector.

Achievements up to XIth Plan.

Table 3.2: Physical Outcomes : Targets & Achievements under NRHM

Sl. No.	Targets (2005-12)	Achievements (up to 2012)
1	IMR reduced to 30/1000 live births	IMR reduced from 58 in 2005 (SRS) to 42 in 2012 (SRS).
2	Maternal Mortality to reduce to 100/100,000 live births	MMR reduced from 254 in 2004-06 (SRS) to 178 in 2010-12 (SRS).
3	TFR reduced to 2.1	TFR reduced from 2.9 in 2005 (SRS) to 2.4 in 2012 (SRS).
4	Malaria Mortality reduction to 60%	70% Malaria mortality reduction- (Reduced from 1707 in 2006 to 519 in 2012).
5	Kala Azar Mortality reduction to 100%	85% Kala Azar mortality reduction- (Reduced from 187 in 2006 to 29 in 2012).
6	Filaria / Microfilaria	60% Filaria / Microfilaria Reduction (Reduced from 1.02 in 2005 to 0.41 in 2012)

	Reduction Rate to 80%	
7	Dengue Mortality reduction by 50%	8% reduction- Dengue Mortality has reduced from 184 in 2006 to 169 in 2011.
8	Cataract operations- increasing to 46 lakhs per year	Cataract operations of more than 63.49 lakhs per year have been reported in 2012.
9	Leprosy Prevalence Rate reduction to less than 1 per 10,000	Leprosy Prevalence Rate reduced from 1.34 per 10,000 in 2005 to 0.68 per 10,000 in 2012.
10	Tuberculosis Control - over 70% case detection & 85% cure rate	Tuberculosis is having 71% case detection and 88% Cure rate in 2012.

Source:Press Information Bureau Government of India, Ministry of Health and Family Welfare

Table 3.1 shows the targets and achievement of NRHM from 2005 up to 2012 in the country. As shown in the table, there is reduction in the IMR, MMR and TFR. The State Mission has done a commendable job in controlling malaria, kala azar, filaria/microfilaria, dengue, leprosy and tuberculosis. The number of cataract operations has also been increased.

Achievements during XIIth Plan

Table. 3:3: Physical Outcomes: Targets & Achievements for NHM/12th FY Plan

Physical Outcomes: Targets & Achievements for NHM/12th FY Plan		
Sl. No.	**Targets (2012-17)**	**Achievements**
1	Reduce IMR to 25/1000 live births	IMR reduced from 42 in 2012 (SRS) to 40 in 2013 (SRS).
2	Reduce MMR to 1/1000 live births	MMR has reduced to 167 in 2011-13 (SRS).
3	Reduce TFR to 2.1	TFR has reduced to 2.3 in 2013 (SRS).
4	Reduce annual incidence and mortality from Tuberculosis by half	Tuberculosis is having 171 incidence (per lakh population) and 19 mortality (per lakh population) in 2013.
5	Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts	Leprosy Prevalence Rate is < 1/ 10,000 population
6	Annual Malaria Incidence to be <1/1000	Annual Malaria Incidence is <1/1000
7	Less than 1% microfilaria prevalence in all districts	Out of 255 districts, 222 have reported mf rate of less than 1%
8	Kala-Azar Elimination by 2015, <1 case per 10000 population in all blocks	Out of 611 block PHCs, 454 have reported < 1 case per 10000

Source:Press Information Bureau Government of India, Ministry of Health and Family Welfare

Table 3.2 shows the targets and achievement of NRHM from 2005 up to 2012 in the country. As shown in the table, there is reduction in the IMR, MMR and TFR. The State Mission has done a commendable job in controlling malaria, kala azar, filaria/microfilaria, dengue, leprosy and tuberculosis. The number of cataract operations has also been increased.

Table 3.4: Infant Mortality Rate(IMR)

Sl. No.	States	2005	2012
	All India	**58**	**42**
1	Andhra Pradesh	57	41
2	Assam	68	55
3	Bihar	61	43
4	Chhattisgarh	63	47
5	Gujarat	54	38
6	Haryana	60	42
7	Jharkhand	50	38
8	Karnataka	50	32
9	Kerala	14	12
10	Madhya Pr.	76	56
11	Maharashtra	36	25
12	Odisha	75	53
13	Punjab	44	28
14	Rajasthan	68	49
15	Tamil Nadu	37	21
16	Uttar Pradesh	73	53
17	West Bengal	38	32
18	Arunachal Pradesh	37	33
19	Delhi	35	25
20	Goa	16	10
21	Himachal Pradesh	49	36
22	Jammu and Kashmir	50	39
23	Manipur	13	10
24	Meghalaya	49	49
25	Mizoram	20	35
26	Nagaland	18	18
27	Sikkim	30	24
28	Tripura	31	28
29	Uttarakhand	42	34
30	Andaman and Nicobar Islands	27	24

31	Chandigarh	19	20
32	Dadra andNagar Haveli	42	33
33	Daman and Diu	28	22
34	Lakshadweep	22	24
35	Puducherry	28	17

Source: Sample Registration System, Statistical Report (Registrar General, India

Table 3.4 shows the Infant mortality rate of 35 states and India as a whole.As shown in the table, there is decline of IMR from 2005 to 2012 as a whole. While there is increase in IMR in some of the states and Nagaland and Meghalaya remains the same, there is reduction of IMR in most of the states.

Table 3.5: Maternal Mortality Ratio (MMR)

Sl. No.	**India/States**	**2004-06**	**2011-13**
	India	**254**	**167**
1	Andhra Pradesh	154	92
2	Assam	480	300
3	Bihar/Jharkhand	312	208
4	Gujarat	160	112
5	Haryana	186	127
6	Karnataka	213	133
7	Kerala	95	61
8	Madhya Pradesh/Chhattisgarh	335	221
9	Maharashtra	130	68
10	Odisha	303	222
11	Punjab	192	141
12	Rajasthan	388	244
13	Tamil Nadu	111	79
14	Uttar Pradesh/Uttarakhand	440	285
15	West Bengal	141	113

Source: Sample Registration System, Statistical Report (Registrar General, India

Table 3.5 shows the Infant mortality rate of 15 states and India as a whole. As shown in the table, there is a great decline of MMR from 2004 to 2013 as a whole. All the 15 states show a reduction of MMR .

Table 3.6: Total Fertility Rate (TFR)

Sl. No.	State	2005	2012
	All India	**2.9**	**2.4**
1	Andhra Pradesh	2.0	1.8
2	Assam	2.9	2.4
3	Bihar	4.3	3.5
4	Chhattisgarh	3.4	2.7
5	Delhi	2.1	1.8
6	Gujarat	2.8	2.3
7	Haryana	2.8	2.3
8	Himachal Pradesh	2.2	1.7
9	Jammu and Kashmir	2.4	1.9
10	Jharkhand	3.5	2.8
11	Karnataka	2.2	1.9
12	Kerala	1.7	1.8
13	Madhya Pradesh	3.6	2.9
14	Maharashtra	2.2	1.8
15	Odisha	2.6	2.1
16	Punjab	2.1	1.7
17	Rajasthan	3.7	2.9
18	Tamil Nadu	1.7	1.7
19	Uttar Pradesh	4.2	3.3
20	West Bengal	2.1	1.7

Source: Sample Registration System, Statistical Report (Registrar General, India)

From table no 3.6 it is evident that there is a decline in Total Fertility rate in the country as a whole in the year 2005 to 2012 and while almost all the 20 states shows decline in TFR, the TFR in Kerela remains the same during this period.

Table 3.7: Leprosy Prevalence Rate

Sl. No	State/UT	Prevalence Rate per1000 Population (2010-2011)	Prevalence Rate per1000 Population (2011-2012)	Prevalence Rate per1000 Population (2012-2013)	Prevalence Rate per1000 Population (2013-2014)
1	Andhra Pradesh	0.49	0.58	0.61	0.55
2	Arunachal Pradesh	0.35	0.21	0.32	0.2
3	Assam	0.4	0.37	0.35	0.3
4	Bihar	1.124	0.89	1.2	0.91
5	Chhattisgarh	1.94	1.69	2.13	2.1
6	Goa	0.29	0.36	0.25	0.4
7	Gujarat	0.79	0.81	0.96	0.83
8	Haryana	0.13	0.21	0.26	0.27
9	Himachal Pradesh	0.27	0.25	0.21	0.22
10	Jharkhand	0.65	0.59	0.66	0.7
11	Jammu and Kashmir	0.16	0.16	0.17	0.15
12	Karnataka	0.44	0.46	0.44	0.44
13	Kerala	0.27	0.26	0.24	0.25
14	Madhya Pradesh	0.6	0.63	0.72	0.7
15	Maharashtra	0.93	1.07	1.09	0.92
16	Manipur	0.06	0.06	0.08	0.03
17	Meghalaya	0.24	0.23	0.09	0.08

Source: National Leprosy Eradication Programme

Table 3.7 shows the Leprosy prevalence rate per 1000 population during 2010-2011, 2011-2012, 2012-2013 and 2013-2014. As shown in the table, while there is a gradual decline of leprosy prevalence in some of the states, Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana and Madhya Pradesh shows a slight increase in leprosy prevalence 2010 to 2013.

Table 3.8: Malaria Incidence Rate

Sl. No	States/UT	Annual Parasite Incidence (API) of malaria per 1000 (2013)	Annual Parasite Incidence (API) of malaria per 1000 (2014)
1	Andhra Pradesh	0.23	0.41
2	Arunachal Pradesh	4.77	4.30
3	Assam	0.59	0.44
4	Bihar	0.03	0.02
5	Chhattisgarh	4.18	4.72
6	Goa	1.04	0.55
7	Gujarat	0.94	0.66
8	Haryana	0.55	0.17
9	Himachal Pradesh	0.03	0.02
10	Jammu and Kashmir	0.13	0.05
11	Jharkhand	2.84	2.94
12	Karnataka	0.24	0.27
13	Kerala	0.05	0.05
14	Madhya Pradesh	1.04	1.26
15	Maharashtra	0.38	0.46
16	Manipur	0.04	0.05
17	Meghalaya	7.82	12.52
18	Mizoram	10.80	20.74
19	Nagaland	1.14	0.96
20	Orissa	5.32	9.08
21	Punjab	0.06	0.04
22	Rajasthan	0.45	0.20
23	Sikkim	0.20	0.17
24	Tamil Nadu	0.21	0.12
25	Telangana	0.00	0.15
26	Tripura	1.94	13.27
27	Uttarakhand	0.14	0.12
28	Uttar Pradesh	0.24	0.20
29	West Bengal	0.38	0.28
30	Andaman and Nicobar Islands	2.17	1.20
31	Chandigarh	0.14	0.11
32	Dadra and Nagar Haveli	4.54	1.64
33	Daman and Diu	0.34	0.20
34	Delhi	0.02	0.01
35	Lakshadweep	0.12	0.00
36	Puducherry	0.10	0.06
	Total	**0.72**	**0.89**

Source: National Vector Borne Disease Control Programme

Table 3.8 shows the Annual Parasite Incidence (API) of malaria per 1000 in 2013 and 2014. As shown in the table, there is a slight increase in annual parasite incidence in the country as a whole. While some states shows a decline in API, some states shows an increase in API.

Table 3.9: Average Microfilaria rates (%) in the State

Sl. No.	States/UT	2005	2006	2007	2008	2009	2010	2011	2012	2013
1	Andhra Pradesh	0.74	0.69	0.26	0.38	0.45	0.35	0.21	0.2	0.22
2	Assam	0.04	0.19	1.46	0.88	0.81	1.06	0.17	0.19	0.15
3	Bihar	2.15	1.38	0.68	ND	1.07	0.94	ND	1.15	ND
4	Chhattisgarh	1.96	ND	0.61	0.45	0.54	0.4	0.1	0.1	0.08
5	Goa	0.04	0.02	0.08	0.01	0	0.01	0	MDA stopped	MDA stopped
6	Gujarat	0.84	0.84	0.42	0.83	0.92	0.46	0.52	0.24	0.31
7	Jharkhand	0.84	1.4	1.34	1.1	1.11	0.82	0.63	NR	ND
8	Karnataka	0.84	0.69	1.15	1.07	0.93	0.89	0.83	0.65	0.6
9	Kerala	0.5	0.67	0.65	0.29	0.39	0.17	0.14	0.21	0.15
10	Madhya Pradesh	0.4	0.38	0.7	0.36	0.4	0.19	0.23	0.09	ND
11	Maharashtra	1.45	1.13	0.83	0.35	0.46	0.53	0.51	0.43	0.46
12	Orissa	2.37	1.11	0.99	0.74	0.69	0.4	0.43	0.34	0.34
13	Tamil Nadu	0.38	0.39	0.29	0.15	0.12	0.07	0.09	0.17	ND
14	Uttar Pradesh	1.01	0.81	0.32	0.41	ND	0.28	0.24	0.38	0.17
15	West Bengal	4.1	2.72	2.83	0.89	0.48	0.44	0.55	0.7	ND
16	Andaman and Nicobar Islands	0.09	0.15	0.34	0.19	0.46	0.1	0.12	0.17	0.14

17	Dadra and Nagar Haveli	2.01	2.91	3.47	1.82	1.23	0.95	1.79	0.71	0.54
18	Daman and Diu	0.14	0.27	0.09	0.07	0.07	0.06	0.07	MDA stopped	MDA stopped
19	Lakshadweep	0.09	0.07	0.02	0.27	0	0	ND	ND	ND
20	Pondicherry	0.5	0.15	0.06	0.03	0	0	0	MDA stopped	MDA stopped
National Average		**1.02**	**0.98**	**0.64**	**0.53**	**0.65**	**0.41**	**0.37**	**0.41**	**0.29**

Source: National Vector Borne Disease Control Programm

ND: Not Done

NR: Not Reported

MDA= Mass Drug Administration

Table 3.9 shows the Average Microfilaria rates (%) in the State from 2005 to 2013. As shown in the table, As shown in the table, the Microfilaria rate in percentage has increased from 2005 to 2013 in the country as a whole. While some states shows an increase in microfilaria rate, some states shows a reduction in microfilaria rate while others stopped mass drug administration.

The information on funds allocated, released and utilized under National Health Mission (NHM) during 2012-2013 and 2013-2014 is given in table 3.10:

Table 3.10: State-wise Allocation, Release and Utilization under National Health Mission **Rs. in crore**

Sl No	**States**	**2012-13**			**2013-14**		
		Allocation	**Release**	**Exp**	**Allocation**	**Release**	**Exp**
1	Andaman & Nicobar Islands	22.60	7.97	27.52	23.83	29.06	29.12
2	Andhra Pradesh	1088.44	837.66	1066.65	1184.24	878.73	1044.81
3	Arunachal Pradesh	74.01	55.06	73.68	86.31	78.60	92.03

4	Assam	1054.14	887.86	1253.73	1214.83	1077.81	956.89
5	Bihar	1421.32	1104.42	1333.54	1487.65	1110.32	1480.68
6	Chandigarh	14.59	6.67	12.65	18.53	11.46	14.42
7	Chattisgarh	473.71	369.36	512.34	500.72	355.98	805.50
8	Dadra & Nagar Haveli	7.54	5.81	7.43	8.73	9.23	9.83
9	Daman & Diu	5.97	1.85	6.85	6.48	6.50	8.40
10	Delhi	169.95	54.21	109.30	211.46	129.78	132.59
11	Goa	23.96	25.11	29.63	27.12	19.35	30.58
12	Gujarat	715.69	669.33	821.11	833.94	833.72	977.48
13	Haryana	289.15	298.27	369.63	313.57	315.94	423.79
14	Himachal Pradesh	141.97	115.40	276.69	225.95	205.29	158.60
15	Jammu & Kashmir	209.75	198.85	293.78	433.87	395.10	391.10
16	Jharkhand	555.83	356.60	423.93	582.97	396.38	521.49
17	Karnataka	721.48	653.83	807.10	814.17	611.11	812.56
18	Kerala	379.23	490.55	628.24	424.15	360.98	673.07
19	Lakshadweep	3.52	2.48	4.44	3.61	3.20	2.28
20	Madhya Pradesh	1032.41	946.08	1223.50	1141.03	865.94	1583.63
21	Maharashtra	1270.27	1418.14	1840.14	1520.71	1218.51	1806.86
22	Manipur	114.66	25.79	68.48	127.75	88.91	74.57
23	Meghalaya	125.45	108.33	104.75	139.24	125.51	71.53
24	Mizoram	75.84	68.41	87.69	86.20	77.43	91.89
25	Nagaland	95.78	95.05	105.35	114.42	99.73	90.40
26	Orissa	653.52	534.49	780.73	678.99	604.20	901.65
27	Puducherry	15.89	14.74	20.53	21.29	18.10	25.43
28	Punjab	318.91	321.69	423.47	362.38	333.47	437.57
29	Rajasthan	980.98	847.12	1181.47	1091.2	922.93	1457.06
30	Sikkim	54.12	34.79	37.30	42.32	45.91	44.82

31	Tamil Nadu	897.98	948.14	900.73	1020.75	906.24	1430.28
32	Tripura	133.44	69.54	118.96	165.43	140.15	101.93
33	Uttar Pradesh	2685.50	2247.20	3263.04	3584.98	3024.60	2924.38
34	Uttarakhand	206.65	176.89	246.97	310.55	245.25	255.28
35	West Bengal	1026.41	937.53	1104.09	1179.64	948.51	1271.71
36	Telangana	0.00	0.00	0.00	0.00	0.00	0.00
Sub Total		**17030.69**	**14935.22**	**19565.44**	**19989.01**	**16493.93**	**21134.19**
Others		11.30	67.23	41.41	132.77	89.77	4.08
Total		**17041.99**	**15002.85**	**20121.78**	**16583.70**	**21138.27**	**21138.27**

Source:Press Information Bureau Government of India,Ministry of Health and Family Welfare

1. Allocation is as per Original outlay / B.E

2. Release is only Central Grants and do not include State share.

3. Expenditure includes expenditure against Central and State release & Unspent balances at the beginning of the year and as per FMR reporting .

Table 3.10 show State-wise Allocation, Release and Utilization under National Health Mission. From the table it can be seen that there is short release of funds, non release of state matching share and over use of the funds.

VIII. General outline of the situation of NRHM in India

The NRHM proposed a complete revamp of the rural health services, claiming provision of effective healthcare with universal access to the rural population. The major success of NRHM in achieving the maternal and child health indicators and fertility related indicators could be totally attributed to the increase in the institutional deliveries, which in turn is attributed to ASHAs and the runaway success of the welfare scheme Janani Suraksha Yojana (JSY). The role of ASHA in

the success of NRHM is worth mentioning. As a social activist and as a health activist, ASHAs perform a dual role of not only empowering the rural population with health awareness, but also facilitating community participation, which is pivotal to the success of any programme. However, the much needed social and professional support from the PHCs and panchayats were lacking in several areas. Moreover, there was duplication of the portfolios in certain states which had similar roles initiated way ahead of NRHM. The other key aspect of NRHM is strengthening of the CHC as first referral units (FRU). This has enabled capacity building of secondary health care and also contributed to provision of quality care. Nevertheless, the access to this quality care has been compromised in certain districts, owing to the distance and the number of FRUs within the reach of the rural population. The implementation of Indian Public Health Standards (IPHS) for the CHCs has been well commended. In consequence to this, there is an imminent need to upgrade the PHCs to provide full range of basic services, including renovating the infrastructure. This could be adeptly carried out by forging efficient partnerships with private bodies in a leasing model, without compromising on identity of the public health system [44]. NRHM is a workforce dependent mission with a larger goal of improvement in the quality of health care practice through the development of a sustainable health care system. This required manpower trained not only in health care practice, but also in administrative and managerial aspects. This has necessitated the need for imparting due training to the health care providers and important functionaries who could carry forward the strategies of the mission.

Although the mission was implemented in all the thirty five states and Union Territories, the performance of some of the states in India are far from satisfactory. In the meantime, the performance of the health care system of Kerela for example, received global recognition. Some of the factors that have been identified to explain the remarkable health care performance of Kerela are:

[44] Negandhi P, Sharma K, Zodpey S. An innovative National Rural Health Mission Capacity Development Initiative for improving Public Health Practice in India. *Indian J Public Health*. 2012;56(2):110-5.

i) The spread of literacy and education which led to the mass movement for the improvement living conditions of the backward classes.

ii) All the Panchayats(villages) are served by a facility in modern medicine which is also called as Allopathic medicine that involves the use of drugs and surgeries to help and cure the disease or solve the problems of the patient.

iii) Kerela acquire adequate provision of financial resources necessary for health care services while other states suffers from inadequate financial resources to cope up with increasing demands for health care.

CHAPTER IV

ORGANISATION AND WORKING OF NATIONAL RURAL HEALTH MISSION IN MIZORAM.

I Profile of Mizoram

Meaning:

The name, Mizoram is derived from Mi (meaning people), Zo(high rise place such as hill) and Ram(land), thus, Mizoram means ‘Land of the hill people' and is a beautiful state located in the northeast of India. Mizoram is a fusion of the old North and South Lushai Mountains. The land of Mizoram has unique natural beauty, a variety of landscapes, rich flora and fauna, clusters of pines, and peculiar villages with bamboo houses.The Tropic of Cancer passes through the middle of Mizoram, and hence the weather remains pleasant throughout the year.

Under the British Administration, Mizoram was known as Lushai Hills District. In 1954 by an Act of Parliament the name was changed to Mizo Hills District. In 1972, when it was made into a Union Territory, it was named Mizoram. With the signing of the Peace Accord between the Union Government and the Mizo National Front in 1986 and consequent upon the passing of the 53rd Constitution Amendment Bill, Mizoram became the third state of the Indian Union on 20th February 1987[45].

Area:

Mizoram covers an area of 21,081 square kilometres, located in the extreme southern part of north east India, lying between 21°58´ and 24°35´ North latitude and 92°15´ and 93°29´ East longitudes. The tropic of cancer runs through the territory. Mizoram shares its boundary on the north with Cachar district of Assam and the State of Manipur, and on the east with the Chin Hills of Myanmar and on the south

[14]https://www.docplayer.net.176474897-Detailed-project-report

with Arakan of Myanmar and on the west by the Chittagong Hills of Bangladesh and the State of Tripura. Mizoram occupies an area of great strategic importance in the North eastern corner of India having an International boundary of the total length of 722 km with Bangladesh (318km) and Myanmar (404km)[46].

Topography:

The whole Mizoram with the exclusion of a small portion lying in the plains is full of rugged hill ranges running in north-south direction varying from about 3,000 to 7,000 feet. The Phawngpui or Blue Mountain stood in the south of Mizoram and is 7,100 feet high. Few plain areas are mostly located in the eastern part of Mizoram and in the northern part. There are few rivers in Mizoram that flow through the narrow valleys namely Tut, Tlawng, Tuirial and Tuivawl located in the north. Kolodyne with its tributaries- Mat, Tiau and Tuipui in the east, Karnaphuli and Tuilianpui in the western part of Mizoram[47].

