The Transition in Health Governance in India: Implications for the Health Service System in Maharashtra

Thesis Submitted to the Jawaharlal Nehru University in Fulfilment of the Requirements for the Award of Degree of

DOCTOR OF PHILOSOPHY

Abnave Dipak Bajarang

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067 INDIA
2016

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110067

Declaration

Date: 21/7/2016

I hereby declare that the thesis entitled **"The Transition in Health Governance in India: Implications for the Health Service System in Maharashtra"** submitted to the Jawaharlal Nehru University by me for the award of the degree of Doctor of Philosophy is my original work and it has not been submitted in part or full for the award of any other degree of this University or any other University.

Abnave Dipak Bajarang

Certificate

We recommend that this thesis be placed before the external examiners for evaluation for the award of the degree of Doctor of Philosophy

Prof.Ritu Priya Mehrotra
(Supervisor)

Prof. Ritu Priya Mehrotra
Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi - 110067

Prof. Rajib Dasgupta
(Chairperson)

CHAIRPERSON
Centre of Social Medicine & Community Health
School of Social Sciences
Jawaharlal Nehru University
New Delhi-110067

Telefax: +91-(11) 2670 4420 (Direct), 26742676, 26741557 (Ext. 4420), E-mail: csmchjnu@gmail.com
Web:http//www.jnu.ac.in/SSS/CSMCH/

Acknowledgements

Pursuing a PhD at JNU was an interesting journey as a first generation learner in the academia. It was both an enjoyable and a painful experience for me which was filled with encouragement, hardships, frustrations as well as the kind help of so many people. At this moment I feel that without their kind support my PhD would not have been possible. Though, it will not be enough to express my gratitude in words to all those people who help me in this journey.

First of all, I would like to sincerely thank my supervisor Prof. Ritu Priya who accepted me as her PhD student without any hesitation. She had trust on my abilities and helped me to overcome my limitations as a student. She always encouraged me to deal with the challenging issues in the academic life. She gave me suggestions, advice, patiently supervised me and guided me in the right direction. I have learned a lot from her in these seven years. Without her help, I could not have finished my thesis successfully.

I cannot move ahead without expressing gratefulness to all the faculty members of the CSMCH centre as they have shaped and build up a perspective in my thinking and action in these seven years of journey. It is all the faculty members who have supported both of us in difficult times and provided the much needed help in our life. Special thanks to Prof. Rama Baru for academic encouragement and motivation.

I am grateful to the DAAD for providing me the Fellowship to visit the University of Wurzburg. I would like to thank to Chair of European Studies and International Relations, Department of Political Science and Sociology - University of Würzburg, Wittelsbacher Platz1, specially Prof. (Dr.) Gisela Müller-Brandeck-Bocquet, and Prof. Rosemarie Sackmann for their mentorship during my stay. I would like to thank Dr. Stephan Schröder-Köhne, Head of Office, University of Würzburg Graduate Schools, Germany for kind support during my stay in Germany. I am thankful to Vikas Dadal who helped me in many ways during my stay.

I would like to express my deep gratitude to Prof. Maarten Bode who invited me to visit the Amsterdam University and his valuable time and support in Amsterdam.

I am extremely grateful to University Grant Commission (UGC) for granting the fellowship to pursue my doctoral work. This financial support helped me to complete my work.

I owe a special thanks to Dr. Pradeep Shinde, Samya and little Sahir with whom I shared enjoyable movement during my PhD. They have been very supportive and caring during our difficult times. Without their help my writing was not so easy.

I am extremely grateful to the help provided by all my respondents, especially the entire team of SATHI, Pune who have provided the needed information and guidance with the field work. I would also like to thank all the persons and institutes who have offered me their time during my data collection. FRCH Parinche Unit, Appasaheb and their all colleagues from Masum Kajal, Hema and Ravi provided immense help me during my fieldwork. I would like to thanks all my field respondents, ASHAs, ANM, PRI members, VHSNC members, PHC, the RH staff, without their contribution this study would not have been possible.

Thanks to the great help provided by Dinesh Sir in using the documentation unit of CSMCH. I am also grateful to the office staff at the CSMCH who have helped me for seven years. I am also grateful to the JNU library staff for their help in my study.

I would like to express my sincere gratitude towards all who have helped and shaped my understanding during study period. I would like to thank the people around me who not only encouraged but also believed in my potentials because of which I could finish my thesis writing. I owe my special gratitude to Dr. Prachin and Dr. Jayashree, Dr. Milind Awad, Dr. Jyoti Bhosale, Prof. Kharat, Prof. Alone, Dr. Arathi PM for their constant guidance and support during my PhD work.

I would like to thank many friends who have always motivated me. Their constant encouragement, support and help in each time not only academically but also at personal level which have helped me in number of ways. I thank, Iqbal, Santosh, Pradeep, Sandeep, Ajit, Catherine, Aparna, Jisha, Pravin-Panchi,, Manisha Paswan, Rakesh, Sameer and my close friend Laxmi Yadav.

Special mention to Lakshmi Kutty who have been supportive since the time I have enrolled at the Centre and also for her moral and academic help during academic life in JNU. My special thanks are for Satya-Eddie for their support, encouragement and guidance. I am also thankful to Chris and Madhura for their constant support and friendship. I am also thankful to my friend Daksha, who assisted me in various ways during my study. I am also hugely appreciative to my close friends Kiran and Pallavi for their support during PhD. Their generous friendship and emotional support have always given strength in my PhD. I have very fond memories with you.

I am extremely grateful to my mother, her understanding and her love encouraged me to work hard and to continue pursuing PhD in JNU. Her kind-hearted personality has affected me to be steadfast and never bend to difficulties encountered in life. She always lets me know that she is proud of me, which motivates me to work harder and do my best. Thanks to my father for keeping me on ground through his critiques. And lastly my Mama Atya and Vikas, Reshama for their love and emotional support that has helped a lot during my PhD.

Thanks to Archu's all family member, mainly Aai, Pappa, Sandipdada, Bhagyashreetai, Pradnesh, Deepa Tai, Shweta, all Mama's and Mavashi's for their love and support that made this PhD work possible.

Last, but not least, I am greatly indebted to my wholehearted life partner Archu. She is backbone and origin of my happiness. Her love and support has enabled me to complete my Ph.D. She shared every responsibility with me during our academic journey. I always feel the strength with her as a life panther.

Dipak Abnave

JNU, New Delhi, July 2016

Contents

List of Table

List of Figures

List of Maps

List of Abbreviations

ADB - Asian Development Bank

AIIMS - All India Institutes of Medical Sciences

AMG - Annual Maintenance Grant

ANM - Auxiliary Nurse Midwifery

AYUSH - Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy

BAMS - Bachelor of Ayurveda, Medicine and Surgery

BDO - Block Development Officer

BMO - Block Medical Officer

BPC - Block Planning Committees

CBHI – Central Bureau of Health Intelligence

CBM - Community Based Monitoring

CDP - Community Development Programme

CGC - Commission on Global Governance

CHC - Community Health Centre

CHW – Community health worker

CII - Confederation of Indian Industry

CMO – Chief Medical Officer

DAC - Development Assistance Committee,

DFID - Department for International Development

DH - District Hospital

DHO - District Health Officer

DHS - Directorate of Health Services

DPC - District Planning Committees

DPDC - District Planning & Development Committees

DPM – District Programme Manager

DPMU - District Programme Management Unit

ECHS - Educational Commission for Health Sciences

EPHF - Essential Public Health Functions

ESCAP - Economic and Social Commission for Asia and the Pacific

EU - European Union

FRCH - Foundation for Research in Community Health

FRU – First Referral Unit

GAVI - Global Alliance for Vaccines and Immunization Alliance

GoI - Government of India

GoM - Government of Maharashtra

HDI - Human Development Index ()

HLEG - High-Level Expert Group of Planning Commission of India

HMC - Hospital Management Committee

HMIS - Health Management Information System

HQ – Head Quarter

HSG - Health System Governance

HSS - Health Systems Strengthening

ICDS – Integrated Child Development Services

IFAD – International Fund for Agricultural Development

IIPA – Indian Institute of Public Administration

ILO - International Labour Organization

IMF – International Monetary Fund

IMR - Infant Mortality Rate

IPD – In Patient Department

IPHS – India Public Health Standards

ISM&H - Indian System of Medicine and Homoepathy

LHV - Lady Health Visitor

MBBS - Bachelor of Medicine and Bachelor of Surgery

MDG- Millennium Development Goals

MFC - Medico Friend Circle

MIS - Management Information System

MLA- Member of Legislative Assembly

MMR – Maternal Mortality Rate

MNP - Minimum Needs Programme

MP-Member of Parliament

MPW – Multi-Purpose Worker

MSG - Mission Steering Group

NCP – Nationalist Congress Party

NFHS - National Family Health Survey

NGO – NonGovernmental Organisation

NHM – National Health Mission

NHP - National Health Package

NHSRC – National Health Systems Resource Centre

NPG – New Public Governance

NPM - New Public Management

NPS - New Public Service

NRHM – National Rural Health Mission

OECD- Organization for Economic Cooperation and Development

OPD - Out Patient Department

PAHO – Pan American Health Organization

PBB - Performance Based Budgeting

PCI -Per Capita Income

PHC –Primary Health Centre

PIP - Programme Implementation Plan

PPM - Public Private Mix

PPP – Public Private Partnership

PRI – Panchayat Raj Institute

PSM - Public Sector Management

RGJAY - Rajiv Gandhi Jeevandayee Arogya Yojana

RH - Rural Hospital

RKS – Rogi Kalyan Samiti

RTI – Right to information Act

SAP - Structural Adjustment Program

SC – sub centre

SDH - Sub District hospital

SEBI - Securities and Exchange Board of India

SHG - Self Help Group

SHM - State Health Mission

SHS -State Health Society

SPMU - State Programme Management Unit

TMO – Taluka (Block) Medical Officer

TNMSC - Tamil Nadu Medical Services Corporation Ltd.

TPMU - Taluka Level Programme Management Unit

UAHC - Universal Access to Health Care

UHC - Universal Health Coverage

UN – United Nation

UNDP – United Nations Development Program

UNESCAP – United Nation the Economic and Social Commission for Asia and the Pacific

UNFPA - United Nations Population Fund

USAID - United States Agency for International Development

USSR - Union of Soviet Socialist Republics

VHSNC - Village Health, Sanitation and Nutrition Committees

WB - World Bank

WHO - World Health Organization

ZP- Zilla Parishad

Chapter-I

Introducing the Research Problem and Its Methodology: Assessing Health Governance Transitions

Chapter I

Introducing the Research Problem and Its Methodology:

Assessing Health Governance Transitions

Significance of Health Governance in Contemporary Times:

The concept of 'governance' has been one of the prime agenda in the present Indian development discourse. The need for changes in political structures so as to bring government closer to the people gained salience in public discourse in India in the mid-1980s and constitutional amendments were adopted towards this. In the early 1990s, there have also been significant changes in the governance structure of different nations because of the global demand for increased socio-economic development with a thrust for economic restructuring that began since the 1980s at the international level. These changes have led to the transition in the model of governance in India with the introduction of structural changes in decision making and policy planning processes (DeLong, 2003). The traditional mode of governance frameworks with a focus on the involvement of public sector and governments was increasingly replaced with the new market-based frameworks that emphasized participation of the private sector. In the Indian context, there was a mixed economy with the involvement of both public and private sector since Independence. However, with the introduction of governance reforms, this has been altered, and traditional public administration was replaced with new public management.

The modern state undertook its activities through public administration structured during colonial times. It included a strong system of bureaucracy which was the backbone of public administration. As notes the old system of bureaucracy was grounded by a set of rules and regulations flowing from public law and the system of control. However, the traditional public administration was severely criticized for its bureaucratic nature and was seen as working through unnecessarily time-consuming procedures. It was considered to be highly paternalistic on citizens, led to a waste of resources, and there

was more focus on process and procedures instead of results (United Nations, 2006) The classic system of public administration was also identified as being too rigid, slow, users, non-responsive to the needs of the user or inclusive in decision-making about services. Further, weak leadership, limited management capacity, and insufficient human resources, was seen to cause inefficiency in the traditional public administration system. This has to large extent undermined the legitimacy of the state (Brinkerhoff and Bossert, 2008). These problems resulted in poor outcomes, declining quality of services, and reduced user satisfaction. Hence, an increased need was felt to brings about changes in the mechanisms of public administration, particularly in its processes and frameworks.

These limitations of the public administration provided space for the introduction of new market led management principles and values framework in the public sector (Hood, 2004). The process of globalization and economic restructuring that happened at the same time brought about significant changes in government activities with the increased promotion of markets in public sector activities. Over the 1970s and 80s, it was generally believed that the private sector was better managed, more efficient and provided better services. Therefore, it was thought that the public sector should adopt principles of management of the private and corporate sector, which emphasized tight control of work processes and planning by managers. Hence, this led to the introduction of management techniques to enhance control over the bureaucracy and make it more accountable for outcomes (Pfiffner 2004). The neo-liberal reforms introduced during the 1990s brought about changes in public administration in the form of New Public Management (NPM). Apart from increased involvement and promotion of the private commercial sector, the new public management viewed greater people's responsibility as important in addition to responsibility of the 'state'. The main components of change were 'community participation' or 'consumer involvement' (Cheema and Rondinelli, 2007). This structural transition then opened up the arena of public administration to more scrutiny and change.

The classical Public Administration was changed to 'New Public Management', then it moved to 'Good Governance' and lastly to 'New Public Service' (Denhardt & Denhardt, 2000). It is important to note that these new forms of state functioning are creating new configurations among the governance actors and policy networks of public, private and

civil society. These changes were aimed at improving performance, increasing efficiency and productivity as well as implementing citizen-centered approaches to service delivery. They included attempts to modify patterns of policy decision making which consisted of deliberate changes to the structures and processes of public sector institutions. Mechanisms of change included redesigning the systems, setting quality standards and focusing on capacity-building (Bourgon, 2009; UN 2006).

This structural shift was undertaken in the sphere of public health as well. Health governance has become part of the current discourse to create more inclusive and better-managed public health (Banda and Simukonda, 1994). This shift was undertaken in India as well as other countries of the world. Most of the health governance framework is central to health systems strengthening.

The health system is defined as "the combination of resources, organization, financing and management that culminate in the delivery of health services to the population" (Roemer, 1991 cited in Annex 2007).[1] The health system aims at involvement of all the actors, institutions and resources to improve and restore health, through addressing determinants of health and improving activities whose primary purpose is to "promote, restore, and maintain health" (WHO, 2000, p.5). The World Health Organization (2007) report expanded definition of health system, as including the following elements: "it includes all organizations, people and actions that were primarily determined to promote, restore or maintain health. It refers to the efforts to influence the determinants of health and direct health-improving activities. A health system is, "more than the pyramid of public health services. It includes inter-sectoral action for the determinant of better health" (WHO, 2007, p.2). The goal of the health system is to protect people's health and treat diseases. For this, traditional practices have existed for thousands of years and co-exist today with modern medicine as a result of the historical interplay of power and knowledge, with provisioning of services by the state, private sector and philanthropy/civil society. In today's context, the health systems are facing challenges

[1] Annex, L. (2007). What is Health System? Healthy Development, The World Bank Strategy for HNP Results, Retrieved from http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/AnnexLHNPStrategyWhatisaHealthSystemApril242007.pdf as accessed on 15th May 2014.

because of the changing role of the state and its relationship with the private sector and civil society as well as because of the questioning of medical systems and re-examination of traditional systems for beneficial contributions (Priya, 2005). It is often argued that the health systems have largely failed to deliver equitable access to health care. The universal health coverage (UHC) slogan has, in the current discourse made an attempt to address this issue at global and national levels. Under this approach, the WHO came with a new concept of Health Systems Strengthening (HSS) framework that focuses on building six blocks of the health service system. It includes governance/leadership, health financing, human resources, service delivery, health technology support and health information. All these elements were considered necessary for health systems strengthening (WHO, 2007). The health service system is not merely the sum of its separate parts, but a set of dynamic entities with interactions (Ibid, 2007) Improving six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements in health services and health outcomes is essential for health systems strengthening. Nonetheless, that is not enough. The health system is not a closed system, and it is influenced by entities external to it such as the private sector, the pharmaceutical industry, and the socio-cultural context; it requires both technical and political actions. WHO gave more emphasis on the emphasis has been on 'management change' and what has been ignored in decision making is the element of knowledge and technology. Therefore, health systems' strengthening is a complex undertaking that may require significant time to implement and take even longer to produce results (Ibid).

