Understanding the Dynamics of Implementation of NRHM and its Effectiveness

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CONTENTS

List of Abbreviations:

AIC	Appreciation-Influence-Control
AMG	Annual Maintenance Grant
ANM	Auxiliary Nurse Midwife
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
ASHA	Accredited Social Health Activist
AWW	Angan Wadi worker
BPMU	Block Programme Management Unit
BRICS	Brazil, Russia, India, China and South Africa
CBR	Crude Birth Rate
CHC	Community Health Centre
CBM	Community-based Monitoring
CBO	community based organization
CCB	Community Capacity building
CDR	Crude Death Rate
CRS	Civil Registration System
DHIS	District Health Information System
DHM	District Health Mission
DPMU	District Programme Management Unit
EAG	Empowered Action Group
FRU	First Referral Unit
GDP	Gross Domestic Product
GP	Gram Panchayat
HMIS	Health Management Information System
HP	Himachal Pradesh
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
LW	Link Worker
MCTS	Mother and Child Trekking System
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoHFW.	Ministry of Health & Family Welfare
MSY	Matri Sewa Yojana
NE	North East
NGO	Non Government Organisation
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health & Family Welfare
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NUHM	National Urban Health Mission

PC	Pre-Conception
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PIP	Programme Implementation Plan
PNDT	Pre-Natal Diagnostic Techniques
PPP	Purchasing Power Parity
PRI	Panchayati Raj Institutions
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
SC	Sub-Centre
SHM	State Health Mission
SPMU	State Programme Management Unit
TFR	Total Fertility Rate
VHSNC	Village Health Sanitation & Nutrition Committees
WHO	World Health Organisation
WTO	World Trade Organisation
TFR	Total Fertility Rate

Abstract

"Health for All" has become now unwritten, or at times, written target of all nations of the World, as envisaged by World Health Organization (WHO). But what does this it mean? "The goal of real healthcare reform must be high-quality, universal coverage in a cost-effective way."-Bernie Sanders. In order to provide, accessible, affordable and quality healthcare services to the poorest of the poor, the Government of India in 2005 launched its most ambitious flagship programme National Rural Health Mission, integrating all its vertical health and family welfare programmes at National, State, Block, and District levels to carry out architectural correction in the basic health care delivery system. India under NRHM has been able to improve its public healthcare delivery system, despite the constraints and limitations of a diverse country like India, evident from improvement in a variety of basic health indicators and the expansion of health infrastructure (both physical as well as manpower) over the years.

But the problem is, how far this improvement of public health in overall India is reflected in its State/Uts? Being a diverse country, all the State/Uts of India are different, be it geographical, political, economical or social. Accordingly, the status of the public health is also different in different state/Uts. There are States like Tamil Nadu with TFR as low as 1.7, whereas there are States like Bihar with TFR as high as 3.7. In the case of Infant mortality, the highest IMR is visible in Madhya Pradesh (56 per 1000 live births) and lowest (10 per 1000 live births) in Goa and Manipur. While looking at the basic health indicators like IMR, TFR, CBR etc, it was realised that Himachal Pradesh(HP) is doing better in all indicators as compared with other State/Uts as well as all India average. It is pertinent to mention that HP is one of the "high focus" State of NRHM, indicating weak public health indicators and weak health infrastructure at the time of the launch of the mission. The research attempts to understand the dynamics of the implementation of NRHM in HP, how it has been able to achieve its targets while many other State/Uts are still lagging behind.

The study has revealed that HP has been able to implement the concept of community participation. It was in fact the first state to introduce to start a community financial management programme. However, the State is using its existing Anganwadi workers to play the key role of implementation of NRHM at grass root level, i.e ASHA. The state is also being successful in integrating AYUSH in the mainstream. It has also been found that the State is implementing a number of other schemes like Parivar Kalayan Salahakar Samiti (PARIKAS), Matri Sewa Yojana(MSY), Pre-Conception (PC) and Pre-Natal Diagnostic Techniques (PNDT) act, 'Beti Hai Anmol', 'Balika Smridhi Yojana' and 'Kishori Shakti Yojana' to improve its public health system. In HP, main problem in health care lies in the unavailability of skilled human resources. Another problem the State faces is that the programmes for family planning are very less effective here, as it includes camps for sterilization which are held only once in a year.

***Key Words** : NRHM, ASHA, RKS, VHSNC, AWW, IMR, TFR, Capacity perspective, Governance, Participation*

Chapter-I
Introduction

1.1 Health Care Delivery System in India

Good Health doesn't merely mean the absence of illness; it is in fact the key to the overall wellbeing of a person. So, the status of health is a vital and one of the most important factors in a person's life. In the same way, the health of the population is an indispensible part of the public policy discourse for a country. The status of health of the population of a country indicates many important phenomenon of the country, like the general welfare level, the extent of socio-economic disparities, coverage of health services, the state of the economy as a whole etc.

1.1.1 Health-care

The dictionary meaning of healthcare is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions [1.1]. The World Health Organisation (WHO) defines health care in terms of primary health care [1.2], that the ultimate goal of primary health care is better health for all. WHO has identified five key elements to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (Leadership reforms); and
- Increasing stakeholder Participation.

1.1.2. Health- care system in India

Structure and Organisation of health system

Politically, India has a federal structure comprising of 29 States and 7 Union Territories, which includes newly created State Telengana. However, for the purpose of the research, 28 States and 7 Union Territories of India (before the creation of Telangana) will be considered to form the political India. As per constitution of India, health is a state subject. "The Directive Principles of State Policy" in Part-IV of the "Constitution of India" (Article 47) prescribes every state that "The State shall regard the raising of the level of nutrition and the standard of living

of its people and the improvement of public health as among its primary duties...." (Constitution of India).

As such, every state has its own healthcare delivery system. Moreover, in India, parallel to the public health sector, there is a vast private healthcare delivery system, especially in the urban India. 92% of private health care providers (individuals and informal providers) are in rural areas (GOI 2005a). So, the healthcare delivery system of each state comprises of both public and private healthcare delivery system. Though states are responsible to take care of the healthcare delivery system within their state, the Central governments has the overall control over the state's healthcare system in terms of policy making, planning, monitoring and coordination and also in providing grants to states for national level programmes.

Regarding organisation, in each state, there is a Department of Health and Family Welfare to deal with the state's healthcare whereas at Centre, there is Ministry of Health and Family Welfare responsible for the healthcare system of the whole of India. The Indian systems of medicine consist of both Allopathy and AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) (Direct Response 2013).

Structure of Rural Health Care System

Since the research is based on rural health system, it will be proper to give a glimpse of rural health care system in India before proceeding further. The health care infrastructure in rural areas has been developed as a three tier system and is based on the population norms. The **Sub-Centre (SC)** is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is required to be manned by at least one **Auxiliary Nurse Midwife (ANM)** / Female Health Worker and one Male Health Worker. **Primary Health Centre (PHC)** is the first contact point between village community and the Medical Officer. A PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. Under **National Rural Health Mission (NRHM)**, there is a provision for two additional Staff Nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centres and has 4 - 6 beds for patients. **Community Health Centre (CHC)** serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. A CHC is required to be manned by four Medical Specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities.

Table no. 1.1: Population covered under SC, PHC & CHC

Centre	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

(Source: Rural Health Statistics India 2012)

As on March, 2012, there are 1, 48,366 Sub Centres, 24,049 Primary Health Centres (PHCs) and 4,833 Community Health Centres (CHCs) functioning in the country.

1.1.3. Challenges of healthcare delivery system in India

India has a universal healthcare delivery system, meaning that healthcare is for everyone living in the country. But it's a great challenge for India's healthcare delivery system to provide effective healthcare to every citizens. As per 2011 Census, India has the huge population of 1028 million of which 72% lives in rural area. Moreover, as per the 2013 report of the Planning Commission, 22% of the total population of India are below poverty line. Again, the World Bank data [1.3], of 2012 indicates that, Government spending on health care in India constitute only 1.3% of its GDP, while the total health expenditure is nearly 5% of GDP, suggesting a huge private out of pocket expenditure at the point of delivery)[1.4]. Adding to these, the topography of India posses another big challenge, where many parts of the country remain inaccessible during different periods of the year.

"Healthcare is one of India's largest service sectors. The Indian healthcare sector can be viewed as a glass half empty or a glass half full. The challenges the sector faces are substantial, from the need to reduce mortality rates, improve physical infrastructure, necessity to provide health insurance, ensuring availability of trained medical personnel etc. There has been a rise in both communicable/infectious diseases and non-communicable diseases, including chronic diseases." (Direct Response 2013). Moreover, general living condition, maternal and child health, food pattern, nutritional status etc. are also not proper among the unprivileged section of the society, especially the rural poor.

1.2. Genesis of the National Rural Health Mission(NRHM)

1.2.1 Background

Due to a fiscal crisis during the nineties, the public expenditure in health care was declining significantly. With no expansion and no reform of the public health care

delivery systems, this led to an overall deterioration of the availability of public healthcare system and skilled health professionals. The private medical sector grew, but this growth was uneven and mostly concentrated in urban areas. All of these factors together contributed to a subsequent decline in access to health care, especially in rural areas. Moreover, in the absence of accessible and well equipped public health care system, the people were forced to go for the private medical sector. Thus, rising costs of health care had become a major public health issue. Moreover, healthcare spending of about 1.3% of GDP had fuelled the out of pocket expenditure, accounted for nearly 80% of total health expenditure in India. This in turn resulted an estimated 3.2% of the population (approximately 39 million people) slipping below the poverty line every year, due to health care costs alone. So it was necessary for the government to go for the architectural correction in the public healthcare system in India, adopting a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water(NHSRC 2013: 2).

1.2.2. The Mission

The Government of India launched the NRHM in 2005 throughout the country with special focus on 18 States, including eight Empowered Action Group (EAG) [1.5] States, the North-Eastern (NE) States, Jammu & Kashmir and **Himachal Pradesh (HP)**, seeks to provide accessible, affordable and quality health care services to rural population, especially the vulnerable sections (GOI 2005). The NRHM was designed to operate as an omnibus broadband programme by integrating all vertical health programmes of the Departments of Health and Family Welfare including Reproductive & Child Health Programme and various diseases control Programmes (GOI 2011).

The NRHM has emerged as a major financing and health sector reform strategy to strengthen States Health systems. So far, it has been successful in putting in place large number of voluntary community health workers in the programme, which has contributed in a major way to improved utilisation of health facilities and increased health awareness. The mission has also contributed by increasing the human resources in the public health sector, by up-gradation of health facilities and their flexible financing, and by professionalization of health management. The policy shift after the initial years of NRHM was towards addressing inequities, through a special focus on inaccessible and difficult areas and poor performing districts. This also required improving the Health Management Information System (HMIS), an expansion of NGO participation, a greater engagement with the private sector to harness their resources for public health goals, and a greater emphasis on the role of the public sector in the social protection for the poor.

1.2.3. Main goals of NRHM are:

- Reduction in **Infant Mortality Rate[1.6] (IMR)** and **Maternal Mortality Ratio[1.7] (MMR)**
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH.
- Promotion of healthy life styles. (GOI 2011)

1.2.4. Progress under NRHM

For the country as a whole, latest available data indicates the following progress under NRHM in terms of key measurable health outcomes:

The **Total Fertility Rate[1.8] (TFR)** has been reduced from 2.9 in 2005 to 2.5 in 2011, IMR from 58 in 2005 to 44 in 2011, **Crude Birth Rate[1.9] (CBR)** and the MMR was estimated at 178 during 2010-12 from 254 during 2004-06(Refer: Table 1.2).

Table no. 1.2:
Core health outcomes during 2004-06 to 2010-12

Health Indicators	2004-06	2010-12
MMR	254	178
IMR	58	44
CBR	23.8	21.8
TFR*	2.8	2.5

Source: Periodic Bulletin of Office of the Registrar General of India.
****: Data from World Bank***

So, it is observed that there have been steady improvements in the core maternal and child health indicators at all India level. However, India being a diverse country, the pattern of progress of various State/Uts under NRHM is bound to be different, which is something really interesting to explore.

For the purpose of NRHM, the State/UTs in India have been grouped[1.10] as **High Focus Non NE** (Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttaranchal, Uttar Pradesh); **High Focus NE** (Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura);

Non High Focus- States (Andhra Pradesh, Goa, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, West Bengal) and **Non High Focus- UT** (Andaman & Nicobar Islands, Chandigarh, Daman & Diu, Dadra & Nagar Haveli, Delhi, Lakshadweep, Puducherry).

1.3. Indentifying Problems

India is a diverse country. The diversity is evident in all aspect, be it geographical, political, economical or social. So, the status of the public health is also different in different state/Uts. This also led to the fact that the impact/progress of NRHM is also different in different state. When the mission was launched, some of the states were at a pathetic condition in terms of public health, whereas there are State/Uts which have always been advanced compared to other states.

Considering present scenario, as per available data, if we look at the Population stabilisation, there are States like Tamil Nadu with TFR as low as 1.7, whereas there are States like Bihar with TFR as high as 3.7. In the case of Infant mortality, the highest IMR is visible in Madhya Pradesh (56 per 1000 live births) and lowest (10 per 1000 live births) in Goa and Manipur. Similar pattern is also visible in case of maternal mortality.

However, it's not only the present status of public health system that matters while examining the progress of a state under NRHM. It is essential to view the performance of the state from before the launch of NRHM to introduction of NRHM in public health system and how far the states have progressed in the direction of successful implementation.

As described above, the problem in implementation of NRHM is that, some states are being able to implement the scheme successfully whereas some others are yet to achieve their set goals and yet to learn to implement the scheme successfully. So, it is proposed to first identify a state, which has been successful in implementing the scheme and then try to find the reasons, how the state is being able to progress under NRHM whereas many others are lagging behind.

To see the reasons behind the success of the public healthcare system due to the successful implementation of NRHM, it would be proper to select a state which has improved considerably during the period under NRHM, which had weak public health indicators and weak health infrastructure before the launch of the scheme. So, it has to be one of the 18 high focus state.

The three key goals set by the NRHM and by the Eleventh Five Year Plan(GOI-PC 2007) of the Government of India included reduction of TFR to 2.1 or less, IMR to 28 and MMR to 100 per 100,000 live births (NHSRC 2013: 7).

For the purpose of the research, only High focus Non NE states of NRHM will be considered. So, the status of these three Key indicators pertaining to the High Focus Non NE states of Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttaranchal and Uttar Pradesh have been considered for selecting a better performing State of NRHM. For this purpose the CBR and TFR have been taken as the indicator for population stabilization, whereas IMR and MMR have been taken as the Indicator for infant mortality and indicator for maternal mortality respectively.

After comparing the performance of these selected indicators (table no. 1.7 in Appendix-I) , it has been observed that the taken together the overall performance of all the four indicators, Himachal Pradesh (HP) appears at the top of the list. Observing the individual performance of the State in comparison with the all India value, it is seen that the TFR for all India is 2.4, whereas the same for HP is 1.7, the IMR for all India is 42 whereas the same for HP is 36, the CBR for all India is 21.6 and the same for HP is 16.2. So, the state of Himachal Pradesh is performing better than all India average in almost all aspects, even though the state is one of the High focus State of NRHM, meaning State with weak health indicator and health infrastructure before the launch of the scheme. The state is meeting majority of the set objectives; for the remaining, it is steadily improving, nearing its goal.

1.4. Objective of the Research

The overall objective of the research is to analyse how the NRHM has been implemented in the state of HP, critically review the outcomes, effectiveness and lessons" Specific objectives are "to analyse the effect of NRHM on a) Financial allocation; b) Human Resource availability; c) Institutional Strengthening; d) Access and Quality of services; e) health outcomes, in the state of HP. The research also intends to analyze, how to implement the scheme successfully and what are the factors responsible for the successful working of NRHM structure in states such as Himachal Pradesh.

1.5. Research Question

The main research question is, therefore, formed as under:

Why and how the state of the Himachal Pradesh is being able to perform better than all India average in almost all aspects and nearing its set goal of NRHM to improve its public health whereas many states are lagging behind?

The Sub-questions of the research process will be:

What is the role of State Government of Himachal Pradesh in implementing the scheme? What are the favourable socio economic factors? Does the decentralisation of health services work? Does the concept of community participation realised, especially through Accredited Social Health Activists (ASHA)]? Has Himachal Pradesh been able to contain corruption at low level? Has Himachal Pradesh been able to build necessary capacity at local level? What is the status of health infrastructure and health manpower in Himachal Pradesh?

1.6. Introduction to the theory of Framework

1.6.1 Concepts

Not only the community participation can be understood as a strategy that to appropriately and effectively address the issues under consideration but is highly critical for the successful implementation of governments' programme, especially in the health sector. Since the implementation of NRHM involves ASHA, Rogi Kalyan Samiti (RKS), Village Health, Sanitation & Nutrition Committee (VHSNC), NGOs etc, so it proposed to examine the NRHM from the angle of **participation** as a concept.

The UNESCAP defines the term 'Governance' as "...the process of decision-making and the process by which decisions are implemented (or not implemented) (UNESCAP 2009)". Hence, it is an important tool for making and implementing decisions. It's not about making 'correct' decisions, but about the best possible process for making those decisions [1.11]. The research intends to see the existence or non-existence of **good governance** in the implementation of NRHM in HP. The paper will also try to look at the existence of **corruption** and extent of **decentralisation** as part of governance of mission. By corruption, here we will concentrate on the public sector corruption only. The public sector [1.12] refers to the part of the economy concerned with providing various government services such as the military, police, transport, public roads, education, healthcare etc.

1.6.1 Theories/Perspectives

It is proposed to analyse the case from the point of view of **Capacity perspective**.