Climate:

The climate of Mizoram is humid on the plains and cool in the upper elevationsi and it is pleasant throughout the year. The state receives heavy rainfall between May and September.The monsoon directly affects the state's overall climate. . The average rainfall is 275 centimeters (2750 mm) every year. The state's northwest region receives the most rainfall, with over 350 centimeters (3500 mm) annually. As humidity rises, rainfall likewise increases southward. Rainfall totals are roughly 215 centimeters (2150 mm) in Aizawl, the capital, and 350 centimeters (3500 mm) in Lunglei, another significant center.The state is located in an area where landslides and cyclones might result in weather-related emergencies. Summertime brings a lot of precipitation, which lasts from May through September

[46] Statistical Handbook of Mizoram 2020.

[47] C. Lalhruaithanga(2020),*Mizo National Movement: A HistoricalL Study of Its Contestations*, a thesis submitted to Mizoram University for the Degree of Doctor of Philosophy,pp2

and into late October. The wettest months are often July and August, whereas the driest months are typically December and January[48].

Forest area:

In Mizoram, out of the geographical area of 21,087 sq.km, 15,935 sq.km is covered by forest which account for about 75 percent of the area of the state. Generally, the forests of Mizoram can be described as wooded forest in the higher elevetion and bamboo forests in the lower ridges. Forest in Mizoram can be classified into -

i)Tropical Wet Evergreen Forests are found at places where there is a high precipitation. In Mizoram, this type of forest is found in the western part of the state. It is rich in vegetation and some species of trees having ecological importance are also numerous in this type of forest.

ii) Tropical Semi-Evergreen Forests are found in the the central part of the region from Chhimtuipui river in the south to north end of the state. Many important timber species found in the tropical wet-evergreen forests are also found in this forest.

iii) Mountain Sub-Tropical Forests are found in higher places, mostly in the eastern side of the state. This type of forests are also found in the western part of W.Bunghmun area and in Sangau area in the south[49].

[48]Pachuau,Rintluanga,(2013),*Mizoram: A study in Comprehensive Geography*, New Delhi:Northern book Centre. pp42

[49] R.Lalthankima, 2023, *Horticulture administration in Mizoram since statehood, A* Thesis submitted to Mizoram University for the Degree of Doctor of Philosophy, pp 21

Economy:

Agriculture is the main source of occupation of the state. The economy and society of the Mizo people were significantly impacted by the administrative and economic reforms imposed by the colonial government. In the Lushai hills, the colonial authorities imposed an annual house tax in 1891 that required each household to pay two rupees, either in cash or in kind. As a consequences, from 1904, the British government stopped paying house tax in kind and accepted only cash[50]

Thus within the decade of British rule, the Mizo economy was progressively absorbed into the global capitalist economy. The Mizo came up with this innovative approach, which gave the growers in the Aizawl areas opportunity to change their agricultural produce into cash and assisted those living in the interior villages in purchasing daily necessities at a lower cost than in the stores. The British government made a deliberate attempt to force the local economy to adhere to the one monetary system of the British Indian empire by collecting house taxes in cash only. After the British administration mandated that house taxes be paid in cash, the people started to recognize the importance and usefulness of money[51]. The state of Mizoram lacks industrial development. The state's main industry include those based on agriculture and forests, as well as handicrafts, electronics, consumer goods, and sericulture. Lack of raw materials has prevented any meaningful industrial development. However, the products of forests have the potential to be developed industrially. In 1989, the Mizoram government formulated the industrial policy. A number of initiatives have been implemented to support the state's food processing sector. There are not many minerals or mines in the state of Mizoram. There is only

[50] Assam Secretariat Proceedings, Foreign-A, No.89, Administration Report of the Lushai Hills for the year 1903-04, p.7

[51] Assam Secretariat Proceedings, Foreign-A, No. 96, Administration Report of North Lushai Hills for the year 1897-1898, p.3.

tertiary formation hard rock accessible for use in road construction and building materials.

Population:

As per the 2011 Census, Mizoram has a population of 1,097,206 with 555,339 males and 541,867 females . The sex ratio of Mizoram is 976 females per 1000males. The density of population is 52 persons per square kilometre which is lower than the national level of 382 persons per square kilometre. Numerous ethnic tribes constituted the population of Mizoram. Most of the people in Mizoram belong to Scheduled tribe and they comprise nearly 95 percent (10,36,115) of the total population of the state. About 50.37% of the total population lives in rural area. Literacy percentage is 91.33 per cent and it ranked the second highest all over India.

Society:

Over the years, the Mizo society's social fabric has experienced significant changes. The village and the clan were essentially the units of Mizo society before the British arrived into the hills. The untranslatable word 'Tlawmngaihna', which means for everyone to be hospitable, kind, selfless, and helpful to others, is central to the Mizo code of ethics. To the Mizo, Tlawmngaihna represents the strong moral power that manifests itself in selflessness in the service of the others. Mizo language officially known as Mizo tawng which is spoken by majority of the Mizo people is mostly drown from the Lusei dialect though some dialects of other sub-tribes are also incorporated into it. The Mizos have been so enchanted with and obedient to their newfound religion in Christianity that the Christian Church Organization has completely revolutionized and shaped their social life, intellectual process and sense of values. The Mizos are a close-knit community that does not discriminate based on sex or class. The community functions like a large family and the entire village participates in important events that include childbirth, village marriages, village deaths, and communal feasts planned by village residents[52].

[52] https://mizoram.nic.in/about/people.htm

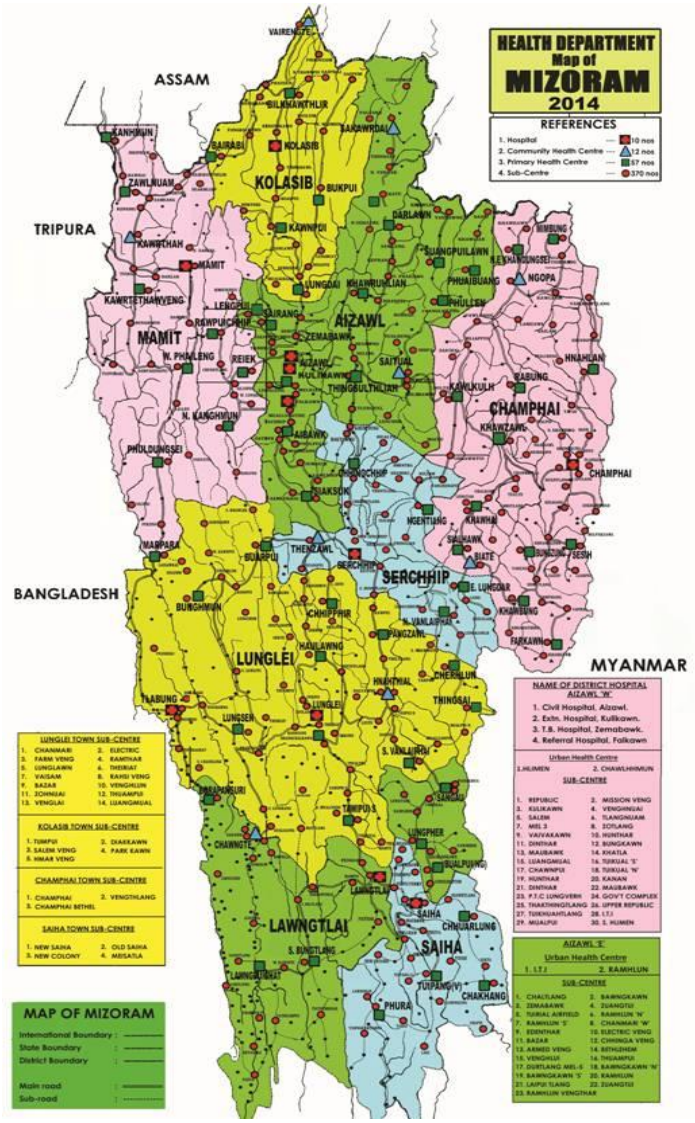
Administration:

The administration of Mizoram consists of an executive, led by the Governor of Mizoram who is appointed by the President for a term of five years, a legislative and a judiciary branch. The Chief Minister is the head of the government of Mizoram like other states of India. He is the head of the Council of Ministers who are responsible for the elected legislature. Mizoram has single chamber legislature consisting of forty (40) members. They are selected by the people of the state every five years. The territory has eleven (11) districts twenty three (23) sub divisions, and twenty six (26) rural development blocks and three (3) Autonomous districts and seven hundred and eighty six (786) village councils, which includes the local councils in urban areas.were yet to be made fully functional and is in a developing phase.[53]The High Court of Mizoram is located in Guwahati. The state capital Aizawl has a bench of the High Court of Mizoram.

[22]https://www.mizorural.nic.in/file/IWMP/ACTION PLAN/Action Plan 2009-2010

Map 4.1

Map of Mizoram



Source: Health Department, Government of Mizoram Map 2014

Health care:

Mizoram is one of the states of Indian Union, which is a signatory to the Alma Ata Declaration of 1978. Therefore it prepared an ambitious innovative plan scheme to attain the goal of 'Health for All' by the year 2000AD through Primary Health Care approach. Primary Health Care is essential health care made universally accessible to individuals and acceptable to them through their full participation and at a cost the community and the country can afford. The strategy of the state to fulfil its commitment is further supported by the National Health Policy of 1983 emphasizing concentration on the development of infrastructure of rural health to ensure provision of Primary Health Care Services to the rural population.

In Mizoram, Primary Health Care Services is essentially taken up in three level systems, each level closely supported and interdependent to each other and they are -

Primary level: To provide the services at the doorstep of the community who are living even in the most interior villages through Health Sub-Centre.

Intermediate - Under this level, the Institutions are Primary Health centres (4-10 beds), Community Health Centres (30 beds), Sub-Divisional/District Hospital.

State/Referral Hospital: The hospital equipped with modern diagnostic facilities and speciality services qualified Doctors are made available.

The health care services in Mizoram are provided primarily by the following groups:

i) Department of Health and Family Welfare, Government of Mizoram.

ii) Hospital and Clinics run by Churches.

iii) Nursing Home run by private NGO[54].

II Profile of Kolasib District

Meaning:

As with the other districts of Mizoram, nothing authentic is known about the ancient or medieval times of the place's history due to the lack of written or other forms of legitimate documents. Only after the State or District was occupied by British overlords in the second half of the nineteenth century were written or accurate records kept. Nonetheless, it can be said that chieftainship systems were widely prevalent in the area during the previous four centuries, even after British administrators occupied this territory. As such whenever this village was referred to, 'Kawla Chief Village was most popularly mentioned. As a result, a chief by the name of Kawla ruled over the settlement that is now known as Kolasib. Thus from Kawla Chief the name Kolasib was given by the Britishers and till date there has not been change of this name.

Area:

The geographical location of Kolasib District is between 92¯ 30'and 92¯ 45'East Longitude and 24¯ and 24¯ 15'North Latitude. The average height of the district is 722 mtrs. (2,370 ft.) above mean sea level. The district covers an area of 1,382 Sq. Kms. The district is flanked by Hailakandi and Cachar Districts of Assam in the north, Aizawl District in the south and east and Mamit District in the west. The North-South extension of the district is 81.6 km and East-West extension is 56 km.

[54] B.Thangdailova *Modernization of Health care service in Mizoram*. In A K Agarwal (ed.),2003 Modernization of the Mizo society. A Mittal Publication, New Delhi. pp. 33

Topography:

The topography in general is undulating with broken mountainous/hilly ranges and between them, there are narrow valleys lands suitable for cultivation of field crops. The hills are suited for Horticultural practices wherever the slopes are gentle/moderate. The soils in hills are rich in humus due to forest cover. However, in abandoned jhum lands the situation is reverse. The soil in general is acidic-pH ranging between 4.5 – 6, deficient in base material, medium in organic carbon, low in available phosphorus and high in potash. The predominant soil taxonomy is Hapladults and Udonthernts wherein moisture retention capacity is very low[55].

Climate:

Kolasib district is located in the northern part of Mizoram state and enjoys a moderate climate owing to its tropical location. It is neither very not nor too cold throughout the year. It falls under the direct influence of the south west monsoon which receives an adequate amount of rainfall during the monsoon season. The average rainfall of Kolasib district is 2703 mm per annum and highest rainfall during a particular month was 852 mm recorded during August and July. The salient thermoscharacteristics of the district is that temperature do not fluctuate much throughout the year. The highest temperature observed during past decades was 35^{o}c in the month of July. The warmest months with mean daily maximum at about 25^{o}c and mean daily minimum at about 23^{o}c was observed during June and July. The temperature normally falls down from the month of November and is at its lowest in December and January.

Forest :

The forest cover type of Kolasib district is mainly tropical wet evergreen forest and tropical semi evergreen forest associated with moist deciduous forests. Moist deciduous forests are commonly found in small pockets on the hill slopes. The vegetation consists of a mixture of several species. Depending on the density of the

[55] https://kolasib.nic.in>about-district

canopy cover the forest have been divided into dense/closed, medium dense and less dense forest.

Population:

As per 2011 census, Kolasib had population of 83955 of which 42,918 are male and 41,037 are female respectively. The sex ratio of .Kolasib is 956 females for every 1000 males, and it has a literacy rate of 93.50%. In Kolasib, 55.84% of the population lives in urban areas and the Scheduled Tribes constitute 87.67% of the population[56].

Administration:

Kolasib district is one of the 8 (eight) districts of Mizoram and 5th in terms of birth. The name of the district has been given after the name of its administrative headquarters – Kolasib - which is situated to the north of Aizawl District. Kolasib was initially created as the centre of Tribal Development Block manned by Project Executive Officer on the day of the birth anniversary of the Father of the Nation in 1957. It was later upgraded to be administered by the Area Administrative Officer. When Mizoram was elevated to a Union Territory in 1972, Kolasib was upgraded as the headquarters of the Sub-Division manned by Sub-Divisional Officer (Civil) on 5th May 1975. Being the seat of administration for more than three long decades, its present status of District was created by the Government of Mizoram in 1998. The Deputy Commissioner of the district is the seniormost Civil Officer who is assisted by the Superintendent of Police and various other district and R.D Block level Officers in running the day to day administration and development activities within the district.

National Highway No.54 passes through the middle of the district from north to south direction. The only railhead in the state is located at a place in Kolasi b district called Bairabi. The only centre for Military Counter Insurgency & Jungle

[56] https://kolasib.nic.in/about-district

Warfare School in the country, which is the largest and most known to the whole of Asia as well as in the world, is located at Vairengte within Kolasib district.

MAP 4.2

Map of Kolasib district

Source: mapsofindia.com/maps/mizoram/districts/kolasib.ht

Public Health Programs and Services

To provide health services to the people within Kolasib District, there is 1 (one) Community Health Centre located at Vairengte, 5 (five) Primary Health Centres viz. Bairabi PHC, Kawnpui PHC, Bukpui PHC, Bilkhawthlir PHC and Lungdai PHC and, 26(twenty six) Sub Centres viz Diakkawn SC, Tumpui SC, Buhchangphai SC, Pangbalkawn SC, Thingdawl SC, Rengtekawn SC, Kawnpui SC, Bualpui SC, Hortoki SC, Lungdai SC, Zanlawn SC, Lungmuat SC, Nisapui SC, Chaltlang SC, Serkhan SC, Pangbalkawn SC, BukpuiSC, ,N.Hlimen SC, Vairengte SC, Phaisen SC, Phainuam SC, Bairabi SC, Bilkhawthlir SC, N,Chawnpui SC, Saiphai SC and Saipum SC. Besides there exist eleven (11) health sub-centres clinic within Kolasib district. Besides, there are eleven (11) health clinics within Kolasib district with sixty one (61) Health Workers along with eighty seven (87) ASHA workers.

The District implements various Health and Public Welfare Programmes for the benefit of the people in the District as mandated by the Union as well as the State government from time to time. These include Malaria Eradication Programme, Leprosy Eradication Programme, TB Tuberculosis Control Programme, Family Welfare Programme and other Health Programmes[57]. In the implementation of these programmes, there is the existence of the District Health Society which functions as the implementing agency for the National Rural Health ission (NRHM). The District Collector/Deputy Commissioner is the Chairman of the Society and the Chief Medical Officer is the Member-Secretary cum Mission Director at the district level, practically speaking who is equipped with a District Program Management Unit. The Society has direct contact, supervision, monitoring and mentoring of all the health programmes including reporting at the state level which is the Office of the Mission Director, National Rural Health Mission/National Health Mission. One key strategy of the NRHM/NHM is that it serves as an integrated approach to co-ordination, supplementation and mainstreaming of all different vertical programmes under the health services and programs throughout the country and integrating Management Information system(MIS), avoiding duplicate and overlapping of programs and

[57] Records maintained by District Hospital, Kolasib

activities with a whole new concept of communitizing health programs to the general masses.

One key strategy of the National Rural Health Mission/National Health Mission is that it serves as an integrated approach to co-ordination, supplementation and mainstreaming of all different vertical programmes under the health services and programs throughout the country and integrating MIS, avoiding duplicacy and overlapping of programs and activities with a whole new concept of communitizing health programs to the general masses.

District Health Society and line agencies

The District Health Society as already mentioned is the actual PIA at the district to grassroots level of all health programs and accounted entity for all 'service delivery point' (all health service units from Tertiary Hospital level to ASHA level). At the village level a Village Health and Sanitation Committee are established where the concerned Health Worker acts as a member secretary cum executive official and the Gram Panchayat Chief as the Chairman. They are mandated with grassroots level activities from event observation, time bound health program operations etc. and are expected to converge with critical programmes as ICDS/ICPS, Village Council activities at the village level etc. Accredited Social Health Activists (ASHAs) are the front line worker at these levels, hence 'Community process' or in other words the concept of community led health intervention, prevention and response is realized by injecting ownership at the grass-root level through this institutional mechanism.

Table 4.1: District-wise number of hospitals and health centre (as on 2021)

		Hospital							
S/n	District	Govt.	Others*	Sub-District Hospitals	CHC	PHC	UPHC	Sub-Centre	Sub-Centre Clinic
1	2	3	4	5	6	7	8	9	10
1	Mamit	1	-	-	1	7	-	33	7
2	Kolasib	1	1	-	1	5	-	26	7
3	Aizawl	2	11	2	3	10	6	95	72
4	Champhai	1	2	1	2	11	-	60	27
5	Serchhip	1	1	-	1	5	-	27	6
6	Lunglei	1	4	2	-	9	2	70	17
7	Lawngtlai	1	2	-	1	6	-	37	22
8	Siaha	1	-	-	-	4	-	24	13
Total		9	21	5	9	57	8	372	171

*Others include hospital run by Church/Society/Private

Source: *Directorate of Health & Family Welfare*

Table 4.1 shows the number of hospitals and health centres in different districts of Mizoram. As shown in the table 1.1, in Mizoram there are 9 government hospital, one for each district except Aizawl which have 2 government hospital. Except in Mamit and Siaha district, private hospitals are running in the districts; we find PHC, sub-centre and sub-centre clinics in all the districts.

Table 4.2: Numbers of hospitals and health centres

Sl. No.	Hospital/Health Centre	2019-2020
1	2	3
1	General Hospital	
	(a)Government	9
	(b)Private/Nursing Home	14
	(c)Society/Church	7
2	Cancer Hospital	1
3	Referral Hospital	1
4	Ayush Hospital	1
5	Leprosy Hospital	1

6	Sub-District Hospital	5
7	Community Health Centre (CHC)	9
8	Primary Health Centre(PHC)	57
9	Urban Primary Health Centre(UPHC)	8
10	Health Sub-Centre(SC)	372
11	Health Sub-Centre Clinics	171
12	Ayush Dispensaries	9
13	Mobile Medical Unit	8

Source: *Directorate of Health & Family Welfare*

Table no 4.2 depicts the number of hospitals and health centres in the district as on 2021. The Government of Mizoram has established 9 general hospitals in the different districts within Mizoram as against 14 private hospitals/nursing homes. There also exist hospitals run by Civil Society Organisations like the Church and Societies which number 7. One each for Cancer, Referral, Ayush and Leprosy hospital is maintained by the state government to provide required health services to the people. There are 9 Ayush Dispensaries and 8 Mobile Medical Units functioning in the State. There are also 5 Sub-District Hospital, 9 Community Health Centres (CHC), 57 Primary Health Centres (PHC), 8 Urban Primary Health Centres (UPHC), 372 Health Sub-Centre, (SC) 171 Health Sub-Centre Clinics in the state.

III Health Care Services in Mizoram

It is difficult to trace the history of the health care services or the implementing agency in Mizoram due to a lack of documents. However, it is one of the oldest functioning agencies or departments in the State. It is generally accepted that modern health care services were introduced by the British Administration and the Christian missionaries. Until 1894 scientific health care facilities were by and large non-existent in Mizoram. Even though there seem to be no acknowledged records of the exact names and dates, the year 1890, following the second British Expeditions against the Mizo (1889-1890), was an important milestone in the history of health services in Mizoram because the first proposal for the sanction and appointment of the first Medical Officer for Mizoram was made this particular year. Since then, the seeds of health care services have continued to germinate in

Mizoram.[58] From available records, an impoverished treatment camp was established at Aizawl in a tent for laborers (kulis) in 1894. This was later upgraded to a full-fledged dispensary in 1896. Subsequently, in the same year, Aizawl Hospital was made functional with 20 beds and Champhai Dispensary with 8 beds. This was followed by the establishment of 8 more 6- bedded dispensaries at Kolasib, Sairang, Lunglei, Champhai, N. Vanlaiphai, Sialsuk, Tlabung, Vahai and Tuipang in 1920.[59].

In Mizoram, the growth of health care facilities in the state has been slow. Two pioneering agencies started and carried on the health care delivery services in Mizoram; one under the Christian missionaries as charity services and another under the government. Both these agencies have continued to work side by side. The contributions of early Christian missionaries were commendable for the growth and development of the modern healthcare system in Mizoram. Dispensaries, which started earlier, were gradually replaced by Primary Health Centre and Community Health Centre. People living in remote rural areas were provided with simple modern healthcare systems like Sub-Centre and Sub-Centre Clinics only after Mizoram attained statehood in 1986[60].

At the time of Independence in 1947, there was a 36-bed hospital at Aizawl and dispensaries as mentioned above. There was an acute shortage of doctors and pharmacists as Mizoram was just another district of Assam. The Health Services organization then was headed by a Civil Surgeon based at Aizawl and supported by a Sub-Divisional Medical Officer based at Lunglei. When the Mizoram District Council was formed in 1952, one (1) more hospital, seven (7) Public Health Dispensaries, three (3) Primary Health Centres and seven (7) Traveling Dispensaries were established. However, during the civil strife in the State from 1966 - 1986, some Dispensaries/Traveling Dispensaries were not functional.

[58] https://health.mizoram.gov.in/page/history

[59] https://health.mizoram.gov.in/page/history

[60]Ibid

A twelve-month Dai Training course was established at Aizawl Hospital from April 1950 till June 1959 during which 101 Dais were trained. Auxiliary Nurse Midwife (ANM) Training Course of 2 years duration was also initiated in 1957 with the objective of training personnel to work as nurses at the community level. A total of 203 ANMs completed the training during 1957- 1981.

The Multipurpose Workers (MPW) Scheme, initiated as a pilot scheme in selected districts in India, covered the entire Mizoram in 1977, being one of the very few States implementing the MPW scheme State-wide. The ANM Training School was upgraded to the Multipurpose Health Worker School in the year 1980 and has still now become one of the most important front-line human resources producers in health services and care.