Thereby, changes in the health governance framework are towards its becoming a more collaborative process. It includes the role of private sector, civil society, and communities for the achievement of agreed health policy goals. This is aimed to strengthen the public health service systems (Brinkerhoff and Bossert, 2008). However, the public policy governance framework is also in consonance with a decrease in the responsibility of the state for provisioning services. It has increased costs on health care that leads to increasing inequalities in access to health services (Baru, 2012).

There are key challenges involved in health governance. Health care planning, financing and implementation of policy are political processes (Navarro, 2009). The new forms of

governance paradigm have changed the thinking about the role of the state and private enterprise that came in the 1980s and 1990s as part of the structural adjustment policies. The international financial agencies have directed these and been responded to by governments. They came with the stated objectives of encouraging a more efficient public service delivery with new values, ethical dimensions, and principles of modern management (Voxted and Lind, 2010). It was also aimed to change. The changes included conceptual moves in the strategy and methods of public health policy and planning as an ongoing transition process, indicated by the terms used to describe the functioning of government and its services: from public administration to public management to governance.

Introducing this Study

This study proposes to investigate how and in what ways India's health governance transition has changed the relationships and accountability between government and citizens regarding the health services. In the past three decades, there have been significant changes in the health service decision-making processes of governments in India. This study attempts to answer the following research question: How has the role of government institutions and other actors changed under the processes of health management and governance? The primary focus was on the two elements involved in the governance transition: the role of state and non-state actors and the space given to the ''community' in decision-making processes. The study examines these issues in relation to the contextual factors that affect health governance transition. The study explores the elements through examination of the decision-making processes and choices involved in policy formulation, operationalisation, planning, implementation, and monitoring of health services.

Hence, the process of decision-making within the public health service system is the central issue in this study. Health service related decisions include prioritizing the health problems and health interventions as well as about building the human resources and the health services delivery system. The study also examines in what ways decision-making under the new health governance gives space for consideration to people's knowledge and experience.

One of the major mechanisms through which structural changes have been introduced in the health services since the mid-2000s is through implementation of the National Rural Health Mission (NRHM). The NRHM has been the largest and most multi-dimensional effort at 'reforming' the health services of the public system (Shukla and Sinha 2014). Hence, the study focuses on processes of decision-making within the NRHM.

Governance as a technical tool is used to fix the problem in the public health system to ensure better service delivery (Lewis, 2006). The contemporary nature of health services delivery involves multiple actors at all levels in different systems of medicine. The approach of health services is growing towards the for-profit or private commercial sector (De Costa and Diwan, 2007). There are intra and interstate variations in availability, accessibility, quality and acceptability of health services. Health services delivery is stratified in terms of scope, scale and roles (Baru and Bisht, 2010). The concept of power and its circulation is running in the background of governance. The idea of power exists in the health system and it exists in the public, private and non-profit sectors (Dodgson, Lee, and Drager, 2002). In the Indian context, the public services, for-profit commercial and non-profit NGO sector are interdependent with an overlap and duplication in their role and functions (Baru and Bisht, 2010). There are alliances and conflict of interest between these actors. The current public sector has alliances with the commercial and Non-Government Organizations (NGO) sectors that are visible in various health programs. There is a need for examining the deeper level dynamics and behavior of institutions within sectors and across the sectors. In the policy discourse, assuming that the government is the main leader and it is critical to see how far the government determines its health policy. The role of the private sector in determining policy making at the local, state and national level also assumes importance. These actors shape public policy by representing as well as by lobbying through networks. The commercial sector lobbies for federal subsidies, demanding for expansion of public health insurance schemes and support for cash transfer (La Forgia and Nagpal, 2012). Thus, the private sector represents a plurality of interests and influences government health policy. NGOs who have engaged with the health movement also raise concerns about equity in the access and rationality of care. There are very different motivations and ideological tie-ups in the planning processes putting pressure on government policy-making. The role of the

corporate sector is also critical, but it is very silent and non-visible. It has consolidated its presence, and plays an influential role at the higher level. (Baru, 2006). Corporate actors are not willing to come under the jurisdiction of the Ministry of Health. However, in the policymaking, they have a direct influence on Ministry of Health and Planning Commission. Also, more important is that the role of the corporate sector is missing and ignored in governance literature, that is the reason they are silent in the whole discourse. The business sector has moved into the primary and secondary level care through pharmacy and diagnostic centers in rural and semi-urban areas (Baru, Qadeer, and Priya, 2000). They have fully networked and developed referral mechanisms in these areas. Focus of governance activity is largely below the district level. There is no major attention at the top, which means at the state and national levels, where the ministry of health and other involved institutions exercises a decisive influence; there is larger governance deficit (Baru 2012).

Governance is defined as the exercise of authority, direction and control on behalf of a public or private organization and management (Goodsell, 2006). It is the act and art of controlling or conducting affairs. Governance provides a value framework for policy. It operates at the top level. Therefore, it includes planning, goal setting, policy development and monitoring progress toward strategic objectives (Governance Handbook, 2002, p.3). The goal of governance is for improving inter-organizational coordination and decision-making. It focuses on changes and adaptations in the relations between governments and other inter-organizational actors. Governance sometimes uses the management technique, including activating actors, organizing research and information-gathering, joint fact-finding, exploring content, arranging interactions and process rules. Governance goals are mainly developed during interaction and decision-making processes (Klijn, 2012).

Many times governance and management is considered as a similar administrative activity. Oakes (2011) tried to differentiate between governance and management. He points out that governance is political as it addresses the concerns such as who is empowered to make which decision, what process they must follow, and whom they must consult. These are political questions and they influence power within a system, the rank within the hierarchy and control on key resources plays a significant role in decision-making. He further explains that governance is beyond management. Governance fixes

the boundaries within which people operate. It identifies who is responsible for making which decisions and defines the process they use to make legitimate decisions. Management is then about making decisions, gathering information, identifying options, making trade-offs. He also argues that when governance encroaches on management, people lose sight of overall priorities, or they make decisions without understanding the operational context. If governance tries to replace people's skills and judgments, it will fail (Oakes, 2011). Priya (2011) made a distinction between governance and management in health. She argues that 'governance is about setting down of the vision and objectives, the policy, principles and priorities of any institution or organized system. Management is about operationalisation of the principles to address the priorities set out in the governance exercise.' According to her if this is viewed as a clear distinction then it would make the decision-making roles clearer. Distinguishing the two would require a different set of policy/principle/priority issues/indicators for the policy setting and more operational dimensions (Priya, 2011, p.12).

Klijn (2012) compares the type of relationship between the actors in the New Public Management and Governance. NPM involves a contractual relationship between government and other actors. In governance, it is an interdependent horizontal relationship. Nevertheless, governance networks are not completely horizontal. In governance, networks have vertical elements. Actors have different kinds of resources. This has caused inequalities in the relations through unequal resource distribution. While formal contacts between various layers of governmental levels, for instance, create some vertical relationships. Nevertheless, there are often mutually dependent relationships. Thus, policy and service delivery are achieved through creating networks of actors who may be public-only inter-governmental networks or multi-level governance or mixtures of public and private actors. The managerial effort in the sense of facilitating such structures has been called network management (Klijn, 2012).

Decision Making for Policy Formulation, Planning, and Implementation

Governance is about how governments and other social organizations interact, how they relate to citizens and how decisions are taken in a complex world. It is a process, where

societies or organizations make their important decisions; determine whom they involve in the process and how they render accountability (Graham, Bruce and Plumptre, 2003, p.1). Governance structures allow for proper strategic planning, coordination and decision-making around key areas. The term governance goes beyond public management. It addresses the fundamental questions such as, how the processes of democracy work, how citizens' involvement in decision-making procedures and administrative functions can be adapted to help countries to resolve the complex public issues (Lovan, Murray and Shaffer, 2004). The elements of governance in a democratic culture are defined as the process of collective decision-making. It has tried to make political institutions, interest groups accountable through the governing body (Kersbergen and Waarden, 2004). The opinion emerges as to who should be involved in policy formulation and decision-making. Governments used a wide range of approaches to move towards policy-making through highly networked, multi-level, multi-stakeholder governance. Transition in governance starts from public administration and is reaching its culmination in modern management (Kickbusch and Gleicher, 2012; Hood, 2004; Kickbusch and Behrendt 2013).

Evidence-based decision-making is one of the influential ideas that have emerged along with new governance. In the health governance domain, health policy is dominated by experts and evidence based knowledge. People's participation in the decision-making and people's knowledge go beyond expert opinion (Priya, 2011). What is evidence and what is scientific? This question cannot be judged only on the basis of modern scientific experts of dominant institutional networks. There is a need to develop a constructive space for community experience and people's perceptions (Priya, 2011). It is argued that new emerging knowledge is used because it is classified as scientific evidence for policymaking (Kickbusch and Gleicher, 2012; Kickbusch and Behrendt, 2013) "The co-production of knowledge by science and society and the inseparable nature of 'facts' and 'values', where both of these elements need to be made explicit and deliberated to achieve innovation in governance" (Kickbusch and Gleicher, 2012, p.14).[2] There is a

[2] Kickbusch, I and Behrendt, T. (2013). *Implementing a Health 2020 Vision: Governance For Health In The 21st Century. Making it Happen*. Copenhagen: World Health Organization Regional Office for Europe

need to strengthen people's knowledge-centric planning and decision making as this will lead to people centered participatory governance (Priya 2011).

Brinkerhoff and Bossert (2013) point out that governance encompasses a policy process that enables the interplay of key competing interest groups to influence policy-making. It involves sufficient state capacity, legitimacy to plan and design programmatic interventions and to enforce and implement health policy decisions Policy-making is about governance, which is deciding the value framework and mechanism of management. It provides the basis for planning, the link between governance and management. Decision-making is an important function of governance and it is required for all the components of governance at all levels, i.e. policy formulation, planning, operationalisation, implementation, and monitoring. Planning is often viewed more as a managerial function. However, decision making about values and principles and planning cannot be implemented separately. They are parts of an integrated process of governance (Priya, 2011). Decision-making about the goals is the process of identifying a set of feasible alternatives and choosing a course of action. Decision-making is a part in planning and involves the process of evaluating alternatives and choosing a course of action in order to solve a problem. The decision-making process in a particular situation identifies the options and finds the threats and opportunities, where the principles and value framework come into planning. It focuses on examining the various options by testing and measuring their effectiveness. It identifies the pros and cons of each alternatives. Unless a decision has been made, a plan cannot implemented in the field (Brinkerhoff and Bossert, 2013).

The operationalization of the plan will require operating principles to be laid down, and guidelines made accordingly. Implementation of the guidelines will again require some principles to be set for enabling to understand how the activities have been undertaken in the particular context. Finally, monitoring of the implementation requires decisions about what parameters and indicators are monitored, and what action is to take on the findings of the monitoring process (Borrmann, 1999).

Thus, this study is based on the assumption that the concept of decision-making about principles and values is central to governance. It is required at all the five levels, which interact and influence each other. Review of the existing literature on governance in health care shows that there is often tendency to look at principles and values in a marginal way and focus more on the operational management aspects (McQueen and Jones, 2007; Hanberger, 2001; Bridges, 2002; Bovaird and Löffler, 2003; Kickbusch and Gleicher 2012). This study conceptualizes the two elements of governance and management in a discrete manner while recognizing their close interconnectedness. Therefore, this study attempts to understand the process of decision-making in five stages namely policy formulation, planning, operationalization, implementation and monitoring of health policy under the NRHM, from the national to the village level.

Purpose of this Study

Scholarly attention to the study of governance or public management has focused mostly on the management aspects. Despite its authoritative oversight role, governance as principle decision making remains the most understudied, undeveloped, least rational element in the enterprise (Carver, 2001). To study governance, many scholars locate their work within an analytic framework. That shows how particular issues of policy design, organization, management and delivery of services are related to a multilevel perspective (Hill and Laurence, 2004b). Governance discourse has evolved based on several principles. These principles change from their original character in the context in which they are applied, and this aspect often has not been studied. The purpose of this research study is to assess the present health services performance and governance performance in the health system and the interrelation between them. It focuses on the contemporary issues and challenges in health governance.

Research Design:

This study attempts to examine the potential democratization of the health service system by the contemporary transition in health governance. It begins by examining the conceptual shifts in health governance at global and national levels and then conducts an

empirical inquiry into the changing processes of governance and their implications for decision-making at meso and micro levels in one state of India.

The Study Area

This study will attempt to identify problems and challenges in health governance in the specific context of the state of Maharashtra in India. Maharashtra is considered as one of the more developed states in India. It shows good economic growth indicators relative to other States. Agriculture and industrialization are the backbones of Maharashtra's economy. The annual plan of 2012-13 shows that, in 2011-12, the per capita income (PCI) of the state of Maharashtra was Rs. 101,314 and Human Development Index (HDI) was 0.572, which was much higher than the national average (Government of Maharashtra, 2012). However, there is wide regional inequality in Maharashtra with respect to the access of social resources. A research study on health services in Maharashtra has shown that there is inequality based on region, caste, class, gender in health status (Mishra, et al., 2008). Certain policy interventions are in place to deal with such adversities. However, greater attention needs to be directed towards the assessment of health deprivation and inequities in Maharashtra.

The healthcare sector in the state of Maharashtra is expanding very fast. It is mainly divided into the government sector and the private sector. The government sector includes government-run hospitals under the Municipal Corporation and Zilla Parishad health care centers in the rural areas. Healthcare services in the state have improved over a period, especially in the rural areas in terms of infrastructure development. The Government of Maharashtra has upgraded the primary health care centers and government hospitals throughout Maharashtra (Shetty, 2013).[3] Under the National Rural Health Mission (NRHM), the government has introduced many schemes that helped to improve the healthcare scenario in Maharashtra. The government of Maharashtra is one of the pioneer states to come out with an e-Governance policy. Most of the departments have taken various initiatives in this regard. In 2012, the e-office was established for the

[3] Kambli, R. (2013, January 8). Maharashtra Needs to Increase Proper Healthcare Infrastructure. *Indian Express*, Retrieved from http://healthcare.financialexpress.com/sections/market-section/1160-maharashtra-needs-to-increase-proper-healthcare-infrastructure as accessed on 14th April 2014.

National Rural Health Mission (NRHM), which is a totally paperless office. In fact, some departments of the government are coming up with e-Governance initiatives and some of them have done well on this front.[4]

In July 2012, the Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY), a health social insurance scheme has been introduced in Maharashtra. The main purpose of this scheme was to create a background for universal health coverage in Maharashtra.

Some studies conclude the Maharashtra is one of the high per capita income states with higher health inequality (William, Mishra and Navaneetham, 2008; George and Nandraj, 1993; Duggal, et al., 2005, Mishra, et al., 2008). NFHS-III for the state of Maharashtra has shown that there was 48.4 % anemia among women (15-49 years) and 41.6 % malnutrition among children of 0 to 3-year age group (Government of Maharashtra, 2012). The challenge faced by the government sector is that inadequate funds are available to the municipal corporations and Zilla Parishads. This is a big issue in itself. The other areas that need attention are the lack of health care infrastructure, especially in rural parts of Maharashtra, and a shortage of trained healthcare professionals. The health service system of Maharashtra is under transition phase (Kielmann, 2002). There is a marked shift in public health care delivery from public to private in Maharashtra. The role of the private sector has strengthened in the Maharashtra's health service system (Baru, 2006). The then health minister of Maharashtra Suresh Shetty said in 2013, 'The transition of Maharashtra's healthcare sector from a static and inconspicuous industry to an increasingly dynamic and significant industry is noteworthy" (Kambli, 2013).[5] The private sector in Maharashtra functions in various ways through hospitals, diagnostic centers, and other healthcare delivery models. Maharashtra's health service sector has been developed in both private and government sectors, but the private sectors have been

[4] E-Gov. Maharashtra is One of the Pioneer States. *Feature News*. Retrieved From http://egov.eletsonline.com/2012/04/maharashtra-is-one-of-the-pioneer-states/#sthash.IJxXwDz7.dpuf as accessed on 22nd July 2013.