Capacity is the ability to perform functions, solve problems, and set & achieve objectives in a sustainable manner (Fukuda-Parr et al 2002: 8). It is "the ability to perform appropriate tasks effectively, efficiently and sustainably" (Grindle and Hilderbrand 1995). In other words, capacity is the ability of people, organizations, and society as a whole to manage their affairs successfully (OECD-DAC 2006: 12). Capacity perspective has a number of dimensions depending on the case under study. As far as NRHM is concerned, the various dimensions of its capacity can be considered as mission, institutional context, stakeholders, other associate factors, output, resources etc.

1.7 Proposed Methodology

For the purpose of analysis, the research will take (i) various health indicators like Demographic indicators, Mortality Indicators and Fertility Indicators and (ii) some of the important components of NRHM. The other factors which affects the outcome of the scheme such as (i) Social (ii) Financial & (ii) Political will be considered as Secondary parameters.

1.8 Data Sources

This research is proposed to be based on both quantitative and qualitative data mainly from secondary sources, due to time and resource constraints. For primary data, information gathered from direct correspondence/telephonic conversation with the personnel involved the implementation of the scheme will be incorporated. The secondary data available from various books, journals, internet sources and the data available with NRHM and State Health Mission (SHM) for the states of Himachal Pradesh are proposed to be used for quantitative analysis. For qualitative analysis, the opinion surveys conducted by Regional Evaluation Teams of the Ministry of health & Family Welfare and various evaluation reports of the State Programme Implementation Plan is proposed to be taken into consideration. Academic literature from the Library of International Institute of Social Studies (ISS), The Hague and On-line library of Erasmus University Rotterdam (EUR), Rotterdam and other scholarly articles will also be used in the studies.

1.9 Relevance and Justifications

NRHM is a scheme which has improved the level of public healthcare in India significantly. It is the only scheme to integrate all the healthcare schemes and initiatives under one umbrella.

But the improvement under the scheme is not uniform. There are states which have done commendable progress under NRHM whereas there are states still struggling to provide the basic healthcare amenities to its entire population, disregarding the basic objectives of the NRHM to make the healthcare accessible to the poorest of the poor. There are articles, debates which criticises NRHM for its lack of desired level of success in some states and there are articles describing the successful implementation of the scheme in some states. No available information or study provides a model for the lagging behind states to make the scheme successful. So, there is necessity to understand the dynamics behind the successful implementation of the scheme and try to devise a model of the successful implementation of the scheme, so that it can be used to make the scheme work in the states where it is not meeting its target, on the basis of the state which is sailing ahead.

1.10 Risks, Ethical Challenges and Limitations of The Research

(a) The most important limitation of this research paper is that due to time and other resource constraints, it will not be possible to go for primary data, which is generally required for any such research. This research will primarily be a desk research based on secondary data.

(b) Since the research will be carried out using secondary data, and mostly published data, so there will not be much ethical issue involved here, which has generally already been taken care of by the agency/organisations involved while collecting.

(c) Another limitation of the research is that, being a candidate sponsored by the Government of India (GOI), only upto the end of August 2014, I will be able to devout my complete time to the research before reporting back for duty as per the order of the GOI. So, it is a challenge to do proper justice to the study considering the fact that during the final part of the study (September to November 2014), I will need to carry out my official duties along with my study.

(d) I intend to devise a model of successful implementation of NRHM in a State from my research, which is, academically a challenge for me.

(e) Since it is a desk research, it might not be able to capture the actual dynamics of the implementation of NRHM.

1.11 Organisation of the Research Paper:

The Research Paper will have seven Chapters, the details of which are as under:

The **Chapter-I** is the I**ntroductory** chapter including the background of the research such as healthcare system in India, its status and challenges, the genesis of NRHM and the status of its progress involving the problems, forming the research question along with the overall objective of the research. The **Chapter-II** is the **Theoretical framework** including the Perspectives, Concepts, Theory and Toolbox of the research including relevant Checklist. This also includes the **Methodology** section. Here both quantitative and qualitative data from secondary sources is proposed to be considered in the light of the various other socio-economic factors which affect the implementation of the scheme. **Chapter-III** is the **Contextual chapter** which provides in details about India and Himachal Pradesh. Here, it is proposed to describe both India and Himachal Pradesh under four broad categories: General facts and figures, Population, Administration and Politics. **Chapter-IV** describes the case under study. It will deal with the **case of NRHM** in India in general with special focus on the case of NRHM in Himachal Pradesh. **Chapter –V** is the **Analytical analysis** including the Toolbox of the research: Role of Capacity, Role of Political Stability, Role of budget and capital, Role of participation of people, Role of Good governance and Role of Corruption in the case under study. **Chapter-VI** will seek to find and present a possible, proper and justified answer to the **Research Question** with relevant data.

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The Chapter-II
Theoretical Framework

The paper intends to understand the dynamics of implementation of the NRHM, in particular in the State of Himachal Pradesh, which has been selected on the basis of the performance of the key measurable indicators of the NRHM. For the purpose, the following concepts and tools have been used:

2.1 Concepts

2.1.1 Participation

Community participation can be understood as a strategy that is used by the policy makers to appropriately and effectively address the issues under consideration. "The process of community participation respects the rights and responsibility of community members to diagnose causes of a community problem and to actively engage in designing, implementing, and evaluating programs that are intended to improve the problem"(Hauser 2002)

Community participation is highly critical for the successful implementation of governments' programme, especially in the health sector. As pointed out by Nicole Cheetham, MHS, Deputy Director, International Division, Advocates for Youth in his article 'Community Participation: What Is It?', "a community's members are a rich source of knowledge about their community and of energy and commitment to that community. When public health professionals envision a program to address health issues in a particular community, tapping into the community's expertise and enthusiasm is frequently an essential issue. Genuine participation by community members is the key. Community members control the project and at the same time professional partners build the community's capacity to make informed decisions and to take collective action" (Cheetham 2002).

As far as NRHM is concerned, in order to ensure that the services reach those for whom they are meant, the NRHM involved an intensive accountability framework that includes Community-based Monitoring (CBM) as one of its key strategies. Community-based Monitoring involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organizations (CBOs), people's movements, voluntary organizations and Panchayat representatives, to directly give feedback about the functioning of public health services. The community monitoring process involves a three-way partnership between healthcare providers and managers (health system); the

community, community-based organizations, NGOs and Panchayati Raj Institutions. (Garg and Laskar 2009).

2.1.2 Good Governance

Governance is the process of decision-making and the process by which decisions are implemented (or not implemented). Government is one of the actors in governance. There are many other actors involved in governance, depending on the level of importance and the issue under consideration, like Civil Society, Corporate sector, NGOs, media, financial institutions, political parties etc. (UNESCAP 2009). Colebatch (2009:10) points out the government policy as 'governance of a specific problem through appropriate measures'. UNESCAP defines the term 'Governance' as "...the process of decision-making and the process by which decisions are implemented (or not implemented)(UNESCAP 2009)".

Here, since the term governance covers both the process of decision making and the process by which decisions are implemented, analysis of governance focuses on

- both the formal and informal actors involved in decision-making and implementing the decisions made
- both the formal and informal structures that have been set in place to arrive at and implement the decision.

"As a structure, governance signifies the architecture of formal and informal institutions; as a process it signifies the dynamics and steering functions involved in lengthy never ending processes of policy making; as a mechanism it signifies institutional procedures of decision-making, of compliance and of control (or instruments); finally, as a strategy it signifies the actors' efforts to govern and manipulate the design of institutions and mechanisms in order to shape choice and preferences" (Levi-Faur 2012:8). World Bank (1994) points out that ***accountability, legal frame work for development and transparency*** is the hallmark of good governance in public sector. According to United Nations Development Programme (UNDP 1997:4) good governance should include "….among other things, ***participatory, transparent and accountable***. It is also effective and equitable. It promotes the rule of law". The research would try to examine whether characteristics good governance is present in the system of governance followed by NRHM Himachal Pradesh.

The paper will also try to look at the existence of **corruption** and extent of **decentralisation** as part of governance of mission. Corruption is the abuse of entrusted power for private gain. Here, we will concentrate on the public sector

corruption only. The public sector corruption is any kind of abuse of entrusted power for private gain that takes place within the government or government bodies counts. Though it is very difficult to get data related to corruption, the researcher will depend on newspaper clipping, discussion with relevant personnel involved in the implementation of the scheme etc. to access the presence of corruption. On the other hand, decentralisation encapsulates three distinct elements: (1) financial decentralisation, entailing the transfer of financial resources in the form of grants and tax-raising powers to sub-national units of government; (2) administrative decentralisation (sometimes referred to as deconcentration) where the functions performed by central government are transferred to geographically distinct administrative units, and (3) political decentralisation where powers and responsibilities are devolved to elected local governments; this form of decentralisation is synonymous with democratic decentralisation.(Robinson 2003)

2.2 Theories/Perspectives

It is proposed to analyse the case of implementation of the scheme of NRHM in HP using the above explained concepts from the **Capacity perspective**. Capacity is the ability to perform functions, solve problems, and set & achieve objectives in a sustainable manner (Fukuda-Parr et al 2002: 8). It is "the ability to perform appropriate tasks effectively, efficiently and sustainably. In turn, capacity building refers to improvements in the ability of public sector organizations, either singly or in cooperation with other organizations, to perform appropriate task." (Grindle and Hilderbrand 1995). In other words, capacity is the ability of people, organizations, and society as a whole to manage their affairs successfully (OECD-DAC 2006: 12).

Capacity building is an ongoing process through which individuals, groups, organizations and societies enhance their ability to identify and meet development challenges [2.1]. The UNDP defines (as cited in Matovu, 2008) capacity as "the ability of individuals, institutions and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner". Hawe, P., L. King, M. Noort, C. Jordens, and B. Lloyd defines capacity building in health sector in their 1999 book "Indicators to help with capacity building in health promotion" as, "an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over" (Hawe et al: 1999).

As far as NRHM is concerned, its more about Community Capacity building (CCB), which is a conceptual approach to development that focuses on understanding the obstacles that inhibit people, governments, international organizations and non - governmental organizations from realizing their developmental goals while

enhancing the abilities that will allow them to achieve measurable and sustainable results[2.2].

There are various aspects of capacity building depending on the issue under consideration like Network and advocacy, financial resources, operations and governance, human resources, programs & planning, marketing, and information technology (Peterhurford 2012). For the purpose of the research, five dimensions pertaining to the implementation of NRHM in HP have been identified as action environment, institutional context, task network, organisations and human resources (Grindle and Hilderbrand 1995)

2.3 Tools

Since, with the help of the stakeholder analysis, it is possible for the policymakers and managers to identity the key actors and to assess their knowledge, interests, positions, alliances, and importance related to the policy, so a **stakeholder analysis** of all organisations, governments, NGOs, community, individuals, groups and institutions with identifiable interest in the implementation of NRHM in HP has been done. Stakeholder analysis is a process of systematically gathering and analysing qualitative information to determine whose interests should be taken into account when developing and/or implementing a policy or program (Schmeer 1999). A **stakeholder analysis table** and a **stakeholder influence and importance** matrix, after categorising the different stakeholders and their respective roles in implementation of the scheme, have been prepared. The main aim of the matrix is "to capture the degree to which each stakeholder has influence over the relevant issues and their level of interest" (Wageningen UR, n.d.) . Here, "'Influence' is the power a stakeholder has to facilitate or impede the achievement of an activity's objectives. 'Importance' is the priority given to satisfying the needs and interests of each stakeholder" (DFID 2003: 2.3).

To bring into practice the philosophy of good governance, the government moves away from the concept that "a single implementing agency can control the actors needed to effect significant change. But the truth is that significant development is invariably outside the control any single organisation (Honadle and Cooper 1989: 1535-36)". **Appreciation-Influence-Control (AIC)** is both a philosophy and a model for action for organising development work. AIC is a process that recognizes the centrality of power relationships in development projects and policies [2.3]. It's a "technique that encourages stakeholders to consider social, political, and cultural factors along with technical and economic aspects that influence a given project or policy (World Bank, n.d.)."

2.4 Methodology

This highlights the methodology which is used for studying the achievements of health outcomes in Himachal Pradesh by evaluating the NRHM services in respective state. The study seeks to use data based on secondary sources both in quantitative and qualitative terms. Further the analysis has been done by considering the various socioeconomic factors which may affect the implementation of the scheme. Here both quantitative and qualitative data from secondary sources is proposed to be considered in the light of the various other socio-economic factors which affect the implementation of the programme.

2.4.1. Primary parameters:

The primary parameters used for the analysis are **Socio-economic as well as demographic indicators** (demographic indicators, mortality indicators and socio economic indicators) and a few **important components of NRHM** like RCH programme such as Immunisation, Maternal & Child health and Family Planning, Role of ASHA, VHSNC RKS, HMIS and Mother and Child Trekking System(MCTS).

2.4.2. Secondary parameters:

There are a number of other parameters, can be considered as Secondary parameters, which influence and also influenced by the implementation of the scheme like Social, Financial & Political environment.

2.4.3. Data sources:

This research is based on both quantitative and qualitative data from secondary sources, due to time and resource constraints.

(a) For detailed quantitative analysis, the secondary data available from various books, journals, internet sources and the data available with NRHM and SHM for the states of Himachal Pradesh.

(b) For qualitative analysis, the opinion surveys conducted by Regional Evaluation Teams of the Ministry of health & Family Welfare and various evaluation reports of the State Programme Implementation Plan is proposed to be taken into consideration.

(c) Academic literature from the Library of International Institute of Social Studies (ISS), The Hague and On-line library of Erasmus University Rotterdam (EUR), Rotterdam.

(d) For the purpose of this research primary data has also been collected having discussion on telephone with senior officers and some personnel who are engaged in implementing the scheme. Some inputs were received through emails also. These data along with secondary data facilitated for stakeholder analysis and understanding governance of NRHM. An attempt has been made to understand the dynamics of implementation and assess the outcome after the launch of NRHM.

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Chapter-III
India and the State of Himachal Pradesh

3.1. India and Himachal Pradesh in general

India, the second-most populous country in the World with over 1.2 billion people as per country's 2011 Census and the Seventh-largest country by area is the largest democracy in the world. Historically, India has witnessed and travelled through the ancient Indus Valley Civilisation to Delhi Sultanates to Mughal empires to colonial India under British rule and finally independent and democratic modern India.

The economy of India is the tenth-largest in the world by nominal GDP and the third-largest by purchasing power parity (PPP)[3.1]. The country is one of the G-20 major economies, a member of BRICS and a developing economy that is among the top 20 global traders according to the WTO. The post independence-era Indian economy (from 1947 to 1991) was a mixed economy with an inward-looking, centrally planned, interventionist policies and import-substituting economic model that ultimately ended with the fiscal crisis in 1991. To overcome the crisis, India went for structural economic reforms which changed its economic policy towards increasingly adopted free-market principles and liberalised its economy to international trade. , it is one of the fastest growing economies of the World.

The state of Himachal Pradesh of the Indian subcontinent has an area of 55,673 sq. km. and a population of 6.08 million. Topographically, mountainous in nature, the state is located in altitudes ranging from 450 meters to 6500 meters above sea level, rich in fauna and flora as well wild life, the forests cover about 38% of the area. Only 7.5% of the total population of the state live in urban area. Most of the people live in rural habitations varying in size from isolated hamlets to conglomerated settlements. There are 12 districts, 77 blocks and 20118 villages. The state has 49 cities and towns. The State has population density of 109 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 17.54% (against 21.54% for the country) and the population of the state is growing at a slower rate than the national rate (Registrar General & Census Commissioner, India 2011).

Himachal Pradesh known as "dev bhoomi", is surrounded by neighbouring states Jammu & Kashmir, Punjab, Uttar Pradesh and Uttaranchal. The history of human settlement in Himachal Pradesh goes back to Palaeolithic period. Throughout in recorded history Himachal Pradesh was divided into different principalities. The

colonial empire bought them under one rule in 1859. In independent modern India, initially, Himachal Pradesh was given the status of Union Territory and later on was given the status of State in 1971.

Table no.3.1: Demographic and Socio-economic indicators

Indicator	Himachal Pradesh	India
Total population (in Crore) (Census 2011)	0.68	121.01
Decadal Growth (%) (Census 2011)	12.81	17.64
Natural Growth Rate (SRS 2011)	9.8	14.7
Sex Ratio (Census 2011)	974	940
Child Sex Ratio (Census 2011)	906	914
Schedule Caste population (in crore) (Census 2001)	0.15	16.67
Schedule Tribe population (in crore) (Census 2001)	0.024	8.43
Total Literacy Rate (%) (Census 2011)	83.78	74.04
Male Literacy Rate (%) (Census 2011)	90.83	82.14
Female Literacy Rate (%) (Census 2011)	76.60	65.46

The above mentioned table shows the demographic and socio-economic indicators of Himachal Pradesh and India. It can be seen from above that some of the key indicators are performing well in Himachal Pradesh in comparison to all India level such as Decadal Growth, Sex Ratio, Literacy rate etc.

3.2. Healthcare delivery system in India

As per Constitution of India, **healthcare is a state subject**. Each state has their own healthcare delivery system, though certain responsibilities fall on the federal (Central) government, namely aspects of policy-making, planning, guiding, assisting, evaluating and coordinating the work of various provincial health authorities and providing funding to implementing national programmes. Considering the organisational point of view, the Ministry of Health & Family welfare is at the Centre, with each state having their own State Department of Health and Family Welfare that is headed by a State Minister and with a Secretariat under the charge of the Secretary/Commissioner. The Indian systems of medicine consist of both **Allopathic** and **AYUSH** (Ayurveda, Yoga, Unani, Siddha and Homeopathy).

Traditionally, India has always been a rural, agrarian economy. 61% of its total population still lives in rural India (Registrar General & Census Commissioner, India 2011). So, Government focus in matters of health has always been the rural India, with a well structured 3-tier healthcare delivery system in Rural India. The healthcare delivery system in Urban India is not organised and structured, mostly dominated by fragmented and unregulated private sector. To address the health concerns of the urban poor population, The Government of India recently launched its National Urban Health Mission (NUHM) on 20 January, 2014 to provide adequate and efficient urban public health delivery system for the urban poor.