IV Organisational Structure of Health Department, Mizoram

Health & Family Welfare Department was bifurcated in the year 2004 into Health Services and Hospital & Medical Education Department headed by Principal Director . Health Services is functioning as a separate Directorate controlling rural health institutions i.e., Principal Medical Office, Kulikawn, Community Health Centres (CHCs), Primary Health Centres (PHCs), Sub-Centres (SCs) and Rural Hospital, Tlabung and all District Medical Offices. Also, Aizawl District has been functionally divided into Aizawl East and Aizawl West districts for health service delivery, each headed by a Sr.CMO while Hospital & Medical Education is also functioning as a separate Directorate controlling Medical Institutions and Teaching Hospitals etc. Further, it is entrusted with the responsibility of implementing teaching, training and research programmes in the medical field and patient care services. Currently, the Principal Director is the Head of the two Departments and he is assisted at the State headquarters by the following designated Programme Officers etc.

Addl. Director, Planning

Jt. Director (Accounts)

Dy. Director (A)

Superintendent

Account Officer

At the district levels, the Chief Medical Officer (CMO) and Medical Superintendent represent the DHS and DHME respectively. The Aizawl District has been functionally divided into Aizawl East and Aizawl West districts for health service delivery, each headed by a CMO.

At the State level, the two Directors are assisted by Joint Directors, Programme Officers, Deputy Directors (Administrators), an Executive Engineer and his team, Medical Officers, Research Officers, Finance & Accounts Officers, Officer Superintendent and ministerial as well as contractual staff[61]. As has been envisaged and recommended by the Cadre Review Committee, Government of Mizoram, the coordination and integration of these two Directorates for better synchrony of administration under the Principal Director at the State level, was finally realized[62].

Generally, block headquarters in Mizoram are facilitated with PHC or CHC health institutions. Government reports reveal that the population coverage of PHC and CHC in Mizoram is better than the national norm. The average population covered by a PHC in Mizoram is around 19,141 persons while 100,000 persons are covered by a CHC. This is far below the national average of 33,191 persons covered by a PHC and 1.83 lakh persons covered by a CHC in India. However, in terms of real coverage, the situation in the state is not better which means that a PHC or a CHC in Mizoram includes a large geographical area under its jurisdiction compared to the smaller geographical area in the national context. This is largely due to sparse population distribution in a hilly state like Mizoram and the dispersed settlements in the state. This has an effect on distances to be covered by the people in availing the healthcare facility in hilly terrain. For example, the average radial distance covered by PHC in Mizoram is 6.66 km in contrast to 10.7 km for the country as a whole.

[61] https://health.mizoram.gov.in/page/history
[62] Formal interview with Dr.Lalchungnunga, Director of Health Services.

Similarly, the average radial distance for CHC in Mizoram is 15.66 km compared to 26.9 km in the case of India.[63].

V National Rural Health Mission in Mizoram

Healthcare covers a broad spectrum of personal health services ranging from health education and information through prevention of disease, early diagnosis, treatment and rehabilitation. The term health services implies organisation, delivery, staffing, regulatory and quality control. Mizoram has a short modern healthcare history compared with many Indian states looking at the temporal aspects of healthcare facilities.[64]

The pace of the Indian Public Health Administration, in a structured, holistic, comprehensive approach can be said to have taken its course only after the birth of the NHP 1983. Prior to this, the approach to organized responsive plan and action from the government to address the various public health needs from primary level care to tertiary level care was mainly focused on the provision of medical services, whereas public health as a concept and as a discipline has a much broader focus and mandate. Its principles have already been adopted while addressing various communicable diseases and maternal child health, the latter known commonly as family planning/family welfare in our country. However, the millennium brought progress and development challenges which have influenced a series of new thoughts, reviews, reformation, transformation, retention of good practices, and supplementation of deficit factors and the NRHM is one of the most important outcomes.

Recognizing the importance of health in the process of economic and social development and improving the quality of life of the citizens, the Government of India, as a flagship scheme of the United Progressive Alliance government launched the National Rural Health Mission (NRHM) in 2005-06 to carry out necessary

[63] T. Jacob John and Jayaprakash Muliyil (2014-2015), Public Health is Infrastructure for Human DevelopmentThe Challenges of the states of North-Eastern, *Indian Journal of Medical Research* 130, July, pp 13-1

[64] B.Thangdailova(2003), 'Modernization Health Care Services in Mizoram' in. R.N. Prasad, and A.K.Aggarwal (ed), Modernization of Mizoram, Mittal Publications, New Delhi. Pp30.

architectural corrections in the basic health care delivery system and address the needs of the rural population with a major focus on the critical importance of child and maternal health.

Organisation of National Rural Health Mission in Mizoram

The Directorate of Health Services in Mizoram has launched many programmes that have been initiated by the Central Government. The health care system provided by the government at present is mostly targeted at the rural population. As per the record of the Directorate of Health Services, Government of Mizoram (2018), there are nine District Hospitals out of which seven are located in seven districts of the state i.e. Lunglei, Siaha, Champhai, Kolasib, Serchhip, Mamit, Lawngtlai and the remaining two is located in Aizawl. There are fifty-seven (57) Primary Health Centres each covering a population of around 20,000 and three hundred and seventy (370) Sub-Centres each covering a population of around 3000. There are 80 Main Centres each covering a population of around 15,000 throughout Mizoram. There are twelve (12) Community Health Centres (CHCs) each covering a population around 80,000 to 100,000 and also twelve (12) Hospitals out of which 2 are Specialized Hospitals; one is 50 -bedded T.B. Hospital and another one is 20-bedded Leprosy Hospital[65].

At the State level, the NRHM functions under the overall guidance of the State Health Mission headed by the Chief Minister of the State. The functions under the Mission are carried out through the State Health Society under a separate secretariat called the State Programme Management Unit (SPMU) at the state level and the District Programme Management Unit (DPMU). District Health Societies chaired by the District Collector/Deputy Commissioner are formed with the Chief Medical Officer as the key official both in terms of implementation and monitoring.

In most of the states, the state-level SPMU functioned under a full-time Director, However, in the case of Mizoram, interviews with the SPMU team revealed that the post of Mission Director was given to the Joint Director of Health Services

[65] Record of Directorate of Health Services(2018), Government of Mizoram

(Family welfare) Moreover, to date, the post of the Mission Director is yet to be created. The SPMU is not an implementing agency as per the machinery but more of a coordinating, supplementing and planning role including monitoring and supervision and collaboration.

Institutional Mechanism:

i) Village Health and Sanitation Samiti (at the village level) consisting of Village Council representatives, ANM/MPWs, Anganwandi workers, teachers, ASHAs community health volunteers. This was later renamed as Village Health Nutrition and Sanitation Committee.

ii) Rogi Kalyan Samiti (or equivalent) for community management of public hospitals.

iii) District Health Mission, under the leadership of Zilla Parishad with district health head as convener and all relevant departments, NGOs, private professionals etc. Represented on it.

iv) The State Health Mission, chaired by Chief Minister and co-chaired by the Health Minister and with the State Health Secretary as convener - representation of related departments, NGOs, private professionals etc.

v) Integration of the Departments of Health and Family Welfare at national and state levels.

vi) The National Mission Steering Group, chaired by the Union Minister for Health and Family Welfare with the Deputy Chairman of the Planning Commission, Ministers of Panchayati Raj or village council, as in the case of Mizoram, Rural Development and Human Resource Development and Public Health Professionals as members, to provide policy support and guidance to the Mission.

vii) Empowered programme committee, chaired by the secretary of Health and Family Welfare, to be the executive body of the Mission.

viii) The Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative.

ix) Task Groups for Selected Tasks (time-bound).

Different health system frameworks were critically appraised and finally the health system framework suggested by WHO was adopted to assess the health system of Mizoram. The WHO framework suggests six building blocks: financing, health workforce, information, medical products and technologies, service delivery and leadership/governance.

The framework and goals for health system of Mizoram is shown in diagram 4.1.

Diagram: 4.1: Health Systems Conceptual Framework for Mizoram

The Six Building Blocks of a health system: aim and desirable attributes[66]

[66] https://www.nhnmizoram.org

CHAPTER V

IMPLEMENTATION AND MONITORING MACHINERY OF NATIONAL RURAL HEALTH MISSION

The biggest challenge for the success of any programme is to establish accountable and effective implementation arrangements. Clarity regarding tasks, teams, roles, functions, powers at all levels of the system will facilitate effective action. Every state have to carry out detailed analysis of the implementation arrangements required to implement NRHM. Additional skills have to be brought into the system wherever required to ensure that all activities of NRHM are satisfactorily managed at the field level. The most important requirement for the success of the NRHM is to be able to develop a block level health management team along with a strong District Health Mission[67]. Decentralized district health action plan is the key corner stone of NRHM and all efforts to build capacities and develop appropriate implementation arrangements at these levels are a priority for NRHM[68] Accordingly, modifications in statutes, rules and acts have to be carried out to provide statutory authority to NRHM structures at block and district level. Functionaries have to be relocated and job cards redefined along with contractual appointment of functionaries with skills that the system does not have. At the district and the block levels, there is a need for a total clarity about the following set of activities.

i) Disease Control

ii) Disease surveillance

iii) Maternal and Child health

iv) Accounts and Finance management

v) Human resource and Training

vi) Procurement, Stores and Logistics

[67] Ibid
[68] https://nhm.gov.in/Write ReadData/1892s/nrhm-framework-latest pdf.

vii) Administration and Planning

viii) Access to Technical Support

ix) Monitoring and MIS

x) Referral, Transport and Communication systems

xi) Infrastructure Development and Maintenance Division

xii) Gender, IEC and Community Mobilization

xiii) Block Resource Group

xiv) Block Level Health Mission

xv) Coordination with Community Organizations, PRIs

xvi) Quality of Care systems[69]

Accordingly, State level structures are reoriented to provide guidance and support to the functional areas identified for blocks and districts. The biggest challenge of NRHM is to establish an effective implementation arrangement at block and district level as without it, all the efforts at decentralized public health action will remain difficult to operationalize. In order to carry out the functions under the Mission, the Mission requires an empowered structure[70]. The Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) has been established under the respective Chairmanship of the Health and Family Welfare Minister and the Union Health and Family Welfare Secretary. To carry out the functions mandated by MSG/EPC, the Mission Directorate has been established in the Ministry of Health and Family Welfare. The Directorate is headed by a Mission Director who is of the level of Additional Secretary to Govt. of India. Under the Mission Directorate, there are 5 Joint Secretary level officers, the roles and functions of which is clearly articulated to ensure that their tasks and responsibilities are

[69] https://nhm.gov.in/Write ReadData/1892s/nrhm-framework-latest pdf.
[70] Ibid

clearly defined[71]. Besides, the technical divisions like Maternal Health (MH) and Child Health (CH), Immunization etc. gives report to the Mission Director through the Joint Secretary concerned. The States is divided amongst the five Joint Secretaries. There is a Programme Management Group (PMG) which is responsible for all interactions with a cluster of States so that the States need to interact with just one nodal officer in the Ministry. The Programme Management Group comprises five State Facilitation Units with each Unit reporting to the Joint Secretary concerned for the cluster of those States. Each State Facilitation Unit comprise a Deputy Secretary / Director level officer, one technical officer at the level of Assistant Commissioner from the technical divisions and one officer drawn from the Statistical Division. The State Facilitation Unit is responsible for interacting with the States, the administration, Technical Division and the Monitoring and Evaluation (M&E) Division[72].

A National Health Systems Resource Centre (NHSRC) is set up to serve as an Apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the States in the Programme. The NHSRC provide necessary technical assistance to the Mission Directorate[73]. The Mission Directorate not only handle the day-to-day administrative of the Mission but also responsible for planning, implementation and monitoring of the Mission activities. Adequate administrative financial powers are delegated to the Mission Directorate to enable it to function in Mission mode. [74].

There is a need to enable many other national institutions to respond to request from states and districts for technical support in planning and implementation of programmes. This improves the quality and relevance of work done in these institutions. Examples of such institutions are the NIHFW, the All India Institute of Tropical Medicine and Hygiene, the National Institute of Nutrition and other ICMR funded Research Institutions, the schools of Public Health and Health Administration

[71] Ibid

[72] https://nhm.gov.in/Write ReadData/1892s/nrhm-framework-latest pdf.

[73] https//www.lawinsider.com/dictionary/apex-body

[74] Ibid

as well as technical support NGOs active in health like VHAI, PFI and FRCH etc. Assistance with incentives for those experts who invest their efforts in playing such demanding roles without detriment to their core research work. Enabling these institutions require both grants in aid to some institutions to expanding their manpower and skills as well as ensuring policies by which they responds to such requests for assistance with incentives for those experts who invest their efforts in playing such demanding roles without detriment to their core research work[75]

The various innovative health care schemes and incentives taken under the mission have changed the existing health scenario in rural India. In fact it is said to be the first rural Health care policy that has promoted intervention and innovation as per local needs and thereby has able to bridge the gap of lack of institutional deliveries among rural women. However, there are some missing points found in the Mission. One of the shortcomings is that the major health indicators (like MMR, IMR, TFR etc.) have registered gradual decline but in slow pace. Further, it has also failed to address the issues like social inequalities, socio- economic differences, and urban - rural disparities, weaken cast system and gender inequality. The reason behind this may be the lack of adequate funds allotted under the mission as well as the corruption of the officials. Despite of the pros and cons, the NRHM has proved to be one of the successful schemes of the Government of India and it has able to change the existing health scenario in rural India[76].

Monitoring can be defined as a continuing function that uses systematic collection of data on specified indicators to provide management and the main stakeholders of an on-going development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds as defined by Organization for Economic Co-operation and Development (OECD).The Implementation and monitoring goes hand in hand in NRHM. From the state level State Program Management Unit (SPMU) to the VHNSC and ASHAs and Anganwadi Worker every personnel or agent is designated as service delivery point.

[75] Ibid

[76]htpp://www.academia.edu/34763832/_National_Rural_Health_Mission_Implementation_and_Impact

With regards to project implementation works and activities are carried out in an annual basis as per the agreed 'Record of Proceeding (RoP)' which is a document of approval sanction letter entailing all the details of physical and financial sanctions for a financial year. This document served both as a guide and a monitoring tool for measuring the overall performance of the mission. Adds on has been made in the subsequent improvement of NRHM/NHM. Allocation of funds for the next financial year is also made based on the performance made in respect of this document. Financial Monitoring is made through Public Financial Management System (PFMS)[77].

The NRHM implementation and monitoring framework is based on rights based approach. The Framework proposed accountability at every level through a three pronged process of community based monitoring, external surveys (SRS, DLHS household surveys by ASHA, facility surveys in the district levels) and stringent internal monitoring. The process of community involvement of the health institutions itself enhance accountability and the NRHM facilitate this process by wide dissemination of the results. For effective monitoring a strong MIS is being put in place known as HMIS or Health Monitoring Information System.

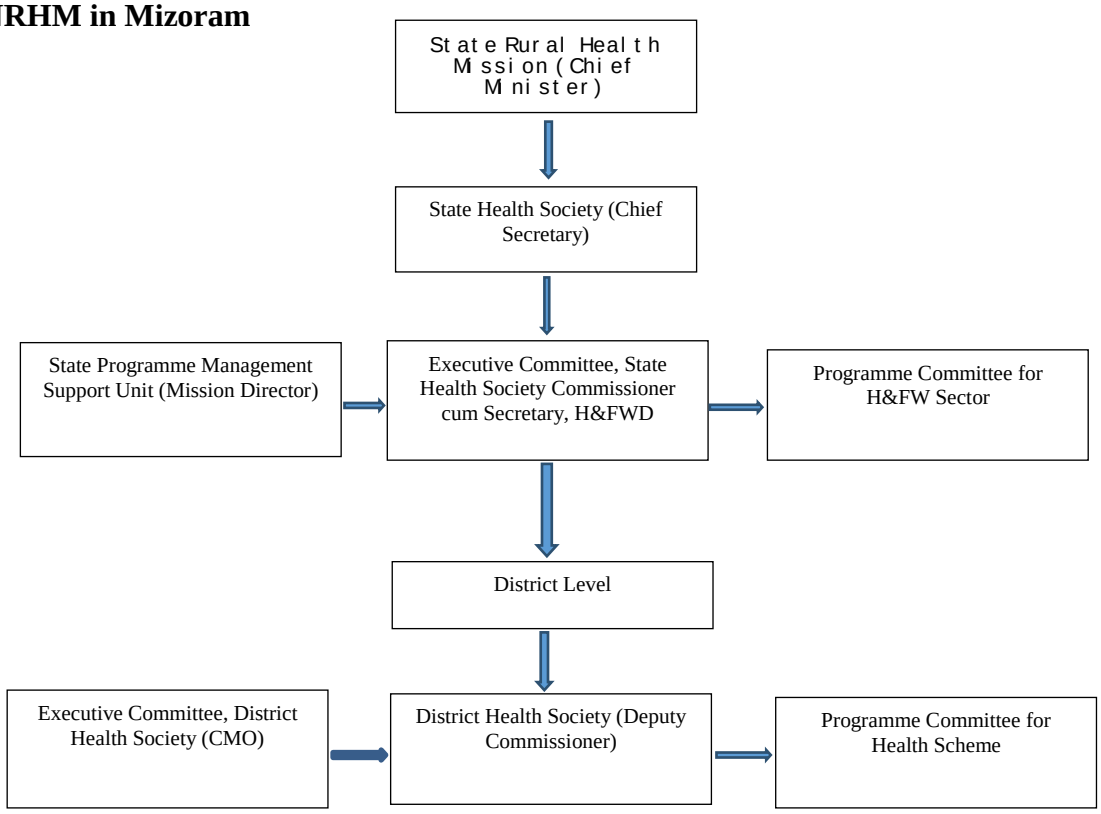
The Citizen Charter was made mandatory as a part of all public facilities under the mission to help the public to know their rights and entitlements at each facility. The setting up of IPHS at each level of health delivery system is instrumental in provision of minimum service guarantees at those levels. Monitoring also is in terms

of service guarantees provided by each facility, utilization of such services by the community (especially weaker sections) changes in their health seeking behaviour etc. The Facilities Survey is expected to create a baseline for each facility and assist in monitoring annual progress against the baseline in terms of services guaranteed. After every 2/3 years an independent review and evaluation is carried out by a group of experts and consultants engaged by the union ministry called the Common Review

[77] https://www.ieg.worldbankgroup.org/what-monitoring-and-evaluation/

Mission (CRM). The role of Memorandum of Understanding (MoU) occupied an important Implementation and monitoring aspect of the whole NRHM mandate which is delivered by the state government. The MOUs signed with the States are meant to enable monitoring progress under NRHM in terms of the agreed milestones. Independent evaluation would ensure midcourse corrections and addressing critical gaps and issues[78].

Diagram 5.1. An organogram showing administrative and monitoring set up of NRHM in Mizoram



Source: Health and Family Welfare Department, Government of Mizoram

[78] https://doczz.net/doc/7445585/framework-for-developing-health-insurance

The intention of NRHM is to make every health facility fully functional by decentralized action. The Central Government provide to the states an indication of the quantum of funds under NRHM budget head including funding for programmes like TB, Vector Borne diseases, Leprosy, Malaria, Disease Surveillance etc., over the Mission period as well as on an annual basis. The availability of funds would be indicated to the states after deducting the portion of funds which have to be retained at the Central level for activities to be taken up at that level. The Centre also indicates the priorities and the normative framework under which the planning exercise is to be taken up[79]. The states in turn would indicate the sub allocations to the districts. The districts would be expected to prepare perspective plan for the entire mission period as well as annual plan on yearly basis.

The District Health Action Plan is the key strategy for integrated action under NRHM. The village is an important unit for planning. The VHSC is responsible for preparation of the plan. It is however realized that extensive capacity building would have to be undertaken before the villages are in a position to take up the planning exercise. The Mission therefore would not insist on village plans at least during the first two years of Mission. The Block Health Action Plan continue to form the basis for District Health Action Plans[80]. The district plan is an aggregation of block plans. These plans would cover health as well as its other determinants like nutrition, drinking water, sanitation etc. The exercise is taken by the District Health Society under the leadership of the District Health Mission. As far as the other determinants are concerned, the funds for the implementation of the programmes related to them continue to flow through the existing channels but the District Plan clearly bring out the convergent efforts being made for the improvement of the status of health as well as its other determinants. The District Health Plan comprises plans on RCH-II, Disease Control Programmes, Immunization and other NRHM activities[81]. The Plan also delineate the steps being taken up for convergence in the vertical health programmes including surveillance activities at the District, CHC and PHC levels and also the rationalization of manpower and resources being brought out

[79] https://vdocs.ro/doc/nrhm-framework-latest-3yo8pd2zm4/
[80] https://vdocs.ro/doc/nrhm-framework-latest-3yo8pd2zm4/
[81] Ibid

in the process. It also reflects on the wider determinants of health and the interventions therein[82].

In order to enable the District Health Mission to take up the exercise for comprehensive district planning, a house hold and facility survey of SHC/PHC/CHC/Sub Divisional/District Hospitals is conducted which act as the base line for the Mission. The activities under the capacity building involve recruitment of personnel with requisite skill, strengthening the training infrastructure at both the district as well as State levels. To make the decentralized planning process a success, there is an imperative need to put in a strong MIS network.

To have IT enabled monitoring a computerized network is being set up under IDSP linking all the districts of the country. This network is used for monitoring the progress under the NRHM as well as for surveillance activities. Using the Mission funds, the District Headquarters is linked up to the PHC level. Appraisal of the District Health Plan is jointly taken up by the national/state Mission[83]. The representatives of the National Mission are nominated by the Mission Director. The States is encouraged to nominate Village Council representatives, institutions, NGOs, etc. as participants in the appraisal process. Funds on normative basis are being set apart for taking up the appraisal process. Since resource allocation between different items of expenditure and between districts and regions need to incorporate the overall strategic and policy considerations, there is a clear guidelines and norms fixed for this at the outset, to be revised mid-term if required and appraisal teams may need to look at adherence to some norms with powers to overrule norms where a case is made out[84].

Based on the appraised District Health Plans, the State Health Mission get the State Plan prepared. After it is approved by the State Health Mission, the Plan is appraised by the National Programme Coordination Committee chaired by the Mission Director already set up for appraising the PIPs prepared under the RCH II

[82] Ibid
[83] https://www.scribd.com/document/346791781/for-upload-8-pdf/
[84] Ibid

(programme) involving all Programme Directors of the Ministry[85]. The appraised Plan is approved by the Secretary, Health & FW (Chairman of EPC) for approval as is followed for the approval of PIPs under RCH-II. This entire process is completed well before the beginning of the financial year so that the implementation of the Plan begins in the right earnest from the start of financial year itself. The first instalment of the funds to the States is made in April/May. The second instalment is released in September/October based on the progress in each State including submission of audited statement/utilization certificate of the previous year.