[5] Kambli, R. (2013, January 8). Maharashtra Needs to Increase Proper Healthcare Infrastructure. *Indian Express*, Retrieved from http://healthcare.financialexpress.com/sections/market-section/1160-maharashtra-needs-to-increase-proper-healthcare-infrastructure as accessed on 14th April 2014.

in the forefront, especially in urban areas. The private sector is also setting up hospitals in various small towns and cities (ibid).[6]

Two viewpoints can be found related to the health care system governance in Maharashtra. There are a number of efforts taken for strengthening the health care system in the state and it is among the better performing in the country. Secondly, there is marked evidence that points to the misgovernance and the failure of the health care system in Maharashtra (William, Mishra and Navaneetham, 2008; George and Nadraj, 1993; Duggal, et al., 2005; Mishra, et al., 2008). In this context, the present research study tries to explore why this gap is prevailing in the health system of Maharashtra. The study focuses on decision making for health governance and management under the NRHM in Maharashtra and attempts to understand how it is implemented from the state to the village level by undertaking a field based study.

Objectives of the Study:

1. To study the trend of traditional public administration to new public governance in the healthcare system of India.

2. To study the operationalisation of changes in health governance and management in Maharashtra and their outcome in terms of performance.

3. To study changes in operationalisation of health governance through the understanding of decision making as reflected in policy processes, planning, and implementation under NRHM

The national level shifts in governance and the decision-making structures and principles envisaged while formulating NRHM at national and state levels have been examined, along with the state and district level planning processes with regard to NRHM.

[6]ibid.

Research Methodology

In the present context, one stream of governance studies has focused on the context of public administration reform. A second stream has concentrated on the trends in international governance and management, and the third approach is the comparative analysis of public administration, management and governance.

Hill and Laurence (2004a) describe empirical research conducted to study governance as having adopted three distinct strategies. The first strategy tends to adopt a historical, descriptive and institutional orientation. Insights and conclusions are based on systematic reviews and assessments of official documents, including surveys reports, interviews, field observations and secondary research studies. The analysis of documents often takes the form of classification of schemes in which reforms or their characteristic features are associated with the contextual and other factors. The second research strategy attempts to identify 'best practices' through the collection of detailed case studies of actual management problems. The third strategy is to study public governance and management by using the formal theories, models, and methods. Focus is also on data of social and behavioral sciences to study governmental processes to develop a body of empirical knowledge. In this study we adopted the first approach.

The contextual elements of governance are used as conceptualized by the 'realistic evaluation' method. Based on the nature of research objectives, the study has adopted a historical, descriptive approach, bringing together data from reviews and assessments of official documents, including surveys reports, interviews, field observations and secondary research studies as well as primary data gathered through qualitative methods. Primarily, the study has documented and analyzed the shifts of public governance in the healthcare system of India. The study made an attempt to examine the major dimensions of decision making in the public health service system, ranging from the state, district to village level governance structures and focusing on implementation of planning and management.

The present study uses the Health System Governance (HSG) assessment framework of Siddiqi, et al. (2009).[7] The HSG principles as enumerated by Siddiqi et al are given in Box- 1.1.

Box-1.1

Health System Governance (HSG) Principle Explanation

Health system governance principles

Governance principle	Explanation
Strategic vision	Leaders have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded
Participation and consensus orientation	All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures
Rule of law	Legal frameworks pertaining to health should be fair and enforced impartially, particularly the laws on human rights related to health
Transparency	Transparency is built on the free flow of information for all health matters. Processes, institutions and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters
Responsiveness	Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users
Equity and inclusiveness	All men and women should have opportunities to improve or maintain their health and well-being
Effectiveness and efficiency	Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources
Accountability	Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization
Intelligence and information	Intelligence and information are essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health
Ethics	The commonly accepted principles of health care ethics include respect for autonomy, nonmaleficence, beneficence and justice. Health care ethics, which includes ethics in health research, is important to safeguard the interest and the rights of the patients

Source- Siddiqi, et al. (2009) pp- 18

The present study has been undertaken in three phases as outlined below:

Firstly, analytical review of the practice of governance in health care services has been conducted to understand the conceptual basis of 'health governance' in the Indian context. Literature has been reviewed to trace the trends in health governance in India.

[7] Siddiqi, S.; Masud, T.; Nishtar, S.; Peters, D.; Sabri, B.; Bile, K. and Jama, M. (2009). Framework for Assessing Governance of the Health System in Developing Countries: Gateway to Good Governance. *Health Policy*, 90(1), 13-25.

This component has focused on understanding the fundamental principles as well as developing practical applications of governance in public health services. A variety of documents, official and unofficial reports, articles, books, working papers, research reports, policy documents and online articles have been systematically examined. Books and research papers on health governance, public health administration, public sector reform in health care services have been referred and used for analysis. These were supplemented with interviews with key actors at and state level.

During the second phase, the focus was on health governance and management of health services under the NRHM in Maharashtra. Analysis of relevant documents and interviews with actors from the state the village level have been undertaken to develop an understanding of health governance in Maharashtra in the pre- and post NRHM stages. The study has been carried out in one district, and the study district was selected based on the performance history under the NRHM in Maharashtra. The study area and study units have been finalized after a preliminary visit to District Hospital, Primary Health Center, Sub-Centers, and villages. It helped to establish a primary contact and rapport with the relevant people. The researcher carried out the main discussion with district officers and other concerned staffs. It has helped to check the possibility and availability of information. Based on this study and visits, final tools for data collection and study area were designed.

In the third phase, data collection has been carried out in Pune district of Maharashtra. The study has been conducted at the various health facility levels such as at the district, block level, PHC, sub-center, and village. The focus was on the operational aspect of governance i.e. policy formulation, planning, implementation, and monitoring. Selection of Pune district is based on two criteria: The Community-based Monitoring (CBM) under NRHM were effectively implemented in Pune district and second, the researcher belongs to the Pune district. Under Pune district, Purandhar block/taluka was chosen, and two PHCs under Purandhar block were selected for the study.

The two Primary Health Centres (PHC) were selected based on the criteria that one PHC was under the community-based monitoring (CBM) programme implementation and the

second PHC was from a non-CBM area. This was to see how the community-based monitoring process has changed the governance and performance for public health services in the state.

Within each PHC area, three panchayat areas that lay along the path of the PHC were included in the study. This meant covering five villages each and three VHSNCs, since the VHSNCs were formed at the panchayat level. Thus a total of six VHSNCs and ten villages were selected.

Selection of Respondents

The table below summarizes the relevant actors in governance activities at various decision-making levels. This table shows the decision-making levels and actors at each level. Often there is an overlap in the boundaries of work.

Box-1.2

Governance Activities and Actors

	Policy Formulation	Health Planning	Guideline for Activities	Implementation	Monitoring
Org. Level	Principles and values for health improvement and health systems dev.	Planning process regarding program/ systems design and financial allocation	Steps and processes, operational principles	Principles of operationalisation	Principles of operationalizatio n
Nation al	Political actors, Public Administrators , Policy Planner, Civil Society, Technical Experts	Policy Planner,	Public administrato rs, Policy Planner, Civil Society, Technical Experts	Public administrators (bureaucracy and expert), Civil Society	Public administrators (Bureaucracy and expert), Civil Society,
State	Political actors, Public Administrators , Policy Planner, Civil	Policy Planner, SPMU	Public administrato rs, Policy Planner, Civil	Public administrators, Civil Society,	Public administrators, Civil Society

	Society, Technical Experts		Society, Technical Experts		
District	PRI Members, Health officers RKS Members	PRI Members, Health officers DPM, CMO	Health officers, Civil Society Organization	Health Service Staff, Civil Society Organization	Staff, Civil Society Organization
Block	PRI Members, Health officers RKS member	PRI Members, Health officers TMO	Health officers, Civil Society Organization	Health Service Staff, Civil Society Organization	Health Service Staff, Civil Society Organization
Village	PRI Members, Health staff, Community Leaders, VHSNC members,	PRI Members, Health officers, VHSNC members, ANM	----	Health Workers, health Staff, VHSNC members, Community	Health Workers, health Staff, VHSNC members, Community

For the research study, purposive and snowball sample selection techniques was used to select respondents according to the five actors in governance, that is the Public Administrator, Political actors, Policy Planners, Civil Society and Community members. The list of respondents is in Annexure- II. Attempts were made to contact those who were available, and selection was done to cover the different periods.

Guiding Questions by Governance Framework Domains

The document review as well as interviews were conducted with a view to answering a set of questions based on the HSG principles. This guiding question list captured the issues to be examined at various levels and was developed based upon Siddiqi et al. (2009) framework for assessing health system governance (HSG) at national and sub-national levels. Some of the questions were added according to study context and purpose. It was conducted with people that are stakeholders under NRHM such as, government service providers, various governing and executive committee members, civil society organization representatives working in one of these fields, PRI members, other community representatives. The interviewer posed the questions, depending on the identity, role and responsibilities in relation to the health services of the interviewee. The

purpose of the guiding check list was to ensure that the overlapping and interconnected governance principles and domains were covered to understand the context and scope of particular governance principle domains under NRHM.

Guiding Questions with Governance Principles

Sr.no	Governance Principles	Guiding questions
1	Strategic Vision	What are the broad outlines and the national programme implementation framework?
	Long-term vision; comprehensive strategy for health and healthcare	How are the health service system decision-making processes conceptualized in India?
		What is the importance of heath in the overall development framework?
		What is the state's shared responsibility in the provision of health care and health?
		Is there a long-term vision and policy for health at the state level?
		Is there a policy/strategic plan stating objectives to be achieved with time frame and resources for the NRHM?
		Are the implementation mechanisms in line with the stated objectives of health policy?
		What is the extent of implementation of the health policy or vision framework?

Participation and Consensus Orientation

Sr.no	Governance Principles	Guiding questions
2	Participation and Consensus Orientation	What is planned for the involvement of elected representatives, civil society and other stakeholders in decision-making processes?
	Participation in decision-making process; Stakeholder identification and voice	How participatory decision making relate to health take place at all levels?
		How are the inputs solicited from stakeholders for health policy?
		How does government reconcile the different objectives of various stakeholders in health decision-making?
		What is convergence plan in policies and programs to tackle health determinants?
		What is the level of decentralization in decision-making?
		What is the extent of community participation in health services provision?

Rule of law

Sr.no	Governance principles	Guiding questions
3	Rule of law	How is a code of conduct and norms set for health service programmes?
	Regulation policy	Are regulations related health service provision, infrastructure, technology, human resources, and pharmaceuticals in place?
		How is the implementation plan incorporate rules, regulations, and procedures related to health care?
		Does the central government consult other line departments for regulations pertaining to health?
		How the regulating bodies' functions at all level?
		What is the capacity of health institutions for contracting, regulating, accrediting, licensing?
		What procedures are in place for redressing grievances of both community people and service providers?
		How are the relevant rules enforced?
		Are tools/instruments for various levels like approval, regulation for health related activities available and how are they enforced/used?

Transparency

Sr.no	Governance Principles	Guiding questions
4	Transparency	Is information about financial and administrative procedures readily available?
	Transparency in decision-making; transparency in allocation of resources	How transparent is the process of resource allocation?
		Are there monitoring mechanisms in place to ensure transparency of decisions?
		Who is involved in monitoring of the health services?
		How does transparency mechanism operate at ground level?
		How soon is information from the financial audit available after the funds are disbursed?

Responsiveness

Sr.no	Governance Principles	Guiding questions
5	Responsiveness	How are health needs conceptualized in health services?
	Response to population health needs; response to	Is needs assessment conducted as part of the policy process?
		Does the health policy address the health needs/burden

	regional local health needs	of the local populations?
		Is the quality of health services and user satisfaction valued high by government programmes?
		How does the health system respond to regional/local priority health problems?
		How responsive are the health services to the medical and non-medical expectations of the population?

Equity and Inclusiveness

Sr.no	Governance principles	Guiding questions
6	Equity and Inclusiveness	Are there any social protection schemes in place to address barriers for the social and economically marginalized section?
	Equity in access of health care; disparities in health	What policies are in place for identifying issues of equity in health services and rectifying them?
		What are the differences in access to care according to caste, class, gender, ethnicity, religion and others?
		Is allocation of public sector resources by states, region and districts equitable?

Effectiveness and Efficiency

Sr.no	Governance principles	Guiding questions
7	Effectiveness and Efficiency	What is the effectiveness and efficiency conceptualized under programme?
	Quality of human resources; communication processes; capacity for implementation	What is the quality of bureaucracy, technocracy (training, qualifications, career development)?
		How efficient and up to date are the communication processes with in service system?
		Is there an in-service training program for staff?
		What is the capacity of government for implementation measured in terms of regulatory, monitoring, financial and human resource management?
		What is the level of utilization of services?
		How cost effectiveness mechanism developed under programme implementation?

Accountability

Sr.no	Governance principles	Guiding questions
8	Accountability	What are the internal accountability and external accountability mechanisms developed under

		programmes?
	Accountability: internal; accountability: external	How health service system implement accountability mechanisms?
		How financial accountability and non-financial operationalized in implementation?
		What evidence is present about the effective enforcement of accountability processes?
		Is existence civil society organizations mechanisms in place for citizens to express views to government?

Intelligence and Information

Sr.no	Governance principles	Guiding questions
9	Intelligence and Information	What information is available about the health system how people access information?
	Information: generation, collection, analysis, dissemination	What is the reliability of information available for development of policies?
		What evidence is there for the use of information in the decision-making process?
		How is the relevant information about health generated?
		How is implementation of health policies monitored?

Ethics

Sr.no	Governance principles	Guiding questions
10	Ethics	How ethical value framework developed under programme?
	Ethical framework	What principles of ethics are included in national state and regional health policy?
		Is there a policy on promoting ethics in health service delivery?
		What are the institutional mechanisms to promote and enforce high-ethical standards in health service delivery?

Data Processing and Analysis

After data gathering and processing, the data was categorized according to the item of information. Raw data was classified according to themes and ideas involved in the research. The data was through the following process outlined by the ESTC (2005).

Box-1.3

Methods for Data Processing

Process	**Purpose**
Reading/Data immersion	Familiarizing oneself: transcripts, audios, field notes, Memos, journals.
Coding	Theme / Idea developing Coding Attaching labels/code
Displaying	Verifications; Evidence search; Text files by themes/category
Reducing	Core category; Core meaning, Text filing by main themes
Interpretation	Relation, pattern, deviant case analysis; differences; consistency; gaps; contextual & theoretical formulations

Source: ESTC (2005)

Ethical Issues

- The researcher informed every respondent about the objective and purpose of the research study. Interviews were conducted after informed consent.
- An audio recording was undertaken after prior permission of respondents and these interviews were transcribed. In cases where recording was not allowed detailed notes were taken.
- Confidentiality of respondents has been mainained as far as possible. Respondents have been anonymized.
- Dissemination for feedback with respondent was undertaken.

Limitations of the Study

- This study deals only with health governance and not with all the other spheres of governance that influence it. It specifically focuses on the decision making processes in

policy and plan formulation as well as implementation across various dimensions of the heath service system, but does not go into the details of any of the several sub-systems.

- As a limitation of an individual researcher, this study was conducted in only one state and one district of Maharashtra, so generalizability will need to be checked through studies in other regions and over time.

Chapterisation:

This study makes an attempt to understand the health governance transition in India particularly focusing on the state of Maharashtra. It aims to understand important dimensions related to the governance of health service systems in the State. The thesis has been structured as follows.

The first chapter titled "Assessing Health Governance Transitions: Introducing the Research Problem and Its Methodology", explains in detail the conceptualization of the research problem and methodology of the study.

The second chapter titled "The Changing Concept of Governance" discusses the concept of governance and highlights the major landmarks in its evolution. The chapter provides a theoretical understanding and helps in identifying the research gaps and limitations in the existing conception of governance. It must be noted that the idea of governance is multi-layered and has emerged within particular political contexts. Thus, the chapter describes the shift in health governance discourse; explores the effect of these shifts and describes the changing patterns of the governance framework. Based on the review of the literature the chapter puts forward contemporary issues of governance in the context of public health in India. The desirable goal of public health is not the only allocation of resources but also addressing other issues of health governance.

The third chapter titled "Health Governance and Its Global Frameworks" deals with two main phenomena. Firstly, it discusses the governance structure and attempts to understand its shift. Secondly, it focuses on how different governance frameworks developed, and how they operationalize its agendas. The chapter provides an understanding of international governance frameworks and their structural analysis.

The fourth chapter titled "Health Governance in the Indian Context" discusses the shift in the Indian context with the introduction of health governance. It describes the post liberalization governance changes in health service system in the Indian context. It also attempts to understand how the Indian health service system responded to the changes brought with the health governance. This chapter then proceeds to discuss three main milestones in the public health care development in the post-1990s. Firstly, it focuses on the denial of health care services. Secondly, it discusses the National Rural Health Mission (NRHM) that gave the new framework for health governance, and thirdly it discusses the Universal Health Coverage (UHC) and the National Health Mission (NHM).