Indian healthcare system is also characterised by the presence of a dominant private sector. The private sector is comprises of both profit and non-profit organisations. The "Report of the Steering Committee on Health for the 12th Five Year Plan", illustrates the strength of the private sector that it controls 80 per cent of doctors, 26 per cent of nurses, 49 per cent of beds and 78 per cent of ambulatory services (GOI 2012: 15).

Another feature of healthcare system in India is less healthcare spending and high out-of pocket expenditure. India spends about 4.1% of its GDP on health sector, 70% of which it is from people's own pockets or private spending meaning that the government spends barely 1% on health. (GOI 2013a). The high OOP expenditure on health care forms a barrier to accessing care and can cause households to incur catastrophic expenditures, which in turn can push them into indebtedness and poverty (GOI-PC 2011: 16).

India launched NRHM in 2005 throughout the country with special focus on 18 States, including eight Empowered Action Group (EAG) States, the North-Eastern States, Jammu & Kashmir and Himachal Pradesh, seeking to provide accessible, affordable and quality health care services to rural population, especially the vulnerable sections.

3.3. Health Scenario of Himachal Pradesh

Himachal Pradesh (HP) is predominantly dominated by rural region, 89.97 percent of population living in rural areas. The population growth rate was 12.65% in rural areas and 15.61 % in urban areas. When health indicators are seen, Himachal Pradesh is performing better than other states, crude birth rate (16.5) and crude death rate (6.7) of Himachal is lower than India as a whole.

Further infant mortality rate is 38 and total fertility rate is 1.8 which proves that state is performing well in certain health indicators where other high focus states are lacking behind.

In HP, health services are provided through Department of Health and Family Welfare and the Department of Indian Systems of Medicines and Homeopathy (GOI-PC, n.d.). The main focus of the state is on providing good health care services through different facilities in the health infrastructure, mainly through its facilities such as SCs, PHCs & CHCs. The state has number of medical, public health and Ayurvedic institution as well as number of specialised institutions for Leprosy, TB and Sexually transmitted infections. Further adequate facilities of X-Ray, Dental, ENT clinics and maternal and child welfares are provided in the State (GOI-PC, n.d.). For 2738 population one sub-centre, 12832 per PHC and 85,745 per CHC is structured in the state. For tribal areas, comprising Kinnaur, Lahaul, and Spiti, Pang and Bharmour, there are three hospitals, nine CHCs, 36 PHCs, 100 SCs, 84 ayurvedic dispensaries and two state hospitals. There are 422 allopathic and 58 ayurvedic beds in the region. Ayurvedic health centres are also there which are quite popular among the masses.

Table no.3.2: Key health indicators

Indicator	Himachal Pradesh	India
Crude Birth Rate (SRS 2011)	16.5	21.8
Crude Death Rate (SRS 2011)	6.7	7.1
Infant Mortality Rate (SRS 2011)	38	44
Maternal Mortality Rate (SRS 2007-09)	NA	212
Total Fertility Rate (SRS 2011)	1.8	2.4
Life expectancy at birth (in years)		
Total	65	
Male	64	
Female	67	

Source: ***http://nrhm.gov.in/nrhm-in-state/state-wise-information/himachal-pradesh.html#state_profile***

MMR: The maternal mortality ratio is defined as the number of maternal deaths per 100 000 live birth

Table no.3.3: Health Infrastructure in India

Rural areas (3-tier system)			
Centre	**Population Norms**		**Total number in all India**
	Plain	**Hilly/Tribal**	
Sub-Centre	5000	3000	8000
Primary Health	30,000	20,000	50,000
Community Health	1,20,000	80,000	2,00,000

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

Table No.3.4: Detailed Health Infrastructure

Particulars	Himachal Pradesh			INDIA		
	Required	In position	shortfall	Required	In position	shortfall
Sub-centre	2055	2065	*		148366	
Primary Health Centre	308	472	*		24049	
Community Health Centre	77	76	1		4833	
Health worker (Female)/ANM at Sub Centres & PHCs	2537	1951	586	172415	207578	6630
Health Worker (Male) at Sub Centres	2065	1183	882	148366	51705	96734
Health Assistant (Female)/LHV at PHCs	472	61	411	24049	16109	9152
Health Assistant (Male) at PHCs	472	22	450	24049	14648	12658
Doctor at PHCs	472	436	36	24049	28984	2489
Obstetricians & Gynaecologists at CHCs	76	0	76	4833	1615	3005
Paediatricians at CHCs	76	2	74	4833	1379	3270
Total specialists at CHCs	304	5	299	19332	5858	13477
Radiographers at CHCs	76	72	4	4833	2314	2557
Pharmacist at PHCs &	548	368	180	28882	26219	5295
Laboratory Technicians at	548	195	353	28882	17525	12494
Nursing Staff at PHCs &	1004	376	628	57880	66424	13521

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI)

The above mentioned tables show the situation of health infrastructure and human resource in Himachal Pradesh and India. In spite of various schemes and efforts, there are difficulties in the implementation of the policies and providing efficient health services to the people due to lack human resources. One interesting feature was that in the state of Himachal Pradesh, the staff positioning in both sub-centre and PHC which was more than the required. But, on the other hand, there was extreme shortage of specialists in CHC.

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Chapter-IV
National Rural Health Mission (NRHM) in Himachal Pradesh

NRHM in India was launched with a few key measurable goal and some process objectives specified in the Eleventh Five Year Plan (GOI-PC 2007) like reducing MMR to 1 per 1000 live births (100 per 100,000 live births), reducing IMR to 30 per 1000 live births, reducing TFR to 2.1, providing clean drinking water for all by 2009, reducing malnutrition among children of age group 0 to 3 to half of its present level, reducing anaemia among women and girls by 50% and raising the sex ratio for age group 0 to 6 to 935 by 2011-12 and 950 by 2016-17(GOI-PC 2011: 7).

Himachal has already achieved most of the milestones which are to be achieved under NRHM by 2012. There are some concerns regarding maternal and child health care which the state is addressing in systematic manner. These concerns and the strategies to address these have been discussed in the PIP for the year 2011-12 General well being of the people of the state and the health care seeking behaviour has improved significantly over the years.

Himachal has opened more health institutions than are required as per norms for the hill states which shows the commitment of the state to meet the challenges in health sector and reflects the priority accorded by the state to Health Sector. This is visible from the gradual increase of the state budget every year for health sector as a whole. One significant indicator is TFR which has stabilised at 1.9 which can also be taken as a proxy indicator for maternal and child health. There are some issues regarding IMR and MMR which need mention here. The IMR for the state has shown one point increase in SRS 2009 over 2008. It was 44 in 2008 and is 45 in SRS 2009. Without denying the validity of the Report of SRS it is pointed out that any sample study including SRS has some inherent limitations which get compounded when we have a small population as is the case with Himachal. Himachal has one of the best Civil Registration System (CRS) which gives an IMR figure of less than 20. Similarly the Anganwari network in the state is very good. 18386 Anganwaris cover the population of the state which puts the IMR at 20 and the analysis of last seven year data shows that IMR has been steady around 20 deaths per 1000 live births. The ICDS Data shows the IMR to be around 20[4.1].

4.1. Anganwadi workers (AWW) in HP

One of the key strategies NRHM is having a Community Health Volunteer named ASHA (Accredited Social Health Activist) for every village. However, in HP, the State did not employ separate ASHA for the purpose, like most other States. So, to perform the duties of ASHA, State is using its Anganwadi network, designating the

AWW playing the role of ASHA as "Link Worker (LW)". Strategies & Activities concerning the LW include Training of LWs, to provide refresher trainings to LWs for three days in every quarter of the year on different components of Maternal and Child Health, to give them performance based incentives on the ASHA pattern as envisaged under NRHM. On an average an AWW is covering a population of 300-800. The average per month performance incentive comes to Rs. 800/-, from their duties as LW.

4.2. Promotion of institutional deliveries in "Ayush" institutions in Himachal Pradesh

The Department of Ayurved Himachal Pradesh is contributing effectively in all the National Public Health Programmes. To promote Institutional deliveries labour room at Regional Ayurvedic Hospital Paprola attached with Govt.PG Ayurvedic College Paprola is functioning round the clock. The number of deliveries is increasing day by day. An average of 2 deliveries per day is being carried out in Regional Ayurvedic Hospital Paprola. The figures for last year is 750. Encouraged from this the department is planning to utilize the vast AYUSH manpower & Institutional infrastructure for conducting Institutional Deliveries in all the AYUSH Institutions under this Department in phased manner.When around 50% deliveries are still conducted by Traditional Birth Attendants(Dai),qualified AYUSH manpower will certainly prove a far better alternative. This venture will not only help in reducing the MMR but IMR also in State. To implement this, a comprehensive plan has been prepared and on trial basis some initial exercise was done in Distt. Ayurvedic Hospital Una with the involvement of NGO.

4.3. Integrated initiatives around HMIS in Himachal Pradesh

The State of Himachal Pradesh has taken a pioneering set of initiatives in HMIS that are integrated and decentralized, so as to strengthen the quality and focus of evidence based decision making in the health domain. First, the individual initiatives are briefly summarized, followed by a description of the nature of their integration.

4.4. Facility based reporting

The state has over time stabilized and strengthened their facility based reporting using an integrated of DHIS2-Web Portal. Facility based, down to the sub centre, data entry takes place through the DHIS2, and the reports required for the portal are generated and uploaded in the portal. This system is well stabilized now, and large scale trainings have taken place of staff down to the facility level. Data reporting levels is now typically more than 80%, and quality is being constantly

improved. The state is now at a stage where we are confident with the quality of data, and are making ongoing efforts to strengthen the utilization of HMIS data by facilities for activities of planning, monitoring and evaluation. Furthermore, the facility based DHIS2 is the hub for the integration being carried out with the other systems.

4.5. Tracking systems for pregnancy and immunization

MCTS, launched as part of NRHM in Dec-2009, is a name based tracking of pregnant women so that adequate and timely feedback may be given to the health workers who may, in turn, ensure that pregnant women receive adequate Ante-natal and Post-natal care besides encouraging institutional deliveries. Moreover, the system also aims to track the new-born so that timely and complete immunization may be ensured to them. The ultimate motive of these measures is that, they bring down the MMR and IMR in line with the Millennium Development Goals (MDGs).(GOI 2013b). The system is implemented in the State of HP since Oct-2010, 100% across State of Himachal via health institutions. Registration and updation of pregnant mothers and new born babies at Block/PHC/CHC/SC level.

4.6. Mobile based reporting

The mobile phone enables two channels of reporting. The first is the reporting of aggregate data which integrates with the facility based reporting carried through the DHIS2. This includes the aggregate reporting both for the NRHM reports that ultimately need to be sent to the GOI, and the other includes the reports that are specific to the monitoring needs of the state. The second is the reporting for the tracking system, which has a two way flow of information. From the mobile phone, service based data for individual cases will be registered on the mobile phone and sent to the NBITS server. Second, from the server the activity plans for the ANMs and the SMS alerts will be sent to the ANM phone. Once the mobile reporting stabilizes and we have confidence over data quality, the direct entry into the facility system will be switched off, and the mobile phone reported data would be used.

4.7. Hospital information system

As a unique and pioneering initiative, the state has initiated the implementation of an open source based integrated hospital information system that includes the modules of registration, billing, pharmacy, inventory, OPD, IPD, RKS, laboratory, and blood bank. After a successful implementation of this integrated system within DDU hospital in Shimla, plans are afoot to scale it to the 20 hospitals in the state. The patient based transaction level data will be aggregated and imported

into the DHIS2 to develop hospital based indicators for the management – such as bed occupancy, disease profile per population etc. This aggregated data will also feed into the district data warehouse.

4.8. Monitoring and Evaluation

The State has put in place proper mechanism to monitor and evaluate physical and financial progress of NRHM periodically. At the State level the programme is assessed through meetings under the Chairpersonship of the Hon'ble Health and Family Welfare Minister and Principal Secretary Health. Similarly at the district level Deputy Commissioners assess and review the functioning of NRHM. The Mission Director and Chief Medical Officers monitor the programme at the state and district level on regular basis. HMIS, Surveys and Evaluation Studies are also used for the purpose. Moreover, the State and District Level Teams have been constituted to check the validity and reliability of data. Himachal has put HMIS in operation up to facility level. The data reported through the HMIS Portal is the single source for all reports sent to MoHFW.

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Chapter –V
Analytical analysis

The Analytical analysis was done as per the Primary and Secondary parameters mentioned in previous chapters as well as the Toolbox of the research. The paper also attempts to understand the role of Capacity, Political Stability, Budget & Capital, Participation, Good governance and Corruption in the case under study.

5.1. The **primary parameters** used for the analysis are the basic health indicators which indicate the status of health in a particular State or country are and a few important components of NRHM**:**

5.1.1. Socio-economic as well as demographic indicators

(a) Demographic indicators such as Crude Birth Rate (CBR), Total Fertility Rate (TFR) and Life Expectancy at birth.
(b) Mortality Indicators such as Crude Death Rate(CDR) and Infant Mortality Rate (IMR)
(c) Socio economic indicators such as population below poverty line, literacy rate and sex ratio.

Crude Birth Rate: Himachal Pradesh is being successful in bringing down its CBR from 22.6 in 1997 to 16 in 2013, which is much less than all India average of 21.4. If we look at the rate of decrease of CBR from 1997 to 2005 and then 2005 to 2013, it is seen that the rate of decrease of CBR, is much higher in post NRHM period, which is 2.75, than before the launch of the mission, which was 1.52 (Table no.5.1 in the Appendix-I).

Total Fertility Rate: The all India TFR was 3 in 2003, which has been set to 2.1 as the target. However, HP has already achieved this target 2002 before the launch of the mission. As per the report of the technical group on population projections constituted by the National Commission on population, May 2006, by the Office of the Registrar General & Census Commissioner, India, the population projections for India and states 2001-2026 indicates that the target TFR will be achieved by India in 2015. What is more interesting is that even after reaching the target, HP is improving continuously to come to the TFR of 1.7 in 2012 (Table no.5.2 in the Appendix-I).

Life Expectancy at birth: Life expectancy at birth in Himachal Pradesh is much higher as compared to that of the country. There is an increase in life expectancy for both the sexes over the years as shown in the table no.5.4 in the Appendix-I.

Crude death rate: CDR has always been declining regularly in the state of HP, as evident from data since 8.1 in 1997 to 6.7 to 2013. But if we look at the rate of growth of decease of CDR prior and post the launch of the mission, it is seen that after the launch of the mission, the CDR has eventually been somewhat stabilised in the state. Moreover, lower than national average indicate improved health status of Himachal Pradesh(Table no.5.5 in the Appendix-I).

Infant Mortality Rate: IMR of the state which was 63 in 1997 as against 71 of the country has declined to 35 in 2013. This figure is below the national average, and it is indicative of improvement in medical care, better nutrition and better obstetric care. Moreover, the rate of decease of IMR has shown to be speed up during the years post 2005(Table no.5.6 in the Appendix-I).

Population below poverty line: Planning Commission periodically estimates the poverty lines and poverty ratios on the basis of Large Sample Surveys on Household Consumer Expenditure conducted by the National Sample Survey Office (NSSO) of the Ministry of Statistics and Programme Implementation. As per the estimated poverty lines for 2011-12, 8.06% of the total population of HP (Rural: 8.48%, Urban: 4.33%) are below poverty lines whereas at all India, 21.925 of the population lives below poverty line. (Table no.5.7 & 5.8 in the Appendix-I)

Literacy: Total literacy of the State was 76.48% in 2001 which has increased to 83.78% in 2011, which is much higher than the all India literacy rate of 74.04% as per 2011 Census (Table no.5.9 in the Appendix-I).

Sex Ratio: The sex ratio was 970 females per 1000 males in 2001, which has slightly been increased to 974 in 2011. The sex ratio of the State has always been better than that of all India (Table no.5.10 in the Appendix-I).

5.1.2. Important Components of NRHM

(a) RCH programme such as Immunisation, Maternal & Child health and Family Planning

Even before the launch of the mission, HP was never a bad performer as far as various RCH programme are concerned. However before NRHM, the various RCH schemes were scattered and there was no comprehensive indicators to actually indicate the status of various immunisation, maternal & child health and family planning. Table no.5.11 in the Appendix-I indicates that percentages of achievement of the need assessed are much satisfactory in almost all the RCH parameters.

(b) Role of ASHA, Village Health Sanitation & Nutrition Committees (VHSNC) &. Rogi Kalyan Samiti (RKS)

One of the key components of the NRHM is a trained female community health activist **ASHA** or Accredited Social Health Activist. ASHA is the bridge between the village and the public health system and is expected to promote universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets. ASHAs undergo series of training episodes to acquire the necessary knowledge, skills and confidence and given a drug-kit to deliver first-contact healthcare. She receives performance-based incentives (http://nrhm.gov.in/communitisation/asha/about-asha.html).

Another key element of the NRHM is the **"Village Health, Sanitation and Nutrition committee (VHSNC)"**. The main purpose of the committee is to take collective actions on issues related to health and its social determinants at the village level. The committee is formed at the revenue village level with a minimum of 15 members, comprising of elected member of the Panchayat (leader of the committee), all those working for health and health related services, community members/ beneficiaries and representation from all community sub-groups especially the vulnerable sections and hamlets/ habitations. ASHA residing in the village is the member secretary and convener of the committee(5.1). In Himachal Pradesh, VHSNCs has been constituted at Panchayat level. There are 3243 VHSNCs as there are 3243 GPs. So far 3, 27,376 VHNDs are held in the state. They have lack of clarity on how to leverage this more effectively for action. In Himachal Pradesh, the GPs are very small in themselves and villages even smaller and fragmented. A meaningful plan of action and institutionalisation needs a critical size and hence, the GP level decision has its strength. Funds are utilized for water and sanitation initiatives and to some referral transport needs and for improvements in anganwadi or sub-centre level facilities.