The funds under the NRHM budget head flow through the integrated Health Society at the State and the District levels. The norms under which the funds is allocated by the Centre to the States and by the States to districts is developed on the basis of population, disease burden, health indicators, state of public health infrastructure, etc. While submitting the Statement of Expenditure (SOE), the districts and the states are asked to indicate programme-wise utilization of funds so that booking of expenditure at the Central level is done accordingly. Regular supervision of the Mission activities is sine qua non for their successful implementation. At least two supervision visits is conducted in each State every year. Like in the appraisal process, the supervision team consist of the representatives of the national as well as State Health Missions.

The Mission aims at extensive up-gradation of the training infrastructure both at the state and district levels. The funds under the NRHM budget head is used for the purpose of up- gradation of training infrastructure as well as for conducting the training programmes. The Mission aims to emphasize on the preventive aspects of health as compared to the curative aspects[86].The IEC has a very important role in creating awareness amongst the rural population for changing the unhealthy habits. The IEC activities so far have been mostly at the Central and State levels. Under the

[85] https://www.nihfw.org/doc/NCHRC-Publications/HandbookForCHM-Eng.doc

[86] Ibid

decentralized model ensured that more and more funds are given to the district, block and village levels to take up IEC activities[87].

There is a need to enable many other national institutions to respond to requests from states and districts for technical support in planning and implementation of programmes. This improves the quality and relevance of work done in these institutions. Examples of such institutions are the NIHFW, the All India Institute of Tropical Medicine and Hygiene, the National Institute of Nutrition and other ICMR funded research institutions, the schools of public health and health administration as well as technical support NGOs active in health like VHAI, PFI, and FRCH etc. Enabling these institutions require both grants in aid to some institutions to expanding their manpower and skills as well as ensuring policies by which they responds to such requests for assistance with incentives for those experts who invest their efforts in playing such demanding roles without detriment to their core research work[88]. Some technical institutions like the PFI or FRCH or CEHAT encouraged taking up the provision of mentoring support to specific state or district resource centres. Other specialized institutions like the NIN or the NICD provide support to states and districts on incorporating areas of their concern into district plans and staying with them through the entire period of programme implementation till these goals are met as part of the integrated district plan[89].

Achievements of NRHM in Mizoram:

In the State, Sahiyas (ASHAs) are operating efficiently and community monitoring initial phase has been effectively finished and the unreached populations are being served by mobile medical units as a result of contractual appointments in NRHM, the number of doctors and nurses available at PHCs and Additional PHCs have been increased. The State and district-level programme management units are already in place and Rogi Kalyan Samiti is active in the states and uses untied funds for its operations.

[87] Ibid
[88] https://www.nihfw.org/doc/NCHRC-Publications/HandbookForCHM-Eng.doc

[89] Ibid

Some Analysis of Financial Monitoring Report for the FY 2008-09

Table 5.1: RCH Flexible Pool for 2008-2009

Component expenditure & Utilization under RCH against the approved PIP				
Mizoram Rs. in lakhs				
1	Maternal Health	146.54	149.24	101.84%
2	Child Health	6.40	3.77	58.91%
3	Family Planning Services	29.89	34.25	114.59%
4	Adolescent Reproductive and Sexual Health	8.55	6.65	77.78%
5	Urban RHC	19.32	16.76	86.75%
6	Innovations/PPP/NGO	16.93	14.42	85.17%
7	Infrastructure & Human Resources	408.78	369.00	89.29%
8	Institutional Strengthening	17.39	15.62	89.82%
9	Training	45.47	31.43	69.12%
10	BCC/IEC	27.68	30.99	111.96%
11	Procurement	28.33	161.30	569.36%
12	Programme Management	792.50	39.28	105.53%
	Total	792.50	868.71	109.62%

Source: mizoram_report.pdf

Table 5.1 shows RCH Flexible Pool 2008-2009: Component expenditure & Utilization under RCH against the approved PIP. As shown in the table, we have the following observations and area of concern-

General Observations:

1. The 101.84% expenditure under MH, is a significant achievement.

2. The 114.59%, expenditure under Family Planning Services, is also a good achievement.

3. Rs.8.68 Crore, i.e.109% of the PIP approved 7.92 crore, has been utilized by the state under RCH-II as compared to average national level expenditure of 71%

Area of concern:

1. The expenditure on Procurement has crossed the limit of approved PIP, by over 469%, which may be looked into.

Table 5.2: Mission Flexible Pool

Component wise expenditure & Utilization under NRHM against the approved PIP				
Mizoram				Rs. in lakhs
	Activities	SPIP	Expenditure	% of Utilization against PIP
1	ASHA	94.30	92.42	98.01%
2	Untied Funds	136.85	136.85	100.00%
3	Hospital Strengthening	0.00	605.58	Error
4	Annual Maintenance Grants	82.80	51.10	61.71%
5	New Constructions/ Renovation and Settingup	1450.05	483.83	33.37%
6	Corpus Grants to HMS/RKS	107.00	117.00	109.35%
7	District Action Plans (Including Block, Village)	10.00	10.00	100.00 %
8	Mainstreaming of AYUSH	0.00	16.80	Error
9	IEC-BCC NRHM	20.00	20.43	102.15%
10	Mobile Medical Units (Including recurring expenditures)	91.26	95.60	104.76%
11	Referral Transport	160.00	160.00	100.00%
12	School Health Programme	9.00	0.00	0%
13	Additional Contractual Staff (Selection, Training, Remuneration)	297.48	321.23	107.98%
14	Training	16.70	13.93	83.41%
15	Procurements	0.00	129.20	Error
16	Support Services	0.00	101.38	Error
17	NRHM Management Costs/ Contingencies	80.22	164.10	204.56%
18	Other Expenditures (Power Backup, Convergence etc)	11.64	0.00	0%
	Total	**2567.30**	**2519.45**	**98.14%**

Source: mizoram_report.pdf

Table 5.2 shows the Mission Flexible Pool: Component wise expenditure & Utilization under NRHM against the approved PIP. Based on table above and record available in FMG, the observations and areas of concern are as follows -

General Observations:

1. The State incurred more than 100% expenditure on activities like Untied Fund, Corpus Grants to HMS/RKS, IEC-BCC NRHM , Mobile Medical Units, Referral Transport, Additional Contractual Staff, which is a good achievement.

2. Out of Rs.25.67 crores approved by the NPCC and Rs.7.82 crores, released the state has utilised Rs.25.19 crores i.e. 98% of approved PIP, which is a good achievement.

Areas of Concern:

1. Activity such as School Health Programme and Other Expenditure were planned but there is no expenditure booked under these heads during the financial year.

2. The expenditure under Hospital strengthening, Mainstreaming of AYUSH, Procurement and Support service to be looked into as no provision made in PIP.

3. The expenditure of Rs.1.64 crore incurred by the state under NRHM Management costs/contingencies under NRHM is double the PIP approved amount of Rs.0.80 crore, which shows excess utilization.

Need for empowerment

The modes for operating NRHM budget heads and the preparation of District / State Action Plan have been prepared and approved in accordance with the normative framework. Even though in general the State Action Plan is in accordance with the normative framework, there could be situations where deviations would have to be made from the norms to achieve the Mission Goals. There could also be situations where new schemes are to be taken up and the existing schemes of the Department of Health and Family Welfare would need modifications to tailor them better for achievement of the Mission Goals. These could include modifications to the existing centrally sponsored schemes such as Routine Immunization, Sterilization Beds, Family Welfare linked Health Insurance Plan, procurement of materials, Pulse Polio Programme, Immunization, Training, IEC, Area Projects, compensation for

sterilization etc. Since the process of seeking modification from the EFC is time consuming one, it would be necessary to empower the EPC to have the same powers as the EFC.

Since the Department of Expenditure is represented in both the EPC and MSG at the level of Secretary (Expenditure) as well as at the level of Additional Secretary; Financial Adviser of the Ministry, there would be adequate financial scrutiny of the proposals. In any event, if it is felt that any proposal involves major deviation from the existing norms, that proposal can always be referred back to the Department of Expenditure for scrutiny and concurrence[90]. It is proposed to empower the EPC, have the powers of EFC to approve schemes under the broad framework already approved by the Cabinet and to modify existing schemes to meet the needs of the Mission, as well as to approve deviations in the norms, wherever necessary. The empowerment required for NRHM is on the lines of empowerment already provided for Sarva Siksha Abhiyaan[91].

The need for capacity building at various levels has already been highlighted. Within the overall norm of not more than 6% of the total outlay to be spent on management cost, the services of experts and other functionaries may have to be hired on contractual basis to carry out the activities under the Mission. The Mission would also need to be vested with authority to strengthen management structures without creating any new permanent posts[92.] Health is a State subject and Family Welfare a concurrent one. The role of the Central Government level Mission therefore becomes even more difficult as it has push reforms in States with its additional financial and human resources. The Central Government will carry credibility with States if it is able to meet the diverse needs of States within its overall broad framework for implementation[93].

Flexibility requires closer monitoring and detailed scrutiny of every proposal placed as part of the Annual Work Plan and Budget. The Mission structure has been

[90] Ibid

[91] https://www.bing.com/ck/a

[92] https://www.ida.org.in/pdf/NRHM_FrameWork.pdf

[93] https://nhm.gov.in/images/pdf/communitisation/task-group-reports/financial-guidelines.pdf

proposed keeping these needs in mind. It has to have the flexibility to carefully appraise and approve State Plans under the NRHM and also the ability to carry out rigorous monitoring and evaluation of the programme from time to time. The Mission also has to work with States to improve their capacities in planning and implementing the programme better. Health and Family Welfare is a sector where a large number of external agencies participate within the overall framework of government programmes[94].

The proposed higher allocations to the health sector for NRHM will also require seeking higher levels of external assistance for the sector. The Mission has to be empowered to negotiate and take decisions regarding such proposals within the framework approved by the Cabinet. The intention of empowerment of the Mission structure is to ensure that no time delays take place in achieving the time bound objectives and outcomes of the Mission. Since resource mobilization will also be a significant part of the proposal, it is important to provide powers to the MSG/EPC to take forward deliberations on the subject, within the framework provided by the Ministry of Finance and the Planning Commission. Since both the Planning Commission and the Finance Ministry is involved at the highest level in the deliberations of the Mission, all concerns of these departments/commissions will be taken on board, before arriving at a decision, to meet the Mission outcomes.

For the purposes of efficient financial management and improved utilization of resources, the special features of a decentralized programme that has to incur expenditures at the community level, some special dispensation is required in the management and release of finances.

The NACP pragmatically evolved as a focus and vertical programme, since the cure for AIDS was the most difficult challenge for the community eventually NACP was devised and came into effect since 1990 which focus on preventive intervention amongst the so-called high risk group which includes female sex workers truck drivers, injecting drug users and migrant workers with a focus

[94] https://www.lawinsider.com/dictionary/annual-work-plan-and-budget

sensitization on usage of condoms, usage of clean needles and syringes along with a general injection of general knowledge on HIV /AIDS. However, this mild intervention with the use of government facilities and dedicated NGOs did not seem to have an anticipated positive result. Accordingly, NACP evolve as a continuum of NACP 1 which was framed as a result of the learning from a NACP1 and its implementation. Blood safety became a critical component of the whole AIDS control programme, this component occupies an important component till today.

It is worthwhile to mention the fact that blood safety and its transmission became an important or priority issue in blood transfusion till today. According to the Joint director IEC MSACS, much contribution was until today in verge with Association for voluntary blood donation. The approval and implementation of the NACP 2 from the lesson learned from NACP1 greater emphasis was laid upon the so-called high risk group (HRG) both in terms of programme planning and budgetary provision. Yet, despite these measures, the situation got worse; HIV AIDS was seen more as a specific population group rather than a generalized epidemic and hence NACP 2 can be seen as a vertical/parallel Programmed where it was not a primary concern for the whole Health Department. Let us reitarate here with that from the administrative structure NACP1 implementation was manned by a dedicated 'State AIDS Cell' while NACP was to be implemented through a newly formed (then) State AIDS Control Society. By this time, the whole country was fully aware that administrative efficiency was the need of the hour and a new structure of AIDS Control Programme was framed to be headed by an IAS officer at the rank of Joint Secretary to the Government of India and headed at the union level by an additional secretary cum Director General to the Government of India.

During NACP 2 it was realized that NACP could no longer function as a vertical programme and has to be mainstreamed with the general health programmes/mission. Accordingly, from NACP 3 the concept of NACP/NRHM was enacted, However, This concept and its materialization bear a utopian philosophy till today[95]. However, there were a load of attempts from donor agencies to make this

[95] https://www.lawinsider.com/dictionary/annual-work-plan-and-budget

concept reality, but for Mizoram the Administrative Protocol and establishment factors have not been able to emphasize this reality/challenge[96].

To conclude, these issues of NACP-NRHM convergence still poses an overarching problem till date where convergence as a desirable concept still is a matter of concern for policy makers, front lines workers and Public health administrators to the extent that a paradigm shift of thoughts needs to be realized to actually fulfil the Mission statement of the NRHM/NHM[97]

[96] Interview with Mr Vanhela Pachuau IAS former Chief Secretary,Government of Mizoram.

[97] https://www.nhmmizoram.org

CHAPTER VI

Field Finding Analysis

For realizing a more in-depth knows how from the field/primary source through direct contact interview schedule, a few critical indicators were formulated and collected from the selected district. These data are made through a structured interview schedule mostly based on quantitative data. The data collection took a lengthy process due to the formalities required at the state level for concurrence by the competent authority for those who are directly employed by the National Rural Health Mission/National Health Mission.

Moreover, during the field visits informal interactions were held with the main staff of the Chief Medical Officer, the district Hospital team of Kolasib, Vairengte CHC, Bairabi PHC which includes observation of their settings, infrastructure, equipment and functioning etc.

Two types of formats were made focusing on the 1) Employee of the National Health Mission/National Rural Health Mission 2) For the general public, beneficiaries etc. The respondents are from Kolasib district and the data was collected through random and stratified method.

These formats have some commonly shared variables as well as some different information relevant to the specific respondent typology. During the elaboration and analysis of the data complementary and supplementary, first-hand knowledge directly obtained from informal interaction with crucial groups at the state level are also incorporated. This also includes observation during the data collection period and each group were questioned separately as follows-

As described above, among the various staff of National Health Mission/National Rural Health Mission available at the time of data collection, interview was held with 78 respondents where the female (69.23%) accounts for almost double the size of the male (workers)

Findings in relation to functionaries:

Table 6.1: Sex of the Respondents

Male	Female	Total	Percentage	
			Male	Female
24	54	78	30.77	69.23

Source: Field study

There are 24 males and 54 female respondents which mean that while male respondents account only for 30.77% out of the total respondents, female respondents accounts for 69.23% out of the total respondents. The availability and actual sex ratio are true not only in NRHM or the whole health sector but for many other work platforms both in the government sectors as well as the private sectors.

Table 6.2: Age of the respondents

Age	Male	Female	Percentage	
			Male	Female
Below 18	0	0		
18-25	1	13	7.14	92.86
26-35	17	38	31	69
36-45	6	2	75	25
46-55	0	1	-	100
56 and above	-	-		
Total	24	54	30.8	69.2

Source: Field study

As can be seen from the table above we can easily infer that most of the workers under the Programme are from the youth group below the age of 35 who assumed over 70% of the respondents. There are only 8 people between the ages of 36 and 45 and only one female between the ages of 45 and 55. There is no respondent above 56 and most of the workers are of younger age in all aspect of life, implying the opportunity to mobilize, capacitance and rationally use this advantage to the goals and objectives of the programme.

Table 6.3: Length of service

			Percentage	
Number in years/month	Male	Female	Male	Female
5 years and below	16	43	27.1	72.9
6-10 years	6	10	37.5	62.5
11-15 years	2	1	66.7	33.3
16-20 years	-	-	-	-
Total	24	54	30.8	69.2

Source: Field study

The table shows 59 respondents out of 78 i.e. 75.64% out of the total respondents with 16 males and 43 females have a working experience in the programme for 5 years and below. 6 male respondents and 10 female respondents length of service is between 6-10 years. There are only 3 respondents 2 males and 1 female who have worked more than 11 years.

Table 6.4: Staffing (Gender based)

Designation	Male	Female	Total	Percentage	
				Male	Female
Staff nurse	5	22	27	18.5	81.5
ASHA Mobilizer	8	16	24	33.3	66.7
Health worker	2	1	3	66.7	33.3
Clerical/Office Assistant	2	11	13	15.3	84.7
Counsellor	7	4	11	63.7	36.3
Total	24	54	78	30.8	69.2

Source: Field study

Staff nurses and ASHA Mobilizer is the major player in the machinery in the NRHM/NHM functions and activities. Among the Asha Mobiliser 33.3% are male while 63.7% are female. Male staff nurse accounted for 18.51% while female staff nurse accounted for a high percentage of 81.51% out of the total respondents. 67% of Health worker are male while female accounted for only 33% out of the total respondents. Among the clerical staff, only 15.38% constitute male respondents

while female clerical staff constitutes 84.62% out of the total respondents. 63.7% counsellors are male while 36.3% are female. However, the above table showed the range of responses and the inclusivity of the different types of workers under NHM/NRHM.

Table 6.5: Educational Qualification of functionaries

			Percentage	
Qualification	Male	Female	Male	Female
PG	7	11	38.9	61.1
Graduate (B.Sc./B/A etc)	8	19	29.6	70.4
HSSLC/Diploma	9	24	27.3	72.7
TOTAL	24	54	30.8	69.2

Source: Field study

The table showed that there are 18 PG degree/diploma holders which are 23.07%of the total respondents out of which 39% are male and 61% are female. A significant portion of degree level i.e., 27 persons are also present in the study out of which 30% represents male and 70% are female. There are 33 12th Standard or Diploma holders among the respondent and 27% are males and 73% are females.

Table 6.6: Mode of recruitment

			Percentage	
Mode of recruitment	Male	Female	Male	Female
Open recruitment	21	53	28.4	71.6
Direct appointment	3	1	75	25
Any others	0	0		
Total	24	54		

Source: Field study

Since all recruitment and appointment are done at the State Program Management Unit (SPMU) level as shown in the table, out of 78 respondents 21 i.e. 28.4% males are open appointment while there are 53 i.e. 71.6% females. There are

only 3 male respondents i.e. 75% who were given direct appointment along with 1 i.e. 25% are females.

Table 6.7: Knowledge level about NRHM/NHM

Parameter	Male	Female	Total
Vaguely	10	14	24
Knowledgeable	11	31	42
Very Much knowledgeable	3	9	12
Specialist	0	0	0
TOTAL	24	54	78

Source: Field study

A question about the respondent's knowledge of NRHM/NHM in general as shown in the table depicts that though 12 of them are well-versed as to the actual mandate of their service along with the 42 respondents who also have a general grasp of the mission, still 24 or almost 1/3rd of them have little knowledge of the whole mission and the administrative and policy guidelines etc.

Table 6.8: Major Problems faced in task

s/n	Problem description	Number of respondent
1	Outreach problem due to poor road condition	12
2	Problem due to slow supply of consumables and replacement of old equipment's	15
3	Delays in disbursement of salary	27
4	Shortage of man power	17
5	Shortage of water and power supply	7
6	Total	78

Source: Field study

The table depicts that out of the total respondents, 12 respondents felt that there is outreach problem due to poor road condition as the transport infrastructure in Mizoram is a fair-weather road. 15 respondents felt the problem due to slow supply of consumables and replacement of old equipment's because of poor road condition. 27 respondents felt that delays in disbursement of salary are a problem and shortage

of man power is a problem felt by 17 respondents. Water and electricity problem is also seen here and 7 respondents have felt it.

Table 6.9: Felt needs of functionaries

s/n	Changes required	Number/Value
1	No idea	23
2	Revision of salary	47
3	Means to strengthen manpower	39
4	Equipment and consumables supply to be improved	43
5	Total	152

Source: Field study

The table depicts the felt needs of the functionaries. 23 respondents have no idea to the felt needs while 47 of the respondents felt the need for salary revision which remains an important challenge, as the salary is very less compared to that of their government counterpart. 39 respondents felt the need to strengthen manpower as there is shortage of manpower. 43 respondents felt the need for improvement of equipment and consumable supply.

Table 6.10: Job satisfaction (on a scale of 1-10)

Scale	Number
1	0
2	0
3	0
4	0
5	0
6	13
7	27
8	38
9	0
10	0

Source: Field study

Reinforcing the previous question on staff satisfaction level through quantifiable indicator rating is concentrated within 6-8 by all. Despite the hurdles and

problems faced in discharging their duties, the data showed a self-satisfactory o on the part of the Nodal Officers and state level officials etc.

Table 6.11: Training's undergone

					Percentage	
s/n	Number and type of training	Male	Female	Total	Male	Female
1	No training	9	14	23	39.1	60.9
2	Induction training	15	31	46	32.7	67.3
3	Refresher training	0	0	-	-	-
4	Other training	17	38	55	31	69
5	Grand total	124				

Source: Field study

In the above table we find 23 personnel 9 of them i.e. 39.1% males and 14 i.e. 60.9% females who have not undergone any type of training. The SPMU visit confirms that there is no induction training or refresher training manual in the programme. But guidelines and specific training programmes are available which can be downloaded from the NHM website. No refresher training courses have been organised while 46 personnel 15 i.e. 32 .7% males and 31 i.e. 67.3% females have undergone induction training. 17 male personnel i.e. 55% male and 38 i.e. 69% female have undergone other training. This variable can be correlated to the previous question on the respondent knowledge and understanding of the Mission.

Table 6.12: Knowledge about the administrative framework and chain of command in NHM/NRHM

Level	Number
Very little	21
Some	46
Know enough	11
Very thorough	0

Source: Field study

The level of knowledge is assessed here, it can be seen that except for 11 respondent the knowledge level of 'some' and below indicates challenges in capacity

building for the headquarter office, since most trainings are centralized at the state level. Moreover, the state does not have a separate dedicated training agency.

At the facility level and at the SPMU level many members of the team had a few level of awareness. Personnel recruited for a specific purpose usually have knowledge of only the specific purpose for which they are recruited for. The chain of command is briefly known to most of them, but is unaware of the different level of committee and forum and decision making process in the overall administration

Table 6.13: Collaboration with other departments, agencies, NGOs

	Yes	No	Remark
NGOs	N/A		
Government Departments	25	53	Cited examples of ICDS, AIDS Control Programme

Source: Field study

As discussed in the previous chapter on convergence with other programs (nationwide developmental schemes/projects/missions) NRHM was originally more of a supplementary and complementary function for overall health alleviation, inter-sectoral collaboration or in other words collaboration was the essence tailored throughout its schemes, which is elaborated in various thematic focus such community process, VHSNC, reduction of IMR/MMR and quality maintenance on total fertility rate. However, the data in the given table reveals not much of convergence in reality. This is clearly seen in such processes and even a state level NACP and NRHM convergence committee exist and during the 12th plan a number of meetings took place focusing mainly on HIV-TB co-ordination and maternal child health and prevention of parent to child transmission of HIV.