The fifth chapter titled "Health Governance Transformation and the NRHM in Maharashtra" discusses health governance in Maharashtra, with focuses on the development of health services in the State. The developmental policies and programs, provisioning, infrastructure and services in Maharashtra have a different political context that largely shapes the governance structure. This chapter is divided into five sub-sections. The first section briefly discusses the history of formation of Maharashtra state. This has played an important role in shaping the structure of public administration in the state and that has had a major impact on the development of different regions of Maharashtra. The second section highlights the demographic, administrative and health profile of the state. The third section will discuss the problem of inter-regional inequalities in Maharashtra. The fourth section examines the development of health services and governance in Maharashtra. The fifth section discusses the challenges of health governance in the State.

The sixth chapter titled "District Health Governance under the NRHM in Pune, Maharashtra" focuses on the district to village level governance implementation and responses. NRHM brought about an important change in the health services system. It incorporated the idea of participatory governance in health service delivery. One of the objectives of NRHM was to empower the community and local bodies to take leadership on health and sanitation issues at the local level. Creating grassroots community bodies

was an important step in decentralizing the policy formulation and community participation. Hence, the chapter analyses the functioning of these new structures at ground level. It compares the functioning of two primary health centers, one in which the system of community-based monitoring was formally operationalised with citizen involvement, and another where there was no community-based monitoring.

The seventh chapter titled "Discussion and Conclusion: Democratizing Health Governance?" highlights the main findings of the study. It also discusses the difficulties and challenges in the governance of health systems. Finally, the chapter also attempts to discuss future directions for research in health governance.

Chapter-I

Introducing the Research Problem and Its Methodology: Assessing Health Governance Transitions

Chapter - II

The Changing Concept of Governance

The idea of governance is multi-layered and interdisciplinary in nature. The conception of governance is applied in different fields such as economics and finance, corporate management, public administration, conflict resolution, environment and international relations. The various fields have given diverse connotations to the idea of governance based on the structure and their aims and objectives. These connotations help to understand different discourses and practice. In practice, governance comprises a plurality of actors from local to global levels. The diverse interests of these actors have an influence on governance practice (Robichau, 2011 cited in Shukla, et al. 2012). Governance has been associated with political authority, institutions of decision-making and implementation. It primarily aims at controlling the mechanisms of the systems in order to organize and control interdependent relations and processes of decision-making (DeAngelis, 2003). The concept of governance has been used in the domain of organizational theory and management of the corporate sector (Bradshaw and Bryan, 2007), while another set of literature has articulated governance in the governmental affairs as a part of public administration and policy formulation. In relation to the latter, there is much focus on governance in social science literature as well as documents of various national and international agencies that acknowledge the changing nature of governance since the past two decades.

The following review of the literature provides a theoretical understanding of the concepts and ideas of governance. It describes the shift in health governance discourse and also helps in identifying the gaps and limitations in existing literature. It explores the effects of these shifts and changing patterns in the governance framework. The review of literature enables putting forward contemporary issues of governance within the public health sector of India. It has been increasingly realized by the policy makers in the last three decades that in order to accomplish the desirable goal of improved public health services mere focus on the allocation of resources is not satisfactory. There is an important need to address the issues of health governance.

Governance is not a new concept. It has been in existence since, the time when civilization began, and people started to form their rule of conducts, a system of organization, their group leader, chief, king to administer society. Therefore, the idea of governance was in existence before the introduction of the modern of the state. The concept of governance existed in pre-modern society when human society began to administer its own life in a collective way. There was the system of law and order as well as a king in society to protect the interests of the people and their general wellbeing (Westmeyer, 1990). However, in recent years, with attempts at rapid transformation in state, market and society relationships, there has been the emergence of a governance discourse. Most often the three major concepts of government, state, and good governance are used interchangeability while conceptualizing the idea of governance.

Several social science scholars have attempted to describe and explain the term governance in a historical context (Westmeyer, 1990, Risse, 2013, Hunt, 1996). In the sixteen century concept of the state emerged with the writing of political scientists. In simple terms, the state can be described as having an elected government to rule over people. In order to understand the concept of governance, it becomes necessary to focus on the nature of the state. However, the concept of the state has been difficult to define. Often it can be used interchangeably with the government. The state includes a set of institutions with objectives and goals to govern society in order to maintain rule of law and order. The state also focuses on regulating the market as well as providing goods and services and regulating the public and private bodies such as Non-Government Organisations (NGOs) and Civil Society Organizations (CSOs). The governmental institutions are meant to uphold the objectives of justice, defined in recent centuries as equity and egalitarianism in society. These objectives of the state can be achieved through the instrument of the government. Hence, it becomes very difficult to define the exact meaning of state. Scholars have a difference of opinion on the issue of state. Some believe that it will lead to a conceptual morose and some define the state as a political institution with a set of formal structures and allocation of power (Nettl, 1968).

The state is a permanent thing or body of institutions. It includes the constitution of the country, the legal system, executives, and the judiciary (Ottaway, 2002). Some of the important parameters of the state are population, territory, government and sovereignty. The state has defined its objectives for government functions. The government is a temporary element in the system. After every election, there can be a change in government. Therefore, the government keeps changing. Often the government functions on the objectives defined by the state. When we discuss a state with this parameter, then naturally the government has become part of the state. At some times the government uses the state to carry out the objectives and implement its policy. Thus, the line between the government and state becomes very narrow. The government has to interact with both the governmental and non-governmental bodies to carry out its functions and implement its policies. As these things have changed, there has been a shift in the term from government to governance (Nettl, 1968).

The state includes the institutions of the legislature, the executive, and the judiciary. The government is the executive wing of the state. Governance is the way of functioning of the government or corporate body (Ottaway, 2002). The public administration of the twentieth century was about functioning of the government as the only implementation institution. In the developed world, it includes some local community involvement but in the developing, it became narrow and distant from communities when it developed in the colonial and post-colonial context. However, political action leads to changes in governance structures even in the context of developing countries. As a consequence, even after independence Panchayati Raj was part of the Constitution of India (Mark, 2015).

How does governance become ‘good governance’? The good comes with the additional emphasis attached to elements such as equity, justice, efficiency, the rule of law, accountability, and responsiveness in the wake of questioning of state-led socio-economic development in the 1970s and 80s (United Nations, 2006). All these associated concepts have always been there in the framework of governance. What made the difference in implementation of governance? There has been a different in the

governance because of the pro-active and reactive, vigilant and more alert citizen and active civil society, NGOs, other non-state actors that directed efforts to make the government more responsive. Governance became good governance with the expectation that government acts more responsively, is accountable and transparent to its citizens (Tandon and Mohanty, 2003).

In the present times, the exposure of people to technology, information and media has increased. Due to processes of liberalization and globalization, many things are coming together. There is growing awareness among people about entitlements. International and multinational organizations come into action, attempting to make the governance better, transforming it into good governance (Douglas, 1999). Globalization has been changing the government role. In the present context, boundaries and barriers for trade are minimal (Rodrik, 1997). There has been an increase in the foreign direct investment in the economy, multinational corporations are coming and intervening in the development sector of developing countries like India. In a context where there is a predominance of the welfare state, citizens always look towards governments as the main provider of public goods and services. With the involvement of the private sector as the main service provider, there has been a change in the notion of the delivery of public good and services. It has promoted the commodification of services. Along with the private sector, the government has taken the help of other actors such as civil society, NGOs in the social sectors such as in health and education. At present, there is a culmination of the government, private/corporate and civil society in governance. So the scope of governance has widened from government and moved towards governance. In such a context, the citizen becomes an active partner in the governance processes (Douglas, 1999; Baru, 2012).

Good Governance

In the year 1989, the concept of governance was first used by the World Bank in the economic context of Sub-Saharan African countries as the rule of law, accountability and information accessibility in the public sector. The developing and underdeveloped nations were being given development aid by international organizations such as the

World Bank, the International Monetary Fund (IMF), and the Asian Development Bank (ADB). A survey of these financial institutions showed that the aid to developing and to the underdeveloped countries had not been utilized for the proper purpose. It was attributed to something wrong with these countries' economies. It was attributed to a crisis of governance and lack of governance in public service systems. Hence, it was increasingly realized that the main need of these countries is to strengthen governance capacity (World Bank, 1992; World Bank, 1994).

Governance needs more effective and efficient framework. It desires accountability and functions within the framework of the rule of law. It has to work towards more transparency, in order to bring equity, justice, and people's participation. All over the globe, formal and informal institutions have embedded the concept of governance. Currently, the framework of governance added the following components as good governance (Rhodes, 1997).

Accountability: It is not only a public administration concept and is used in many ways. Various actors like the private sector and the civil society use this concept. However, the main point is that actor should be accountable to the system, the government, and the citizen. Governance should be good as accountable. It has to ensure mechanisms and processes of accountability. Accountability principle imposed not only on government but also on non-state actors. They need to be accountable for the objective for which they are stated to be working.

Participation: Citizens should not be passive receivers from the government. They need to involve in various activities as this community is one of the development partners in the process. This will help them to realize the worth of services they are getting.

The rule of law: All the institutions should function under the domain of the rule of law. They have recognized conduct procedures and rules for working.

Decentralization: In India, the Panchayati Raj system is a decentralization experiment that falls under the conception of good governance. Government decisions and powers

under public sector are decentralized through this system and provide an interface between the state and society.

Citizen Charter: This concept is one of the best components of governance practice. As a citizen, it is each one's right to know about what kinds of services they are getting from a public institution. If the services users are not satisfied with service provision, then there should be a redressal mechanism to claim delay or denial of services. These kinds of practices make the citizens aware of the services provided by the government. The major challenge with these kind governance frameworks is how to put together and operationalise in a proper channel. Many mechanisms for the citizens should capacitate them to claim services. It will possibly strengthen good governance (Pollitt, 1994).

The above components make up the concept of good governance. Was governance based on an accountability framework aiming to foster equity is a question that has been asked of it. In this context, if the doors for the market and private forces are open, it will possibly create a crisis in governance instead of good governance. That it will bring participation and function within the framework of the rule of law attracted many countries to adopt models of good governance for development. Thus, since the 1990s, there has been a shift from public administration to new public governance (Rhodes, 1997).

In India too there has been an adoption of this kind of framework of governance. In this, there should be a focus on issues of equity, justice, gender, non-discrimination, rural-urban inequalities, poverty and formal education gap. Presently, the government has accepted that the state has failed to deliver public goods and services. The state has invited the private and corporate actors to these areas to deliver services. This has created new chaos within the system. In reality, one set of the population were aware of their rights and entitlements and getting the benefits of public services even earlier. It has been argued that instead of dealing with the reasons for inadequacy of provisioning and building accountability into the system, the state is withdrawing from its responsibility of ensuring equity of access (Joshi, 2007).

To practice good governance, India needs to institutionalize good practices of transparency and accountability with other actors. In the crisis, the government has relied on these various actors for setting the regulation mechanism. The contribution of the Right to Information (RTI) Act is important for transparency and creating awareness among citizen about their entitlements. Leadership in the governance should be decentralized and sensitive to its people. There is also a need to strengthen the role of media as it is one of the pillars of good democracy and governance. A major challenge is how to create co-ordination among these actors to be accountable for their activities. There is a need for developing standards for governance; that is open to people and obligatory on the concerned actors with the recognition of parliament.

In the late eighties, the failure of the government in fulfilling its duties was one of central factors that came into development discourse. There was a rollback of the government and focus was put on the involvement of non-state actors in the delivery of the public good. Market forces were functioning in the economy. During this period, the developing and under-developed countries were going through financial crisis including India. India also had an economic crisis. Countries in crisis had approached the international financial institutions for financial support. However, the financial aid from the global institutions came with multiple conditionalities. It called for the reduction of public sector expenditures (Ahluwalia, 2002). There was no priority given to social services such as health and education and there was a decline in investments to social sectors which were seen as less profitable. These important factors gave prominent space to the private sector to intervene in the public sector. However, introduction of the private and corporate sector formally into the public sector led to the introduction of user charges to access and use public services. For example, there was the introduction of user charges in the public health services. Further, in Delhi, heavy user charges were also introduced for drinking water and electricity. In Andhra Pradesh, farmers were unable to pay high electricity bills. However, while there was the introduction of user charges, India have been facing the problem of poor infrastructure for public services.

It has been argued that the public system cannot treat citizens as consumers and customers. State has to follow the welfare objectives for policy implementations. Private sector plays an important role, and the government should regulate that. There are some civil society initiatives for monitoring and regulating of the private sector. To deal with the present context, the government should play an active role. The intervention of the state is important to protect the interests of people (Baru 2012). There was an increasing realization that the intervention of the private sector has failed to protect the interest of the people. The state has to intervene in the times of crisis. This shift marked a paradigm shift. The state has moved from low paradigm to high paradigm. Later it was also realized that the state has controlled all affairs of the economy and not delivering public good to the citizen. Hence, this created a crisis of governance. It is in this context; many countries have chosen different types of governance model to govern its economy (Atkinson and Coleman, 1992).

India had chosen a mixed economy model to deliver its public goods. The thinking behind this model was that the state has to play a major role in the fulfillment of basic needs of the citizen. At the same time, some areas were to be reserved for the private sector and other non-state actors to operate. Since India became independent, the mixed economy model had been adopted for policy planning and decision-making. It sometimes functions with limited power and authority while sometimes the state uses unlimited power and authority. These kinds of a model of the state economy had an effect on the governance because it is taking all the assets from the state.

The limited state option will open the window for the private in the public sector. In another way, unlimited or high state option like the Union of Soviet Socialist Republics (USSR) countries, will limit the role of the non-state actors. Presently, all over the world limited state model is functioning in government affairs. Due to globalization and liberalization policies, the growth of information technology brings people together. New governance functioning is moving in hands of technology in the form of e-governance. These sectors in policy and planning domain are creating autonomy within the sector (Douglas, 1999).

To summarize the arguments, governance needs institutionalization of mechanisms and practices of good governance. There is a need for people's participation in policy decision-making processes and a focus on people-centered information technology for improved governance. There is an also a need for developed communication and interaction between different actors. The role of media is to give voice to the citizens and thereby hold responsible the state and non-state actors.

Definitions of Governance

The preliminary conception of governance has been around government institutions and its affairs. The Webster's Third New International Dictionary defines governance as "Governance is a synonym for government. It is the act or process of governing, specifically authoritative direction and control".[8]. It maps out that the concept of governance is the executive arm of government. In another view, the British Council emphasizes, that governance is a broader notion than government, and it goes beyond the control of the state. Srivastava (2009) has pointed out that Governance means "the process of decision-making and the process by which decisions are implemented or not implemented" (Srivastava 2009, p. 6). According to Guy and Pierre (1998), governance refers to sustaining the coordination and coherence among a broad diversity of actors with different roles. These players may include politicians and institutions, interest groups, civil society, and non-governmental as well as multinational organizations. The available literature has articulated governance with a focus on government and public institutions matters. The role of the state and power is central in the whole discourse. The following section will define the concept of governance as put forward by different international organizations.

[8] Webster's Third New International Dictionary (1986). This definition is cited in concept note on governance titled *Understanding the Concept of Governance*, as retrieved from http://www.gdrc.org/u-gov/governance-understand.html as accessed on 15th May 2014.

Box-2.1

International Organizations Views on Governance

World Bank: Governance is primarily exercise of power in the management of a country's social and economic resources. The World Bank has acknowledged three distinct aspects of governance: 1. the form of political regime 2. The process by which autonomy is exercised in the management of the country's economic and social resources for development and 3. The capacity of governments to design, formulate and implement policies and discharge functions (Fukuda-Parr & Ponzio, 2002, p.).
United Nations Development Programme (UNDP):-views governance as the exercise of economic, political, and administrative authority to manage a country's affairs at all levels. It comprises mechanisms processes and institutions, through which the citizens and the groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences (Fukuda-Parr & Ponzio, 2002, p.2).
Organisation for Economic Co-operation and Development (OECD): The concept of governance denotes the use of political authority and exercise of control in society about the management of its resources for social and economic development. This broad definition encompasses the role of public authorities in establishing the environment in which economic operator's functions in determining the distribution of benefits as well as the nature of the relationship between ruler and the ruled.