Institutionalizing Hospital Management Society, named as **'Rogi Kalyan Samiti (RKS)'** is an important step of NRHM, which formalises the development of a proper management structure. RKS is a simple, yet effective management structure, which is a registered society, acting as a group of trustees for CHC/ hospitals/ to manage the affairs of the hospitals. It consists of members from local P.R.I., NGOs, local elected representatives and officials from Government Sector, who are responsible for proper functioning and management of hospitals/ CHCs/ FRUs(5.2). Constituted at PHC and CHC levels, the main duty of the RKS is to supervise improvement and maintenance of physical infrastructure.

(c) Health Management Information System(HMIS)

The web based Health MIS portal "HMIS" was launched in October, 2008 to facilitate data capturing at District level and lower level as a part of NRHM. The purpose of HMIS was to improve health care delivery through improved monitoring, supervision and planning. Before HMIS, there was no regular data flow at any level. Summary of data was calculated by hand and therefore prone to errors, with long delay to produce reports. Now, with the launch of HMIS, data is accessible at all levels, reports are produced on time and the same are used for monitoring and decision support. The state runs HMIS system to track records at the facility level. The data entered in HMIS system shows reporting gaps, under reporting and over reporting which states that there is not much utilization and the programme is not too effective in providing required information. Duplication of the data is also found in the reporting system. A feedback on this has been sent to the state mission director, but it is not possible to act upon the information. The use of HMIS data for planning has improved considerably. At present Himachal has shifted to Facility based reporting in 2010-11. Data related to institutional deliveries is being captured from the private sector health facilities in the state. Other data will also be captured in 2011-12. The MIS for the National Disease Control Programmes, the FMRs, infrastructure details, facility survey reports are also expected be reported on HMIS portal. The Dashboard prepared using RMNCH+A strategy, based on HMIS data (Diagram 5.1 of the Appendix).

(d) Mother and Child Trekking System(MCTS)

As per GOI guidelines, the state has made active efforts towards the implementation of the tracking systems. Firstly, training on the formats have carried out state wide, and the synchronization of the primary registers with the formats have taken place. While waiting for the availability of MCTS as per state requirements, the State have implemented the NBITS in Solan district, and an entire database of nearly 9000 cases (pregnancy and immunization) have been created, and processes of data quality analysis and analysis reports generation is taking place. Furthermore, technically the State is in the process of generating interoperability between NBITS and MCTS so as to enable smooth mutual transfer of data. All the NBITS data will be aggregated and imported into the DHIS2 facility reports for sub centre. More than 55 data from NBITS are what is reported in a sub centre facility report, and by this process of electronic aggregation and importing, we will be able to have a one point entry of data – thus avoiding redundancies and improving quality of data. A further first in this regard, is the State's efforts to

completely integrate the NBITS with the UID – both for registration and authentication at the time of JSY payments.

5.2 There are a number of other parameters, can be considered as **Secondary parameters,** management of which influence the implementation of the scheme like **Social**, **Financial** & **Political** environment as well as management.

Himachal Pradesh can be considered the least urbanized state in India with nearly 90% of population living in rural area. So, the mission, targeting the rural population of India is of paramount importance to the State. However, NRHM has found favorable **social** environment in HP to implement its various programmes/schemes. If we look at the socio-economic indicators of the State, the State has always been a better performer than many other States of the Union of India, with better performing indicators compared to their all India average value. As per 2011 Census, HP has the Decadal Growth of population as 12.81% against the all India rate of 17.64%. The Sex ratio of HP is 974 against the all India Sex ratio of 940. If we look at the literacy rate, be it Total Literacy Rate, which is 83.78% in HP against all India 74.04%, or Male Literacy Rate, which is 90.83% in HP against all India 82.14% or Female Literacy Rate 76.60% against 65.46% of all India, the HP is having a higher value than the all India average figure. (Ref: Table no.3.1: Demographic and Socio-economic indicators in Chapter-III).

The role of **financial** management in the implementation of NRHM is very important. The plan of action for NRHM includes a commitment to increase public expenditure on health. The State signed a Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act, and performance benchmarks for release of funds. Also, as per the MoU, the central government would provide 85% of the flexi-pool under NRHM, whereas the remaining 15% have to be provided by the states. The funding arrangement highlighted in the Mission document also says that the Mission envisages an additionality of 30% over existing Annual Budgetary Outlays, every year, to fulfil the mandate to raise the Outlays for Public Health from 0.9% of GDP to 2-3% of GDP and the States are expected to raise their contributions to Public Health Budget by Minimum 10% p.a. to support the Mission activities [5.3]. The funds allocated under the NRHM include Annual Maintenance Grant, Corpus Fund and Untied funds (GOI 2013c). These funds shall be utilized in accordance with the guidelines issued by NRHM from time to time. Moreover, the reward amount received by any RKS for outstanding performance can be utilized for general cause of RKS/ patients [5.4].

In Himachal Pradesh under NRHM the process of planning starts with the completion of Household Survey and Facilities Survey. The Health Action Plan for District is formulated considering the various village health plans. The District Health Action Plan is discussed in the Governing Body of the District Health and Family Welfare Society. The appraisal of District Health Action Plan takes place at the State Level and further consolidation of State PIP is formulated and placed for consideration of the Governing Body of the State Health and Family Welfare Society under the Chairmanship of Chief Secretary to the Government of Himachal Pradesh. As per the budget tracking study done by NHSRC in 2007-08, the increase in states own share of health budget over the previous year for Himachal Pradesh is 13%.In the state under the scheme of NRHM, 116 Health Institutions were identified to provide 24 hours emergency services. Apart from this 573 RKSs are also functioning at District Hospitals, Civil Hospitals and CHCs. A sum of 10.32 crore has been distributed to all the RKS till 31.12.2013 (GOHP 2014).

As far as health infrastructure and healthcare delivery services are concerned, the role of **political** set up in a particular state plays an important role in making different policies work at the grass root level. The importance of political stability becomes relevant as there should be coordination between state and central government in implementation of health schemes. Further the role of administration is essential in the field of policy formulation and implementation, so public health infrastructure of any state can't be studied in isolation without studying the administration and political scenario of the state (Simmi and Sharma 2011). Further politics becomes a tool for discussions on these relevant issues and a medium through which society responds to such issues and decides how to resolve them. Politics and administration are two side of one coin; both of them can't do without each other's support. When it comes to political set up of Himachal Pradesh, major role of local governing bodies come into the picture. In Himachal Pradesh statutory local governments (PRIs) were established in 1954 under the HP Panchayat Raj Act, 1952. With a view to bringing about uniformity by establishing the two-tier panchayat system, the HP Panchayat act was brought into the picture in 1968 and it was implemented in 1970s. The HP Panchayat Raj Act, 1994, enacted in the light of the 73rd Constitutional Amendment Act, 1992, came into effect from April 1994. With this, the existing two-tier system, with GP and Panchayat Samiti, there was introduction of three-tier system, with the addition of the Zilla Parishad (ZP) (Sthitapragyan 2007). Gram Sabha consist of a minimum of seven and maximum of fifteen, including the Pradhan and Up Pradhan. Seats are reserved for women, schedule caste and schedule tribes so that they can also take part in the decision making process. Gram Panchayats are involved in regular functioning day to day village level functioning which includes functioning of sub-centres, regular immunization programs being carried forward. These Panchayats plays important role in maintaining village level sanitation

programs and rural health. The government of Himachal Pradesh has advocated the decentralized model of governess and encouraged participatory form of politics (ibid).

5.3. Participation and NRHM in HP

The implementation of NRHM involves participation, from grass root to SHM level. In Himachal Pradesh, the **Panchayati Raj Institutions** (PRI) was established in 1954 under the HP Panchayat Raj Act, 1952. So, with the launch of the NRHM in HP, the existing PRIs became a part of its public healthcare delivery system. Representatives from PRIs are part of the institutional mechanism of NRHM through VHSNC at the village level (Village Panchayat), RKS at community level (Block/Community Panchayat) and DHM at district level (Zila Panchayat).

One of the key strategies NRHM is having a **Community Health Volunteer** named **ASHA** (Accredited Social Health Activist) for every village with a population of 1000 (5.6). However, in HP, the State decided not to have separate ASHA for the purpose. Instead, the State decided to use their existing Anganwadi worker (AWW) to carry the duties of ASHA, terming the AWW as "Link Worker". An AWW is in charge of an "**Anganwadi"**, a government sponsored child-care and mother-care centre in India, covering a population of about 1000. An AWW is a health worker selected from the community (5.7).

In the Mission Document itself, the NRHM defined the role of **NGOs** in its implementation. The role of NGO is included in institutional arrangement at National, State and District levels. The NGOs are to be part of Task Groups, in training, technical support for ASHAs, health resource organizations, service delivery, monitoring, evaluation and social audit etc (GOI 2005). In HP, many NGOs are working in this field and involved in the process of public healthcare delivery, such as Adyatam welfare Society, Kullu; Tika Aima, Kangra; Help Social Organisation, Shimla; Himachal Head Neck Foundation, Hamirpur; Himalaya Van Aushidhi Sanrakshan Avam Utpadan Pras, Shimla and Himachal Pradesh Voluntary Health Association, the first NGO to be approved by the Ministry of Health & Family Welfare, GOI, to name a few(5.8).

5.4. Stakeholder analysis

A stakeholder analysis was done in the case study of the implementation of NRHM in the State of HP to understand and portray the importance/interest of the various stakeholders involved in the process of the implementation as well as

policy making. Here, "a stakeholder is any individual, community, group or organisation with an interest in the outcome of a programme, either as a result of being affected by it positively or negatively, or by being able to influence the activity in a positive or negative way" (DFID 2003: 2.3).

The various stakeholders involved in the case under study have been identified as Union government of India through its Ministry of health & Family Welfare, State Dte. Of Health in HP, Parliament, State Legislative Assembly of HP, Private Doctors, Private Hospitals, Targeted beneficiaries , Audio Visual media, HMIS, MCTS, Health related NGOs, VHSNC, RKS, PRI etc. All of these diverse stakeholders have been grouped under the headings of Government, Law Maker, Private Sector, NGO & Others, Media and Health Support systems. The stakeholders so identified and grouped are placed at Figure 5.2 in the Appendix-II.

5.4.1. Stakeholder Analysis Table

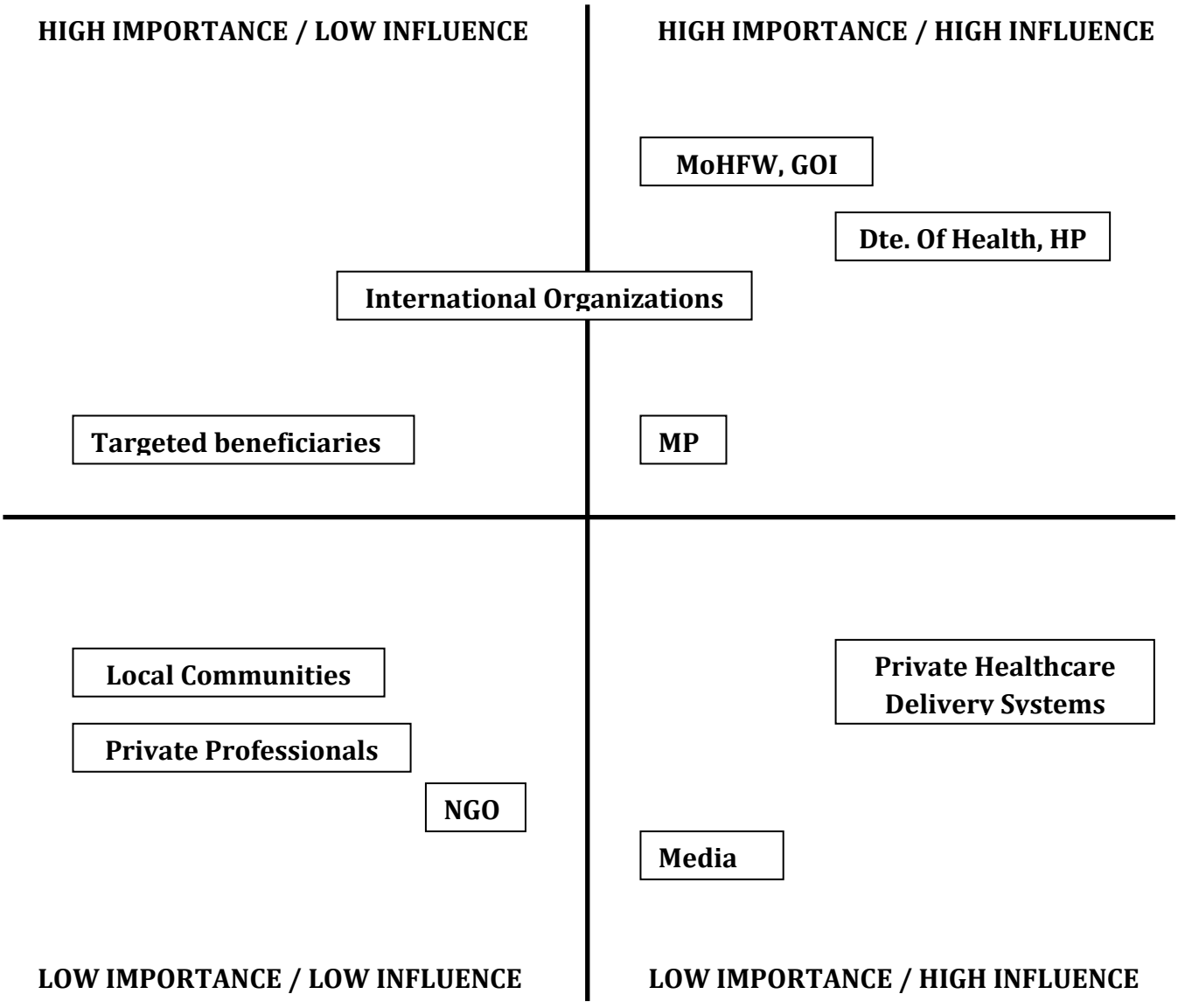
After identifying the stakeholders, the stakeholders have been categorised as Key stakeholder, Primary stakeholder and Secondary stakeholder as per the "Tools for Development: A handbook for those engaged in development activity" (DFID 2003: 2.3). The Key stakeholder are those who can significantly influence or are important to the success of an activity, the Primary stakeholders are those who can significantly influence or are important to the success of an activity, either as beneficiaries (positively impacted) or dis-beneficiaries (adversely impacted). All other individuals or institutions with a stake, interest or intermediary role in the activity are Secondary stakeholder (ibid). A stakeholder analysis table as per the Groups prepared (Government, Law Maker, Private Sector, NGO & Others, Media and Health Support systems) indicating the category of stakeholder (Key, Primary & Secondary) have been prepared to clarify the interests, impact/influence and priority of various stakeholders and placed at table no. 5.13 in the Appendix-I.

5.4.2. Stakeholder Influence and Importance Matrix

Stakeholder Influence and Importance Matrix is used to recognize the power of the various stakeholders which may influence a project or scheme for accessing the relative risks posed by these stakeholders (ICRA, n.d:5). Since "stakeholders with much power and influence can easily divert project resources from important intended beneficiaries with little power or influence" (ibid), hence it is important to understand the dynamics of power through this analysis. Moreover, the matrix indicates the relative positions of a stakeholder's influence and importance, so it also helps to understand the actors whose voice is heard (ibid).

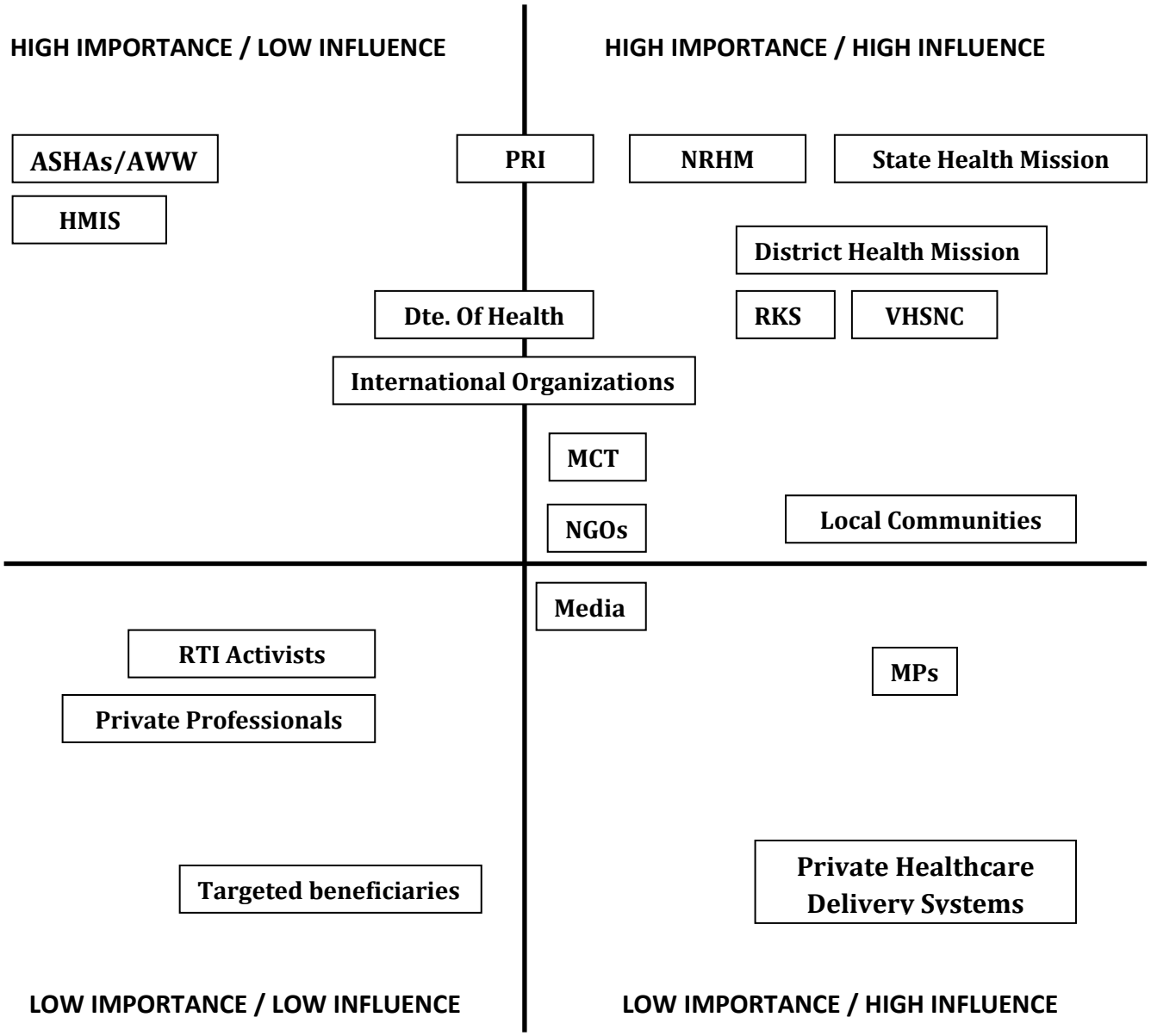
For the purpose, two Stakeholder Influence and Importance Matrices have been prepared, one depicting the power position of the stakeholders at the time of the launch of the mission and the other, the same after nine years of the mission, and placed respectively at Figure 5.3 & 5.4 of the Appendix –II. It is clear from the two Matrices that the number of active stakeholders involved in the implementations of the public health programmes have increased manifold after the launch of the mission. Out of these, most increase is observed in the High importance/high influence area. It is pertinent to mention that in HP, the role of ASHA, who is considered as the backbone of implementation of NRHM, is played by the already existing Angan Wadi Workers (AWW). However, with the mission, the role of

Figure 5.1: Stakeholder Influence /Importance Matrix of Implementation of health programme in HP before NRHM (2005)



AWW, being termed as Linked Worker, has increased and become an important
AWW, being termed as Linked Worker, has increased and become an important
part of the implementation strategy. SHM and DHM are two new stakeholders emerging out of NRHM with very High importance and high influence. Though the importance of the Members of Parliaments (MP) is not that significant after implementation of the scheme, they still influence the implementation of the scheme either positively or negatively depending on their own outlook of governance.