Table 6.14: Functionality level of District Health Society

s/n		Number of respondents
1	Not functioning	0
2	Partial	16
3	Active	52
4	Commendable	10
5	Total	78

Source: Field study

The functionality of the District Health Society and its activeness level is visible to all respondents. 16 out of the total respondents felt the partial function of DHS while 52 respondents found it active. 10 of the respondents found it very commendable and the response from the functionaries (respondent) showed a positive impact of their presence

Table 6.15: Number of manuals read by the respondents

Response	Number of respondents
None	5
Once	43
2-3 times	22
More than five times	8
Total	78

Source: Field study

From the NHM website it can be seen that there are more than 30 manual and other reading materials from management level to front line workers. 5 respondents never read about the manual or other reading material while 43 out of the total respondents read the manual once and 22 respondents read two to three times while 8 respondents read it for more than five times. During the field visit which include both informal interaction with key officials and observation of the facilities, for each and every functionary a number of documents for improving their performance is available, reading with a purpose of learning and improving oneself is low as reflected by the table.

Table 6.16: Suggestions for meeting the goals of NRHM/ NHM

s/n	Responses	No. of respondent
1	No idea	11
2	Ensure adequate supply of equipment's and consumables in time	33
3	Adequate HR placement and sanction policy	52
4	Retention of employees	54
5	Others (Fund flow mechanism needs to be made smooth and in time)	4

Source: Field study

The table depicts that 11 respondents have no idea to give suggestion for meeting the goals of NRHM/NHM. 33 respondents suggest ensuring adequate supply of equipment's and consumables on time while 52 respondents suggest adequate HR placement and sanction policy. Retention of employees is suggested by 54 respondents while only 4 respondents suggest the need to make the fund flow mechanism smooth and on time.

Findings in relation to beneficiaries:

As already mentioned in the beginning of the chapter, the type II respondent is mainly targeted on the rural population who were the beneficiaries of NRHM. This exercise is to assess the opinion and feedback from the third party regarding highly deemed information which are common to the questions put forth in the previous Schedule for the functionaries of NRHM/NHM. There are a total of one hundred and forty-two (142) respondents with more male respondent at seventy-seven (77) i.e., 54.2% and forty-two (142) and sixty-five (65) i.e., 45.8% females.

Table 6.17: Age and sex of respondents

Age	Male	Female	Percentage	
			Male	Female
18 – 25	25	35	41.7	58.3
25 - 35	31	35	47	53
35 – 45	39	15	72.2	27.8
45 - 55	12	0	100	-
Total	77	65	54.2	45.8

Source: Field study

Out of the total of 142 respondents, 60 persons are from the age group of 18-25 out of which 25 persons are male that constitute 41.7 % of the total respondents, 35 persons i.e. 58.3% female respondents. From the age group 25-35, 31 i.e. 47% of the respondents are male while 35 i.e. 53% are female. From the age group of 35-45, there are more male respondents at 39 i.e. 72.2% while there are only 15 i.e. 27.8% female respondents. In the age group of 45-55, only male respondents are there.

Table 6.18: Marital Status

Status	Male	Female	Percentage	
			Male	Female
Married	44	21	67.7	32.3
Single	33	44	42.9	57.1
Divorced	0	0		
Widowed	0	0		
Total	77	65	54.2	45.8

Source: Field study

Out of the total respondents, 77 i.e. 54.2% are male while 65 i.e. 45.8% are female, 44 i.e. 67.7% males are married and 21 i.e., 32.3% females are married. As depicted in the table, 33 i.e. 42.9% males are single while 44 i.e. 57.15% are female.

Table 6.19: Educational qualification

Level	Male	Female	Percentage	
			Male	Female
Illiterate	0	0	-	-
Literate	5	0	3.5	-
Middle School	5	0	3.5	
HSLC	30	15	21.1	10.5
HSSLC	19	22	13.3	15.5
Graduate	14	24	9.8	17
PG	4	4	2.9	2.9
Doctorate/Specialist	0	0		
TOTAL	77	65		

Source: Field study

In terms of education, we find 5 male respondents who can just read and write while another 5 male respondents completed up to VIIth standard. 45 are Matriculates out of which 30 i.e. 21.1% are male while 15 i.e. 21.1 are female. 41 respondents have completed 12th Standard where 19 i.e. 13.3% are male and 22 i.e. 15.5% are female. Out of 38 graduates 14 i.e. 9.8% are male and 24 i.e. 17% are female. There are only 8 Post Graduate 4 male and 4 female respondents.

Table 6.20: Occupation

			Percentage	
Occupation	Male	Female	Male	Female
Government servants	67	58	47.1	40.8
Member of social work	2	3	1.4	2.1
Any others	5	7	3.6	5
TOTAL	74	68		

Source: Field study

Except for 17 out of 142 respondents all of them are government employees implying that the household is well taken care of and there is security and stability in their income. 67 respondents i.e. 47.1% are male government servant while 58 i.e. 40.8% are female. 5 respondents are connected with social work where 2 i.e. 1.4% are male respondents and 3 i.e. 2.1% are female. There are 12 respondents who are

engaged in other occupation out of which 5 i.e. 3.6% are male while 7 i.e. 5% are female.

Table 6.21: Knowledge about NRHM/NHM

			Percentage	
Level	Male	Female	Male	Female
Not aware	0	0	-	-
Basic knowledge	77	62	54.2	43.7
Well-versed	0	3	-	2.1
Total	77	65		

Source: Field study

Most of the respondents that is 139 out of 142 out of which 77 respondents i.e. 54.2% males and 62 i.e. 43.7% females are briefly aware of NRHM/NHM i.e. having a basic knowledge of the Mission like it is a mission of the central programme targeted for rural areas while 3 female respondents i.e. 2.1% are more than aware and have a more insight to the programme.

Table 6.22: Benefit from NRHM/NHM

Response	Number of respondents
Yes	57
No	85
Total	142

Source: Field study

The above table shows that out of the total of 142 responses, 57 of them i.e. 40.1% are direct beneficiaries of NRHM/NHM while 85 of them (as per their knowledge) i.e. 59.9% do not benefit from NRHM/NHM directly at all.

Table 6.23: Satisfaction regarding NRHM/NHM activities in the state

Responses	Number	Percentage
Not satisfied at all	0	-
Satisfied to some extent	9	6.3
Satisfied	133	93.7
Highly satisfied	0	-
TOTAL	142	

Source: Field study

Despite having stated that they are not being directly benefited by NRHM/NHM as shown in table no 6.24, there is a certain amount of knowledge by which all the respondents came to be aware of the mission. 9 out of the total respondents i.e. 6.3% are satisfied to some extent and the remaining 133 i.e. 93.7% are satisfied to the performance and activities of the Mission. This is an overall impression felt by the respondents.

Table 6.24: Attended any clinical service, awareness programme, trainings etc.

s/n	Responses	Number of respondents	Percentage
1	Yes	4	2.9
2	No	138	97.1
	TOTAL	142	

Source: Field study

From the table only 4 i.e. 2.9% of the respondents have the chance of exposure to the clinical service awareness programme, training etc. while 138 respondents i.e. 97.1% not attended any. This indicates that for saturated coverage of raising all parameters of health among the public there is still a huge void to be addressed.

Table 6.25: Knowledge on District Health Society and their functioning.

Responses	Not Aware	Aware	Percentage	
			Not aware	Aware
No. of respondents	137	5	96.4	3.6

Source: Field study

The presence of the district health Society is not known by 137 out of 142 respondents which is 96.4%. Only 5 out of the total respondents i.e. 3.6% are aware of it. District Health Societies are the actual spear-header of the mission in the district However, though the NRHM/NHM and functions/activities are common, the District Health Society which is mandated to sit only once in every quarter may not be publicized adequately. But it is important that the general public is aware of its presence and its function as a district level entity responsible for the whole mission with the participation of representative from the media, general society, Voluntary organization, Church members etc.

Table 6.26: Perceived major challenges of NHRM/NHM in Mizoram

s/n	Responses	Number of respondents	Total respondents	Percentage
1	Don't have any experience/ No idea	79	142	55.7
2	No following on programme	1		0.7
3	Lapses of beneficiaries	1		0.7
4	Posting of non-resident functionaries	38		26.8
5	Lack of awareness	20		14
6	The burden of communicable diseases persists in rural areas	3		2.1

Source: Field study

Tab;e 6.26 table depicts perceived major challenges of the beneficiaries in the NRHM/NHM. 79 respondents out of 142 i.e. 55.7% have no clear cut clue. 1 person i.e. 0.7% highlighted that the outcome of tobacco cessation counselling clinic was not seen as a very successful intervention. Another 1 person i.e. 0.7% mentioned about the Intensified Diarrhoea Control Fortnight where according to the respondent the quality of awareness program was easy to understand session but blamed the

targeted audience being not following instructions with the lessons imparted. 38 respondents i.e. 26.8% asserted that posting of non-resident functionaries poses some problems for the local residence that are in need of emergency medical care. 20 respondents of the target communities i.e. 14% are not aware of the facilities, services and programmes offered by NRHM leading to not availing of such by the community. This is similar to the interaction with the SPMU where the team led by the Mission Director expressed the need to invest more on generating demand to alleviate public health seeking behaviour which was seen to be very low even after almost two decades of the implementation of the mission. 3 respondents i.e. 2.1% stressed the burden of communicable diseases in rural areas.

Table 6.27: Suggestion for NRHM/NHM to meet its goals and objectives

s/n	Responses	Number of respondent	Total number of respondents	Percentage
1	More awareness	83	142	58.4
2	More workers from place of posting	35		24.7
3	More focus on remote areas	23		16.1
4	Medical infrastructure	1		0.8

Source: Field study

Awareness as the first stage towards public health promotion is seen as important by 83 i.e. 58.4% respondents out of the total of 142. 35 of the respondents i.e. 24.7% suggested more workers from the place of posting and 23 respondents i.e. 16.1% suggested that more focus should be given on remote areas. Only one person from the respondent felt the need for medical infrastructure.

CHAPTER VII

CONCLUSION

This chapter provides the summary and major findings of the study from the discussion in the previous chapters. An attempt has also been made to offer suggestions and recommendations wherever possible.

I: Summary and Findings

Health is seen as a development issue rather than just a medical issue in today's world because the health status of the people is considered as an important indicator of development. The government of India has taken a major initiative to deal with the issue of health under the umbrella of National Rural Health Mission (NRHM) which exist as a sub-mission of the National Health Mission on 1st May 2013 and are managed by the Ministry of Health and Family Welfare in close association with the states. The NRHM bridge the gap in rural health care service through improved service delivery mechanism by introducing advanced health care infrastructure, decentralization of programme, increase of human resource and effective utilization of resources. The NRHM governs itself through its five core approaches which are: i) Communitization, ii) Adequate and Flexible Financing, iii) Monitoring against IPH Standards, iv) Innovations in Human Resource Management, and v) Building Capacity at different Grassroots levels for Decentralized Health Action.

The services under NRHM are being offered from Block to Village level through a proper structure. At block level there is a Block Hospital known as BPHC, followed by PHC at clusters of village level, Sub Centre at the Village Council level and at the village level there is village Health Sanitation and Nutrition Committee (VHSNC). The administrative structure of NRHM is closely connected from state to district level. These structures have some similarities as well as differences. As per the Mission Document, at the national level, the NRHM has Mission Steering Group and Mission Directorate. At state level, NRHM has State Health Mission and State Health Society. State Health Mission considers policy matters related to health and

also review the progress in implementation of NRHM. The study reveals that under NRHM health services are reaching the beneficiaries at the district level where there is a District Health Mission and District Health Society. District Health Mission is responsible for planning, implementing, monitoring and evaluating the progress of the Mission at the district level.

Response to the research questions

1. *What are the administrative structures and mechanism involved in the process of implementation of NRHM?*

For its implementation, the NRHM/NHM at the national level has a Mission Steering group (MSG) headed by the Union Minister for Health & Family Welfare and an Empowered Programme Committee(EPC) headed by the union secretary for Health & Family Welfare. This EPC implements the Mission under the overall guidance of the MSG.

At the state level, the Mission functions under the overall guidance of the State Health Mission headed by the Chief Minister of the State. The functions under the Mission are carried out through the State Health Society under a separate secretariat called the State Programme Management Unit (SPMU) at the state level and the District Programme Management Unit (DPMU) at the district level. District Health Societies Chaired by the District Collector/Deputy Commissioner was also formed with the Chief Medical Officer as the key official both in terms of implementation and monitoring.

The District Health Society is the actual PIA at the district to grassroots level of all health programmes and accountable entity for all 'service delivery point' (all health service units from Tertiary Hospital level to ASHA level). At the village level a Village Health and Sanitation Committee are established where the concerned Health Worker acts as a member secretary cum executive official and the Village Council President as the Chairman. They are mandated with grassroots level activities from event observation, time bound health program operations etc. and are expected to converge with critical programs as ICDS/ICPS, Village Council

activities at the village level etc. Accredited Social Health Activists (ASHAs) are the front line worker at these levels, hence 'Community process' or in other words the concept of community led health intervention, prevention and response is realized by injecting ownership at the grass-root level through this institutional mechanism

2. *What are the basic components of NRHM/NHM implemented in Mizoram?*

There are six main financial components of the NRHM/NHM which were-

i) NRHM-RCH Flexi pool.

ii) NUHM Flexi pool.

iii) Flexible pool for Communicable disease.

iv) Flexible pool for Non communicable disease including Injury and Trauma.

v) Infrastructure Maintenance and capacity building.

vi) Family Welfare Central Sector component.

Though for implementation, the programme is divided or compartmentalized into the following:

a) RMNCH+A (Reproductive, maternal, New born, Child and Adolescent Health

b) Health system Strengthening

c) Communicable and Non-communicable disease control programme

d) Infrastructure Maintenance.

a) RMNCH+A: Improving the maternal and child health and their survival are central to the achievement of national health goals under the National Health Mission (NHM). SDG Goal 3 also includes the focus on reducing maternal, new born and

child mortality. In the past years, innovative strategies evolved under the national programme to deliver evidence-based interventions to various population groups.

Following the Government of India's "Call to Action Summit" in February, 2013, the Ministry of Health & Family Welfare launched Reproductive, Maternal, New born Child plus Adolescent Health (RMNCH+A) to influence the key interventions for reducing maternal and child morbidity and mortality. The RMNCH+A strategy is built upon the continuum of care concept and is holistic in design, encompassing all interventions aimed at reproductive, maternal, new born, child, and adolescent health under a broad umbrella, and focusing on the strategic lifecycle approach. The RMNCH+A strategy promote links between various interventions across thematic areas to enhance coverage throughout the lifecycle to improve child survival in India.

b) Health system strengthening: The Department of Health and Family Welfare (DoHFW), Government of Mizoram with technical and financial support from the World Bank, is implementing 'Mizoram Health Systems Strengthening Project' (MHSSP) in the State for improving the health status of its citizens. The MHSSP intends to strengthen the management capacity and quality of health services in Mizoram. The activities under the project are structured under the following four broad components:

Component 1: Strengthen management and accountability through Internal Performance Agreements: This will support the creation of an enabling environment for reforms at each level (state, district and sub-district), enhance performance of the DoHFW and its subsidiaries, and improve efficiency of the public health administration.

Component 2: Improve the design and management of the government-sponsored health insurance programs in the state: This will focus primarily on improving the overall design, management and the effectiveness of the health insurance schemes including the community interventions to increase enrollment in the program.

Component 3: Enhance the quality of health services and support innovations: The activities will support the development of the state health system, structural quality improvements and also pilot health innovations. Developing a comprehensive quality assurance system, improving biomedical waste management, enhancing human resource management are critical sub-components.

Component 4: Contingent Emergency Response Component: A mechanism for provision of immediate response to an Eligible Crisis or Emergency, as needed.

c) Non-communicable diseases:

i)National Program for Prevention and control of Cancer, diabetes, cardiovascular diseases and stroke (NPCDCS)

ii) National mental health Programme (NMPH)

iii) National programme for Healthcare of elderly (NPHCE)

iv) National programme the prevention and control of Deafness (NPCCD)

v) National Tobacco control programme (NTCP)

vi) National Oral Health Programme (NoHP)

vii) National Programme for Pallative Care (NPPC)

viii) National programme Prevention and management of Burned injuries (NPPMBI)

ix) Other Non-communicable disease control programmes.

Over and above the mentioned programmes, there are two types of implementation structures which are NACP-NRHM Convergence Committee and HIV-TB Co-ordination Committee both of which are Chaired by the Health Secretary.

3. *What are the measures adopted for improving the health of the people?*

For improving the health of the people/community the NRHM/NHM in Mizoram supplement and complement existing health programmes while instilling new innovation such as RKS, JSY, JSSK, Mobile Ambulance and strengthening critical unit as Village Health, Sanitation and Nutrition Committee (VHSNC). The establishment of Neonatal Intensive Care Unit (NICU) to reach and attain child survival and also care for the elderly which was more of social justice/Social Welfare mandate was also initiated. The new programme of Non-communicable diseases also served as an important and indispensable health initiative. IEC and IPC activities form a crucial element of the NRHM/NHM.

The increasing out of pocket expenditure (OOPE) was also addressed by the state government by means of attempting to implement Generic drugs at low cost (top 100 highest demand drugs were listed) with a low investigation scheme for top 100 laboratory investigations. However, as expressed by the SPMU team this did not yield the desired and expected result. As awareness was still low and many Doctors would prescribed only branded company made medicine and diagnostic facilities of the private sector, the situation is not to be amazed of, however the concern to remove this would yield in reducing OOPE by the general population and moreover the rural populace and low income groups

4. *What are the major challenges faced in the implementation of the NHM/NRHM?*

There is a highly un-negligible level of response from the 3 different respondents highlighting the needs to address the following:

1. There is inadequate HR in the service delivery point (health institutions).
2. There is shortage of specialist and nurses
3. There is problems in equipment, machineries and consumables where timely delivery is a top priority.

4. The service matter and salary not only in the volumes but also the amount paid to the highly demanding Terms of Reference (ToR) of the job of the respondent is very crucial to the service quality and performance.

5. *What measures can be taken to improve the implementation of the NRHM/NHM?*

As per the field level data (primary) obtained from the respondent three things are very clear i.e. inadequate HR, salary delay and the amount, equipment and machineries including consumables etc. Taking these into account along with observation and informal interaction with the key functionaries of the whole health department the following points need to be kept in mind

1. Adherence to guidelines: In no instances of place, people or setting, it was seldom a sight to witness adherence to the guideline right from the incumbent of the Mission specialists in the SPMU i.e. the Epidemiologist and an SMO who looks after M&E.

2. Fund flow problem as was reflected across all respondents' typologies has to be addressed. It highly recommended that the SPV concept needs to be retained again so that funds from union and state directly be credited to the Society's account. This will have a positive impact on salary, procurement of needs.

II: Problems and Challenges

1. The State government has introduced health care scheme to cover medical treatment for those who registered themselves under the scheme. While such cover has helped many people, there is evidence in the State that medical reimbursement takes over a long period of time which becomes a hindrance for getting further treatment especially for the rural poor.

2. As incorporating patient views into quality assessment offers one way of making health services more responsive to people's needs, the excessive emphasis on service coverage and inputs in the provision of health services has ignored the needs of the very people for whom these health services exist.

3. In principle, many rural programmes of the government including the NRHM are meant to be complementary and synergistic. But in reality, there seems to be lack of coordination and synergy between the workers employed by the different programmes while the goal of health for all requires cooperative teamwork among the many schemes and departments of the government.

4. The NRHM is intended to strengthen and support the existing State health systems and services. The administrative machinery of the NRHM and health services at the national, State and district levels remains separate without complete integration, making the programme less effective and the services less than optimal. Independent and vertical disease control programmes also continue to operate with separate societies and line management.

5. There is a marked variation in the NRHM process indicators, utilization of funds, improvement in health care delivery, health indices and in community participation which suggests that region with good health indices have shown marked improvements, while those with prior poor indices have recorded a much lesser change.

6. Poverty and lack of financial resources contribute greatly to health care challenges in rural India. Many rural people cannot afford to pay for health care services or medications and this financial problem deter them from seeking medical help.

7. Population health and its impact on the social and economic production system is a major development challenge. Inspite of the remarkable economic progress in recent years, it does not seem that these benefits have translated into a quicker transition to better health or an increase in the general state of people's health.

8. One of the most significant health issues confronting humanity is antimicrobial resistance, which arises when bacteria, viruses, fungi, and parasites cease to respond to antimicrobial medications. This issue needs to be addressed seriously.

9. There is limited emphasis on preventive healthcare. There is a lack of focus on promoting preventive measures such as health education, awareness campaigns, and immunization programs which can lead to a higher burden of preventable diseases in rural areas.

10. Another challenge is to make the district plan an effective tool of organising the health system as a single multifunctional district level network. For this, one needs to base district planning on information (provided before planning) about the resource envelope available to it, and more pragmatically provide for a post sanction implementation-planning stage with provision for greater flexibility of moving resources to respond to needs and utilization patterns within an agreed plan.

The problem of data collection may be mentioned herewith that, there the collection process was hampered by Covid-19 pandemic where restrictions and Standard Operating Procedures etc. were strictly imposed and implemented throughout the state, mobility was a problem and took days of application from moving one place to another. Both at the Health Institution settings and offices the covid fright had a huge impact and it can be clearly seen that people are not in the mood for responding to this kind of interview and visits

III: Suggestions

1. Timely payment of salary would make the workers under NRHM/NHM to work with more zeal and dedication.

2. There is a need for better utilization of budgetary resources, both under the state department of health and the National Rural Health Mission, to increase health manpower and improve quality through training and better management resources in order to improve district health systems in Mizoram.

3. Without having enough capability of personnel it is not possible to bring all kinds of new and innovative medical services. There exist shortage of personnel under NRHM/NHM which should be taken into consideration so that their potential could be realized and increase the working performance of existing personnel system.

4. There is a need to make the people aware of the programme of NRHM/NHM. Most of the respondents only have basic knowledge of it.

5. All the health facilities must achieve the Indian Public Health Standards (IPHS) norms for continuous improvement in quality and serve as a benchmark for assessing the functional status of health facilities.

6. First Referral Unit (FRU) which is a clinical facility equipped to provide round the clock services for emergency obstetric and new born care, in addition to all emergencies that any hospital of substantially similar size is ordinarily required to provide should be strengthened.

7. There is a need for improvement of female sterilization which should attract more attention especially for family planning.

8. Due to inadequate medical treatment many patients who lived with prolonged chronic diseases died in the hospital which calls for the need for establishing multi specialty hospitals.

9. A well laid out and well-maintained road network is essential for cost-effective affordable and accessible movement of people and for transportation of medicines.

10. Health problems are arising due to rapid urbanization of environmental degradation. The nationwide health infrastructure and the on-going national health programmes have failed to provide adequate and quality health care to meet the need of the population. The study suggests that effective health information system should be established.

11. Private sector can support the health promotion and disease prevention activities under public–private partnership and through the corporate social responsibility initiatives.

12. Due to the shortage of doctors and nurses, the patients waited for a long time in the hospital. To ensure more effective health services to the people, sufficient doctors and nurses who are trained under NRHM should be placed in rural areas.

13. Good quality and adequate drugs, vaccines and equipment should be manufactured and made available at affordable prices.

14. Home-based neonatal care, including management of sepsis reduced neonatal and infant mortality among the malnourished, illiterate approach would reduce neonatal mortality substantially in the state.

15. It is difficult to place the doctors trained under NRHM in remote rural areas without a differential payment and which lack in basic amenities and services at the health centre as well as the locality. Therefore, there is a need for differential payments to make it attractive for the health care staffs who works in remote situations and difficult contexts.