Department for International Development (DFID):- The Department for International Development adopts the same approach to governance as that provided by the OECD's Development Assistance Committee (DAC), which identifies four key elements of governance. 1) The legitimacy of government (political system), 2) accountability of political and official elements of government (public administration and financial system), 3) competence of government to formulate policies and deliver services (public administration, economic system, and organizational strengthening). The DFID believe that the DAC conceptualization is seen to reflect the broad degree of convergence in bilateral donor thinking on good governance. Since the good governance, agenda has a strong normative content. It has led to call for an approach which is more sensitive to the particular historical contextual realities within the recipient countries. An additional point is the issue of donor governance, highlighted by many host countries.

Asian Development Bank (ADB): ADB adopts the definition of governance as provided by the World Bank. As discussed earlier the Bank regards good governance synonymous with sound development management. It involves both the public and the private sectors. It is related to the effectiveness of which it is used, the impact of development programs and projects (including those financed by the Bank). Thus, irrespective of a precise set of economic policies that finds favor with a government, good governance is required to ensure that those policies have their desired effect. In essence, it concerns norms of behavior that help to ensure that governments deliver to their citizen what they say they will deliver.

United States Agency for International Development (USAID): USAID views governance to encompass the capacity of the state, the commitment to the public good, the rule of law, the degree of transparency and accountability, the level of popular participation, and the stock of social capital. Without good governance, it is impossible to foster development. According to USAID, no amount of resources transferred, or infrastructure built can compensate for or survive bad governance.

Commission on Global Governance (CGC): Governance is the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may accommodate, and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as an informal arrangement that people and institutions either have agreed to or perceive to be in their interest.
Institute of Governance, Ottawa: defines, governance as comprising of institutions and processes. It includes conventions in society, which determine how power is exercised, how important decisions were made affecting the society and how various interests accorded a place in decisions making (Institute of Governance, 2002).
Commission on Global Governance: The Commission on Global Governance defines governance as the sum of the many ways of individuals and institutions both private and public.

Source: IIPA, 2013; UN, 2006; Fukuda-Parr & Ponzio, 2002, p. 2

From the above definitions and meaning of governance, it is only the definition provided by the UNDP that has been widely referred to in the literature. For instance, the (UNDP in its 1997 policy document has defined governance as "the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises of mechanisms, processes, and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences" (UNDP 1997 cited UN 2006, p. 3). This definition of governance has been used widely due to its comprehensiveness. The UNDP had a focus beyond the administrative and management aspect of governance and emphasized more on democratic governance. This framework had also focused on the consideration of political freedom and non-discrimination in delivering public goods (IIPA, 2013).[9]

[9] Indian Institute of Public Administration (IIPA). (2013). *India Governance Report 2013*. New Delhi: Indian Institute of Public Administration.

Development programs of the UNDP have democratic governance central to its agenda. The UNDP has used democratized governance in its development program strategies for the underdeveloped nations. It has acknowledged the thinking of people as central to policy formulation and people's participation in planning and implementation to hold the government accountable (UN, 2006).

Canada's Institute of Governance has given primary importance to the community processes, actor's involvement in organizational decisions and views governance as using formal and informal norms to achieve the policy and institutional goals. It defines governance as *"*the organizational structures, administrative processes, managerial judgment, systems of incentives and patterns, administrative philosophies, or combinations of these factors*"* (Graham et al. 2003). Laurence, Heinrich and Hill (2000) have focused on the administrative matters and have given importance to the legislative action, the structure of administrative actors and the processes adopted for their activities. Similarly, a significant dimension of governance is related to who is involved in and influences the decision-making process. It is important to note that governance is a contextual concept. It is based on policy goals. The process and practices in which it is applied will vary significantly given the environment in which they are used. In short, the term 'governance determines who holds power, who makes decisions and how other players are prepared to make their voice heard.

The application of governance has meant to realize organizational and social problem solving through policy decision, planning, and implementation. The goals of governance are to be achieved through institutional integration and fragmentation, formal and informal actors and norms, the role of administrative power and democratic values. Governance includes authority, power, decision making in the institutional arenas of civil society, politics, policy, and public, private and non-profit administration (Biersteker, 2009; Brinkerhoff and Bossert, 2013).

World Bank and Good Governance

As discussed earlier the term "governance" has its origins in the African context after the failure of economic interventions of the World Bank with regard to the poverty

eradication programmes in-sub-Saharan Africa. The crisis of governance and widespread economic corruption in the service delivery system were identified as the main reasons for this intervention. The governance system in underdeveloped and developing countries was a challenge before the development agencies.

In 1980-90s, all over the world, new economic changes had taken place. The neoliberal policy framework has changed the interaction between different nations. There was an initiation of new economic dialogue across the globe. New business opportunities were developed with new litigations. Every country focused its attention on examining its capacities as a nation. The process of neo-liberalization focused on efficiency and accountability. Further, the restructuring of the public institutions was central to the market mechanisms. These new developments needed major shifts in the policy domain. Hierarchical bureaucracy made a shift towards market principles, and emphasis was on semi-government structure and networks. Most often the national policy decisions were influenced by the international and transnational economic initiatives. This marked shift happened both at the national to international level, bringing changes in the mode of public service delivery. At the same time, the non-state actors came forward to deliver the public goods. International and corporate actors had an advantage and dominated the pace of public policy formulation and decision-making (IIPA, 2013).[10] The World Bank first defined the term "governance" in 1989 to describe the context of institutional reform for an efficient public sector in African countries (Haruna and Kannae 2013). In the beginning "governance" was defined as the "the exercise of political power to manage a nation's affairs". In 1992, the World Bank referred to the definition of governance in a report titled as 'Governance and Development'. The elements of the previous definition have changed, and governance was defined as the following, "in the manner in which power is exercised in the management of a country's economic and social resources for development" (World Bank, 1992, p. 1).

In 1994, the Bank came with a new definition of governance, and this concept had a wider perspective (Maldonado, 2010). It defined governance as:

[10] IIPA. (2013). Ibid.

"Governance is epitomized by predictable, open, and enlightened policy-making (i.e., transparent processes); a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions, and a strong civil society participating in public affairs; and all behaving under the rule of law" (World Bank, 1994, p. 7).

The governance debate has gone forward and added adjective "good" to governance. The adding of 'good' has been debated in development discourse. The term 'good' has different meanings. However, the World Bank played an important role in defining what good governance means. The new version of "good governance" came with additional elements. There is also a difference in the meaning of governance between the 1992 and 1994 reports on governance. The World Bank has changed its position on the matter of governance within two years (IIPA, 2013).

After two decades, the World Bank has the changed perspective on good governance. Initially, the World Bank was unwilling about the word 'good' while using term governance as the term 'good' denoted very generalized and imprecise meaning. The term 'good' changes according to the context where the governance framework was implemented. The World Bank framework of "good governance" focused on public sector management, accountability, and a legal framework for development and transparency and information. Public Sector Management (PSM) was already on the agenda of the World Bank. The bank has strengthened the space for the private sector through its transparency and information approach. It also includes corruption-free practice, the rule of law and people's participation issues in the good governance framework (Maldonado, 2010).

The discourse of good governance has changed the World Banks approach towards the development sector. The bank has implemented macroeconomic reforms under the structural adjustment program in developing and under-developed countries. During the period of 'good governance' the Bank has given emphasis on institutional performance, the issue of corruption and people's participation along with the introduction of macroeconomic policies (Maldonado, 2010). The World Bank has mentioned dimensions of governance on their website focusing on "property rights and rule-based governance;

the quality of budgetary & financial management; the efficiency of revenue mobilization; the efficiency of public expenditures; and transparency, accountability, and corruption" (World Bank, 2013).

The World Bank observed that the larger problem of economic corruption and public service delivery was the outcome of the 'crisis of governance.' The World Bank has emphasized against the political issues of inequalities, model of development, natural resources, and their control. There is a need to develop administrative and management capacity of public institutions. The Bank has offered a very technical solution to this problem, and the state has been overtaken by the market principle and neoliberal logic. The role of government has shifted from the domain of governance. The market has blurred the boundary between government and governance. The wave of globalization and neoliberalism offered this solution to many countries. Developing and under-developed countries accepted this framework to tackle problems. The development program of many welfare countries triggers this approach of policy formulation and implementation. The role of the market was seen as the main provider of public goods. In the name of efficiency and cost-effectiveness, privatization and commercialization are the solutions to public service delivery. New methods of accountability and transparency have been introduced to make the public service system accountable (IIPA, 2013).

The term 'Good Governance' has been proposed in the development discourse by the World Bank after the failure of structural adjustment programs (SAPs). The Good Governance frameworks have been built upon six underlying principles of accountability, transparency and openness, integrity, stewardship, efficiency and leadership. These frameworks change the role of the state in the development process. The performance of a state was the central issue in the debate. Two main issues have been highlighted in the good governance framework. One is the negative impact of corruption and second is people's participation in the development process. The negative impact of corruption highlighted the issue of transparency, accountability and economic performance. Moreover, the second issue was the people's participation model in practice, minimizing the role of the state (Maldonado, 2010; Simms, 2008; Santiso, 2001).

The World Bank uses the concept most frequently, defining "good governance" as the traditions and institutions by which authority in a country is exercised for the common good (Baziliana, Nakhoodab, and Graaf 2014).[11] It includes (1) the process by which those in authority are selected, monitored and replaced (2) the capacity of the government to effectively manage its resources and implement sound policies, [12] and (3) the respect of citizens and the state for the institutions that govern economic and social interactions among them.[13] It means that governance is measured by looking at how authority representatives are selected, whether they are accountable to the public, whether they produce sound policies and whether they can implement and manage their resources effectively. The World Bank framework promoted democratization in the context of a free economy (Santino, 2001). It compels governments to be more accountable, less corrupt and hence more efficient developmentally (Harlow, 2006). Thus, participation, accountability, and transparency formed the triad of the good governance value framework. The World Bank has embraced decentralization as one of the major governance reforms on its agenda. The Bank emphasizes on decentralization. It aims at reducing the role of central government and administration, replacing command and control economy to a market economy, increasing intergovernmental competition (Coskun and Hayrettin, 2008, p. 179-80)

Guhan (1998) has provided a critic of the World Bank conception of governance. According to him, it is narrow and highly "techno-economic". It is based on the state vs. market logic, and it focuses only on economic administration. He argues that the new public management (NPM) on an ideological level is very market-oriented, and it is replacing the state with the market (Guhan, 1998 cited in Hood, 2004, p. 270).

The Governance framework became popular during the implementation of Millennium Development Goals (MDGs). It was increasingly believed that improved public services

[11] Baziliana, M.; Nakhoodab, S. and Graaf, T. (2014). Energy Governance and Poverty. *Energy Research & Social Science*, 1, 217-225

[12] WHO-Health Systems Strengthening Glossary, Retrieved from http://www.who.int/healthsystems/hss_glossary/en/index5.html as accessed on 13th June 2015).

[13] Governance Indicators - World Bank Retrieved from http://info.worldbank.org/governance/wgi/index.asp as accessed on 13th July 2015).

quality and quantity through good governance framework was considered as an alternative under the MDGs to service delivery.

De Angelis (2003) divided the concept of governance into two types, the 'regulatory system' and management flow. He made a differentiation between policy and governance. Policy is the course of action with defined objectives and clear means. Governance is "accommodation and articulation between conflicting and diverse interests; taking of cooperative action, social stability" (De Angelis, p. 3).

Foucault has also conceptualized governance in his work on "Governmentality" and "Biopolitics". According to him, it is "a varied and complex regime of power, whose founding principle lies in the administration and production of life, rather than in threatening death" (Dillon and Reid, 2001 cited in De Angelis, 2003, p. 1).

Thus, governance is the subject of multiple definitions and interpretations in the social sciences. Definitions inform that the concept of governance has been used with great variation and ambiguity in the meanings. Some definitions focus on technical roles and some focus on the administrative aspect. It becomes clear from the above that some of the conceptions focus on instrumental performance through efficiency and effectiveness. This approach concerns governance as technocratic elements of operational capacity in management and public administration. These aspects mainly focus on the functional characteristics of governance. The scope of the governance concept was initially associated with the government affairs and society. However, a major limitation of this conception is, this has been not fully incorporated into the government system or not fully withdrawn (Milward and Provan, 2000). When the issue of implementation emerges, the state remains central to the governance framework.

Development of Corporate Governance in India

The Indian government adopted a mix economy approach to run the economic affairs of the country. India has had large stock markets, the manufacturing sector, banking sector in developing stage since independence. Corporate governance structures were adopted from the British. However, the state has taken a socialist approach in the realm of the

banking sector. Most nationalized banks had become the major providers of both debt and equity capital for private firms (Afsharipour, 2011; Banaji and Mody, 2001). The state has controlled most of the commerce activity. In the post-independence period, the Companies Act of 1956 was the first form of regulation for the corporate governance in India. It set a benchmark to control finance and market activities as well as regulated the industrial sector of India. There were no major changes in corporate regulation and governance structure until the 1990s (Kulkani and Maniam, 2014).

However, in the post-1990s there have been significant changes in the nature of corporate governance.This period is marked as Corporate Governance reform period. It took almost a full decade to restructure the corporate governance. Two major factors contributed to these reforms. One was the financial crisis at the global level the implications of which was felt in India. The second was the economic liberalization at the global level. The Prime Minister of India, Shri Narasimha Rao formally introduced liberalization policy in India during the early 1990s. The new global market had its own new agendas and opportunities. In 1992, the Government of India was opened up to the regulation of the market and corporate sector from the Securities and Exchange Board of India (SEBI). After the 1990s, due to liberalization policy changes, international business activities escalated in India. SEBI has been playing an important role in the regulation of the stock market. The establishment of SEBI has helped to control malpractices in stock markets. It contributes to maintaining transparency. It has given a platform to international players to invest in Indian business firms (Afsharipour, 2011; Raju, Subramanyam and Dasaraju, 2012).

Another initiative is a first voluntary code of corporate governance set up by the Confederation of Indian Industry (CII). It is India's largest industry and business association. CII had studied the corporate governance issues in the Asian Context through committee. This committee came with a voluntary code of corporate governance practice. CII document known as "Desirable Corporate Governance" was published in 1998 (Afsharipour, 2011).

In early 1999, Kumar Mangalam Birla Committee, known as Birla Committee, was set up to promote and raise the standards of good corporate governance. The Birla Committee recommended the United States based model of Management Discussion and Analysis (MD&A) section in the report of the company (Kulkani and Maniam, 2014). In early 2000, the SEBI board had accepted and ratified key recommendations of this committee, and these were merged into Clause 49 of the listing agreement of the stock exchanges. The Ministry of Finance and Company Affairs appointed the Naresh Chandra Committee in August 2002 by the Department of Company Affairs (DCA). It has been examining corporate governance issues. The Committee has made recommendations on financial and non-financial aspects of corporate governance (Vyas, 2010; Raju, Subramanyam & Dasaraju, 2012).

The Narayana Murthy Committee recommendations were an important initiative on corporate governance in India. The committee was set up by the SEBI, under the chairmanship of Mr. N. R Narayana Murthy, to review the clauses and suggest measures to improve corporate governance standards. The Birla and Murthy Committees provided clear consideration of Anglo-American standards of governance. It is not a new fact that India's corporate governance reform effort should contain similar provisions to reform efforts outside of India that adopted such models (Pande and Kaushik, 2012).

In the meanwhile, the Indian corporate community was in shock due to a massive financial scandal of Satyam Computer Services (Satyam) in January 2009. It is one of India's largest information technology companies. The Satyam scandal prompted quick action by the Indian government, including the arrest of several Satyam executives and financial auditors, investigations by the SEBI, and substitution of the company's directors with government nominees (Afsharipour, 2011).

The focus of governance is in the realm of government programs and their implementation. However, this is an inadequate approach to the understanding of conception of governance. Private and corporate actors have an influence on governance processes. The well-known corporate scandal such as Satyam, WorldCom, and Enron has

highlighted the need for good corporate governance. These big corporate enterprises overcome the government institutions in terms of resources. They have influenced the basic needs of people. They have expanded through Non-Governmental sectors. Therefore, in order to regulate and govern the corporate sector, the role of government is extremely important. The model of changes in commerce, financing, market and industrial sector have effect on social sectors. Post-1990s private business and corporate networks found new business space within the public sector. The neoliberal processes of Liberalization, Privatization and Globalization (LPG) created public sector dependency on the private and the corporate sector. New financial profit interest came with global actors and their new management techniques to the public sector. For example, the concept of New Public Management (NPM) was introduced by global financial institutes such as the World Bank. The international development agencies and financial institutions tried to merge both sectors (the nonprofit and for-profit sectors). NPM is fully corporate, and business model of governance introduced in developing countries (Selsky and Parker, 2005). It is important to note that new modes of direct and indirect interventions affected the social sector.