Figure 5.2: Stakeholder Influence /Importance Matrix of Implementation of NRHM in HP (2014)

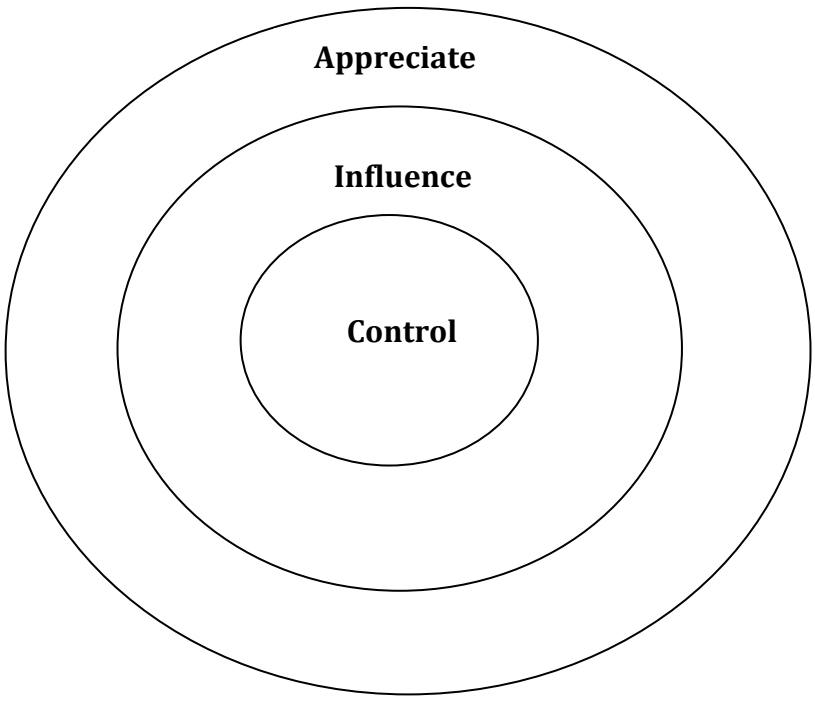


5.5. Appreciation-Influence-Control

Appreciation-Influence-control framework is useful in identifying the need to move beyond ***control*** (Honadle and Cooper 1989: 1535) in governance. It assumes that the key to success may be the expansion of ***influence*** (ibid). Here, the realm of control is a small circle in the centre that depicts the ***control*** of the organisation under consideration. Beyond the small circle lay a larger circle a larger area where the organisation can ***influence*** what was going on, but is unable to control it because others have resources they could use, independent of the organisation, to effect action in that arena. This influence arena is embedded in a still larger area where the organisation can not influence what is happening, but since events here can influence the other arenas it is necessary to keep abreast of development. This is called the area of ***appreciation*** (ibid).

As far as health care programme are concerned, we can assume the State Directorate of Health, Himachal Pradesh to be the single implementing agency of various healthcare programme introduce by the Government of India, before the launch of the mission, since, health is a State subject as per the constitution of India. But, with the launch of the mission, which can be considered as an umbrella over the all existing vertical and horizontal health care programme with a lot of

Figure 5.3: AIC Framework



new initiatives, it is felt that "convergence with all Departments that influence outcomes of wider determinants of health is necessary for improved health indicators (GOI, 2005b:80)". Moreover, in the context of bigger scenario like the MDG goals including "reduction of IMR requires greater convergent action to influence the wider determinants of health care like female literacy, safe drinking water, sanitation, gender and social empowerment, early child hood development, nutrition, marriage after 18, spacing of children, and behavioural changes etc.(GOI, 2005b:32)."It is also seen from the Stakeholder Influence and Importance Matrices (in Figure 5.1 & 5.2 above) that many new players have emerged in the field of implementation of NRHM over the years since the launch of the mission. So now, the SHM, instead of State Directorate of Health, Himachal Pradesh is at the helm of affairs for implementing the NRHM, who is at the ***control arena*** of the AIC framework. The SHM can control areas like allocation & disbursement of funds, guidelines pertaining to NRHM in HP, approval of various proposals and monitoring & evaluation. However, the SHM need to work in tendum with other players like NRHM, DHM, State Dte. Of Health, Health related NGOs etc. for the successful implementation of the scheme. This is the **arena of influence** in the AIC. However, there are other players involved in the implementation of the scheme, who are not under direct control of the SHM like Angan Wadi Workers (AWW) who works as Link Worker for NRHM in HP, Media, Panchayati Raj Institutions, VHSNC, HMIS, MCTS, Public Health Expert like NHSRC, NIHFW, PHFI etc. can be considered to be the ***arena of appreciation***. Similarly AIC frameworks are working for the DHM at district level, RKS at the community level and VHSNC at the village level.

5.6. Good governance and NRHM in HP

In Himachal Pradesh, all the districts have been constantly making district plans to improve their health status and facilities and these plans were quite effective, implicating good governance in the State and the State has initiated numerous initiatives for the betterment of the weaker and vulnerable section of the society, indicating the good governance.

After the launch of **Matri Sewa Yojana(MSY)**, which offers free prenatal as well postnatal treatment to every woman irrespective of their economic status in the state, the state implemented the JSSK scheme. Providers and beneficiaries are well aware of the scheme and are availing the privileges provided to them under JSSK scheme which includes free diagnostics, free drugs, free diet and free referral transport facility. The JSSK scheme in Himachal Pradesh is running fluently but facing the only hurdle as transport is not always available due to lack of transport vehicles which also leads to home deliveries more often. The state has adopted Measures for enforcement of **Pre-Conception (PC)** and **Pre-Natal Diagnostic**

Techniques (PNDT) act at State and district level. In Hamirpur district, there are 16 Ultrasound clinics, 4 of which are in public facilities and 12 in private facilities. Kinnaur district has six ultrasound clinics of which one is private. District & Block Level Workshops were being organized every year for sensitisation of service providers. A highly visible state wide mass media sensitization campaign on the girl child called **'Beti Hai Anmol'** was also launched in 2009 and a number of IEC/BCC activities have been undertaken under this scheme. The state has adopted a multipronged strategy to through running multiple schemes by different departments. These include **'Balika Smridhi Yojana'** by Department of Education, **'Kishori Shakti Yojana'** by Department of Women and Child Welfare, which provides meals and IFA tablets to adolescent girls. The **"SABLA"**, a Centrally-sponsored scheme introduced in the year 2010-11 for adolescent girls, is being implemented on pilot basis in District Chamba, Kullu, Solan and Kangra to improve nutrition and health status, self development and empowerment. Birth rates are down to 12 per 1000 and the decadal growth rate is just 7%. There were anecdotal reports of infertility and there is a need to know whether there is de-population. The resulting situation in gender equity is much better than most places. **Gender sensitization trainings** of medical officers, nurses and FHWs have also taken place in the state. The introduction of the Menstrual Hygiene Programme based on production by local self help groups lead to the training of AWWs on Menstrual Hygiene, which is in progress. However, it has been hampered on account of the plastic ban in Himachal Pradesh.

There are three Programme Management Units; one at state level known as State Programme Management Unit (SPMU) , second at district level known as District Programme Management Unit (DPMU) and third at block level known as Block Programme Management Unit (BPMU). Supervision from the directorate of the district is good as there are periodic visits carried out by the directorate to the districts. The major training programmes are managed directly from the directorate thereby, slowing down the roll out. The state has begun to insist on qualifications of public health officials which are hampering the progress in health and management sector.

One more aspect of implementation of scheme that the paper tries to look into is the existence of **corruption.** NRHM is the biggest health care program in India which involves vast amount of moneys as well as the vast number of personnel for its implementation. So it may become one of the major sources for corruption. In fact one scam of NRHM has already come to light in the state of Uttar Pradesh in India. The scam not only involved the murder of a few health functionaries but also huge amount of misappropriation of funds where around Rs. 13.4 crores did not reach health project and facilities in the state (Shukla 2012). There are other scams also, highlighted in past regarding the misusing of NRHM funds.

5.7. Capacity perspective and NRHM in HP

The capacity perspective includes a variety of aspects while considering the implementation of NRHM in the Himachal Pradesh. So, to enhance the overall public healthcare delivery system to be more effective, the strategies formed would need to target the capacity building of all aspects in order to improve the overall system.

a) Institutional Capacity considering the institutional mechanism including Village, Health, sanitation & Nutrition Committee(VHSNC) at village level, RKS at Community level, DHM at district level and SHM at State level(Details of Institutional mechanism is at Figure 5.2 in the Appendix-II).
b) Capacity building of Health human resources at SCs, PHCs & CHCs, for both medical and Para-medical staff.
c) Strengthening the infrastructure of SCs, PHCs & CHCs as per Indian Public Health Standards (IPHS) norms.
d) Upgrading Average Rural Area (Sq. Km), Average Rural Population, Average Number of Villages and Average Radial Distance (Kms) covered by SC, PHC & CHC as per IPHS norms.
e) Capacity building of ASHA, the backbone of implementation of NRHM at grass root level. In HP, there is no ASHA. Instead, the Angan Wadi Workers (AWW), termed as Link Worker carry out the work of ASHA.
f) Capacity building of the Panchayati Raj Institutions (PRI), which is an important part of the public healthcare delivery system. They are involved as member at each level of the institutional mechanism. At village level, a member of the Village Panchayat is a member of the VHSNC to oversee the SC, at community level, a member of the Block/Community level Panchayat is a member of the RKS to oversee the PHC & CHC and at district level, a member of the Zila Panchayat is a member of the DHM to oversee the District Hospital.
g) Technical assistance in Himachal Pradesh includes health resource institutions such as Population Research Centre, Regional Resource Centre, State Institute of Health & Family Welfare and NGOs as resource organisations. It also includes HMIS portals. Strengthening of capacities for data collection, assessment and review is required for evidence based on planning, monitoring and supervision.
h) Preparation and Implementation of an inter-sectoral District Health Plan prepared by the DHM, including drinking water, sanitation & hygiene and nutrition.
i) Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.

j) Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.

Dimensions of Capacity

As per the "Capacity building to improve public sector performance" by Grindle and Hildebrand(1995), a framework of capacity has been prepared identifying five dimensions that and five levels of brief analysis that affect capacity and capacity building interventions."They incorporate a panorama of factors that affect the ability of organizations to achieve specific goals."

The five dimensions pertaining to the implementation of NRHM in HP and along with their five levels of brief analysis are presented below:

The ***action environment*** is the social economic and the political environment of HP in which the mission is being implemented. "The performance of development tasks can be significantly affected by the condition in the action environment such as economic growth, political stability and legitimacy of government" (ibid). The **economic factors** have been identified as: the HP being a agriculture based economy, 45% of SDP comes from the agriculture planning. The central focus of development in HP is though five yearly planning. However, being agrarian economy, the State is neither favourable for industry nor industrialised is encouraged in the State. Moreover, there are exclusive Community development programme in HP. The **social** factors have been identified as: the HP being composed of mostly rural areas, any scheme targeting the rural population is sure to have a wide working area. The social indicators of the State like population growth, population density, sex ratio, Literacy rate etc. are seen to be satisfactory. Though being topographically, mountainous in nature, sometimes accessibility becomes a hinder while implementing any scheme. Politically, the State is divided into 12 districts. The Panchayati Raj Systems is effective in HP, which makes the NRHM involving community participation workable here. Moreover, the HP enjoys reasonably stable government.

The ***institutional context*** of the public sector includes rules, procedures, the responsibilities of the government and other such factors which constrain or facilitates the accomplishment of a particular task. In the case of NRHM in HP, the measurable goals, flexible financing, monitor progress against standard, Community participation, improved management through capacity and innovation in HRM have been categorised as institutional context. However, it is worth mentioning here that these factors are not exhaustive and there are many other such factors, which dictates the terms and conditions of the working of NRHM in the states. The various goals have been set in terms of MMR, IMR, TFR, drinking

water for all, reducing malnutrition among children of age group 0 to 3, reducing anaemia etc. Flexible financing is evident in NRHM at all SC, PHC & CHC level.

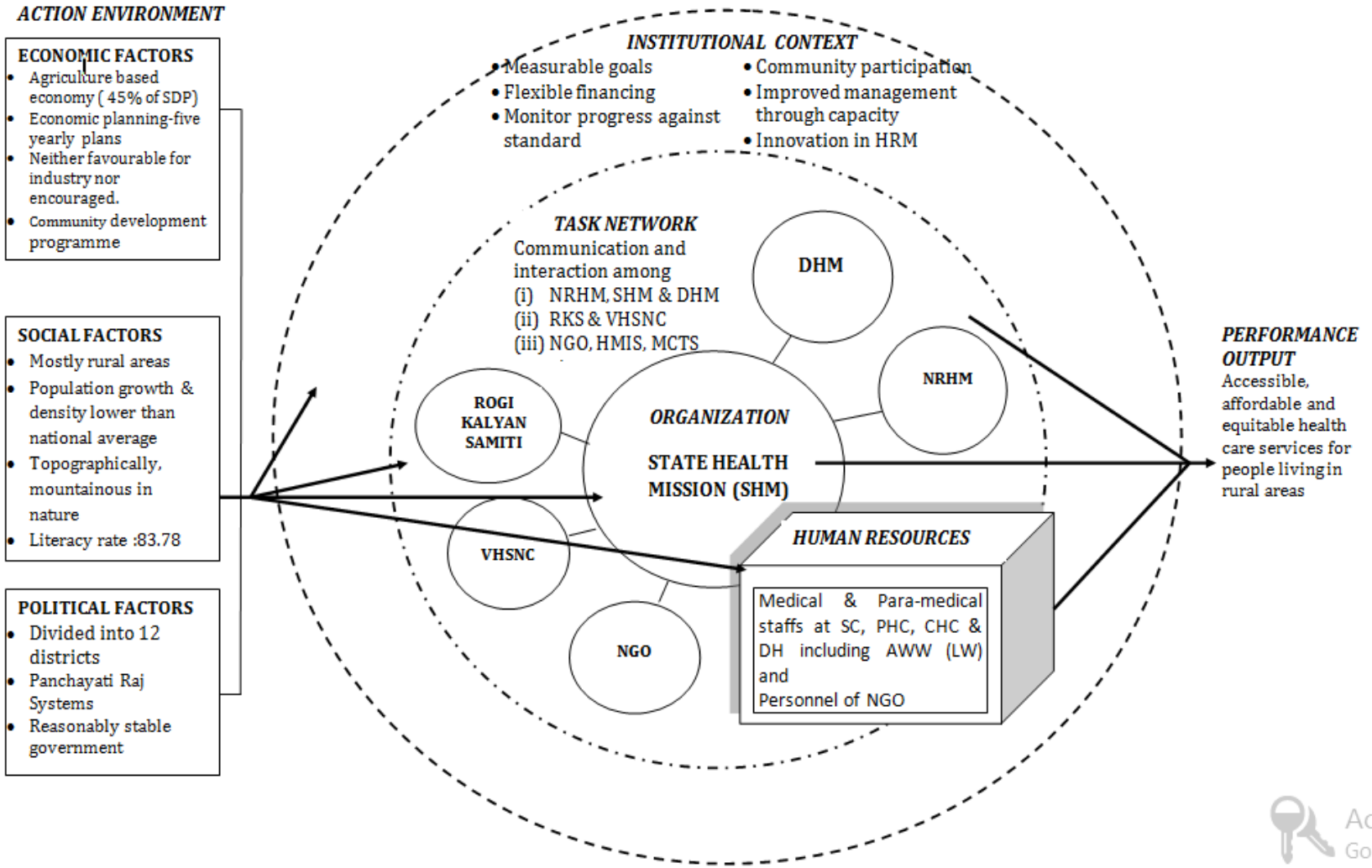
"The ***task network*** refers to the set of organisations involved in accomplishing any given task (ibid)". The task network consists of the communication and interactions among Primary organisations, Secondary organisations and Support organisations. For implementing the NRHM in HP (i) the mission at national level, State Health Mission(SHM) & District Health Mission(DHM) have been considered as primary organisations (ii) RKS and & VHSNC as Secondary organisations and (iii)NGO, HMIS & MCTS have been considered as Support organisations. The Primary organisations have the central role in implementing the NRHM in HP, the Secondary organisations are essential to the work of the Primary organisations and Supporting organisations provide important services or support that enables the implementation of NRHM in HP effectively.