16. The government should release the fund on time not only for giving the salary under NRHM/NHM but also for programmes and activities.

17. All the villages should be served by a facility in modern medicine also known as Allopathic medicine that involves the use of drugs and surgeries to help and cure the disease or solve the problem of the patient.

18. For the improvement of living conditions of the backward classes of the state, there should be a wide spread of literacy and education

19. In course of the interview, it was found that Medical reimbursement under NRHM takes a long time which makes it difficult for the patient to get further treatment. The government should look into this problem and tries to release the medical reimbursement as soon as possible.

IV: Evaluation of the working of NRHM in Mizoram

Based on the study, it can be said that there are a number of issues, including insufficient funding released, non-payment of the State's share, inadequate use of funds, financial mismanagement, lack of personnel in critical positions, inadequate infrastructure, arbitrary procurement practices, insufficient supply of medications

and ssvaccines, disregard for endemic areas, undue financial benefit to suppliers, diversion of funds, and a failure to meet the scheme's objectives.

Regarding service delivery, the NRHM ensure the availability of adequate number of health facilities and also improve the quality of services. As for the health workforce, it establishes a policy for human resources for health, improve the availability of human resources for health and also improve the skills of health workers. As for the health information, it improves the availability and access to health information. It also streamlines reporting channels and improves the use of data. In governance, it foster stewardship in the health sector, in still managerial and leadership instincts in the health workforce and also improve community participation in governance. The critical evaluation of NRHM in Mizoram up to June 2009 maybe summarized as follows-

The State and District Health Missions have been meeting on a regular basis; the meetings of State Health Mission was held three (3) times and the District Health Mission met forty-four times. Nine (9) districts have completed merging their societies, 817 Village Health and Sanitation Committees(VHSC) have been established, and 786 joint accounts at the sub-center level have been operationalized. There are 56 Primary Health Centres (PHC), 9 Community Health Centres(CHC), and 8 District Hospital (DH) that are served by Rogi Kalyan Samiti (RKS). In order to make the 32 PHCs operational for work around-the-clock, each PHC has been fortified with three staff nurses. The State has 292 completed facility surveys and 367 CHCs that are open around-the-clock (including other health facilities that are below the district level). As First Referral Units, 33 District Hospitals are now in operation. Mobile medical units (MMUs) are operational in each of the eight districts. A total of 978 Accredited Social Health Activists (ASHA) have been selected and 978 are trained up to the second module. And 943 ASHAs have been provided with drug kits. 421 sub-centres are functional with an ANM, and 138 SCs are strengthened with a second Auxiliary Nurse and Midwifes(ANM). The State has appointed 10 contractual Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy(AYUSH) and as far as manpower augmentation is concerned, 36

Doctors, 202 Student Nurse(SN), 373 Auxiliary Nurse and Midwifes(ANM) were recruited on a contractual basis.

Institutional deliveries have been improved from 0.14 lakhs (06-07) to 0.19 lakhs (07-08). During the year 2008–2009 Institutional deliveries in the state are 0.15 lakhs. There is no difference in the number of JSY beneficiaries and is the same 0.13 lakhs in 06-07 and 0.13 lakhs in 07-08. The number of JSY beneficiaries was 0.14lakh during the year 08-09. Female sterilization have increased from 0.003 lakh (06-07) to 0.02 lakh (07-08) and male sterilization has the same number from 0 (06-07) to 0 (07-08). During the year 2008–2009, 1301 female and 4 male sterilizations were done[98]. The number of cases at different Block PHCs and sub-centers has gone up and vaccinations are regularly administered at all centers.

As per the MOU signed between the State Government and the GOI, the State Government was to contribute 15 per cent of the funds released by the GOI for 2007-08 and State share on health budget was to be increased by at least 10 per cent every year during the Mission period (2005-12). The State Government failed to release (2007-08) its share of Rs. 3.51 crore. The commitment on increasing its budgetary allocation was also not met, as the increment was well below four per cent for the years 2005-08[99].

The objective of providing accessible health care in hilly and remote areas, however, was not achieved, since these centres were not equipped with adequate staff as per norms. Based on the prescribed staffing norms of the Indian Public Health Standard (IPHS), the CHCs, PHCs and SCs are to be manned and equipped with sufficient basic physical infrastructure and essential equipment to provide essential/specialist services. As against these norms, it was revealed shortages in manpower (especially medical officers including specialists and paramedical staff) for providing basic/ specialist services. Thus, though the number of centres were

[98] https://www.nhm.gov.in › pdf › mizoram_report PDF

[99] https://cag.gov.inCivil_Mizoram_2008 › chap_3

above the prescribed norms, yet they were not able to function effectively due to the absence of the required manpower and other infrastructural facilities.

The performance of RCH programme was reportedly impeded by the lack of adequate ANMs and MPWs, inadequate motivation and lack of utilization of trained female community health workers i.e. Accredited Social Health Activist (ASHA) network to be provided in each village, insufficient and irregular supply of essential drugs, contraceptives, vaccines, equipment etc. to health centres, low IEC activities, and shortage of manpower in key functional posts.

Household surveys and facility surveys were not conducted during 2005-07 and it was only in 2007-08 that the facility survey was conducted by the staff of the health department. These staff were, however, not imparted any specific training on the basic modalities of the survey. Further, the Perspective Plan (2005-12), State PIP for 2005-06 and District Health Action Plan for 2005-07 were not prepared. However, State PIP for 2006-07 was prepared based on the feedback received from the district level and the PIP for 2007-08 was prepared based on the appraisal of the District Health Action Plans[100].

Since its inception, a Letter of Undertaking/Memorandum of Understanding was signed between the Union government and the state government with a 75:25 budget sharing between the union and the state except for NE states and other backwards Union Territories etc. who are relaxed to a 90: 10 basis with a number of terms of references and detailed mandatory functions by both the parties. In the States and Union Territories, the states were mandated to have a State Health Society with layers of committees the highest under Chief Minister chairpersonship and a Village Health and Nutrition committee at the grass root. The actual main functional executive was the Executive Committee Chaired by the Principal/Commissioner of Health Department at the state level and the Mission Director being the Member Secretary (who should be an IAS of Supertime scale). The states were mandated to

[100] https://cag.gov.in › Civil_Mizoram_2008 › chap_3

have a secretariat headed by the Mission Director with a few administrative and technical experts at his disposal. District Health Societies were to be the arms and branches of the SPMU having its own District Program Management Unit. In 2005, Mizoram also oathed and commenced the NRHM with a poor administrative policy of human resource. The post of Mission Director was given to the Joint Director of Health Services (Family welfare) and through assessment we can see from the following points that such deliberation against the Memorandum of Understanding was quite a negative start. Hardly was the government/department aware that the Mission Director would be calling the District collector/Commissioner at least twice or thrice in a year. Now gathering a few facts and finding as mentioned:

i)The state government was not aware from head to tail of its mandatory obligation and function of NRHM before signing the Memorandum of Understanding with the Centre

ii) The state did not strive enough to put IAS officers to the Mission Director post much to the liking of the Mizoram Health services.

iii) However, there was already Public Health specialist among the medical fraternity, already in the state for whom post could be allotted.

iv) The state or any governing political party has a strong, dynamic, and SMART (Specific, Measurable, Attainable, Relevant, Time Bound) health policy and should have been prioritized above all others. As a result, the state of Mizoram can now have its own health policy in addition to simply adhering to the federal guidelines.

v) The National Health Policy, the NRHM/NHM mandates, and public health policy could work together and merge

vi) The success or failure or achievement of the NRHM/NHM was quite dependent on individuals rather than system.

vii) Both at the National and state level, many ideal connotation and terms were repeatedly used as an indispensable task such as convergence, inter-sectoral

collaboration etc. lie unpracticed in the so called modus operandi, note sheets and in meetings.

viii) At the state level the SPMU functions like an implementing agency and decentralization was not properly administered as envisaged. It took decades to follow the PFMS in financial administration and procurement, recruitment etc.

ix) The declining performance across most of the states came when funding pattern which was earlier directly credited to the Society was shifted to the state government through finance department. This resulted in delayed implementation of activities, all or most of the NRHM/NHM staff (contractual) was delayed on salaries, TA/DA reimbursement, procurement delay, civil works etc.

x) Public Health cadre is not made lucrative and till date it has miles to go especially on the posting and transfer norms, training & capacity building norms. While clinical PG courses remained the aspirations of most of the general duty medical officers, as they could earn hugely from their private clinic.

xi) Mizoram is fortunate to have at least 2-3% of its GDP on Health but this is not judiciously and strategically planned or utilized most of it goes to salaries and HR it is almost totally dependent on NHM now.

xii) Absence of bottom up approach in planning, Monitoring & Evaluation learning and documentation

xiii) Lack of convergence among the different key technical groups even within the health administration such as nursing, food and drugs control, AYUSH, paramedical etc.

It is important to be reminded oneself that NRHM/NHM is a public health strategic mission to alleviate the public health, healthcare quality and provision of sufficient components and policies through a comprehensive and public health approach. Though the mission statement, objectives and framework seemed exhaustive in principle however, the implementation claimed a number challenging factors and raising concerns and issues.

V: Conclusion

NRHM primarily aimed to address the health needs of underserved rural areas through an architectural correction of the health system. The key goals of NRHM is towards enabling and achieving the stated vision, making the system responsive to the needs of the citizens, and building a broad-based inclusive partnership for realizing the goals of the government which focuses on the survival and well-being of women and children, reducing existing disease burden and ensuring financial protection for households. The idea behind the Mission is to provide universal access to equitable, affordable, and quality health through an integrated approach as well as to bring about institutional changes such as decentralization of the public health system; integration of organizational structures; community participation and ownership of assets; and convergence in services which co-determine health outcomes (e.g. food, nutrition, water and sanitation).

NRHM is a mission that has immediate potential to improve the health of the people in the country and provide equitable, affordable, and quality health care to the people, especially for those residing in rural areas, the poor, women, and children. The study reveals that despite numerous problems, the NRHM has proved to be one of the successful schemes of the Government of India and it has able to change the existing health scenario and began to make a difference in the lives of rural inhabitants India. The present study is the first attempt in Kolasib district to look into the implementation and working of NRHM. These results suggested that the scheme has a significant impact on improving the health of the people in rural areas. The findings and suggestions are hoped to have further policy implications for policy makers for years to come.

APPENDIX-I

INDICATORS (NFHS 15-16) Kolasib District

SL/NO	Population and Household Profile	URBAN	RURAL	TOTAL
1.	Population (female) age 6 years and above who ever attended school (%	94.7	88.0	92.8
2	Population below age 15 years (%)	28.4	36.0	30.7
3	Sex ratio of the total population (females per 1,000 males)	1,031	909	992
4	Sex ratio at birth for children born in the last five years (females per 1,000 males)	1,001	977	992
5	Children under age 5 years whose birth was registered (%)	99.6	96.2	98.3
6	Households with electricity (%)	99.2	97.8	98.8
7	Households with an improved drinking-water source1 (%)	97.5	96.0	97.0
8	Households using improved sanitation facility2 (%)	90.1	79.7	87.0
9	Households using clean fuel for cooking3 (%)	82.0	38.9	69.2
10	Households using iodized salt (%)	99.7	98.1	99.2
11	Households with any usual member covered by a health scheme or health insurance (%)	60.6	65.3	62.0
Characteristics of Adults (age 15-49)				
12	Women who are literate (%)	97.2	88.1	94.7
13	Men who are literate (%)	99.5	96.6	98.6
14	Women with 10 or more years of schooling (%)	36.6	17.1	31.1
Marriage and Fertility				
15	Women age 20-24 years married before age 18 years (%)	13.8	20.3	15.5
16	Men age 25-29 years married before age 21 years (%)			(20.4)
17	Women age 15-19 years who were already mothers or pregnant at the time of	6.7	10.6	7.8

	the survey (%) 6			
Current Use of Family Planning Methods (currently married women age 15–49 years)				
18	Any method4 (%) 34.1 32.3 33.5 19. Any modern method	34.1	32.3	33.5
19	Any modern method4 (%)	33.9	32.1	33.3
20	Female sterilization (%)	15.4	15.2	15.3
21	Male sterilization (%)	0.0	0.2	0.1
22	IUD/PPIUD (%)	3.1	2.3	2.8
23	Pill (%)	13.9	13.7	13.8
24	Condom (%)	1.5	0.8	1.3
Unmet Need for Family Planning (currently married women age 15–49 years)5				
25	Total unmet need (%)	15.8	24.8	18.7
26	Unmet need for spacing (%)	11.2	15.9	12.7
Quality of Family Planning Services				
27	Health worker ever talked to female non-users about family planning (%)	15.6	23.3	17.7
28	. Current users ever told about side effects of current method6 (%)	53.5	42.5	49.9

INDICATORS (NFHS 15-16) Kolasib District

SL/NO	Maternal and Child Health	URBAN	RURAL	TOTAL
29	Maternity Care (for last birth in the 5 years before the survey	72.9	52.8	66.1
30	Mothers who had antenatal check-up in the first trimester (%	78.6	43.8	66.8
31	Mothers who had at least 4 antenatal care visits (%	89.8	75.5	84.9
32	Mothers whose last birth was protected against neonatal tetanus7 (%)	66.2	44.6	58.8
33	Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	53.8	26.8	44.7
34	Mothers who had full antenatal care8 (%)	99.2	94.9	97.8
35	Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	72.9	55.6	67.1
36	Mothers who received postnatal care from	52.0	37.1	48.0

	a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)			
37	Mothers who received financial assistance under Janani Suraksha Yojana (JSY) for births delivered in an institution (%)	3,292	2,360	3,024
38	Average out of pocket expenditure per delivery in public health facility (Rs.)	*	0.0	0.0
39	Children born at home who were taken to a health facility for check-up within 24 hours of birth (%)	*	11.9	2.8
40	Children who received a health check after birth from a doctor/nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	*	*	*
Delivery Care (for births in the 5 years before the survey)				
41	Institutional births (%	98.5	66.0	86.3
42	Institutional births in public facility (%)	88.9	60.4	78.3
43	Home delivery conducted by skilled health personnel (out of total deliveries) (%)			
44	. Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	98.5	71.4	88.4
45	Births delivered by caesarean section (%)	12.5	4.7	9.6
46	Births in a private health facility delivered by caesarean section (%)	11.6	6.9	10.2
Child Immunizations and Vitamin A Supplementation				
47	Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	55.1	44.9	51.3
48	Children age 12-23 months who have received BCG (%	63.5	65.0	64.1
49	Children age 12-23 months who have received 3 doses of polio vaccine (%	63.7	56.5	61.0
50	Children age 12-23 months who have received 3 doses of DPT vaccine (%)	62.7	56.9	60.5
51	Children age 12-23 months who have received measles vaccine (%)	60.2	50.0	56.4
52	Children age 12-23 months who have received 3 doses of Hepatitis B vaccine (%)	58.0	56.1	57.3
53	Children age 9-59 months who received a vitamin A dose in last 6 months (%	77.8	60.8	71.4
54	Children age 12-23 months who received	96.5	100.0	97.8

	most of the vaccinations in public health facility (%)			
55	Children age 12-23 months who received most of the vaccinations in private health facility (%)	3.5	0.0	2.2
Treatment of Childhood Diseases (children under age 5 years)				
56	Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey (%	3.0	5.5	3.9
57	Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%)	*	*	(83.3)
58	Children with diarrhoea in the last 2 weeks who received zinc (%).	*	*	(10.5)
59	Children with diarrhoea in the last 2 weeks taken to a health facility (%)	*	*	(55.9)
Treatment of Childhood Diseases (children under age 5 years)				
60	Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey (%)	3.0	5.5	3.9
61	Children with diarrhoea in the last 2 weeks who received oral rehydration salts (ORS) (%	*	*	(83.3)
62	Children with diarrhoea in the last 2 weeks who received zinc (%)	*	*	(10.5)
63	Children with diarrhoea in the last 2 weeks taken to a health facility (%)	*	*	(55.9)
64	Prevalence of symptoms of acute respiratory infection (ARI) in the last 2 weeks preceding the survey (%)	1.5	0.9	1.3
65	Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility (%)	(73.8)	(40.4)	61.5
Child Feeding Practices and Nutritional Status of Children				
66	Children under age 3 years breastfed within one hour of birth9 (%)	79.6	79.9	79.7
67	Children under age 6 months exclusively breastfed10 (%)	*	(81.5)	70.6
68	Children age 6-8 months receiving solid or semi-solid food and breastmilk10 (%	*	*	(79.6
69	Breastfeeding children age 6-23 months receiving an adequate diet10,11 (%)	18.5	19.3	18.8
70	Non-breastfeeding children age 6-23 months receiving an adequate diet10,11 (%)	*	*	(11.5)
71	Total children age 6-23 months receiving an adequate diet10,11 (%	18.4	16.9	17.8
72	Children under 5 years who are stunted	22.3	33.3	26.3

	(height-for-age)12 (%)			
73	Children under 5 years who are wasted (weight-for-height)12 (%)	6.4	6.8	6.6
74	Children under 5 years who are severely wasted (weight-for-height)13 (%)	2.4	2.3	2.4
75	Children under 5 years who are underweight (weight-for-age) 12 (%)	9.7	14.5	11.4

APPENDIX-II: QUESTIONNAIRE

Interview Schedule I

(For beneficiaries)

Date & time_____

Name and of interviewee :

Occupation :

Age and Marital Status :

Qualification :

1. What do you know about NRHM/NHM in Mizoram?

2. Are you directly benefitted by NHM ?

3. How satisfied are you with role and function of NHM in Mizoram in alleviating Public Health?

Not satisfied at all -

Satisfied to some extent -

Satisfied -

4. Have you attended any clinical service, awareness program, trainings, etc. under NHM ?

5. Are you aware of the District Health Society?

6. Based on your experiences/knowledge what do you think are the major challenges of NHM in Mizoram.

7. Given the chance to do what you think is necessary what will you do in NHM for meeting its goals and objectives?

Thank you for your time

Interview Schedule II

(for Health personnel govt/private/NGO)

Date & Time_____

Name and of interviewee :

Occupation :

Age and Marital Status :

Qualification :

1. How long have you been in the service?

2. What is your role in NRHM?

3. What do you know about NHM Mizoram?

Vaguely-

Knowledgeable-

Very much Knowledgeable-

Specialist-

4. Based on your experiences/knowledge what do you think are the major challenges of NHM in Mizoram

5. What, in your opinion are the felt needs of NRHM?

6. How satisfied would you be in your role on a scale of 1-10?

7. Do you have any training under NRHM?

8. What do you know about the administrative framework and chain of command in NRHM?

9. Are you aware of the District Health Society? How functional is the District Health Society?

10. Have you ever read the manuals of NRHM? If yes, how many times

11. Given the chance to do what you think is necessary what will you do in NHM for meeting its goals and objectives?

Thank you for your time

BIBLIOGRAPHY

Books

Bose, A., Gupta, D.B., & Premi, M.K. (1982). *Social Statistics, Health and Education In Mizoram*. Vikas Publishing House Private Ltd.

Goel, S.L. (1984). *Public Health Administration*. Sterling Publishers Pvt Ltd.

Kanagasabai, C.S. (2003). *Economics of Human Resources Development*. Rasse Publications.

Ma, S. & Sood, N. (2008), *Comparison of the Health Systems in China and India.* Rand Corporation.

Prasad, R.N. & Aggarwal, A.K. (2003). *Modernization of Mizoram*. Mittal Publications.

Journals

John, T.J. & Muliyil, J. (2009). Public Health is Infrastructure for Human Development The Challenges of the states of North-Eastern" *Indian J Med* Res *130*(1), 9-11.

https://pubmed.ncbi.nlm.nih.gov/19700794/

Patil, A.V., Somasundaram, K.V., & Goyal, R.C. (2002). Current health scenario in rural India. *Aust J Rural Health, 10*(2), 129-35. DOI: 10.1046/j.1440-1584.2002.00458.x accessed on 18.07.2017

Peters, D.H., Rao, K.S., & Fryatt, R. (2003). Lumping and splitting: the health policy agenda in India. *Health Policy Plan 18*(3): 249–260. DOI: 10.1093/heapol/czg031

Web Sources

htpps://www.indianetzone.com/47/kolasib_district.htm accessed on 29.12.2017

https://nhm.gov.in/New_Updates_2018/NHM/NHM_Framework_for_Implementation__08-01-2014_.pdf accessed on 18.07.2018

www.nhm.gov.in/images/pdf/about-nrhm/nrhm-framework-implementation accessed on 28.04.2019

Ministry of Health and Family Welfare, Government of India. *National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation 2005-2012.* accessed on 15.07.2018

https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf accessed on 25.07.2017

https://www.yumpu.com/en/document/view/4086436/national-training-strategy-ministry-of-health-and-family-welfare. accessed on 06.8.2019

https://www.health.gov.in accessed on 06.05.2017

https://nhm.gov.in/index1. accessed on 8.12.2019

www.nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf accessed on 14.09.2017

https://www.niti.gov.in/sites/default/files/2023-Impact of NHM on Health Systems 15.05.2018

https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf 18.07.2017

National Rural Health Mission (NHRM), Budgeting for change series, 2011. www.cbgaindia.org/wp-content/uploads/2016/04/NRHM.pdf accessed on 14.09.2017

Sharma, A.K. *Sociological Critique of the National Rural Health Mission: Issues and Priorities,* Sociological Bulletin Vol. 63, No. 2, May - August 2014 accessed on 19.02.2019

http://home.iitk.ac.in/~arunk/Paper on NRHM.pdf accessed on 12.12.2017

https://www.researchgate.net/publication/290447383_Historical_Development_of_Health_Care_in_India accessed on 12.05.2018

BRIEF BIO-DATA OF THE CANDIDATE

Name : LALENGMAWII

Date of Birth : 22nd April 1973

Occupation : Assistant Professor,

Department of Public Administration

Govt. Kolasib College, Kolasib, Mizoram

Permanent Address : B 58/1, Mac Donald Hill,

Zarkawt, Aizawl, Mizoram

Email ID : maengi.khawlhring2012@gmail.com

Educational Qualification:

Educational Qualification	*Division*	*Board/ University*
HSLC	IInd Division	Mizoram Board of School Education
PU	IInd Division	North Eastern Hill University
BA	IInd Division	North Eastern Hill University
MA	IInd Division	North Eastern Hill University
M.Phil	A Grade	Mizoram University
NET(2000)	Lectureship	University Grant Commission

PARTICULARS OF THE CANDIDATE

NAME OF CANDIDATE	: LALENGMAWII
DEGREE	: Doctor of Philosophy
DEPARTMENT	: Public Administration
TITLE OF THESIS	: Health care administration in Mizoram: A Study of National Rural Health Mission in Mizoram
DATE OF ADMISSION	: 12.8.2014
BOS	: 8.4.2015
SCHOOL BOARD	: 1.5.2015
MZU REGISTRATION NO.	: 5915 of 2012
Ph. D. REGSITRATION NO.& DATE	: MZU/Ph. D/769 of 01.05.2015

(Prof. LALRINTLUANGA)
Head
Department of Public Administration

ABSTRACT

HEALTH CARE ADMINISTRATION IN INDIA: A STUDY OF NATIONAL RURAL HEALTH MISSION IN MIZORAM

AN ABSTRACT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

LALENGMAWII

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DEPARTMENT OF PUBLIC ADMINISTRATION

SCHOOL OF SOCIAL SCIENCES

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BY

LALENGMAWII

Department of Public Administration

Supervisor

Dr. LALTANPUII RALTE

Submitted

In partial fulfillment of the requirement of the Degree of Doctor of Philosophy in Public Administration of Mizoram University, Aizawl.