Types of Governance

The literature on public administration mentions four different types of governance based on the institutions involved. This includes corporate governance, non-profit governance, collaborative governance and public sector governance. Corporate governance is associated with the structure and functioning of the corporate agencies such as companies or business firms. It includes the stewardship of companies. The second type of non-profit governance is related to the affairs of non-profit organizations. The third is collaborative governance. Under this framework public and private actors, work together, and they use commonly agreed processes. They also make use of laws, rules and guidelines for the provision of public goods. This new form of governance emerged to replace adversarial and managerial modes of policymaking and implementation by the state. Collaborative governance creates public and private stakeholders in collective forums with public agencies to engage in consensus-oriented decision-making. The Public Sector Governance is a fourth type of governance. The neo-liberal reforms sought

to shift the balance from a hierarchical bureaucracy toward maximum use of markets and quasi-market networks for public services delivery (Bevir, 2009, Hartley, 2005). The new form of governance diminishes the role of the state and increases dependency upon other organizations (private, non-profit and civil society) to implement its policies. Indirectly, this has created space for other multinational and international institutions such as the UN, the World Bank, the IMF, and the European Union (EU). The new concept of 'public sector governance' in the early 1990s aimed to distinguish between governance and government and promote a mode of governance that they defined as good based on their values (Ansell and Gash, 2008). India Governance Report 2012 describes six types of governance. It is used in practice such as the minimal state, corporate governance, new public management, good governance, socio-cybernetic systems, and self-organized networks (IIPA, 2013).

Shifts in Public Administration: Concepts, Structures, and Operationalisation

There have been four phases of governance in independent India that have been described in literature. Since India's independence; the first phase began in the early 1950s with a focus on 'Public Administration'. It then moved in the 1980s to Public Management. During the 1990s it was known as New Public Management, while in the early 2000s, there was a shift to New Public Governance. Since the early 1990s, LPG policies have been underway in India. The neo-liberal era gave rise to 'adjustment of the state' and the paradigm shift from classic public administration to the 'new governance' or 'modern governance' (Hufty, Báscolo and Bazzani, 2006).

Public Administration:

The concept of public administration is defined as an instrument of action to implement the constitutional and operational goals of welfare policy. The focus of public administration is in the entire area of public policy and its analysis. The state has developed bureaucratic and administrative systems to implement policies. It has to operate within a specific political setting and get involved in decision-making, planning, formulating objectives and goals, and also work with the legislative settings (Cheema, 2004). Public administration is conceptualized as a set of state structures, institutions and

processes (Guy and Pierre, 1998). It is characterized based on parameters such as hierarchy, continuity, impartiality, standardization, legal-rational authority, professionalism, societal standards, and sustaining the rule of law. The traditional public administration has been severely criticized as being too time-consuming because of rigid bureaucratic procedures. It is a very slow process of working, as it was based on the logic of paternalism vis-à-vis citizens. It was seen as a waste of resources and it involved too much focus on process and procedures instead of results (UN, 2003 cited in Cheema, 2004). Present governance issues with public administration deal with the financial management practices in the government health sector that are permitting corruption and causing the unreliable delivery of critical inputs. Information on health sector planning, operations, and financing is unavailable, unreliable, or inaccessible thereby reducing accountability and service delivery effectiveness (Cameron, 2004). Administrative mechanisms were inadequate to enable citizen's participation. Capacity for oversight of non-state service providers was also weak. Most often efficiency was reduced by limited management capacity and insufficient human resources. This undermined the legitimacy of the state. Government health actors were oriented toward pleasing their superiors rather than responding to citizens' needs (Brinkerhoff and Bossert, 2008). Restructuring the public administration to overcome these problems was a major challenge. Hence, public management approach is seen as the first alternative to tackle the problem associated with public administration.

Public Management:

The second phase of public management; sought to use private sector principles in public sector organizations (Hill and Lynn, 2004a). It focused on the application of private sector management principles such as efficiency in the application of resources, consumer orientation, dependence on market forces and greater sensitivity to consumer satisfaction in the public sector (Fukuda-Parr and Ponzio, 2002; Hood, 1991). It called for enhancing the role of the private sector while at the same time it emphasized on minimizing the size of the public sector and the domain of traditional public administration (Pollitt and Bouckaert, 2004). While this phase introduced the idea of market principles, it was in the phase of New Public Management that these principles

were operationalised in practice in the domain of public sector governance. The concept of 'public manager' is central to public management (Hood, 1991).

New Public Management:

The third phase of governance is known as the New Public Management (NPM). It was introduced during the neoliberal economic policy of the 1990s. It continued the previous trends of public management and added some element of linkages external to the public sector. It emphasized on outcome-based partnerships between the public and the private sector to provide services to citizens (Hood, 1991). The classical model of organization and delivery of public services is based on the values of organizational administrative hierarchy, planning, centralization, direct control and self-sufficiency. It is replaced by a 'New Public Management' model (Androniceanu, 2007; Larbi, 2003, p. 12). Osborne and Gaebler (1992) were the pioneers of the articulation of new public management for improving the administration of the public sector. The basic strategies of new public management emphasize on the governments to focus on achieving results rather than to comply only with the procedures. It adopted market-like competition, innovations, and entrepreneurial strategies. It called governments to be customer-driven and to rely on market-based mechanisms to deliver public services (Osborne and Gaebler 1993).

After independence, only peripheral services were delivered by the private sector. The public sector was largely overburdened and was looking for solutions. Hence, it started initiatives like quality circle, team improvement plan, and in-service training programmes. This method has just to restructure the size and reform itself (Baru, 2012). In the globalization era, the public system was looking for new paradigms. It was in this context that the new public management was seen as the way forward for a developing country like India. There was pressure both from internal and external agencies such as the World Bank, the IMF to implement NPM in the public sector. NPM come with aid conditionalities that forced countries to adjust their development programmes. It introduced new kinds of reforms. It has been argued that the nature of adjustment was more a global compulsion than a national necessity to choose NPM (Hood, 1991).

The main principles of the NPM were to follow the promotion of more efficient, entrepreneurial and results-oriented management including steering rather than rowing. It introduced business principles into public affairs including outsourcing and contracting out. It emphasized on promoting professional ethics in the public sphere, such as performance-based management and budgeting (Cheema, 2004, p. 2). New public management aims at bringing about changes in the culture of public administration to make flexible, innovative and problem-solving, entrepreneurial and enterprising, as opposed to rule-bound, process-oriented with a focus on inputs rather than results (UN, 2006). Labri (2003, p.12) has pointed out that the reform has changed the role of the state. Further, the institutional character of the state has been under increasing pressure, to be more market-oriented and management-oriented.

This shift from traditional to modern governance opened the window to the adoption of new public management. Raghavan (2004) pointed out in their critique that the "NPM constitutes a set of business-like or neo-managerial practices", focused exclusively on aspects of public governance" (Raghavan, 2004, p. 3). NPM is primarily defined as a set of beliefs or ideology based on creating institutional and organizational contexts in the public sector. It is seen as critical aspects of private sector mode of organizing and managing transactions in the public sector (Dawson 2002 cited in Raghavan 2004, p. 1). Bovaird and Löffler (2003) have identified the limitations of new public management as having a focus on economic aspects. A partnership with the private sector was seen to be more important under the NPM. The role of the citizens was conceived as consumers. They were seen as service users in the NPM process. However, in the entire process their role as members of communities that co-planned, co-designed and co-managed public initiatives were largely ignored or under-valued (Bovaird and Löffler, 2003).

The various ideas and themes of NPM have been categorized broadly into two perspectives, one is the idea of 'managerialism' and the second is new institutional economics. Managerialism emphasizes on implementation of management and business principles in the government sector. The ideas emanating from new institutional economics focused on markets and competition as a way forward to promoting efficiency in service delivery (Larbi, 2003, p.13). Tandon and Mohanty (2002) explain that almost

all segments of the social sectors are being restructured to make them more productive and competitive. This had an important impact on governance methodology. This incorporated corporate and private sector management techniques in the public sector in the name of new public governance reform. Presently, the new governance has been defined as "the joint responsibility of the state, market and citizens to mobilize public resources and promote public decision-making towards the advancement of common public good" (Tandon and Mohanty, 2002, p.36).

Sigamani (2011), has analyzed the case study of Tamil Nadu Medical Services Corporation Ltd. (TNMSC) model for procurement of drugs and equipment for the public sector health services. He argues that it is a new public management experiment in India. NPM tries to implement business management tools in the public system. It was introduced with the hope that this would increase its accountability and consumer satisfaction. Various kinds of reforms were introduced in the public sector such as larger civil service reform that included performance-based pay or promotion and performance-based budgeting (PBB). The bigger sphere of governance involved efforts initiated by civil society organizations at national and international donor agencies. In the Indian context, NPM was implemented as Public Private Mix (PPM) for health services. NPM largely emerged in the form of the collaborative venture. It has been characterized as, different stakeholder's creation of semi-government bodies or autonomous bodies or quasi-government and public-private partnership and outsourcing of health service including clinical and non-clinical services, decentralization and introduction of user charges (Sigamani, 2011).

Some other experiments were also taken to improve governance mechanisms, such as scientific management, human relations approach, behavioral system approach, network theory and public choice theory. The purpose of these changes is performance and production of system, outcome, and cost-effectiveness in service delivery. However, all these approaches of governance have sung the same tune. The previous public administration, bureaucracy-laden approach has changed with neo-liberal methods of administration such as principal-agent theory, public choice theory. NPM is based on the

neo-liberal perspective. This approach got prominent visibility in the 1980s. Failure of the public administration led to replacing it with the NPM approach.

Scholars arguing in favor of neo-liberal policies consider NPM as a reformist model, to bring the transformation of socio-economic development in the public sector. According to them, there are many problems associated with the traditional public administration methods. The state has played a commanding role. NPM has come for two purposes: to correct the public system and to deliver public goods and services. The major challenge is how this approach will correct the failures of the welfare state. This model is a mission and goal oriented model while the bureaucracy model is based on rules, processes and regulation mechanisms (Denhardt and Denhardt, 2000). NPM has not found good acceptance and has invited criticism in social science literature. Often it is considered to be based on the cost reduction model, with a focus on result and flexibility. Non-performance of the public administration created the NPM approach for the public system (Hood, 1991).

The NPM is not promoting total privatization, rather it is focused on the collaboration of state and market. However, it emphasizes on redefining the role of the state. It was for this reason that methods of control were introduced. It believes that competition between public agency actors and non-government actors such as private corporate and civil society creates choice, quality, and access. NPM also advocates the decentralization method in governance (Kumara and Handapangoda, 2008).

NPM model had originated in and been tested in United Kingdom (UK) and the United States of America (USA). 'Reinventing government' has been conceptualized by David Osborne in the USA. The developed countries experience shows that they have implemented NPM, but they have not sidelined or ignored public agencies. These agencies have been central to the interest of users and responsiveness of the state.

One of the major limitations of NPM is that it focuses only on the core of the system of service delivery while it does not pay much attention to the periphery. Further, NPM is also silent on the issue of rights; it only talks about entitlements and improvement of existing public sector structures (Christensen and La egreid, 1999). Though it is

introduced as a new paradigm for governance, it does not include previous good methods such as the parliamentary legal system, Public Interest Litigation (PIL), Lokpal, Lokayukta and public hearings. NPM is merely replacing one form of bureaucracy with another form of bureaucracy. Traditional models of public administration also pointed out the mechanism of efficiency, effectiveness and, accountability. The only difference is that the vocabulary of NPM is very beautiful and attractive in nature (Lapsley, 2008). A significant question that needs to be answered is, do we need market value based systems to govern the public sector? Do we have the capacity to adopt this kind framework of governance in public interest?

New Public Service Concept for Governance:

Contemporary NPM has been replaced by New Public Service (NPS) approach that mainly points to citizen needs, democratic values, and the role of the state, market and civil society. It is a collaborative framework for governance. There were some limitations of the David Osborne model of New Public Management and the good governance of the World Bank in addressing the pro-people concerns. The critique of the public sector and public administration led to the emergence of 'New Public Service' approach for governance provided by Robert B Denhardt and Janet Vinzant Denhardt. They argued that public administration is limited to accomplish democratic principles, which includes fairness, participation justice, and shared interest (Denhardt and Denhardt 2000, pp. 556-57). However, New Public Management is defined as "ideas and practices that seek, at their core, to use private-sector and business approaches in the public sector. Therefore, they proposed New Public Service as "a movement built to work in democratic citizenship, community and civil society, and organizational humanism and discourse theory". Instead of running government like a business, which new public management theory proposes, new public service believes that the government system should place citizens at the center (Denhardt and Denhardt, 2000; Denhardt and Denhardt, 2011). The framework of a New Public Service is based on the following Seven Principles**:**

- ***To serve rather than steer*** - help citizens articulate and meet shared interests instead of controlling or "steering" society in a new direction.

- ***The public interest is the aim, not the by-product*** -public administrators must build a shared interest among constituents, instilling in them shared an interest and shared responsibility for their community.

- ***Think strategically, act democratically*** - government programs and policies effectively achieved if there is a collective and collaborative effort by civic leaders.

- ***Serve Citizens, not customers*** - The relationships between government and citizens is different from the relationships between businesses and their customers. The government must build relationships of trust and collaboration to build a shared public interest.

- ***Accountability is not simple*** - also to market forces, administrators must pay attention to statutory and constitutional law, community values, political norms, professional standards and citizen interests.

- ***Value people, not just productivity*** - policy and organizational efforts will be more likely to succeed if there is a process for inclusion and collaboration for both public administrators and the citizenry.

- ***Value citizenship and public service above entrepreneurship*** - Meaningful contributions to society are more important than treating the public program or organization like their business trying to maximize productivity and being opportunistic (Denhardt and Denhardt, 2000; 2011).

The New Public Governance has come in literature after the year 2000. Robert B Denhardt and Janet Vinzant Denhardt coined the term new public service under the new public governance. They have tried to re-conceptualize the term governance. They defined governance as a system of values, institutions and policies to deal with economic, political, and social affairs. It includes interactions between the state, civil society, and private sector. It comprises the mechanisms and processes for citizens. People can

articulate their interests, mediate their differences, and exercise their legal rights and obligations" (Denhardt and Denhardt, 2000). UNDP defined governance on similar lines of action for governance, and they pointed out that, it is the rules, institutions and practices that have set limits and provide incentives for individuals, organizations, and firms". UNDP points out the importance of the value framework. The new public governance gives primacy to the market values of competition, contracts. While, Denhardt and Denhardt (2000 and 2011) have given a different set of values within the outline of new public service. The three actors involved in governance are the same: the State, which creates institutions to establish political power and law and order; the private sector, which creates employment and income opportunity; and the civil society, which played a mediator role for social and political interaction. The essence of governance is to foster interaction between these three types of actors to promote people-centered development (de Durand, 2016; Denhardt and Denhardt, 2000; Denhardt and Denhardt, 2011).

The NPS approach is new in articulation and not much debated in social science literature. It has come with an alternative approach to NPM; the entire approach of New Public Service Governance is focused on citizenship and people-centered governance at the theoretical level. Nevertheless, in practice, it is concentrated on implementation of market-based principles through the democratic value framework. The international donor reports such as that of the World Bank for the year 1992 and 1994 have mentioned that market and business models had failed in democratic countries. For this reason, these economic approaches are not considered democratic value frame strategies for implementation. They only focused on economic outcomes. On similar lines, the World Bank has come with good governance and accountability approach to development.

Osborne (2010) focuses on public administration or governance and summarizes their conceptual origin and practice as given bellow Box 2 further characterization by Denhardt and Denhardt (2000 and 2011).

Box-2.2

The Shift in Element of Public Administration to New Public Governance

Paradigm/ key Elements	Theoretical roots	Nature of the state	Focus	Emphasis	Relationship to external (non-public) organizational partners	Governance mechanism	Value base
Public Administration	Political science and public policy	Unitary	The policy system	Policy implementation	Potential elements of the policy system	Hierarchy	Public sector ethos
New Public Management	Rational/public choice theory and management studies	Disaggregated	Intra-organizational management	Service inputs and outputs	Independent contractors within a competitive market-place	The market and classical or neo-classical contracts	Efficacy of competition and the market-place
New Public Governance	Organizational sociology and network theory	Plural and pluralist	Inter-organizational governance	Service processes and outcomes	Preferred suppliers, and often inter-dependent agents within ongoing relationships	Trust or relational contracts	Neo-corporatist

Source: Osborne, S (2010), p. [14]

Given the market oriented value frame of the governance framework that has developed through these shifts, Denhardt and Denhardt's (2000) conception of a New Public Service (NPS) framework reflects the common objectives stated by the proponents of New Public Management and New Public Governance for the advancement of common public good. However, this is not a concept that has been much used or propagated, even by the international agencies and governments that focus on peoples' involvement as a governance principle.