"The ***Organisations*** are the building blocks of the task network (ibid)". The organisational output is affected by the structure, management style, working style, financial resources etc. factors of the organisations (ibid). Here, NRHM, SHM, DHM, RKS, VHSNC and Non Government Organisations (NGO) have been identified as the building blocks in the case under study. Collectively, these factors promote the implementation of NRHM in HP in this case.

"The fifth dimension of capacity focuses on the ***human resources*** (ibid)". Here, Medical & Para-medical staffs at SC, PHC, CHC & DH including AWW (LW) and personnel of NGO working in the field of healthcare delivery system have been identified as human resources. The capabilities and efficiencies of these human resources are crucial for the success of the implementation of the NRHM in HP. For example, at CHC level, almost all the posts of specialists are vacant in HP, which can be a potential threat in proper functioning of the CHCs.

The figure depicting the dimensions of capacity as explained above is placed below:

Figure 5.4: Dimensions of capacity



Chapter VI
Conclusion

This paper has tried to cover various issues and constraints regarding performance of NRHM with special context to Himachal Pradesh(HP). Himachal Pradesh is chosen as case study because of its good performance when it comes to implementation of NRHM. In the introductory note we discussed about the health care system in India regarding its past and present policies, indicating the challenges and difficulties in providing public healthcare delivery system in India. Further we tried to highlight the importance of NRHM in Indian health scenario and genesis of the mission including its objectives, goals and progress under NRHM so far. Focus has been given to the research question which highlights the problems in the implementation of NRHM in different states and why some states are performing better than others. So in the present study, we selected one state which is performing better and various reasons are being indentified which contributes to the successful implementation of the policy. Focus has been given to various question related to the role of state government of Himachal Pradesh in implementing the NRHM, favourable socio-economic factors, community participation, capacity building and reducing corruption at lower level etc.

We have tried to analyse the dynamics of implementation of NRHM in HP from the perspective of capacity. The role of "Community Participation", which is essential for successful implementation of any policy has been elaborated. The issues of "Good Governance" which includes the process of making and implementing the decision including the existence of "decentralisation" in it and the extent of "Corruption" which is one of the important factors in performance or non-performance of any scheme or policy have been highlighted. The extent of good governance has been seen through the concept of Appreciation-Influence-Control as well as Stakeholder analysis. We have also focussed on the issue of capacity building including the dimensions of capacity.

Both types of data i.e qualitative as well as quantitative have been used based on secondary sources. For quantitative analysis we have taken the secondary data available from various books, journals, internet sources and the data available with NRHM and SHM for the states of Himachal Pradesh. For rigorous qualitative analysis various report of State Programme Implementation Plan (PIP) and opinion surveys conducted by Regional Evaluation Teams of the Ministry of health & Family Welfare has been taken. Academic literature from the Library of International Institute of Social Studies (ISS), The Hague and On-line library of Erasmus University Rotterdam (EUR), Rotterdam is referred for this study. Efforts have also been made to access the status and constraints of implementation of the mission in HP through direct interactions with

the senior officers and personnel who are involved in the implementation of the mission in HP.

The case under study i.e. NRHM in HP has been discussed thoroughly in the paper. It provided a brief introduction about the India and the State of Himachal Pradesh demonstrating the healthcare delivery system in India as a whole and the health scenario of Himachal Pradesh in particular. We also tried to give an illustration of the NRHM in HP including Anganwadi workers (AWW), promotion of institutional deliveries in "Ayush" institutions, integrated initiatives around HMIS, facility based reporting, tracking systems for pregnancy and immunization, mobile based reporting, hospital information system and monitoring & evaluation.

While trying to explore the situation in HP, which might be favourable while implementing the mission, we tried to develop suitable methodology for evaluating the influence of NRHM services in the state. For this purpose assessment of NRHM services have been done in the State by incorporating a number of primary parameters, such as various socio-economic and health indicators like Demographic indicators, Mortality Indicators and Fertility Indicators and some of the important components of NRHM. The other factors which affect the outcome of the scheme such as Social, Financial & Political are considered as Secondary parameters. For this purpose, the Crude Birth Rate (CBR), Total Fertility Rate (TFR) and Life Expectancy at birth have been taken as Demographic indicators; Crude Death Rate (CDR) & Infant Mortality Rate (IMR) have been taken as Mortality Indicators and population below poverty line, literacy rate & sex ratio have been taken as Socio economic indicators. RCH programme such as Immunisation, Maternal & Child health and Family Planning, Role of ASHA, Village Health Sanitation & Nutrition Committees (VHSNC), Rogi Kalyan Samiti (RKS), Health Management Information System (HMIS) & Mother and Child Trekking System (MCTS) have been discussed as important components of NRHM. Moreover, the Social, Financial & Political environment as well as management have been discussed as secondary parameters. All these discussions have been carried out on the basis of analytical data and empirical evidence.

A detailed analytical analysis has been done on the basis of the theoretical framework. The issue community participation has been highlighted indicating the role of the Panchayati Raj Institutions (PRI). It has also been brought to light that the HP is using its existing Anganwadi network to carry out the role of key strategies of NRHM i.e Community Health Volunteer named as "ASHA". The involvement of NGO has also been incorporated in the research as part of participation. A stakeholder analysis was done in the case study of the implementation of NRHM in the State of HP to understand and portray the importance/interest of the various stakeholders involved in the process. For this purpose various stakeholders have been identified as Union government of India through its Ministry of health & Family Welfare, State Dte. Of Health in HP, Parliament, State Legislative Assembly of HP, Private Doctors, Private Hospitals, Targeted

beneficiaries, Audio Visual media, HMIS, MCTS, Health related NGOs, VHSNC, RKS, PRI etc.. A stakeholder analysis table has been prepared after grouping the various stakeholders into six homogeneous groups such as Government, Law Maker, Private Sector, NGO & Others, Media and Health Support systems and indicating the category of stakeholder i.e Key, Primary & Secondary to clarify the interests, impact/influence and priority of various stakeholders. A Stakeholder Influence and Importance Matrix has been prepared to recognize the power of the various stakeholders which may influence a project or scheme for accessing the relative risks posed by these stakeholders. An Appreciation-Influence-control framework was used to identify the extent of good governance while implementing the NRHM in HP. For this purpose, the control, influence and appreciation arena for the State health Mission of HP has been demonstrated in an AIC figure. Various schemes/regulations launched in the State to improve its public health have been discussed in brief like Matri Sewa Yojana(MSY), Pre-Conception (PC) and Pre-Natal Diagnostic Techniques (PNDT) act, 'Beti Hai Anmol', 'Balika Smridhi Yojana' and 'Kishori Shakti Yojana'. The existence of corruption has also been touched upon.

Capacity perspective and NRHM in HP has been discussed in detail. The research tried to highlight the areas which need capacity building in order to improve the overall public healthcare delivery system in HP, which has already achieved most of the milestone which are to be achieved under NRHM by 2012. An attempt was made to understand the Dimensions of capacity. For this purpose, five dimensions of capacity i.e action environment, institutional context, task network, organisations and human resources have been identified in the context of implementation of NRHM in HP and their five levels of brief analysis have also been attempted.

Key findings of the research

Himachal Pradesh has already achieved most of the milestone set by NRHM. It has one of the best Civil Registration System (CRS) which gives an IMR figure of 36 and TFR stabilised at 1.7(in 2012), which can also be taken as proxy indicator for maternal and child health. Facility based reporting using an integrated DHIS2 Web Portal has been strengthened in the State. Data reporting level is now typically more than 80% and quality has is being constantly improved. NBITS in Solan District has been implemented to track pregnancy and immunization cases. The State has initiated the implementation of an open source based integrated hospital information system that includes the modules of registration, billing, pharmacy, inventory, OPD, IPD, RKS, laboratory and blood bank. The state has put in place proper mechanisms to monitor and evaluate physical and financial progress of NRHM periodically. HMIS, Surveys, and Evaluation Studies are also used for the purpose. Data entry has started on MCTS in Himachal Pradesh. Moreover, the state has opened many health institutions to meet the challenges of capacity building in health sector.

The Indian systems of medicine consist of both Allopathy and AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy). One of the goals of NRHM was mainstreaming AYUSH. The state of HP is being really effective as far as bring AYUSH to the mainstream is concerned. The State has total 1159 AYUSH institutions, most of which are Ayurvedic institutions and almost every institute has one AYUSH Medical officer. There were 60 lakh AYUSH out patients last year. District Ayurveda Offices are placed in all the 12 districts of the state. AYUSH officers are doing great work in RKS. AYUSH doctors are also involved in implementing school health program and anaemia free initiative across the state. The department of Ayurved Himachal Pradesh is contributing effectively in all the National Public Health Programmes as an average of 2 deliveries per day are being carried out in Regional Ayurvedic Hospital Paprola.

The formation of **Parivar Kalayan Salahakar Samiti (PARIKAS)** is another initiative taken by Himachal Pradesh government in order to provide smooth functioning of health infrastructure. At the panchayat level, the PARIKAS is headed by the Pradhan, with the health worker, male or female, as the secretary, local NGO representatives, village opinion leaders, local social workers, office bearers of mahila mandals/women SHGs, local school teachers, forest guards, anganwadi workers and Ayurvedic doctor. The Notification provides for the meeting of the PARIKAS once in a month. Its functions broadly include the monitoring of rural health and family welfare programmes and supervision of the sub-centre. Thus, by institutionalising community monitoring of health care delivery, the PARIKAS seeks to enforce social rather than mere bureaucratic accountability (Sthitapragyan 2007). This initiative has one of the instruments of governess which includes the local participation and involvement in decision making process. The role of the block and district PARIKAS are to provide effective leadership and able guidance; hold periodic inspection of health through sub-committees. Further Aganwadi centers are actively involved in the providing health care services. The State is also implementing various schemes/regulations to improve its public health like **Matri Sewa Yojana**(MSY), **Pre-Conception** (PC) and **Pre-Natal Diagnostic Techniques** (PNDT) act, '**Beti Hai Anmol'**, '**Balika Smridhi Yojana'** and '**Kishori Shakti Yojana**'

Himachal Pradesh was the first state to introduce to start a **community financial management programme.** These were Rogi Kaliyan committees which were anonymous in nature and were capable of improving the hospitals by collecting finances from the community and levying user charges. As these committies were charging differently in different districts there was resentment among the population regarding the user charges, as a result state government recently changed the name of these committees to Hospital welfare societies and rationalised the user charges.

Himachal Pradesh State has not engaged ASHA workers because State already supports a vast and effective network of **Angan Wadi Worker** (AWW)s. At present there are 18386 Anganwadi Centres in Himachal Pradesh. These AWW already take care of a major component of ASHA workers' duties in relation to Maternal and Child Health Services and are delivering good results. Due to this State Government decided that this system based on AWWs may be continued and they should be provided training to update and strengthen their skills in relation to MCH Services. And State has designated these AWWs as "Link Workers" under NRHM. On an average an AWW is covering a population of 300-800 and average per month performance incentives comes to Rs. 800. The Anganwadi workers were determined and were performing all the duties of ASHAs as there was no ASHA programme in the state. The funds for ASHAs was provided to AWWs and they were trained as per the same module as ASHAs are trained in other states. AWW are given training in module 5, 6 and 7 as per the ASHA training module for other states. In spite of the 38 court case filed in high court against transferring of ASHAs fund to AWW, state government is not considering a separate programme for ASHA due to very less population. One problem generally heard about the ASHA in other States that "the ASHA scheme,..., could have been better planned" and "the average ASHA is hardly getting the promised Rs.1400 per month"(Ashtekar 2008:25). This problem has been effectively taken care of by HP.

In Himachal Pradesh, programmes for family planning are very less effective as it includes camps for sterilization which are held only once in a year. This leads to higher pregnancy as they have to wait the whole year for sterilization services. The state also conducts Mukhyamantri Vidyarthi Swasthya Karayakaram which includes check up/screening, medication and advice for de-worming, anemia and other health issues, counseling session, lectures, health talks and counseling session with parents and boys and girls (Class 9 to Class 12), AYUSH doctors and medicines are also involved in the program. For the financial year 2010–11, the state had examined 29% of the students and of these 14% had a referral. The percentage of referrals was 6.8. Medical team for cluster camp health check- up had been constituted this year, but due to the crowding at the cluster camp, there is a loss of quality. There were no checklists to guide those screening and simple body-mass index was also not being recorded. Follow up for the checkup was not ensured. Records maintenance is weak; therefore, it cannot be passed on to the next level.

In Himachal Pradesh, main crucial problem in health care lies in the unavailability of skilled human resources. There are 834 filled posts for MBBS MOs, out of 1597 sanctioned posts. There is a crunch of medical health specialists. The state has recently sent its recommendations to state service commission for recruitment of ANMs as there was no recruitment carried out for ANMs since long time. The state runs an AYUSH programme which is not running smoothly due to lack of Ayurveda medical officers, specialists, pharmacists and paramedics. Considering the technical support institutes of

NRHM at State level, the State Institutes of Health And Family Welfare (SIHFW), is weak due to lack of human resource as it includes only 3 persons. The (state Health System Resource Centre (SHSRC) has been announced but not strengthened enough to perform drastically. State had proposed to hire government officers who had done a public health course and then further train them with NHSRC support, to overcome the administrative reluctance to induct contractual staff. Himachal Pradesh does have a pool of medical officers with public health qualification but has failed to make use of this.

There are still room for improvements which have been observed through the course of the research. One such improvement can be in the field of health financing, by way of differential financing. The different financing is required because the physical as well as manpower conditions of all Sub Centres are not same, however similar they may be. Some of the sub centre buildings are located Government building whereas some other are located in community buildings, rent free donated or private buildings or in rented buildings. Moreover, the requirement of maintenance fund of these buildings is also different. Thus uniform Grants for AMG and Untied Funds are not justified. There is urgent need to rationalise this otherwise the money gets blocked at lower level of institutions and the staff is forced to spend it which may lead to misuse of money or needless blockage of money at the level of the institution.

There is urgent need to link the release of money to the SCs on the basis of performance. Grants may be released on Quarterly Basis on the Performance Parameters which shall be publicised and placed in the domain of the Gram Sabha. Rating of the Institutions shall be published every quarter. For the First Quarter, the performance of previous year will be taken into account and for the remaining quarters the actual performance in the preceding quarter will be the basis of release of funds. This system will also help in encouraging the Health Workers to perform better so that they can avail the additional funds for their Sub Centres. Gram Panchayats, Gram Sabhas, VHSC will be involved and competition between Panchayats will be encouraged to put social pressure on the Health Sub Centre locate in their area to get more funds.

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NOTES

(1.1): <http://medical-dictionary.thefreedictionary.com/health+care> Accessed on 30 August, 2014

(1.2): < http://www.who.int/topics/primary_health_care/en/ >Accessed on 30 August, 2014

(1.3): < http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS > Accessed 26th August 2014

(1.4): < http://www.who.int/countries/ind/en/ > Accessed 26th August 2014

(1.5): Traditionally, for historical reasons, some States depicted a tendency of higher growth in population. Recognizing this phenomenon, and in order to facilitate the creation of area-specific programmes, with special emphasis on eight States that have been lagging behind in containing population growth to manageable limits, the Government of India constituted an Empowered Action Group (EAG) in the Ministry of Health and Family Welfare in March 2001. These eight States were Rajasthan, Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh and Orissa, which came to be known as 'the EAG States'.

(1.6): Infant mortality rate (IMR) is the number of deaths of children less than one year of age per 1000 live births.

(1.7): Maternal Mortality Ratio (MMR) refers to the number of women who die as a result of complications of pregnancy or childbearing in a given year per 100,000 live births in that year.

(1.8): The Total Fertility Rate (TFR) of a population is the average number of children that would be born to a woman over her lifetime if:

(i) She were to experience the exact current age-specific fertility rates (ASFRs) through her lifetime, and

(ii) She was to survive from birth through the end of her reproductive life.

(1.9): The Crude Birth Rate is the number of births per 1,000 people per year.

(1.10): < http://nrhm.gov.in/nrhm-in-state/state-wise-information.html > Accessed 08 June 2014

(1.11):<http://www.goodgovernance.org.au/about-good-governance/what-is-good-governance/> Accessed 08 June 2014

(1.12): < http://www.investorwords.com/3947/public_sector.html > Accessed 08 June 2014

(2.1): < http://crs.org/capacity-building/ > Accessed 08 June 2014

(2.2): < http://www.gsdi.org/gsdiconf/gsdi10/papers/TS47.1paper.pdf > Accessed 08 June 2014

(2.3): < http://www.kautilyasociety.com/tvph/presentation/appreciation.htm > Accessed 28 August 2014

(3.1): < http://www.worldbank.org > Accessed 28 August 2014

(4.1): From actual data collected from 18396 Anganwari Centres spread all over the state by the Population Research Centre.

(5.1):<http://nrhm.gov.in/communitisation/village-health-sanitation-nutrition-committee.html> Accessed 20 August 2014

(5.2): <http://203.193.146.66/hfw/PDF/rks.pdf > Accessed 20 August 2014

(5.3): NHSRC: Budget Tracking Toolkit

(5.4): < http://hpayurveda.nic.in/rksguidelines.pdf > Accessed on 2nd October 2014.