Introduction

The term ‘Health’ is as large and complex as the entire scope of human activities. Health is a vital component as well as a crucial index of social and economic development of a country. WHO defines health as, ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ and has defined a health system to include all the activities whose primary purpose is to promote, restore or maintain health. Health is the World’s largest industry. Health is not the mere absence of disease. Good Health confers on a person or group’s freedom from illness - and the ability to realize one's potential. Health is, thus, best understood as the indispensable basis for defining a person's sense of well-being. Health care covers not merely medical care, but also all aspects of preventive care too. It is the maintenance or improvement of health through prevention, diagnosis, treatment, amelioration, or cure of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields. Providing health care services means the timely use of personal health services to achieve the best possible health outcomes. Health care administration is the management of all the non-clinical functions involved in operating a healthcare facility, from day-to-day operations to staffing to budgeting and finance to long-term strategic planning to ensure the success of the healthcare provider or system. Healthcare administration represents an essential component of the healthcare industry, ensuring the efficient and coordinated delivery of health services, and the effective management of hospitals and other healthcare facilities. It is a field related to leadership, management, and administration of public health systems, hospitals, and hospital networks. Health care administration is a profession that deals with the provision of leadership, guidance and management in health systems. Health care remains one of the most important human endeavours to improve the quality of life. The main objective of any health care system is to facilitate the achievement of optimal level of health to the community through the delivery of services of appropriate quality and quantity.

As such India has to prepare to meet the health care challenges of the new millennium. Despite several growth-orientated policies adopted by the government, the widening economic, regional, and gender disparities are posing challenges for the health sector. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy, the infant mortality rate, and maternal mortality rate in the rural areas; however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at the national and state, and district and regional levels in a holistic manner.The focus of India's health services right from the early 1950s has been on health care to tackle common health problems of the public in general and the vulnerable groups in particular. At the same time, improvement in the health and nutritional status of the population has been one of the major thrust areas for the social development programmes of the country. Recognizing the importance of health in the process of social and economic development and improving the quality of life of the citizens, the Government of India has resolved to launch the National Rural Health Mission (NRHM) which has now been renamed as National Health Mission (NHM) covering both the rural as well as urban areas. The Union Cabinet, in May 2013, had approved the launch of the National Urban Health Mission (NUHM) as a Sub-Mission of an overarching National Health Mission (NHM), with NRHM being the other Sub-Mission of the National Health Mission. The NRHM was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. The goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women, and children. The NRHM has been developed to bridge the gap in rural health care services through the creation of a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to the district level to improve inter-sectoral convergence, and effective utilization of resources.

The current health policy and systems have evolved from the Report on the Health Survey and Development Committee, commonly referred to as the Bhore

Committee Report, 1946 under the chairmanship of Sir Joseph Bhore, the Indian Government resolved to focus health care delivery services on rural people which has been a landmark report for India. The first National Health Policy of India (NHP) was formulated in 1983 with the main objective of the provision of primary health care to all by 2000 while the first national population programme was declared in 1951. The NHP 2002 further built on NHP 1983, with an objective of providing health services to the general public through decentralization, use of private sector and increasing public expenditure on health care overall. Indian government announced the National Population Policy (known as NPP 2000). Two years later India also announced the National Health Policy which may be called the forerunner of NRHM which was to start from 2005. For improving the status of health, the then Honourable Prime Minister Manmohan Singh launched NRHM on 12th April, 2005 throughout the country which was implemented in all the 35 states and Union Territories.

Mizoram has implemented the Mission towards attaining the goals and objectives shared under National Rural Health Mission (NRHM), National Population Policy (NPP) and Millennium Development Goals (MDG on June, 2005 by setting up a State Health Mission which brought the Scheme of Reproductive and Child Health (RCH-II) as well as National Disease Control Programme and various family related activities under its umbrella. NRHM has transformed public health service delivery in the State. In Mizoram, the number of people living in urban areas is more than that lives in rural areas and therefore, the government does not differentiate between rural and urban areas in implementing most of the programme. Despite the difference in rural and urban areas, the same schemes are being implemented in both the areas.

The NRHM implementation and monitoring framework is based on rights based approach. For effective monitoring a strong MIS is being put in place known as HMIS or Health Monitoring information system. The role of Memorandum of Understanding (MoU) occupied an important Implementation and monitoring aspect of the whole NRHM mandate which has to be delivered by the state government. The

MOUs signed with the States are meant to enable monitoring progress under NRHM in terms of the agreed milestones. Independent evaluation would ensure midcourse corrections and addressing critical gaps and issues. To have IT enabled monitoring a computerised network is being set up under IDSP linking all the districts of the country. This network would be used for monitoring the progress under the NRHM as well as for surveillance activities.

NRHM primarily aimed to address the health needs of underserved rural areas through an architectural correction of the health system. The key goals of NRHM is towards enabling and achieving the stated vision, making the system responsive to the needs of the citizens, and building a broad-based inclusive partnership for realizing the goals of the government which focuses on the survival and well-being of women and children, reducing existing disease burden and ensuring financial protection for households. The idea behind the Mission is to provide universal access to equitable, affordable, and quality health through an integrated approach as well as to bring about institutional changes such as decentralisation of the public health system; integration of organisational structures; community participation and ownership of assets; and convergence in services which co-determine health outcomes (e.g. food, nutrition, water and sanitation).

As a whole, NRHM is a mission/programme that has immediate potential to improve the health of the people in the country and provide equitable, affordable, and quality health care to the people, especially for those residing in rural areas, the poor, women, and children. The study reveals that despite numerous problems, it has begun to make a difference in the lives of the rural inhabitants.

Review of Literature

The researcher has undertaken a review of 4 books and 38 articles:

Books

1. Rajendra Pratap Gupta (2016) in his book *Healthcare Reforms in India* laid down the comprehensive methods need to be followed to attain excellence in healthcare

industry. According to him practice oriented healthcare organizations can gain a competitive edge through superior operations. He opined that there will be huge benefits if the entire healthcare industry is aligned with the parameters. The study precisely depicts that how negotiation to be made between various prospective of clinicians and administrators by offering a uniform platform so that competitive advantage can be enjoyed. He also identified various tools that will aid in bringing solutions to the problems and improve the healthcare facilities

2. Park J E (2002) in his book *Text Book of Preventive and social Medicine* brings to light that there is vast inequality in health care provisions between various social sectors. The health care expenditure is continuously increasing. Due to low government expenditure, the out-of pocket expenditure takes away a significant portion of individuals' income. It has its own impact on the patient, the patient's family and the economy.

3. P.Michael Pagano (2016) book on *Health Communication* emphasized the need for maintaining of good and healthy relationship with patients, peers and colleagues as cornerstone of effective utilization health care services. The study described the theories and abilities needed by all healthcare providers like nurse medicine professional, physiotherapist, pharmacist, dentist, physician and opticians. It incorporates recommendations for specific multimedia, suggestions for class discussion and interactive case studies to provide a rich and multi-perspective learning experience for gaining optimal expertise in effective health communication. It teaches about the behavioural aspect of healthcare service providers in diverse healthcare context and assesses its efficacy.

4. Raje V.N, (2014) in his book *Health Education and Community Pharmacy* discussed about evolution of healthcare industry in India. He also recognized different institutions that paved the way for healthcare industries in the country. These institutions deliver healthcare services, finance healthcare services and manufacture products which are being utilized in these services. This study also discussed about 28 the innovative efforts to raise the capital for the development of healthcare sectors.

Articles

1. Aalok Ranjan Chaurasia (2013) in his article *India: Health System Performance Assessment* analysed details on the performance of health system of India. He says that population health and its impact on the social and economic production system remains a major development challenge in India even today. In the recent past, India has recorded an impressive economic growth but gains on the economic front do not appear to have been translated in hastening health transition and improvement in the health status of the people. An analysis carried out by the Government of India indicates that, at the current pace, India is likely to miss health related Millennium Development Goals (Government of India, 2014). Although, there has been improvement in the health and mortality situation in the country, yet, the pace of improvement has been substantially slower than what has been planned or expected in the context of social and economic development needs of the country. He further says that the slow pace of health and mortality transition in India has implications for global health and mortality transition as India is the second most populous country in the world. During 2005-10, India accounted for more than 17 per cent of average annual number of deaths in the world (United Nations, 2013). This proportion is the highest among all countries of the world. Obviously, future global health and mortality transition will depend largely upon the pace of health and mortality transition in India.

2. Anita Raj et al, (2010) in their article, *The effect of maternal child marriage on morbidity and mortality of under 5 in India: a cross-sectional study of a nationally representative sample* showed that infant and child malnutrition is significantly more likely among the children born to mothers married as minors than in those born to women married as adults. Also, the study concludes that association between the maternal-child marriage and low infant birth weight as well as infant and child mortality seem to be a consequence of early motherhood, low maternal education, and other indicators of poor maternal health and socioeconomic status factors all significantly linked to an early marriage of girls.

3. Arun Kumar Sharma (2009) in his article *National Rural Health Mission: Time to take stock* deals with the poor performance of the Indian Public Health System which has been widely acknowledged. Analysts have attributed this failure to a number of factors, which include almost all the components that make a system functional, that is, infrastructure, human resources, logistics, and participation of the community. However, some attribute this failure primarily to low and declining public investment in healthcare and secondarily to structural and managerial weaknesses in the system. After groping with the challenges for decades, the planners have come up with a comprehensive mission-oriented approach to revamp the rural healthcare delivery system, which was aptly named National Rural Health Mission (NRHM). The mission was launched on 12 April, 2005, to be completed in a time frame of seven years. The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as a healthcare provider. It also recognizes the need to make optimal use of the non-governmental sector to strengthen public health systems and has increased access to medical care for the poor. The core objective of NRHM is to create fully functional health facilities within the public health system. It is expected to provide a certain service guarantee at each level of the healthcare delivery system starting from a Sub-centre (SC) to a District Hospital (DH).

4. Brijesh C Purohit (2016) in his article, *Health Care System Efficiency: A Sub-State Level Analysis for Orissa (India)* gave renewed emphasis efficiency in resource utilization in the healthcare sector. This paper explores sub-state level health system efficiency in Orissa, a low-income state in India. They explore the reasons for relative performance of different districts using a frontier estimation technique. There is a substantial difference in performance between the most efficient district of Jharsuguda and the least efficient district of Balangir, resulting from inadequate utilization of available health care resources. Their study also identifies complimentary of private health care resources and the role of other factors, such as sanitation facilities, village electrification, and rural population growth. Their results suggest a need for better utilization of budgetary resources, both under the state department of health and the National Rural Health Mission, to increase health

manpower and improve quality through training and better management resources in order to improve district health systems in Orissa.

5. D. Benerji (2005) in his study, *Politics of Rural Health in India* highlights politics of national rural health mission programme initiated by government of India. According to him government has not considered the past experience for implementation of such an important programme throughout the nation. To him, successive government could not successfully implement various health programmes in past and causes of failure in past should have been considered before implementation of national rural health mission so that the promises given by government becomes fulfilled.

6. Dilip T.R. (2002) in his article, *Utilisation of Reproductive and Child Health Care Services: Some Observations from Kerala* found from his study that the preference of public / private sector depends on nature of service in demand. The role of private providers in health care was found to be limited in the case of family planning services, but almost 50 per cent availed delivery care services from the private sector. A majority of women were found to prefer treatment from the private medical service providers if their children were suffering from fever or cough. Class differentials were severe, with the public sector being the major provider of Reproductive and Child Health care services for the poorer sections of society. People with a higher potential to pay preferred the private sector irrespective of the nature of service they required.

6. D.Rajasekhar and Sasikala (2013) in their article, *An Impact of Stress Management on Employed Women* stated that today's women are in a state of transition caught between the illusory safety of traditional role on one hand and the challenge to realize their potential outside on the other hand. Women have a lot of balancing to do between home and workplace, and balancing between social and personal requirements. The major issues are maternity, menopause, parenthood, gender roles, conditions at home and workplace, familial and social support, often blight women's lives in the long run. Stress is the reactions people have, to excessive pressures or other types of demand placed on them. Stress make a person more susceptible to

disease, which then aggravates any existing illness or chronic condition such as heart disease, depression, ulcers, irritable bowel disease, diabetics, the common cold, urinary tract infections. Depression, only one type of stress reaction, is predicted to be the leading occupational disease of the 21st century, responsible for more days lost than any other single factor.

7. Duggal R. (1994), in his article, *Health care utilization in India* revealed that India has a plurality of health care systems as well as different systems of medicine. The government and local administrations provide public health care in hospitals and clinics. Public health care in rural areas is concentrated on prevention and promotion services to the detriment of curative services. The rural primary health centers are woefully underutilized because they fail to provide their clients with the desired amount of attention and medication and because they have inconvenient locations and long waiting times. Public hospitals provide 60% of all hospitalizations, while the private sector provides 75% of all routine care. The private sector is composed of an equal number of qualified doctors and unqualified practitioners, with a greater ratio of unqualified to *qualified* existing in less developed states. In rural areas, qualified doctors are clustered in areas where government services are available. With a population barely able to meet its nutritional needs, India needs universalization of health care provision to assure equity in health care access and availability instead of a large number of doctors who are profiting from the sicknesses of the poor.

8. Gandhi, I.C (2002) in his article, *Public Health in India: Future Challenges* observed that most of the countries in the world including India and other countries in the South East Asia region have recorded impressive gains in health and development in the 20th century. The green revolution in India has increased the consumption of horticultural produces and leafy vegetables, which has significantly reduced important micro-nutrient malnutrition. Despite overall improvements in control of some communicable diseases, many are still deep rooted in the country and are still the major causes of mortality. Health problems are arising due to rapid urbanization of environmental degradation. The nationwide health infrastructure and the on-going national health programmes have failed to provide adequate and quality

health care to meet the need of the population. Study suggests that effective health information system should be established. Good quality and adequate drugs, vaccines and equipment should be manufactured and made available at affordable prices. Balanced development of basic, clinical and problem-oriented health research be encouraged. So in order to meet the challenges of 21st century and to achieve the objectives of National Health Policy 2001, it is necessary that health should be attached higher priority on political and the development agenda.

9. Glenn Laverack, (2006) in is article, *Centre for Health and Population Research Improving Health Outcomes through Community Empowerment* reviews the literature on how empowerment can lead to an improvement in the health status of an individual, group, or community. There is a broad body of literature on empowerment, and this review has been designed to identify material, particularly case studies, that can be included within the following 'empowerment domains': Participation; Community-based organizations; Local leadership; Resource mobilization; Asking 'why'; Assessment of problems; Links with other people and organizations; Role of outside agents; and Programme management. The paper discusses the results of the literature review and provides examples, from both developed and developing countries, of how each of the 'empowerment domains' has led to an improvement in health outcomes. The results of the review should be of interest to the planners and practitioners of health, population and nutrition programmes that have a particular focus on empowerment.

10. Gokhale M.K. et al, (2002) in their article, *Infant mortality in India: use of maternal and child health services in relation to literacy* showed in their study that Illiteracy of females had a more detrimental impact on rural than on urban areas. In the event of high female illiteracy, male literacy was beneficial for improving the use of services for reducing infant mortality rate. The micro-level study supported all major findings obtained for the national-level aggregate data. Programmes, like providing free education to girls, will yield long-term health benefits.

11. Gopinathreddy et al, (2006) in their article, *Politics of Pro-Poor Reform in the Health Sector – Primary Healthcare in Tribal Areas of Visakhapatnam* found that

poverty is the prime cause for ill health, persistent morbidity and early death among the tribal population of Vishakhapatnam. Lack of access to the right foods and basic healthcare services is the main reason for the marked gap in health indicators between tribal areas and the more developed parts of the state. Tribal suffer disproportionately to their population from communicable diseases like T.B. and Malaria where they account for more than 75 percent of the state's total deaths. The study also finds that the politicization of the health system of appointments and transfers within the health system led to the extremely poor performance of the Public Health Centre and Community Health Worker scheme, resulting to the deteriorating health status of the tribal people. Patterns of use of health facilities are shaped in part by party and political concerns, and the health sector reform policy is influenced by the professional doctor's association in the state, with the overall effect of leaving the private medical market under-regulated and the work of public sector doctors under-monitored.

12. Guha Mazumdar P. et al, (2007) in their article, *Indian system of medicine and women's health: a client's perspective* shows that for the majority of women's health problems biomedicine is regarded as the first choice, failure of which leads clients to seek treatment from Indian System of Medicine (ISM) as a final resort. Nevertheless, women showed a preference for ISM treatment for certain specific health problems, strongly backed by a belief in their efficacy. Of the predictors that positively influenced women's choice of ISM treatment, 'strong evidenced-based results' was found to be the most important. Women's preference for ISM is dependent on the availability of competent providers.

13. Julia Hussein et.al, (2011) in their article, *A review of health system infection control measures in developing countries: what can be learned to reduce maternal mortality* highlighted that a functional health system is a necessary part of efforts to achieve maternal mortality reduction in developing countries. Some developing countries have recently experienced increased use of health facilities for labour and delivery care and there is a possibility that this trend could lead to rising rates of puerperal sepsis. This article reviews health system infection control measures pertinent to labour and delivery units in developing country health facilities.

Organisational improvements, training, surveillance and continuous quality improvement initiatives, used alone or in combination have been shown to decrease infection rates in some clinical settings. There is limited evidence available on effective infection control measures during labour and delivery and from low resource settings. A health systems approach is necessary to reduce maternal mortality and the occurrence of infections resulting from childbirth. Organisational and behavioural change underpins the success of infection control interventions. A global, targeted initiative could raise awareness of the need for improved infection control measures during childbirth.

14. Kalaisigamani J and Sangameshwaran A, (2013) in their article, *Health Insurance in India* stated that India is gradually becoming health conscious and this is because youngsters have new ambitions, big dreams and high goals and they have the motivation and drive to make them all come true. Their lives are fast paced and because of this fact there is an absolute need for health care so that they are able to overcome all the obstacles that might come their way. For this reason, Indians have realized the importance of health insurance India. Owing to this realization, the medical insurance sector is one of the fastest growing segments in India today.

15. Kaleeswari V.and Sridhar T (2012) **,**in their article, *Economics of Health and Health Care Issues in India* highlighted that Health is very important for human life. Wealth without health is of no use in our life, life is miserable and painful for an individual with ill health. A sound mind is housed in a healthy body. Though modern man could enjoy all sorts of materialistic comforts in life, thanks to the advancements of science and technology yet he falls often sick due to highly polluted environment in which he lives and works. The country still has enough potential to be a super power in the world. However, a major road block in this regard is the health issue in India. The general health standard of India is extremely bad. Health economics is a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and health care. This paper analyses health economics, health issues and health education, human resources made up of youths not only well educated and skilled but also well-built and robust in health.

16. Kumar Patra et al, (2013) in their article, *National Rural Health Mission (NRHM) & Health Status of Odisha: An Economic Analysis* stated that to improve the prevailing situation, the Government of Odisha launched the National Rural Health Mission (NRHM) programme through the state on 17th June 2005. NRHM has completed its six years of journey in Odisha. It becomes necessary to assess the impact of NRHM on the health infrastructure and on the health indicators and to analyze the determinants of health status in the health development of Odisha. The study shows that the health status of study area is very poor and is gradually increasing as a result of the implementation of NRHM and the staple reasons for this tendency are: low income, illiteracy, shortage of doctors, unwillingness doctors to go to remote areas and lack of health care facilities and lack of production of laboratory technicians and radiographers.

17. Krishna D. Rao et al, (2006) in their article, *Towards Patient-centered health services in India a scale to measure patient perceptions of quality* found in their study that better staff and physician interpersonal skills, facility infrastructure, and availability of drugs have the largest effect in improving patient satisfaction at public health facilities. Also in their study they concluded that, in India and many developing countries, the excessive emphasis on service coverage and inputs in the provision of health services has ignored the needs of the very people for whom these health services exist. Incorporating patient views into quality assessment offers one way of making health services more responsive to people's needs. It also gives users an opportunity to voice their opinion about their health services. They further stated that while conducting this study, they found many instances in which patients were eager to record their concerns about the services they had received in the hope that some action would be taken. It is likely that the very act involving patients in evaluating their health services will make providers more sensitive and alert to patient needs.

18. Krishna D Rao et al, (2014) in their paper, *Health systems research in the time of health system reform in India* viewed that research on health systems is an important contributor to improving health system performance. Importantly, research on program and policy implementation can also create a culture of public accountability.

In the last decade, significant health system reforms have been implemented in India. These include strengthening the public sector health system through the National Rural Health Mission (NRHM), and expansion of government-sponsored insurance schemes for the poor. This paper provides a situation analysis of health systems research during the reform period

19. Lewando Hundt et al, (2012) in their article, *The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan* found in their study that there are issues of accessibility in terms of distance, and of acceptability in relation to the lack of local and female staff, lack of cultural competencies and poor communication. Also they found that provision of accessible acceptable health care in rural areas poses a challenge to health care providers and these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area.

20. Mand MTE Huymen et al, (2005) in their article, *The health implications of globalization by framing a conceptual framework* developed the framework by first identifying the main determinants of population health and the main features of the globalization process. As for globalization, they have identified (the need for) global governance structures, global markets, global communication and diffusion of information, global mobility, cross-cultural interaction, and global environmental change as the important features. In this paper, globalization is perceived as an overarching process in which simultaneously many different processes take place in many social domains. In addition, the conceptual framework is embedded in a holistic approach towards population health. The resulting conceptual model explicitly visualizes that globalization effects the institutional, economic, social-cultural and ecological determinants of population health, and that the globalization process mainly operates at the contextual level, while influencing health through its more distal and proximal determinants. The developed framework provides valuable insights in how to organize the complexity involved in studying the health effects resulting from globalization.

21. Meenakshi Gautham et al, (2011) in their article, *First we go to the small doctor:First contact for curative health care sought by rural communities in Andhra Pradesh & Orissa, India* found that most rural persons seek first level of curative healthcare close to home, and pay for a composite convenient service of consulting – cum-dispensing of medicines. Non Degree Allopathic Practitioners (NDAPs) fill a huge demand for primary curative care which the public system does not satisfy and are *de facto* first level access in most cases.