Abbas and Baloch (2013) have pointed out that the goal of the decision-making process should be accountability to the people. Society and social rules in the form of social culture and values affect the action which is seen as legitimate, and this may require

[14] Osborne, S. (Ed.) (2010). *The New Public Governance? Emerging Perspectives on the Theory and Practice of Public Governance*. London: Routledge

negotiations, in the case of divergent views. Therefore, decisions made in organizations are to be concerned with not only economic gains but with socially granted legitimacy as well. These are social pressures, which influence governance.

It is clear from the above literature that the concept of governance has broadly shifted in three phases. The emergence of the Public Administration was the first stage of public governance. The second stage was the New Public Management (NPM), while the third stage is the New Public Governance (NPG) which is emerging from the last two decades. Governance in India is in a phase of transition. There are transitions in governance approach and value framework. The elements of each stage of governance can frequently co-exist or overlap with each other. There are various ideas and concepts which have tried to explain the problem. Nonetheless, it has remained unanswered in many ways.

The shift has been from a hierarchical bureaucracy towards a greater use of the market, quasi-markets and networks in order to deliver public services. This has created a new superstructure to control the decision making. Along with it, there is a set of new 'entrepreneurial pattern' to deliver public goods and services. The new mechanism is an outcome of transition in the concept of governance. However, it is not about total withdrawal of the state. The state has been playing a meditating role to channelize this process.

It becomes clear from the review of literature that there are four dimensions of governance, these are the political governance, legal and judicial governance, social governance, and economic governance. Political governance envisages stability of the government and a democratic accountability framework for delivering the goals of governance. Legal governance focuses on the rule of the law, the judicial protection and the aspects of social justice in the implementation of policies and programs. Social governance emphasizes on the government welfare provisions and improvement of the quality of life of people. Economic governance focuses on the financial management and economic security to the citizen.

In order to improve the governance framework following steps should be taken. There is a necessity for improve participation of the people in planning and decision-making

process, primary focus should be on decentralization of powers, increase access to government information through right to information for the people, reforms in the revenue systems and judicial reforms. Mobilization of supportive resources, involvement of non-governmental actors and civil society, public service and administrative reforms, involvement of marginalized and excluded sections of the society and use of information technology for good governance.

With this global background, there is a need to examine how these shifts have unfolded in the local context of India and what have been their consequences for India. In the Indian situation, the health services in the public health care system have remained poor in coverage and quality. The various shifts in governance have attempted to improve them. In this context, the study examines the changes in the health system governance by contextualizing the transitions in Maharashtra within the national and international processes.

Chapter-III

Global Health Governance

Chapter – III

Health Governance and Its Global Frameworks

Context and Background

The international arena has been changing after the post 1990s neoliberal policy transitions. This gave a fillip to the emergence of new socio-economic actors on global platforms and economic exchange was the prime agendas in these processes. Along with this, corporate global diplomacy has influenced the power dynamics between nations and international agencies. There are larger global challenges resulting from these neoliberal processes, which have direct and indirect impact on health and health care systems. The World Bank has become a major actor in international health. The policies of the WHO have been also influenced by these new agendas. It changes the understanding and notion of health governance at global level. To deal with common global health problems, collective action and global governance for health was needed (Kickbusch, Hein, & Silberschmidt, 2010) Unlike the mid-20th century, many nations coming together on international platforms for these issues includes private players with commercial interests in the health sector, such as the pharmaceutical companies.

The understanding of global health governance involves various terminologies. The term '*global*' is used to describe international, the international system, internationalization, interstate, intergovernmental transnational aspects of the economy (Finkelstein, 1995, p. 367). All these terminologies have changed their meaning in the context of globalization. The idea of globalization refers to the process of increasing economic, political and social interdependence. Globalization is understood as 'global integration that occurs as capital, traded goods, people, concepts, images, ideas and values diffuse across national boundaries' (Taylor, 2002, p. 975). Globalization has serious consequences for global public health and governance. New international collaboration frameworks have emerged as an effect of the globalization processes. Regulation and control were the primary issues to address global health problems. As a result, new law frameworks and treaties have been signed between many countries. However, the majority of the developing nations have not benefited from these processes (Taylor, 2002). The new institutional

configuration of an evolving global health governance structure (like networks and partnerships between different types of actors) functions as a mode of integration and building compromises at the global level (Kickbusch, Hein, & Silberschmidt, 2010)

Fidler (2001) argues that the globalization of public health has led to the development of 'international health diplomacy' as a part of global health governance. Global governance emerged in the mid-19th century when 'international health diplomacy' evolved because of international politics and concerns about controlling of infectious diseases. This side of diplomacy has been extended in the realm of states, international organizations, and non-state actors. The negotiation happened to deal with global health threats through international law and with international institutions (Fidler, 2001, pp. 842-43).

Fidler (2001) also points out that, after 1951, the role of World Health Organization (WHO) assumed importance, as it set international legal rules to control infectious disease. He also gives several other examples of international organizations that emerged during this period to serve the goal of global governance. The 19th century process of industrial revolution came with a new set of health problems. For instance, there were questions about worker's health, exploitation of workers, dangerous working conditions, and occupational safety became the prime concerns at the international level. Hence, there was a larger demand for creating international labor standards that led to the formation of International Labour Organization (ILO) in 1919 (Fidler, 2001).

In the past twenty years, another characteristic of global health politics has been identified. This has been associated with the involvement of non-state actors, especially the Non-Governmental Organizations (NGOs) and philanthropic organizations that have increased their participation in the development sector. For example: the Carter Foundation, Clinton Foundation and the Gates Foundation. The activities of NGOs, especially those engaged in human rights advocacy and philanthropic foundations endowed with substantial resources can be conduits for outside interference in a State's domestic affairs (Fidler, 2010). The WHO, the United Nation (UN) agencies, the World Bank and large country aid programs have highlighted the issues of regulations in public health. Thus, the emergence of global health governance framework led to the development of the global health governance plan to fulfill the demand of health

regulation. The key role in this framework was played by international multilateral, bilateral and private agencies. The WHO, the UN agencies, the World Bank, the Bill and Melinda Gates Foundation; Bloomberg Philanthropies; Clinton Global Initiative and public/private partnerships, the Global Alliance for Vaccines and Immunization Alliance (GAVI); The Global Fund to tackle health problems such as AIDS, Tuberculosis, and Malaria. Alliances among these large funders, industry partners and civil society organizations created an effective partnership to develop the global health-governing framework. These players have a significant influence on the development of global health governance mechanisms. In the global health governing framework, legislative measures are seen as a major tool for combating health inequalities and global health problems (ibid).

An increasing volume of literature is focussed on assessment of governance in which quantitative information on different aspects of policies, systems, and institutions has been collected, generally through surveys. However, there are limitations of survey methods in diverse national and cultural surroundings. In most cases assessment of governance scaling and scoring, methods have been used. This was a traditional approach to assessment of the performance of health service system.

Health Governance:

Health governance came into focus with the international discourse on economic and health policies and with the national needs of the poorly functioning health system itself. Strengthening of health systems may be referred to as the important goal of health governance (Kickbusch and Gleiche, 2012). The subject of health governance is mainly concerned with the institutional spheres of policies, programs, and activities related to fulfilling public health functions and larger health objectives. Health governance involves three sets of actors. First, it involves the State as an actor which includes politicians, policymakers, and government officials. The second are those who are operating beyond the government health sector; that is the private commercial sector, the civil society and, voluntary sector providers. The third set of actors is service beneficiaries and users. The general expectation from the health governance framework is that governance rules

should ensure some level of accountability (Brinkerhoff and Bossert, 2008). The WHO has shown five types of new approaches in governance for health. For instance, the first is about governing by collaboration. The second focusses on governing through citizen's engagement. Third is governing by a mix of regulation and persuasion. The fourth is about governing through agencies and expert bodies, and fifth is governing by adaptive policies. The major limitation of this method is that it is only providing a new vocabulary for the good governance discourse (Kickbusch & Gleicher, 2012)

The new form of governance is moving towards a participative nature incorporating democratic values in its framework (Kearney, et al. 2007). This form of democratization of health has been linked to new participatory features. Traditional forms of governance in the public and private sector have been ineffective (Rhodes, 1996). Hence, new forms of governance include a broader range of active players; in particular, they have depended to an increasing degree on the involvement of the governed. New forms of leadership are emerging, which are continuously shifting the allocations of power and weakening centralized, top-down decision-making structures (Kickbusch and Gleicher, 2012). This new governance reflects a two-sided development: firstly, global structures and processes led by corporate and medical industry interests were centralized at the global level. Secondly, national and sub-national level decentralization that decreases the role of the state in developing countries and creates space for greater community involvement, besides providing private sector provisioning (Bingham et al., 2005).

International Position on Governance:

Global changes has been influencing the nature and character of governance. The purpose of governance framework is to deliver social services in a better way. However, it has been a debatable issue in the contemporary period. At the international level, a number of efforts have been made to develop governance frameworks. In the 1990s, global aid donors and a range of international institutions adopted the new governance agenda. This included the multilateral development banks, the Organization for Economic Cooperation and Development, the International Monetary Fund, United Nations Development Programme, all were formally adopting 'governance' agendas. Every international

organization carries various agendas through their governance framework, depending on their vision and mission in the development discourse (Fidler, 2001).

World Bank and International Monitory Fund (IMF) carry the agenda of economic development with management and preliminary focus on economic corruption. USAID is underpinning the democratic values and principles of justice through its framework (Orr, 2002). Sustainable human development is the large agenda of the UNDP governance framework, With conflict resolution and prevention having been its historical agenda. OECD, DFID, and UNDP are currently developing assessment indicators for governance evaluation and monitoring. These agendas came with specific contexts to serve certain goals and in many working areas, they are overlapping.

The UN and their interrelated organizations have played a major role in developing the governance assessment and evaluation framework for development. These frameworks have been developed according to the agenda of the particular organizations. United Nation Development Programme (UNDP) puts forward the principles of good governance. The World Bank had developed six basic aspects of governance. Pan American Health Organization (PAHO) envisaged Essential Public Health Functions and World Health Organization (WHO) introduced domains of stewardship in health governance. Each of the governance analysis frameworks has been explained in detail as follows: There have been remarkable changes in health system understanding and its performance assessment since the 2000s. Many international organizations have made an effort to develop governance. In health, the WHO and PAHO came up with qualitative governance frameworks that reflect the reformulation in the 2000s of functions of the state concerning public health.

PAHO's Essential Public Health Functions

The Pan American Health Organization (PAHO), established in December 1902, operates as the American Regional Office of the World Health Organization. It has been known as the American initiative working for improving the health service system and living standards of people. They have conceptualized 11 Essential Public Health Functions

(EPHF) in the 2001-2002 period, which has been seen as collective actions to assess the health service system performance. Caroline and José (2008) called this as a new methodology to evaluate public health systems. The following are the 11 Essential Public Health Functions listed by PAHO:

Box-3.1

Essential Public Health Functions: PAHO

1. Monitoring, evaluation, and analysis of health status
2. Surveillance, research, and control of the risks and threats to public health
3. Health promotion
4. Social participation in health
5. Development of policies and institutional capacity for public health planning and management
6. Strengthening of public health regulation and enforcement capacity
7. Evaluation and promotion of equitable access to necessary health services
8. Human resources development and training in public health
9. Quality Assurance in personal and population-based health services
10. Research in public health
11. Reduction of the impact of emergencies and disasters on health

Source- Caroline and Jose (2008), P. 2

EPHF were implemented and tested in the Region of Latin America and the Caribbean (LAC) and non-LAC region. In 2003, the EPHF assessment survey was carried out in India. Monica Das Gupta and Manju Rani (2004) used Essential Public Health Functions framework to assess the performance of the public health system in India. This survey was carried out in India by using modified questionnaires to take input and feedback from experts. They pointed out that this assessment survey has helped to increased awareness about the functioning of public health care system practice. India has very low health outcome at the population level in comparison with other countries. This study described the limitations and identified three broad areas for improvement in the health service systems. Firstly, it addresses the lack of regulations and their enforcement. Secondly,

there are administrative, and management challenges to deliver services, mainly related to the use of resources, insufficient evaluation and assessment system, management of information and technology, limited space for new learning and innovation. Though it set the priorities of financial resource to allocation; it has not fulfilled the felt needs. Third, the role of other key actors has been central especially with state governments and at grassroots level with communities (Gupta and Manju, 2004).

Stewardship Conception of WHO:

The World Health Organization (WHO) has conceptualized the idea of 'stewardship' for health governance. World Health Report 2000 introduced the concept of 'stewardship' identifying four essential functions of the health system: service provision, resource generation, financing and stewardship. The concept of stewardship implies 'setting and enforcing the rules of the game and providing strategic direction for all the different actors involved' (WHO, 2000, p. 8) (Abelson 2011). Stewardship has been defined as 'the careful and responsible management for the well-being of the population, the very essence of good government'. The framework suggests that the state should play a steering role. It does not mean that the government needs to fund and provide all health interventions. However, it needs to set the direction for both public and private sectors to ensure that the health system contributes to human development. The operational framework describes six functions of stewardship (Travis, et al., 2002)

1. To define the vision for health and strategy to achieve better health;
2. To exert influence on all sectors for better health;
3. To govern the health system in a way that is consistent with prevailing values;
4. To ensure that systems design is aligned with health system goals;
5. To better leverage available legal and regulatory instruments; and
6. To compile, disseminate and apply intelligence (Travis, et al. 2002, p. 2).

Stewardship is a health systems performance assessment framework. It includes Essential Public Health Functions for assessment. Stewardship framework tried to overcome the overlapping components which were involved in the conception EPHF framework. WHO has developed both the frameworks. However, the only difference is

context. Stewardship focused on strengthening the health system as well as the regulation and accountability aspects beyond health ministry initiatives. While the EPHF framework has focused on resource generation of the health system, stewardship and governance have similar background principles. Governance addresses the large systemic issues and stewardship address the health system issues. The application of the concept is more important than its design. At the theoretical level, many scholars are dealing with issues of governance. Major critiques of this idea were that it was unclear on the definition and vague about the implementation challenges. It was thought that there is a need to develop sub-functional elements of the framework (Veillard, et al., 2011; WHO, 2001).

United Nations Development Programme's Governance Framework

The United Nations Development Programme (UNDP) posed a series of questions to the economic governance model and introduced a new aspect into the concept of human development. The Human Development Report (1997) points out "if income is not the sum total of wellbeing, lack of income cannot be the sum total of poverty", rather it focused on people's ability to generate new things. Beyond economics other aspects determines the process of development. UNDP focused on the role of state and social determinants (Weiss, 2000). UNDP development report titled as 'Governance for Sustainable Human Development' (1997) describes governance as having three important aspects: economic, political and administrative. Economic governance comprises the country's economic activity, and it effects on decision-making processes. Political governance is the process of policy formulation related decision-making processes. Administrative governance is the realm of policy implementation. It is encompassing good governance processes and structures that guide political and socioeconomic relationships (UNDP, 1997).

There was a change in the UNDP position on governance post-2000. After that UNDP has been advocating for the principles of democracy and social equality. They have come with the governance framework of 'Democratic Governance'. Under this framework, the UNDP has developed five Principles of Good Governance. This includes Legitimacy and Voice, Direction, Performance, Accountability and Fairness (Shukla and

Lassner, 2012). This marks a shift from the economic poverty alleviation model to democratic governance. This framework position comes from UNDP's experience in countries facing political conflict where there was a larger demand for political governance to incorporate democratic principles. UNDP has been largely contributing towards establishing democratic set-up in conflict-ridden countries. This democratic value framework is also seen in the larger governance transition. The new governance framework such as 'New Public Service' mainly enforces on democratic principles for better governance (Santiso, 2002).