(5.6): < http://www.nrhm.gov.in > Accessed 08 June 2014

(5.7): < http://www.aanganwadi.org/ > Accessed on 2nd October 2014

(5.8): <http://ngo.india.gov.in/ngo_stateschemes_ngo.php> Accessed 20 August 2014

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Appendix

Appendix-I

TABLES

Table no. 1.3: Crude Birth Rates

States/All India	2005	2012
All India	23.8	21.6
STATES		
Bihar	30.4	27.7
Chhattisgarh	27.2	24.5
Himachal Pradesh	20.0	16.2
Jammu & Kashmir	18.9	17.6
Jharkhand	26.8	24.7
Madhya Pradesh	29.4	26.6
Odisha	22.3	19.9
Rajasthan	28.6	25.9
Uttaranchal	20.9	18.5
Uttar Pradesh	30.4	27.4

(Source: Periodic Bulletin of Office of the Registrar General of India)

Table no.1.4: Total Fertility Rates

States/All India	2005	2012
All India	2.9	2.4
STATES		
Bihar	4.3	3.5
Chhattisgarh	3.4	2.7
Himachal Pradesh	2.2	1.7
Jammu & Kashmir	2.4	1.9
Jharkhand	3.5	2.8
Madhya Pradesh	3.6	2.9
Odisha	2.6	2.1
Rajasthan	3.7	2.9
Uttaranchal		
Uttar Pradesh	4.2	3.3

(Source: World Bank Data)

Table no.1.5: Infant Mortality Rates

States/All India	2005	2012
All India	58	42
STATES		
Bihar	61	43
Chhattisgarh	63	47
Himachal Pradesh	49	36
Jammu & Kashmir	50	39
Jharkhand	50	38
Madhya Pradesh	76	56
Odisha	75	53
Rajasthan	68	49
Uttaranchal	42	34
Uttar Pradesh	73	53

(Source: Periodic Bulletin of Office of the Registrar General of India)

Table no.1.6: Maternal Mortality Rates

States/All India	2004-06	2007-09
All India	254	212
STATES		
Bihar	312	261
Chhattisgarh	335	269
Himachal Pradesh		
Jammu & Kashmir		
Jharkhand	312	261
Madhya Pradesh	335	269
Odisha	303	258
Rajasthan	388	318
Uttaranchal	440	359
Uttar Pradesh	440	359

(Source: Periodic Bulletin of Office of the Registrar General of India)

Table no.1.7: Comparisons of latest available values of all the four Indicators (Data pertains to 2012):

States/All India	TFR	IMR	MMR	CBR
ALL INDIA	**2.4**	**42**	**212**	**21.6**
Himachal Pradesh	1.7	36		16.2
Jammu & Kashmir	1.9	39		17.6
Odisha	2.1	53	258	19.9
Chhattisgarh	2.7	47	269	24.5
Jharkhand	2.8	38	261	24.7
Rajasthan	2.9	49	318	25.9
Madhya Pradesh	2.9	56	269	26.6
Uttar Pradesh	3.3	53	359	27.4
Bihar	3.5	43	261	27.7
Uttaranchal		34	359	18.5

Table no.5.1: Crude Birth Rate in Himachal Pradesh over years

Year	CBR		CAGR
	HP	INDIA	
1997	22.6	27.2	
1998	22.6	26.5	
1999	23.8	26.1	
2000	22.1	25.8	
2001	21	25.4	
2003	20.6	24.8	
2004	19.2	24.1	
2005	20	23.8	-1.52
2006	18.8	23.5	
2007	17.4	23.1	
2008	17.7	22.8	
2010	16.9	22.1	
2011	16.5	21.8	
2012	16.2	21.6	
2013	16	21.4	-2.75

Data source: SRS Bulletin of O/o RGI, GOI

Table no.5.2: Total Fertility Rate in Himachal Pradesh over years

Year	TFR		CAGR in HP
	HP	INDIA	
2003	2.1	3	
2004	2.1	2.9	
2005	2.2	2.9	2.35
2006	2	2.8	
2007	1.9	2.7	
2008	1.9	2.6	
2009	1.9	2.6	
2010	1.8	2.5	
2011	1.8	2.4	
2012	1.7	2.4	-2.29

Data source: SRS Bulletin of O/o RGI, GOI

Table no.5.3: Year by which the target of TFR 2.1 will be achieved

Sl. No	India and Major States	Year by which projected TFR will be 2.1
	India	2015
1	Andhra Pradesh	2002
2	Assam	2019
3	Bihar	2021
4	Chhattisgarh	2022
5	Delhi	Achieved in 2001
6	Gujarat	2012
7	Haryana	2012
8	Himachal Pradesh	Achieved in 2002
9	Jammu & Kashmir	n. a.
10	Jharkhand	2018
11	Karnataka	2005
12	Kerala	Achieved in 1988
13	Madhya Pradesh	2025
14	Maharashtra	2009
15	Orissa	2010
16	Punjab	2006
17	Rajasthan	2021
18	Uttar Pradesh	2027
19	Uttaranchal	2022
20	Tamil Nadu	Achieved in 2000
21	West Bengal	2003
22	North-East (Excl. Assam)	2005

Table no.5.4: Life expectancy at birth

State	Gender	Actual		Projected		
		2002-2006	2006-2010	2011-15	2016-20	2021-25
India	Total	63.5	66.1			
	Males	62.6	64.6	67.3	68.8	69.8
	Females	64.2	67.7	69.6	71.1	72.3
HP	Total	67	70			
	Males	66.5	67.7	70.8	71.6	72.4
	Females	67.3	72.4	74.3	75.3	76.1

Source: Rural Development Statistics, Censusindia.gov.in and nird.org.in

Table no.5.5: Crude Death Rate in Himachal Pradesh over years

Years	HP	INDIA	CAGR in HP
1997	8.1	8.9	
1998	7.7	9	
1999	7.3	8.7	
2000	7.2	8.5	
2001	7	8.4	
2003	7.1	8	
2004	6.8	7.5	
2005	6.9	7.6	-1.98
2006	6.8	7.5	
2007	7.1	7.4	
2008	7.4	7.4	
2010	6.9	7.2	
2011	6.7	7.1	
2012	6.7	7	
2013	6.7	7	-0.37

Source: Rural Development Statistics, Censusindia.gov.in and nird.org.in

Table no.5.6: Infant Mortality Rate in Himachal Pradesh over years

Years	HP	INDIA	CAGR in HP
1997	63	71	
1998	64	72	
1999	62	70	
2000	60	68	
2001	54	66	
2003	49	60	
2004	51	58	
2005	49	58	-3.09
2006	50	57	
2007	47	55	
2008	44	53	
2010	40	47	
2011	38	44	
2012	36	42	
2013	35	40	-4.12

Source: Rural Development Statistics, Censusindia.gov.in and nird.org.in

Table No. 5.7: State specific Poverty Lines for 2011-12

S. No.	States	Monthly per capita (Rs.)	
		Rural	Urban
1	Andhra Pradesh	860	1,009
2	Arunachal Pradesh	930	1,060
3	Assam	828	1,008
4	Bihar	778	923
5	Chhattisgarh	738	849
6	Delhi	1,145	1,134
7	Goa	1,090	1,134
8	Gujarat	932	1,152
9	Haryana	1,015	1,169
10	Himachal	913	1,064
11	Jammu	891	988
12	Jharkhand	748	974
13	Karnataka	902	1,089
14	Kerala	1,018	987
15	Madhya Pradesh	771	897
16	Maharashtra	967	1,126
17	Manipur	1,118	1,170
18	Meghalaya	888	1,154
19	Mizoram	1,066	1,155
20	Nagaland	1,270	1,302
21	Odisha	695	861
22	Punjab	1,054	1,155
23	Rajasthan	905	1,002
24	Sikkim	930	1,226
25	Tamil Nadu	880	937
26	Tripura	798	920
27	Uttarakhand	880	1,082
28	Uttar Pradesh	768	941
29	West Bengal	783	981
30	Puducherry	1,301	1,309
	All India	816	1,000

Source: http://planningcommission.nic.in/news/pre_pov2307.pdf

Table No. 5.8: Number and Percentage of Population below poverty line by states - 2011-12 (Tendulkar Methodology)

S.No.	States	Rural		Urban		Total	
		% of persons	No. of persons (in lakhs)	% of persons	No. of persons (in lakhs)	% of persons	No. of persons (in lakhs)
1	Andhra Pradesh	10.96	61.8	5.81	16.98	9.2	78.78
2	Arunachal Pradesh	38.93	4.25	20.33	0.66	34.67	4.91
3	Assam	33.89	92.06	20.49	9.21	31.98	101.27
4	Bihar	34.06	320.4	31.23	37.75	33.74	358.15
5	Chhattisgarh	44.61	88.9	24.75	15.22	39.93	104.11
6	Delhi	12.92	0.5	9.84	16.46	9.91	16.96
7	Goa	6.81	0.37	4.09	0.38	5.09	0.75
8	Gujarat	21.54	75.35	10.14	26.88	16.63	102.23
9	Haryana	11.64	19.42	10.28	9.41	11.16	28.83
10	Himachal Pradesh	8.48	5.29	4.33	0.3	8.06	5.59
11	Jammu & Kashmir	11.54	10.73	7.2	2.53	10.35	13.27
12	Jharkhand	40.84	104.09	24.83	20.24	36.96	124.33
13	Karnataka	24.53	92.8	15.25	36.96	20.91	129.76
14	Kerala	9.14	15.48	4.97	8.46	7.05	23.95
15	Madhya Pradesh	35.74	190.95	21	43.1	31.65	234.06
16	Maharashtra	24.22	150.56	9.12	47.36	17.35	197.92
17	Manipur	38.8	7.45	32.59	2.78	36.89	10.22
18	Meghalaya	12.53	3.04	9.26	0.57	11.87	3.61
19	Mizoram	35.43	1.91	6.36	0.37	20.4	2.27
20	Nagaland	19.93	2.76	16.48	1	18.88	3.76
21	Odisha	35.69	126.14	17.29	12.39	32.59	138.53
22	Punjab	7.66	13.35	9.24	9.82	8.26	23.18
23	Rajasthan	16.05	84.19	10.69	18.73	14.71	102.92
24	Sikkim	9.85	0.45	3.66	0.06	8.19	0.51
25	Tamil Nadu	15.83	59.23	6.54	23.4	11.28	82.63
26	Tripura	16.53	4.49	7.42	0.75	14.05	5.24
27	Uttarakhand	11.62	8.25	10.48	3.35	11.26	11.6
28	Uttar Pradesh	30.4	479.35	26.06	118.84	29.43	598.19
29	West Bengal	22.52	141.14	14.66	43.83	19.98	184.98
30	Puducherry	17.06	0.69	6.3	0.55	9.69	1.24
31	Andaman 7 Nicobar islands	1.57	0.04	0	0	1	0.04
32	Chandigarh	1.64	0.004	22.31	2.34	21.81	2.35
33	Dadra & Nagar Haveli	62.59	1.15	15.38	0.28	39.31	1.43
34	Daman & Diu	0	0	12.62	0.26	9.86	0.26
35	Lakshadweep	0	0	3.44	0.02	2.77	0.02
	All India	25.7	2166.58	13.7	531.25	21.92	2697.83

Source: http://planningcommission.nic.in/news/pre_pov2307.pdf

Table no.5.9: Literacy rate in India and HP

State	2001	2011	Change
HP	76.48%	83.78%	7.30%
India	64. 83%	74.04%	9%

Source: Census of India, O/o RGI.

Table no.5.10: Sex Ratio in India and HP

State	2001	2011	Change
HP	970	974	+4
India	933	940	+7

Source: Census of India, O/o RGI.

Table no.5.11: Performance of State on RCH parameters

Indicators			2008-09					2012-13				
			Need Assessed		All India (2008-09)	Himachal Pradesh	% Achvt of need assessed	Need Assessed		All India (2012-13)	Himachal Pradesh	% Achvt of need assessed
			Nos.	Units				Nos.	Units			
A. Immunisation	A. 1	BCG	1,10,000	Estimated number of children upto 1 year of age	271,05,997	1,34,314	122.1	1,09,000	Estimated number of children upto 1 year of age	236,57,602	1,20,481	110.5
	A. 2	DPT	1,10,000	Estimated number of children upto 1 year of age	241,57,990	1,30,842	118.9	1,09,000	Estimated number of children upto 1 year of age	213,83,551	1,13,566	104.2
	A. 3	DT (2nd Dose)	1,19,000	Estimated number of children of 5 years of age	141,88,374	1,10,500	92.9	1,15,000	Estimated number of children of 5 years of age	101,63,315	82,180	71.5
	A. 4	Measles	1,10,000	Estimated number of children upto 1 year of age	242,99,289	1,22,201	111.1	1,09,000	Estimated number of children upto 1 year of age	227,25,315	1,10,370	101.3
	A. 5	Polio	1,10,000	Estimated number of children upto 1 year of age	249,48,389	1,30,840	118.9	1,09,000	Estimated number of children upto 1 year of age	222,78,327	1,13,642	104.3
	A. 6	T.T. (10 years)	1,25,000	Estimated number of children aged less than 10 years of age	134,90,014	1,17,555	94.0	1,15,000	Estimated number of children aged less than 10 years of age	141,21,782	99,322	86.4

Indicators			2008-09					2012-13				
			Need Assessed		All India (2008-09)	Himachal Pradesh	% Achvt of need assessed	Need Assessed		All India (2012-13)	Himachal Pradesh	% Achvt of need assessed
			Nos.	Units				Nos.	Units			
	A. 7	T.T. (16 years)	1,37,000	Estimated number of children aged less than 16 years of age	117,76,455	96,163	70.2	1,28,000	Estimated number of children aged less than 16 years of age	135,59,460	1,16,617	91.1
	A. 8	Prophylaxis Against Blindness – 1st Dose	1,10,000	Estimated number of children upto 1 year of age	182,46,526	1,20,312	109.4	1,09,000	Estimated number of children upto 1 year of age	172,28,860	1,07,866	99.0
	A. 9	Prophylaxis Against Blindness - 5th Dose	1,15,000	Estimated number of children of 3 year of age	114,37,921	8,695	7.6	1,16,000	Estimated number of children of 3 year of age	117,24,718	1,27,351	109.8
	A.10	Prophylaxis Against Blindness – 9th Dose	1,18,000	Estimated number of children of 9 years of age	95,87,093			1,15,000	Estimated number of children of 9 years of age	101,52,699	1,24,803	108.5
B. Maternal and Child Health	B. 1	Maternal Health - ANC	1,27,000	Estimated number of pregnant women	266,97,628	1,53,712	121.0	1,24,000	Estimated number of pregnant women	276,71,007	1,27,827	103.1
	B. 2	Maternal Health - Home Deliveries			55,30,246	52,154				34,39,194	24,382	
	B. 3	Maternal Health - Institutional Deliveries	1,15,000	Estimated number of pregnant women	132,96,359	59,280	51.5	1,13,000	Estimated number of pregnant women	166,98,870	75,117	66.5

Indicators			2008-09					2012-13				
			Need Assessed		All India (2008-09)	Himachal Pradesh	% Achvt of need assessed	Need Assessed		All India (2012-13)	Himachal Pradesh	% Achvt of need assessed
			Nos.	Units				Nos.	Units			
	B. 4	Tetanus Immunisation (Expectant Mothers)	1,27,000	Estimated number of pregnant women	250,95,466	1,34,203	105.7	1,24,000	Estimated number of pregnant women	227,39,244	1,10,185	88.9
	B. 5	Prophylaxis Against Nutritional Anaemia Among Women	1,27,000	Estimated number of pregnant women	226,33,331	1,17,541	92.6	1,24,000	Estimated number of pregnant women	213,21,251	1,08,125	87.2
C. Family Planning	C. 1	Condom-User	5,20,000	Eligible Couples	92,95,442	99,731	19.2	5,46,000	Eligible Couples	52,95,458	79,655	14.6
	C. 2	Oral Pill Users	5,20,000	Eligible Couples	47,25,637	29,802	5.7	5,46,000	Eligible Couples	30,93,355	27,383	5.0
	C. 3	IUD Insertions	5,20,000	Eligible Couples	55,31,348	25,663	4.9	5,46,000	Eligible Couples	54,13,171	19,892	3.6
	C. 4	Sterilisation	5,20,000	Eligible Couples	49,50,151	30,813	5.9	5,46,000	Eligible Couples	45,79,565	23,180	4.2
	C. 5	Tubectomy	5,20,000	Eligible Couples	46,56,481	26,873	5.2	5,46,000	Eligible Couples	44,58,690	20,658	3.8
	C. 6	Vasectomy	5,20,000	Eligible Couples	2,93,670	3,940	0.8	5,46,000	Eligible Couples	1,20,875	2,522	0.5

Table no.5.12: Status of health infrastructure on HP over periods of NRHM

Sl.No.	Indicators	2005	2014
1	Number of Sub-Centres, PHCs & CHCs functioning		
	SC	2068	2068
	PHC	439	489
	CHC	66	78
2	Building Position for Sub Centres		
	Govt. Building	1262	1353
	Rented Building	14	18
	Rent Free Panchayat / Vol. Society Building	792	697
	Buildings under construction		252
3	Building Position for PHCs		
	Govt. Building	312	372
	Rented Building	46	39
	Rent Free Panchayat / Vol. Society Building	81	78
	Buildings under construction		164
4	Building Position for CHCs		
	Govt. Building	65	78
	Rented Building	0	0
	Rent Free Panchayat / Vol. Society Building	1	0
	Buildings under construction		37
5	Health worker (female) / ANM at SCs & PHCs		
	In position	1790	2002
	Vacant	420	211
	Shortfall	717	555
6	Doctors at PHCs	467	571
7	Specialists at CHCs		
	Required	264	312
	Sanctioned	NA	0
	In position	NA	8
	Shortfall	NA	304
8	Nursing Staff at PHCs & CHCs		
	Required	901	1035
	Sanctioned	1540	546
	In position	1259	434
	Vacant	281	112
	Shortfall	No.	601