22. Mukherjee and Karmakar, (2008) in their article *Untreated Morbidity and demand for healthcare in India: An Analysis of NSS Data* studied the problem of poor health outcomes in India from the demand side, and using the unit level data from the 60th round of the National Sample Survey analyses the determinants of not accessing medical care. The authors investigated the health-seeking behaviour of the respondents of the survey, and explored three avenues through which health and human development outcomes may be related-demographic characteristics, education level of the head of the household and expenditure group. The intra-family relationship, as well as the level of education of the head of the household, exerts considerable influence on health-seeking behaviour. This analysis is confined to persons who have reported being ill within 15 days of the survey but have not sought either public or private professional medical services. There are systematic variations in accessing healthcare between rural and urban areas, as well as between males and females in each sector. While in the rural areas, the demand for healthcare increases significantly with the education level of the head of the household, in the urban areas the evidence is mixed. Richer economic sections constitute a larger proportion of sick persons who do not access medical care, especially in urban areas. Paradoxically, among poor households, which cite financial reasons for not accessing healthcare, women are less likely to be discriminated in rural than urban areas. In this study, educational qualification has also taken as an important parameter to assess the stakeholders' knowledge and understanding the analysis of Health System of their own state. In Mizoram the majority of people are educated and they know something about the administrative system on which the present health care system is functioning.

23. Nandan D, (2010) in his article, *National Rural Health Mission: Turning into reality* mentioned that on 12 April 2005, the Government of India took a major welfare initiative by launching National Rural Health Mission (NRHM) in 18 states with weak public health indicators and infrastructure and extended it across the entire country. What constituted the conceptual build-up to this mission was a spectrum of systemic deficiencies in the health system. According to him, the NRHM employed five main approaches while addressing these issues - communitization, flexible financing, improved management through capacity building, monitoring progress against standards, and innovations in human resource management, which became the mainstay. On the other hand, untied funds are making things somewhat easier for the peripheral health facilities, while overcoming small day-to-day problems. One of the success stories being attributed to NRHM is a huge increase in institutional deliveries.

24. Nirupam Bajpai, (2010) in his article, *Improving Access and Efficiency in Public Health Services: Mid-Term Evaluation of India's National Rural Health Mission (English*) presents a systematic mid-term evaluation of the processes of the National Rural Health Mission (NRHM), India's biggest rural health programme. Data from District Level Health Surveys (DLHS), National Family Health Surveys (NFHS), and Sample Registration System (SRS) as well as primary data collected from field surveys and interviews with health functionaries have been utilized for undertaking empirical analysis in the study. It discusses the challenges and successes of the Mission with the help of extensive field observations, data analysis and inputs from experts on health and nutrition sectors focusing on maternal, newborn and child health issues and chronic diseases. The book draws from data collected in field visits in the three states of Madhya Pradesh, Uttar Pradesh, and Rajasthan. After assessing the NRHM processes and progress achieved so far, it discusses important ground realities, identifies the gaps and bottlenecks in the implementation of the Mission, and recommends corrective actions.

25. Peter Berman and Ricardo Bitran, (2011) in their article, *Health Systems Analysis for Better Health System Strengthening* is a proposed article entitled 'health systems

analysis' as a distinct methodology that should be developed and practiced in the design of policies and programs for health system strengthening. It identifies key elements of health systems analysis and situates them in a logical framework supported by a wide range of data and methods and a sizable global literature. Health systems analysis includes evidence on health system inputs, processes, and outputs and the analysis of how these combine to produce the outcomes. Health systems analysis proposes causes of poor health system performance and suggests how reform policies and strengthening strategies can improve performance. It contributes to implementation and evaluation. Health systems analysis should be an integral part of good practice in health system strengthening efforts, including planning, policy development, monitoring, and evaluation. Health systems analysis can be conceived in a coherent and logical fashion and can be practiced and improved.

26. Partha De et al, (2002) in their article, *Determinants of child immunization in four less developed states of North India* showed that children are more likely to receive immunization if their parents are a couple, with the father literate and the mother with at least a middle-school-education level who received antenatal care or delivered in an institutional environment.

27. Ramila Bisht et al, (2000) in their article, *Championship Management for Healthcare Organizations* says that the national and transnational health care systems are rapidly evolving with current processes of globalisation. A structured scoping exercise was conducted to identify relevant literature using the lens of India – a rising power with a rapidly expanding healthcare economy. A five step search and analysis method was employed in order to capture as wide a range of material as possible. Via electronic bibliographic databases, websites and hand searches conducted in India, relevant articles, books and reports were identified. These were classified according to topic area, publication date, disciplinary perspective, genre, and theoretical and methodological approaches. Topic areas were identified initially through an inductive approach, then rationalised into seven broad themes. Transnational consumption of health services; the transnational healthcare workforce; the production, consumption and trade in specific health-related

commodities, and transnational diffusion of ideas and knowledge have all received attention from social scientists in work related to India. This survey of India-related work suggests a young and expanding literature. The field would benefit from further cross-fertilisation between disciplines and greater application of explanatory theory. Literatures around stem cell research and health related commodities provide some excellent examples of illuminating social science. Future research agendas on health systems issues need to include innovative empirical work that captures the dynamics of transnational processes and that links macro-level change to fine-grained observations of social life.

28. Ravendra K. et al, (2010) in their article, *Newborn Care among Tribes of Central India Experiences from Micro Level Studies* demonstrates that utilization of maternal and child health services is very poor among the tribes of central India. Clinically acceptable maternal and newborn care practices for delivery, cord cutting and care, bathing of mother and newborn and skin massage are uncommon. Therefore, newborns remain at high risk of hypothermia, sepsis and other infections.supplementary feeding practices and delay in breastfeeding are very common, although colostrum is less frequently discarded. Malnutrition is a severe problem among tribes and many tribal children and women are severely malnourished as well as anemic.

29. Ray S.K. et al, (2011*)* in their article, *An assessment of rural health care delivery system in some areas of west Bengal – An overview* found in their study that large no of patients did not avail any services when they fall sick especially in the tribal district where distance, poor knowledge about the availability of the services and non-availability of the medicine in addition to the cost of treatment and transport. Utilization of government health facilities was around 38% followed by unqualified Practitioners and Private Practitioners. Referral was mostly by self or by close relatives / families. Also attention is required with respect to the cleanliness of the premises, safe drinking water, face-lift of PHCs and SCs, clean toilet with privacy. Also they concluded that an attempt should be made to improve utilization by cordial

behavior, providing more time for patient care by the doctor, and staff, explain their prescription and report, reducing time for registration.

30. R. Subhashini, (2012) in his article, *National health policy, the need of the hour: an analysis in Indian perspective* formulate a renewed national health policy, which should enable to strive towards achieving the concept of 'healthcare for all' conceptualized by the World Health Organization (WHO) through health insurance scheme. The purpose of this paper is to identify and discuss the various gaps affecting the health care systems and to evolve strategic issues in health care in India through an exploratory survey on as well as waiting and finally cost of medicine they can afford.

31. Sharad D. Iyengar et al, (2009) in their article, *Comparison of Domiciliary and Institutional Delivery care Pracices in Rural Rajastan, India* indicate that several factors had contributed to maternal mortality. Lack of skilled attendance and immediate postpartum care were major factors contributing to deaths. Improved access to emergency obstetric care facilities in rural areas and steps to eliminate costs at public hospitals would be crucial to prevent pregnancy-related deaths. Although the high prevalence of health conditions and diseases, including TB and anemia, are identifiable as direct or indirect causes of death, important societal and health systems factors constrain women from accessing quality health services. If reduction in maternal mortality is to become a reality, women in rural regions will require more efficient access to high-quality delivery and emergency services at an affordable cost.

32. Sisira Sarma, (2009) in his article, *Demand for Outpatient Healthcare: Empirical Findings from Rural India* studied the Demand for Outpatient Healthcare in Rural India. The main objective of the study was to examine the role of monetary and non-monetary price, income, and a variety of individual- and household-specific characteristics on the demand for healthcare in rural India. The study found that contrary to many earlier studies on the demand for healthcare in developing countries, prices and income were statistically significant determinants of the choice of healthcare provider by individuals in rural India. Demand for healthcare was

found to be price and income inelastic, corroborating the findings from other developing countries. Distance to formal healthcare facilities negatively affected the demand for outpatient healthcare, an effect that was mitigated as access to transportation improved. Age, sex, healthy days, educational status of the household members and the number of children and adults living in the household also affected the choice of healthcare provider in rural India. After controlling for a number of socio-demographic factors, it was found that prices, income and distance are statistically significant determinants of the provider chosen by individuals; nevertheless, the demand for healthcare is price and income inelastic in rural India.

33. Srivastava R.K. et al, (2009) in their article, *Assessment of utilization of RCH services and client satisfaction at different levels of health facilities in Varanasi District* revealed that the utilization of RCH services in the government facilities was higher among the backward classes than the general category; and higher the level of education the lower was the utilization of the government services. Also the users were not satisfied with the services provided by the governmental health facilities especially with the behavior of medical officer and health workers and non-satisfaction was highest among SC category. Also authors concluded that all the health facilities need to be made functional according to the Indian Public Health Standards (IPHS) of National Rural Health Mission (NRHM).

34. Susmita Bharati et al, (2007) in their article, *Obstetric care practice in Birbhum District, West Bengal, India* showed in their study that the status of literacy of mothers and standard of living of the family are of prime importance in improving the obstetric health care practices. The study indicates that the educated women with high standards of living have an emphasized role in the practice of more maternal health care. The study shows that rural antenatal care is still mostly based on Indian traditional system. It is the women who need to be educated and must be made aware about the importance of the health care for ensuring healthy pregnancy and safe delivery.

35. R. Subhashini, (2012) in his paper entitled *National health policy, the need of the hour: an analysis in Indian perspective,* formulate a renewed national health policy,

which should enable to strive towards achieving the concept of 'healthcare for all' conceptualized by the World Health Organization (WHO) through health insurance scheme. The purpose of this paper is to identify and discuss the various gaps affecting the health care systems and to evolve strategic issues in health care in India through an exploratory survey.

36. Vikash Bajpai and Anup Saraya, (2012) in their article, *NRBM the Panacea for Rural Health in India: a critique* highlight the reason for failure of government to fulfil objectives of national rural health mission. According to them government could not fulfil its objective of rural health care in last seven years of implementation of national rural health mission in India. Deficit in infrastructure and manpower in government health care sector is major cause of problem of health for them. Rather private health care institutions are growing in India. According to them, government should change its strategy to implement the programme properly.

37. William Joe et al, (2008) in their article, *Health Inequality in India: Evidence from NFHS-3* utilized the National Family Heath Survey-3 data and presented an empirical assessment of the income-related health inequality in India. It undertakes state-level analysis of inequities in child health by employing the widely accepted measures of the concentration curves and concentration indices. As the key indicators for child health, it employs the information available on under-five mortalities, immunization status and nutritional performance (stunting and underweight) of the child population of the different states. It found that the poorer sections of the population are plagued with ill health whether in the quest for child survival or due to anxieties pertaining to child nutrition. Further, an attempt is made to comprehend the relationship between income inequality and the health status in the Indian context. The analysis reveals that the degree of health inequalities escalates when the rising average income levels of the population is accompanied by rising income inequalities. The income-poor sections have different needs and therefore, planning and intervention necessitates understanding of the sources of inequality and recognition of the vulnerable groups to arrive at efficient resource allocation and policy decisions.

38. Zakir Husain, (2011) in his article, *Health of the National Rural Health Mission* stated that the National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. With the completion period drawing to a close in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website, this paper attempts a desk review of the progress of the mission with respect to its core strategies - provisioning of health services to households through Accredited Social Health Activists (ASHA), strengthening rural public health facilities, enhancing capacity of panchayats to control and manage provisioning of health services and positioning of an effective health management information system.

Statement of the Problem

The majority of India's population live in rural areas and one of the foremost agenda in the development process is the improvement of the rural areas in all aspects, including the health conditions. Realising the importance of improving the health conditions of the rural areas, the Government of India has taken initial steps in improving the health conditions of the rural areas by introducing NRHM. The main focus of NRHM is on Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). NRHM suggest that IMR and MMR determine the overall health condition of a specific community or county as they represent the health status of the community as well as the status and standard of health programs, services, facilities and infrastructures, policies, governances and investments.

IMR and MMR are the influencing factors which drives all the projects and activities under the National Rural Health Missions based on the annual Program Implementation Plans prepared by the different states with the bulk of its program and budget mandated towards the then Reproductive Child Health (RCH) into the newly termed Reproductive, Maternal, Neonatal, Child, Health, Adolescent Plus (RMNCH+) along the saying 'from womb to tomb' as the new National Health

Policy since 2013-14 had incorporated urban health, non-communicable diseases (NCD), geriatrics within its functions and mandate. NHRM stresses on universal access to public health services such as women's health, child health, drinking water, sanitation and hygiene, nutrition and universal immunization, prevention and control of communicable and non-communicable diseases and its main goal and objectives is reduction of infant mortality and maternal mortality. Inspite of the benefits that local communities can acquire through this Mission there is lack of awareness, especially among the rural population. What the urban areas treat as a common disease could become fatal or a highly challenging medical problem for the rural areas because of negligence and ignorance of the importance of going to the hospital immediately and, most importantly, because of lack of taking proper treatment at the initial stage which by the technical definition of the NRHM guiding principles of 'efficient system' includes early and correct diagnosis and appropriate treatment at the right time, which consists of referral, linkages and networking within the health system and chain of referral.

It is in this background that the study had been undertaken with a focus on IMR and MMR in the district of Kolasib. The study determined the gaps in governance and administrative machinery in Mizoram which are the causal factors for understanding National Rural Health Mission and its implementation.

Scope of the study

This study concentrates on the implementation, functions, issues and problems of NRHM in Mizoram with special focus on Kolasib District. Although the program was implemented from 2005, the targeted communities are still not aware of the importance and significance of this Mission. So, much research work is yet to be done on the working and implementation of NRHM as a specific part and parcel of the overall National Health Mission with evidence gathered and analysed through the scope of study incorporated within Kolasib district. The study covered the period from the period of its implementation i.e. 2005-2006 Financial year till the present day i.e. 31st March 2021.

The study comprised of the various indicators of NRHM programs, targets and achievement made since its implementation and the issues and relevant challenges including bottlenecks found along the process of the study. However, it will not incorporate all parameters of the empirical data from the National Health Mission due to the degree of their relevance to the study and plausible indication in the objective of the study findings.

Objectives of the study

The objectives of the study are:

(1) To study the background and origin of implementation of NRHM in India in general and in Mizoram in particular

(2) To understand the implementation and monitoring process and mechanism of the mission in Mizoram

(3) To assess the benefits of the mission in terms of improvement in public health alleviation.

(4) To find out the shortcomings and the problems faced in the process of implementation of NRHM in Mizoram from a public health administration perspective.

(5) To understand the implications and make suitable suggestions for the effective performance of NRHM.

Research Questions

The study has attempted to answer the following research questions:

(1) What are the basic components of NRHM implemented in Mizoram?

(2) What are the administrative structures and mechanism involved in the process of implementation of NRHM?

(3) What are the measures adopted for improving the health of the people?

(4) What are the major challenges faced in the implementation of the NRHM?

(5) What measures can be taken to improve the implementation of the NRHM?

Methodology

The study had adopted mixed method. Field study and data collection were done through key informant interviews, questionnaire structured format which are descriptive in nature on one hand, while the district specific data related to NRHM which are empirical in nature are acquired through the different annually prepared Program Implementation Plan (PIP) and the Monitoring Information System maintained by the District Program Management Unit (DPMU) as well as the State Program Management Unit (SPMU).

Purposive stratified random sampling method was used to represent the respondents/beneficiaries, community workers, employees of NRHM, public and other health personnel from NGO or private who are not paid out of NRHM fund. Secondary data were collected from different sources such as books, magazines, articles and journals, PIPs, HMIS etc. as mentioned in the previous segments.

Chapterization

Chapter I : The ***first*** Chapter is introductory one which deals with the basic background information of the state, vital information related to socio-demography, climate and a focused description of the meaning and importance of health care in general and specifically to Kolasib district within the ambit of NRHM. It also includes the concept of National Rural Health Mission, Review of Literature, Objectives of the present study, Research Questions, Area of the Study and Method

of Data Collection. It also contains a brief profile of the state of Mizoram as well as Kolasib District within which the present study will be concentrated.

Chapter II : The ***second*** Chapter deals with the conceptual study of Healthcare Administration, policies and development in India.

Chapter III : The ***third*** Chapter traced the origin and historical background of NRHM in India.

Chapter IV **:** The ***fourth*** Chapter deals with the organizational structure and working of NRHM in Mizoram, introduced by the Central Government.

Chapter V : In the ***fifth*** Chapter, an attempt has been made to assess the implementation and monitoring machinery of NRHM.

Chapter VI : The ***sixth*** Chapter deals with the field finding analysis of NRHM in Kolasib district of Mizoram.

Chapter VII : The ***seventh*** Chapter is a concluding Chapter which has brought out the summary and findings of the study. It has also made some suggestions for the improvement of the organisational set-up of NRHM, the implementation of which would enable the district level machinery to implement the mission in a more effective manner.

Major findings

I. There are six main financial components of the NRHM/NHM which were-

a) NRHM-RCH Flexi pool.
b) NUHM Flexi pool.
c) Flexible pool for Communicable disease.
d) Flexible pool for Non communicable disease including Injury and Trauma.
e) Infrastructure Maintenance and
f) Family Welfare Central Sector component.

Though for implementation, the programme is divided or compartmentalized into the following:

1. Reproductive Maternal Neonatal Child Health + Adolescent (RMNCH+A)
2. Health system Strengthening in rural and urban areas
3. Communicable and Non-communicable disease control program

II.

III. For improving the health of the people/community the NRHM/NHM in Mizoram supplement and complement existing health programs while instilling new innovation. The establishment of Neonatal Intensive Care Unit (NICU) to reach and attain child survival and also care for the elderly which was more of social justice/Social Welfare mandate was also initiated. The new program of Urban Health alleviation and Non-communicable diseases also served as an important and indispensable health initiative. Information Education Communication (IEC) and Infection Prevention and Control (IPC) activities form a crucial element of the NRHM/NHM.

IV. As per the field level data (primary) obtained from the respondents, there exist inadequate human resources in the service delivery point (health institution), problems in equipment, machineries and consumables where timely delivery is a top priority. There is also delay of payment of salary which is very crucial to the service quality and performance.

V. For improving the health of the people/community the NRHM/NHM in Mizoram supplement and complement existing health programs while instilling new innovation. The establishment of Neonatal Intensive Care Unit (NICU) to reach and attain child survival and also care for the elderly which was more of social justice/Social Welfare mandate was also initiated.

Problems and Challenges

1. The State government has introduced health care scheme to cover medical treatment for those who registered themselves under the scheme. While such cover has helped many people, there is evidence in the State that medical reimbursement takes over a long period becomes a hindrance for getting further treatment especially for the rural poor.

2. In principle, many rural programmes of the government including the NRHM are meant to be complementary and synergistic. But in reality, there seems to be lack of coordination and synergy between the workers employed by the different programmes while the goal of health for all requires cooperative teamwork among the many schemes and departments of the government.

3. The NRHM is intended to strengthen and support the existing State health systems and services. The administrative machinery of the NRHM and health services at the national, State and district levels remains separate without complete integration, making the programme less effective and the services less than optimal. Independent and vertical disease control programmes also continue to operate with separate societies and line management.

4. There is a marked variation in the NRHM process indicators, utilisation of funds, improvement in health care delivery, health indices and in community participation which suggests that region with good health indices have shown marked improvements, while those with prior poor indices have recorded a much lesser change.

Suggestion

1. Timely payment of salary would make the workers under NRHM to work with more zeal and dedication.
2. Without having enough capability of personnel it is not possible to bring all kinds of new and innovative medical services. There exist shortage of personnel under NRHM which should be taken into consideration so that their potential could be realised and increase the working performance of existing personnel system.
3. There is a need to make the people aware of the programme of NRHM/NHM. Most of the respondents only have basic knowledge of it
4. Due of inadequate medical treatment many patients who lived with prolonged diseases died in the hospital which calls for the need for establishing multispecialty hospitals.

5. A well laid out and well maintained road network is essential for cost-effective, affordable and accessible movement of people and for transportation of medicines.
6. Due to the insufficient number of doctors and nurses, the patients waited for a long time in the hospital. To ensure more effective health services to the people, sufficient doctors and nurses who are trained under NRHM should be placed in rural areas.
7. It is difficult to place the doctors who are trained under NRHM in remote rural areas without a differential payment for working in remote rural areas which lack in basic amenities and services at the health centre as well as the locality. Therefore, there is a need for differential payments to make it attractive for the health care staff to work in remote situations and difficult contexts.
8. In course of the interview it was found that medical reimbursement under NRHM takes a long time which makes it difficult for the patient to get further treatment. The government should look into this problem and tries to release the medical reimbursement as soon as possible.

Bibliography

Books

1.Bose, A., Gupta, D.B., & Premi, M.K. (1982). *Social Statistics, Health and Education In Mizoram*. Vikas Publishing House Private Ltd.

2.Goel, S.L. (1984). *Public Health Administration*. Sterling Publishers Pvt Ltd.

3.Kanagasabai, C.S. (2003). *Economics of Human Resources Development*. Rasse Publications.

4.Ma, S. & Sood, N. (2008), *Comparison of the Health Systems in China and India.* Rand Corporation.

5.Prasad, R.N. & Aggarwal, A.K. (2003). *Modernization of Mizoram*. Mittal Publications.

Articles

1.John, T.J. & Muliyil, J. (2009). Public Health is Infrastructure for Human Development The Challenges of the states of North-Eastern" *Indian J Med* Res *130*(1), 9-11.

2.https://pubmed.ncbi.nlm.nih.gov/19700794/

3.atil, A.V., Somasundaram, K.V., & Goyal, R.C. (2002). Current health scenario in rural India. *Aust J Rural Health*, *10*(2), 129-35. DOI: 10.1046/j.1440-1584.2002.00458.x accessed on 18.07.2017

4.Peters, D.H., Rao, K.S., & Fryatt, R. (2003). Lumping and splitting: the health policy agenda in India. *Health Policy Plan 18*(3): 249–260. DOI: 10.1093/heapol/czg031

Web Sources

1.India Netzone (2010). Kolasib District, Mizoram. htpps://www.indianetzone.com/47/kolasib_district.htm

2.Ministry of Health and Family Welfare, Government of India. Framework for Implementation, National Health Mission, 2012 – 2017.

3.www.nhm.gov.in/images/pdf/about-nrhm/nrhm-framework-implementation

4.Ministry of Health and Family Welfare, Government of India. *National Rural Health Mission: Meeting people's health needs in rural areas Framework for Implementation 2005-2012.*

5.https://nhm.gov.in/WriteReadData/l892s/nrhm-framework-latest.pdf

6.Ministry of Health and Family Welfare, Government of India. (2008) National Training Strategy for In-Service Training Under National Rural Health Mission.

7.https://www.health.gov.in

8.National Rural Health Mission (2005 – 2012)

9.www.nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf accessed on 14.09.2017

10.National Rural Health Mission Implementation and Impact.
11.htpp://www.academia.edu/34763832/_

12.National Rural Health Mission (NHRM), Budgeting for change series, 2011. www.cbgaindia.org/wp-content/uploads/2016/04/NRHM.pdf accessed on 14.09.2017

13.Sharma, A.K. Sociological Critique of the National Rural Health Mission: Issues and Priorities.

14.http://home.iitk.ac.in/~arunk/Paper%20on%20NRHM.pdf

15.Tabish, S.A. (2000). Historical Development of Health Care in India.

16.https://www.researchgate.net/publication/290447383_Historical_Development_of_Health_Care_in_India