Table no.5.13: Stakeholder Analysis Table

Category of Stakeholder	Stakeholder	Key, Primary or Secondary	Interests	Impact	Priority
Government	Union government of India through its Ministry of health & Family Welfare	Key	Allocation of funds and guideleines for the implementation of the policy	Positive	High
	Dte. Of Health, HP	Key	Disbursement of funds and monitoring of activities	Positive	Medium
	NRHM	Key	Allocation of funds for the implementation of the policy,guidelines, approval of various proposals and monitoring & evaluation	Positive	High
	State Health Mission	Primary	Allocation & Disbursement of funds, guidelines, approval of various proposals and monitoring & evaluation	Positive	High
	District Health Mission	Primary	Disbursement of funds and monitoring of activities	Positive	High
Law maker	Judiciery	Secondary	To attend any dispute related to the implementation of the scheme & irregularity like cases of corruption	Uncertain	Low
	Parliament	Primary	Bring out the necessary change in the policy for implementation of the scheme	Uncertain	Low
	State Legislative Assembly, HP	Primary		Uncertain	Medium

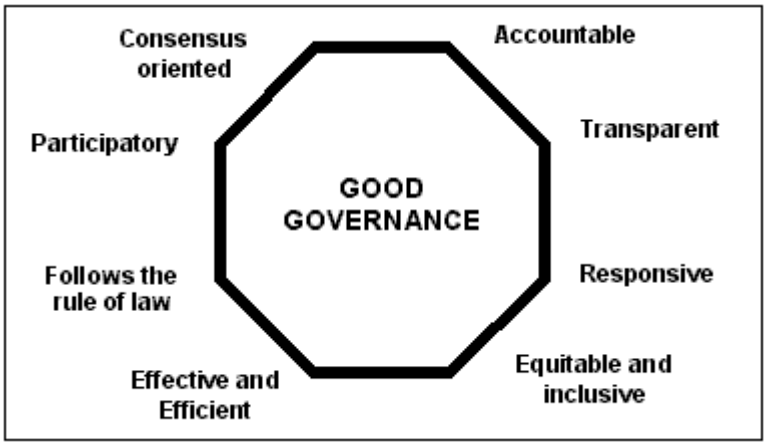
Category of Stakeholder	Stakeholder	Key, Primary or Secondary	Interests	Impact	Priority
Private sector	Private Doctors	Secondary	Get benefit from the absence of proper & effective public healthcare delivey system	Negative	Low
	Private Hospitals	Secondary		Negative	Low
	Private medical stores	Secondary		Negative	Low
	Private Para-medical staff	Secondary		Negative	Low
Non Governmental Organisations (NGO)s and others	Panchayati Raj Institutions	Primary	Involved in the implementation of the scheme.	Positive	High
	Local Communities	Primary	To be part of the effective implementation of the scheme.	Positive	Medium
	Targetted beneficiaries	Primary	Enjoy the benefit of timely and proper implementation of the scheme.	Positive	High
	Health related NGOs	Primary	Timely and proper implementation of the scheme as well as Reduction of Out of Pocket expenditure.	Positive	Medium
	RTI Activists	Secondary	Transpareny of information related to the implementation of the scheme.	Positive	Medium
	International Organizations like WHO, UNICEF etc.	Secondary	Proper implementation fo the scheme.	Positive	Low
Media	Print media	Primary	Make people aware of various programmes and benefits of the scheme	Positive	Medium
	Audio Visual media	Primary		Positive	Medium
Health Support	ASHAs/ Angan Wadi	Primary	Act as the interface between the	Positive	High

Category of Stakeholder	Stakeholder	Key, Primary or Secondary	Interests	Impact	Priority
systems	Workers (AWW) in HP		community and the public health system for promoting various healthcare delivery programmes, especially for Janani Suraksha Yojana(JSY).		
	RKS	Primary	Community management of public hospitals	Positive	High
	VHSNC	Primary	Prepare theVillage Health Plan, promote intersectoral integration and involved in the expenditure of funds received through the mission at village level.	Positive	High
	HMIS	Primary	To facilitate data capturing at District level, ensuring faster flow of information from the district at the facility level.	Positive	High
	MCTS	Primary	Track pregnant women to ensure Ante-natal and Post-natal care, timely & complete immunization of new-born and encoure institutional deliveries.	Positive	High
	Public Health Expert (NHSRC, NIHFW, PHFI etc.)	Secondary	Providing technical support as well as conducting evaluation study of the implementation.	Positive	Medium

Appendix-II

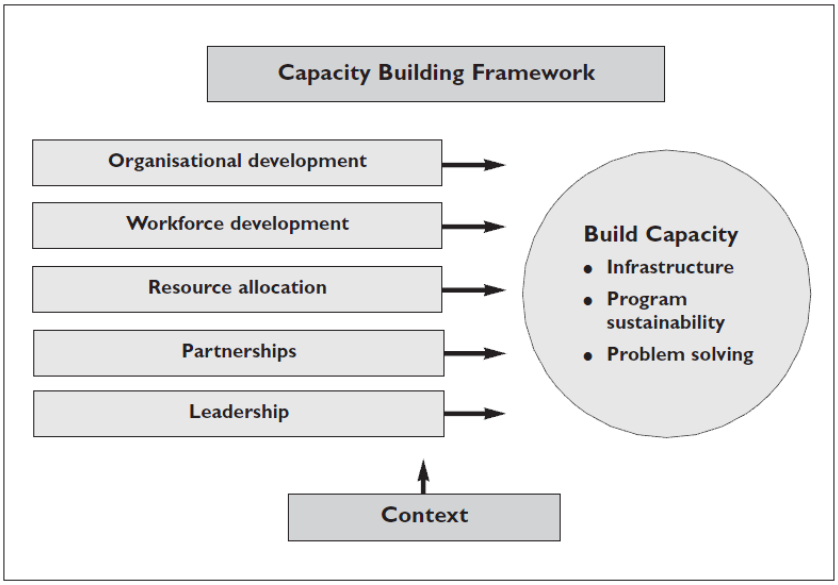
FIGURES

Figure 2.1: Characteristics of good governance



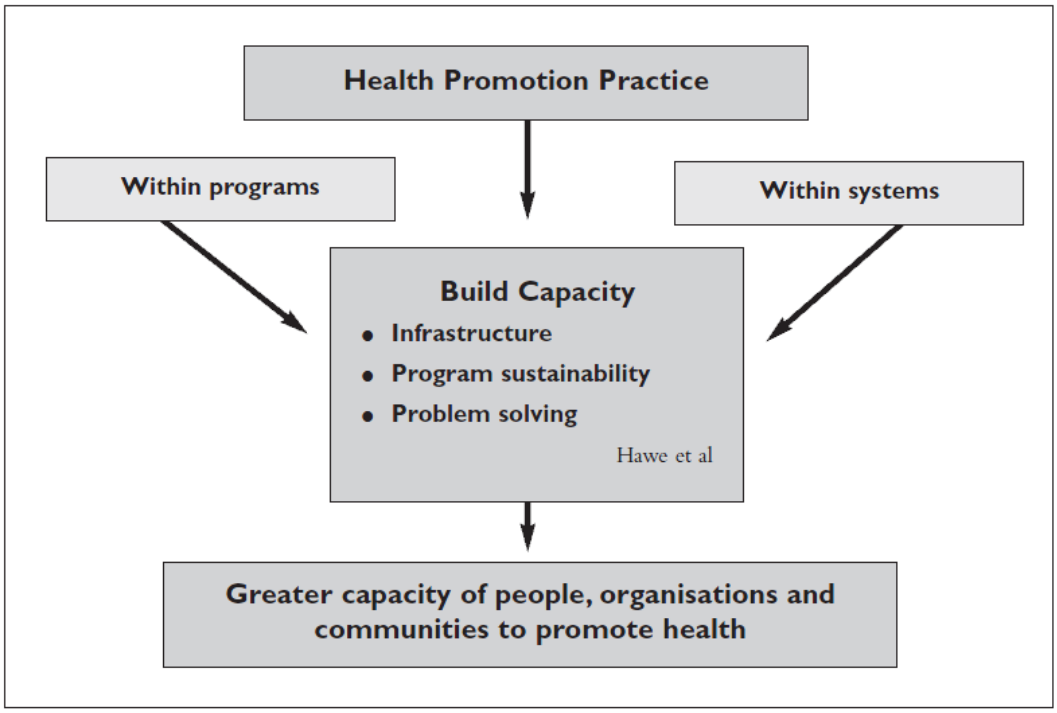
Source: UNESCAP (2009) What is Good Governance?

Figure 2.2: Capacity building framework



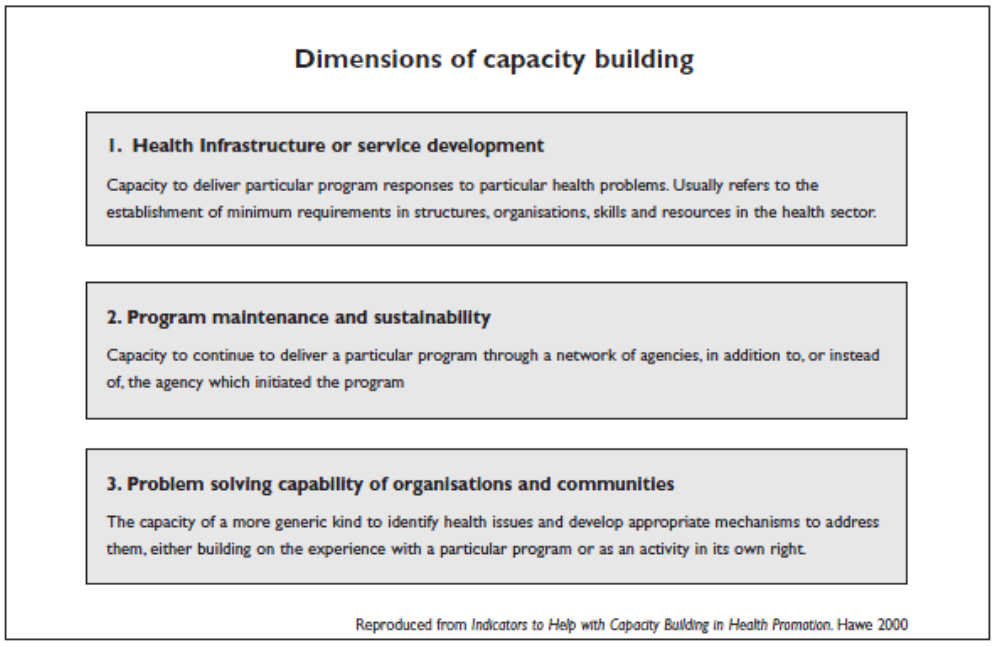
Source: Reproduced from "A Framework for Building Capacity to Improve Health": NSW Health Department 2001

Figure 2.3: Levels of Capacity building



Source: Reproduced from "A Framework for Building Capacity to Improve Health": NSW Health Department 2001

Figure2.4: Dimensions of Capacity building



Source: Reproduced from "A Framework for Building Capacity to Improve Health": NSW Health Department 2001

Figure 2.5: Institutional Mechanism of NRHM

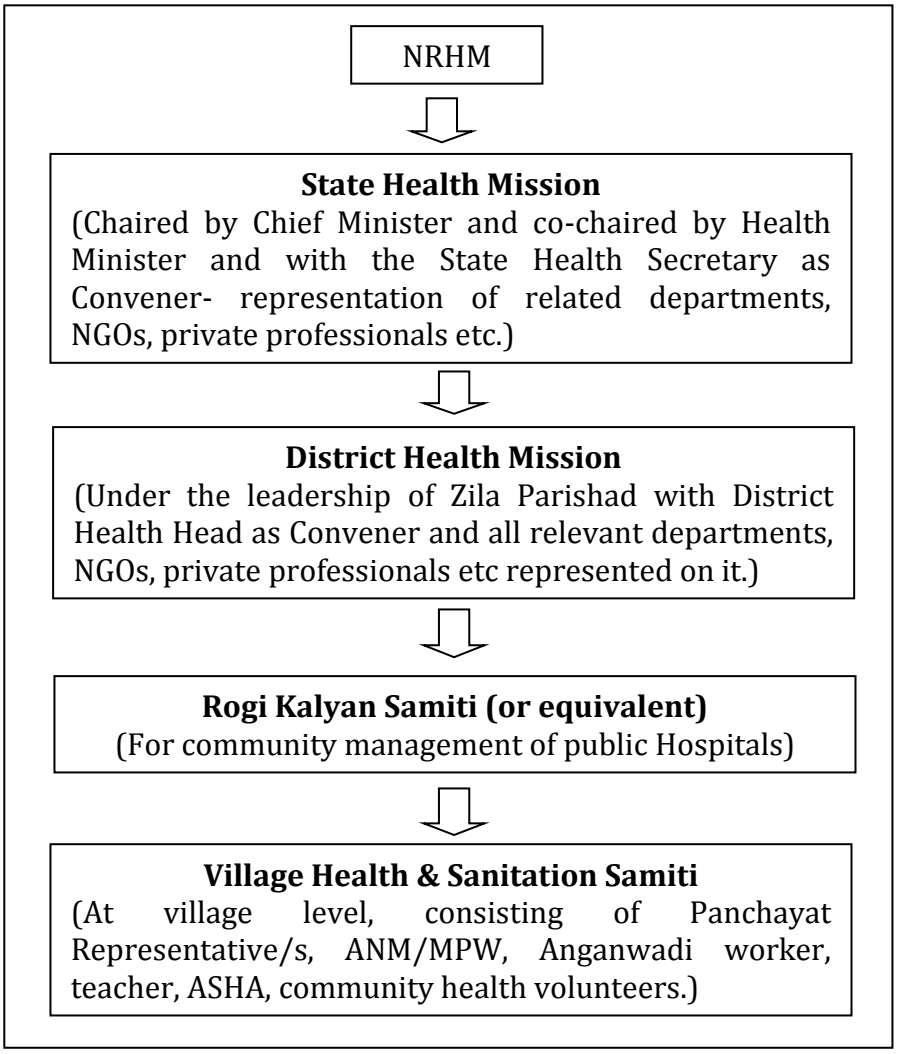
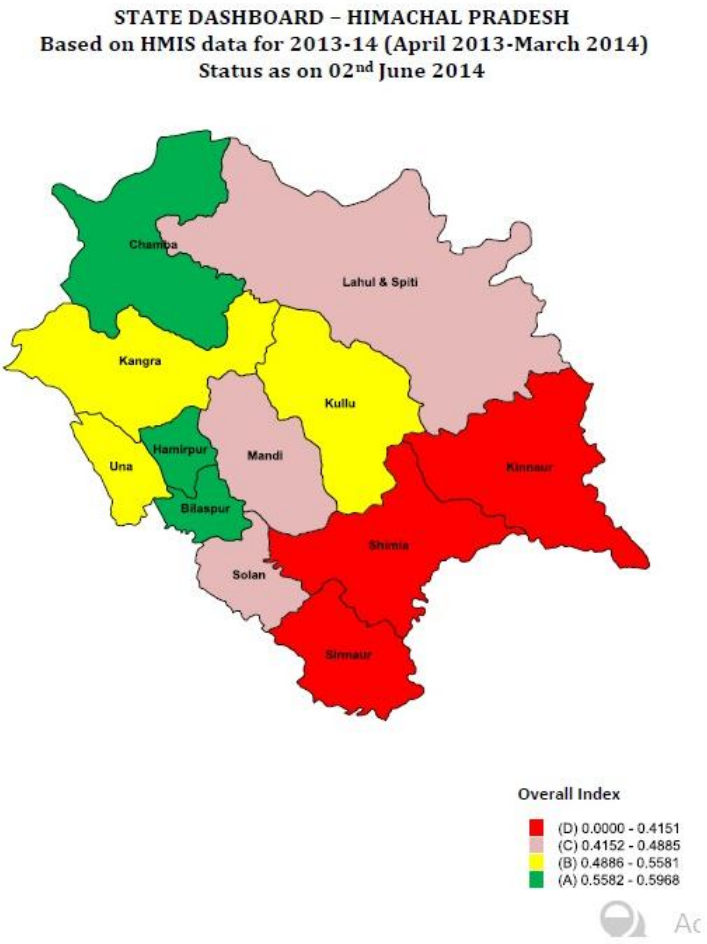


Figure 5.1: State Dashboard based on HMIS data

Comparison	Overall Index	
	2013-14	2012-13
Hamirpur	0.5968	0.5769
Chamba#	0.5883	0.4705
Bilaspur	0.576	0.5041
Una	0.5401	0.4464
Kullu	0.5381	0.4992
Kangra	0.5164	0.5419
Lahul & Spiti#	0.4605	0.4858
Solan	0.4434	0.3873
Mandi#	0.426	0.4627
Sirmaur	0.4041	0.3733
Kinnaur#	0.3374	0.3891
Shimla	0.2676	0.3522

HMIS data reported by district Chamba requires examination as the district has shown huge variation when its performance is compared with DLHS-3 ranking.

#: High Priority District



Source: Health Management Information System, Ministry of Health & Family Welfare, GOI

Figure 5.2: THE STAKEHOLDERS

Government	Law Maker	Private Sector	NGO & Others	Media	Health Support systems
Union government of India through its Ministry of health & Family Welfare	Parliament	Private Doctors	Panchayati Raj Institutions	Audio Visual media	ASHAs/AWWs
State Dte. Of Health, HP	State Legislative Assembly, HP	Private Hospitals	Local Communities	Print media	RKS

NRHM	Judiciery	Private medical stores	Targetted beneficiaries		VHSNC
State Health Mission		Private Para-medical staff	Health related NGOs		HMIS
District Health Mission			RTI Activists		MCTS
			International Organizations like WHO, UNICEF etc.		Public Health Expert (NHSRC, NIHFW, PHFI etc.)