Health System Governance (HSG) Assessment Framework

Siddiqi, et al. (2009), have developed a Comprehensive Governance Assessment Framework. They have consolidated four existing frameworks: the framework of the World Health Organization's (WHO) domains of stewardship; the Pan American Health Organization's (PAHO) Essential Public Health Functions; the World Bank's six basic aspects of governance and the principles of good governance; and finally the United Nations Development Programme (UNDP) Democratic Governance framework. Based on this framework is developed the Health System Governance (HSG) assessment framework. It has ten principles, which includes strategic vision, participation and consensus orientation, transparency, the rule of law, equity and inclusiveness, responsiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics. Their analytical framework poses questions and items for each principle at three levels, i.e. at the national development level, the health policy formulation level and the policy implementation level. This assessment framework has developed altogether 63 broad questions across the ten governance principles ranging from contextual and descriptive to process-related and outcome-related questions. The detail description of Siddiqi framework has been given in Annexure II (Siddiqi et al., 2009). This framework originated from an international agency viewpoint. It needs to be recognized that the principles are value driven and not normative and must be seen in the social and political context. The framework mainly uses a qualitative method and did not follow the traditional approach of scoring or ranking system to the assessment of governance. It provides understanding on the ability to utilize external resources without dealing with

aid effective issues. A review of the Siddiqi framework suggests that, though it provides a good assessment of the health governance framework, it focuses on a set of principles and questions that help to analyze the health system governance (Ruhanen, et al. 2010). The major challenge with this framework is that it mainly focuses on the national level because it assumes that Ministry of Health is fundamental to the health governance structure; it does not include regional level structures of the health system. Further, the above framework incorporates policy formulation and implementation within its fold and includes planning, operationalization, monitoring, and evaluation.

Frameworks for the Analysis of Governance:

World Bank: The World Bank has described a framework for governance. The World Bank report on Sub-Saharan Africa of 1989 characterized the crisis in the region as a 'crisis of governance'. The Bank's economic policies have failed to deliver expected outcomes of their economic intervention for poverty elimination in Sub-Saharan Africa. The main reason behind this crisis of governance is huge economic corruption and democratic instability in this region (Harrison, 2005). After that, World Bank came with a new approach to governance for development interventions. The World Bank developed six basic aspects of Governance, which include accountability and voice, political instability and violence, regulatory mechanisms, the effectiveness of government, the rule of law and control corruption in all forms (Drake, et.al 2001, p.12). The previous chapter on the idea of governance has discussed World Bank governance framework in detail.

The International Monetary Fund (IMF): Historically, IMF's main focus was on macroeconomic policies of countries i.e. to minimize disparities, for control of inflation, promotion of trade and exchange, market reforms to improve efficiency and sustained economic growth (IMF, 1997). IMF has been providing technical assistance to many countries with the objective of helping to improve good governance and promoting public sector transparency and accountability. The IMF advocated the good governance framework for economic efficiency and growth. However, this has been limited to the economic policy aspects of the country. Economic corruption is, therefore, one aspect addressed by the IMF framework of governance along with public sector management

and institutional reforms (Shukla and Lassner, 2012). It focused on improving the management of public resources through reforms. It covered public sector institutions involved in the process of development. It emphasized on maintenance of a transparent and stable economic and regulatory environment conducive to efficient private sector activities (IMF, 1997).

The International Fund for Agricultural Development (IFAD): In the governance framework, IFAD focuses on private sector role in governance more prominently. It articulated that governance includes the state but transcends it by taking in the private sector and civil society, all of which are critical to sustaining human development (Haas and Haas, 1995). The institutions of governance are the state, civil society and the private sector designed to contribute to this development by instituting the political, legal, economic and social circumstances (IFAD, 1999, pp. 5-6).

The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP): The ESCAP framework of good governance has eight major characteristics. It includes the principles of participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive governance that follows the rule of law (Brand, 2007). The major agendas of this framework minimized economic corruption in the implementation of a development program. It has promised that vulnerable and marginalized segments of society will be at the center and must seek their involvement in decision making primary in this framework. This will determine the present and future needs of society (Shukla and Lassner, 2012).

The European Union (EU):

The European Commission recognized the reform of European governance as one of its strategy in the early 2000s. The European Union applied the principles of good governance in its global responsibilities. It aimed to boost the effectiveness and enforcement powers of international institutions. The commission started a systematic dialogue with European and national associations of regional and local government at an early stage of policy shaping (Eberlein and Kerwer, 2002). The European Union defines governance to include five principles, i.e. openness, participation, accountability,

effectiveness and coherence for their member states that promote democratic values. These principles also apply to all levels of government global, European, national, regional and local (Hix, 1998).

Reviews of the various governance frameworks have shown the critical issues involved in this frameworks. It was a marked fact that all the governance frameworks developed only post-1990s. The economic policy shift changed the nature of social sector development. The crisis of governance was one of the reasons behind this policy change. It was evident that most of the development agencies changed their agendas. Some were focused on economic aspects and some international organizations enforced human social development. These factors are then clearly translated in their ideas of governance and implementation frameworks.

At the theoretical and principle level, most of the frameworks are dealing with common principles. There is conceptual overlapping between different issues involved at the principle level and in the theories ideas of governance. The application of the concept is more important than its design. At the theoretical level, many scholars are dealing with several issues of governance.

The health governance frameworks have concentrated on health service system determinants such as financing, service delivery, and performance issues. It has been largely silent on the determinants of health. It should acknowledge both the health and health service system determinants for a better governance framework.

The generalization of global health governance framework is a difficult task because different countries have different political, economic and institutional structures. The contextual factors and key players have an important role as it influences the outcomes of governance. The goal of health systems differs from country to country. The ultimate goal of every national health system reflects in governing the value frame, principles, and systems design. Implementation of the health governance framework at the international, national and local levels is an opportunity to overcome problems and develop innovations.

The new governance framework uniformly acknowledging the role of the private sector and non-state actors in health system strengthening. There is ambiguity on the scope and levels of involvement of non-state actors, and there is silence about regulation of non-state actors.

While defining global health governance it overlaps with the scope of global health. There has been criticality involved about common goals and aims of global health system. The health diplomacy played withal role while fixing strategies and allocation of resources. However, developing global health governance framework is essential step to develop common understanding on issues of global public health.

The literature on global health governance largely multi-disciplinary in nature. Which has gap between at level of theory and implementation. There need to reconsideration the principles and value framework used of global health governance. The new global health governance framework implementation processes have involved pro people accountability and transparency strategy to restructure system. Presently there is domination of philanthropic multilateral agencies on new global health governance framework. Similarly, there has been unregulated private actors dominating development discourse along with market forces. It has failed to deliver public good in practice.

The Indian public health governance has been influenced by both market and welfare perspectives. Both public and private actors have influence over public health systems. but lager processes controlled by market forces. Presently, Indian health system is moving from public to private. The Universal Health Coverage (UHC) process in India is an example of this process. The selective experimentation happened in terms mode of financing and changes in structure of decision-making.

Chapter-IV

Health Governance in the Indian Context

Chapter- IV

Health Governance in the Indian Context

The Historical Context

Health has been an integral part of India's national development since the last sixty years. A large network of public health service infrastructure exists in the country. However, the public health services in India are still in preliminary stages of development. The establishment of Indian public health system began in the pre-independence under the British rule. Subsequently, it has developed and taken shape through the vision and planning efforts of various health Committees and Commissions set up by the Government of India (GOI). During this period various pilot projects and programmes were implemented in the country. These Committees and Commissions have reviewed the situation and challenges faced by the Indian health sector. They have suggested and provided overarching recommendations for various aspects of the health care system. This course of action has shaped the decision making process for health services development.

The following list of major health committees and commissions in India reviewed health service situation and made recommendations which structured the health system. Through these committee's significant changes and developments happened regarding the public health sector, which changed the scale and nature of public health in India.

- Health Survey and Development Committee known as Bhore Committee (1946)
- Sokhey Committee (1947)
- Chopra Committee (1948)
- Etawah Project (1948-52)
- Community Development Programme (1952)
- Mehta Committee (1957)
- Mudaliar Committee (1961)
- Renuka Roy Committee (1960)
- Chadha Committee (1963)
- Mukherjee Committee (1966)

- Jain Committee (1967)
- Jungalwalla Committee (1967)
- Kartar Singh Committee (1973)
- Srivastava Committee (1975)
- GOI (1981):The Working Group on Health for All
- Mehta Committee (1983)
- Bajaj Committee (1987)
- Mashelkar Committee (2003)
- GOI (2005): National Commission on Macroeconomics and Health.
- GOI (2011): High Level Expert Committee on Universal Health Coverage in India (2011)

Health Survey and Development Committee (Bhore Committee) 1946:

This committee was constituted in 1943 under the leadership of Sir Joseph William Bhore, who was an Indian Civil Servant. Its name was 'Health Planning and Development Committee' but it was popularly known as 'Bhore Committee.' The objective of this committee was to do a survey of existing health conditions and organisation of health services and thereby provide suggestions for future health service development of India. The contribution of this committee regarding governance was that it reviewed the scope of health administration and recommended changes in the structure of health administration. This committee made pioneering efforts and the committee submitted a detailed four volume reports in 1946. The recommendations provided by the committee to improve the health status of the population as well as the health services of India have set the blueprint for the future development of healthcare system in the country. The committee gave short term and long term recommendations for health care planning and development.

The major highlights of recommendations were, the short term plan implementation had a time frame of only 5-10 years. It recommended that every primary health centre should cover 40,000 populations in the rural area. The primary health centre (PHC) should have the manpower of two medical officers, one nurse, four public health nurses, four midwives, four trained dais and fifteen class IV employees. It envisioned that the

secondary health centre should serve the role as a supervisory, coordinating and referral institution. Under Long term plan, the committee recommended three-tier health care system designs. At the first tier level, primary health units for each 10,000-20,000 population should be established as 75 bedded hospitals. The manpower for this unit was to include six medical officers, six public health nurses, two health assistants, two sanitary inspectors, and other supportive staff. At the second tier, it recommended 650 bedded Regional Health Unit (RHU) to serve as a referral centre for 30- 40 PHUs. At the third tier level, it recommended the setting up of district hospitals with two thousand five hundred beds to serve the needs of about 3 million population. One of the important recommendations of the committee was regarding the concept of 'Social Physicians' who had completed the three months training programme in preventive and social medicine. Special emphasis was given on preventive work and integration of curative and preventive services. It also recommended that the village health committee consisting of five to seven individuals for increasing the community participation in the local health programme. It also highlighted a detailed plan for inter-sectoral coordination of health services with other departments. The committee stressed upon the necessity for social orientation of medical practice and public participation in decision-making and planning process (Bhore Committee, 1946).

Sokhey Committee (1947):

This Committee was constituted before the Bhore committee, but it submitted its report in 1947. It recommended dietary and nutrition standards for all the population. It provided suggestions on the various epidemic situations prevalent at that time. It also addressed the problems of high infant and maternal mortality among women and children. It emphasized on collecting vital statistics, such as birth and death rates. It suggested a basic structure for public health service system. It also made recommendations on the importance of health insurance, medical training, and research, production of drugs and medical technology (Sokhey Committee, 1947).

Chopra Committee (**1948**): This committee worked on the advancement of indigenous medicine and its incorporation in an integrated medical system along with modern

medicine. It recommended measures for this through education and multi-disciplinary research (Chopra, 1948).

Etawah Project (1948-52):

Etawah Project (1947-48) was a pilot project of Community Development in India before the Community Development programme. This project was implemented under the leadership of Albert Mayer's an American planner and architect. This project was the first experimental project for Rural Planning and Development. This development project set an administrative pattern to deliver extension activities to the village level. Various trial and error based activities were carried out under the project. This project channelized convergence of various development departments in one platform. The idea of multipurpose village level worker was first experimented under the Etawah Project (Chandra, 2008).

Grow More Food Campaign:

The primary goal of the First Five Year plan after independence was increasing agricultural production. In 1947, the 'Grow More Food Campaign' (GMFC) was launched. Hence, from the district to the village level additional workforce was appointed to carry out agro activities.[15]

The GMF Enquiry Committee (1952) was appointed to review and examine the implementation of this programme. This committee came up with a detailed report and gave the following recommendations to improve basic strategies:[16]

- The administrative machinery of the Government should be reorganized and equipped for India as a welfare state.
- Availability of non-administrative leader must be emphasized for mobilization of farmer community in village areas to improve socio-economic status.
- Use of an extension organization strategy to reach out the programme benefit at the ground level.

[15]Introduction to Agriculture Extension - NISCAIR, Retrieved from http://nsdl.niscair.res.in/jspui/bitstream/ 123456789/501/1/PDF%20Rural%20develop as accessed on 24th June 2016).
[16] Ibid.

- The administrative staffing structure sufficient for Block Development Officers (BDO's) such as (four technical officers and twelve Village Level Workers (VLWs) for a Tehsil, coverage of 120 villages).
- District Collector was the top authority in the district to implement developmental activities. Elected representatives such as Memebr of Parlaiment (MPs) and Member of Legislative Assembly (MLA's) were also included as members on board.
- The state level functioning should have shared responsibility with cabinet members and a non-official board. All rural development programme authority has to be given to the Development Commissioner
- The economic and social factors have an influence on village life structure. Agriculture development interlinked with village level social issues. It is all about the collective effort needed to tackle these issues (Chandra, 2008).

Community Development Programme (1952):

Based on the G.M.F. Enquiry Committees recommendation the Community Development Programme (CDP) was formulated in 1952. The prime agenda of this programme was on rural and agricultural development. The holistic development of rural people through optimum utilisation of physical and human resources was central to the programme strategy (Karunaratne, 1976). It aimed to develop the socio-economic status of rural villages through the growth of agricultural production. Other focused areas of this programme were development communication pattern in rural India, rural public health service development and formal education for all.[17] This programme has articulated an administrative framework for rural India, district to village level structure was developed for service delivery and extension communication. Development Block was considered as a district level unit. The BDO was made in-charge of the development in each block all over India. Below block level a VLW was responsible as in-charge of 10-12 villages. Thus a nationwide administrative configuration was created (Ruttan, 1984). Various programmes were designed to train the BDOs and VLWs. It was an effort to link

[17] The Community Development Programme of India, Retrieved from http://www.yourarticlelibrary.com/india-2/the-community-development-programme-of as accessed on 24th June 2016

government services at the village level through a proper administrative set-up (Rudramoorthy, 1964). The higher decision-making authority was 'Community Development Organization' and a Community Development Research Center.

Health initiative under CDP: Health service development was one of the sub-components of CDP. It distinguished between the primary and secondary level health care framework. Primary health organisation structure was provided in the development block. At the secondary level, hospital and mobile dispensary were developed to serve all project areas as a whole (Chandra, 2008). This programme had an important impact on agricultural initiatives after independence. It helped to increase mass awareness among the peasantry all over India. According to the First Five Year Plan, India covered 77.5 million populations under the Community Development Programme. Nayar (1960) argued that the community development programme intervention in India helped the Congress party for mass political mobilization of the rural population.

Mehta Committee (**1957**)

This committee was popularly known as Balwant Rai Mehta Committee. It was set up to review the performance of the Community Development Programme, 1952. This committee came to the conclusion lack of major initiative by Government of India caused the failure of the community development programme (Mehta, 1957).

Mudaliar Committee (1961):

This committee was shaped under the chairmanship of Dr. Lakshmanaswami Mudaliar in 1959. The objective of this committee was to make an assessment in the field of medical relief and evaluation of public health since the submission of the Bhore Committee Report. It also aimed to review the Health projects under the First and Second Five-Year Plans and make recommendations for the forthcoming plan of health development in the country (Mudaliar, 1961).

The Committee observed that essential health facilities had not reached the grassroots level and high priority was only given to urban areas in the distribution of hospitals. The functioning of the PHC was not up to mark and the quality of services was very low. It

argued that there was a need for referral system and more human resources were required to develop a better public health service system. The main recommendations were on strengthening of district hospitals to serve as a central base for specialist services, upgrading and strengthening of the PHC for a 40,000 population. Extension of functions of the University Grants Commission to education in the field of medicine and integration of Medical and Health services (Mudaliar, 1961).

Renuka Roy Committee (1960)

The Renuka Ray committee known as the School Health Committee recommended the promotion of preventive care through schools which include developing the facility of mid-day meals, health education as a part of curriculum and integration of school health and primary health network (Priyadarshini, 2015[18], Park 2009).

Chadha Committee 1963

The Chadha Committee was constituted by Government of India in 1963, under the leadership of Dr. M.S Chadha. He was the Director General of Health Services of India during that period. The purpose of Chadha committee was to review the maintenance stage of the National Malaria Eradication Programme in relation to the primary health centres. It also reviewed the requirements of human resources at the primary health centre level for the National Malaria Eradication Programme. The committee recommended reinforcement of general health services, particularly at block and district level and to appoint a basic health worker for every 10,000 populations for malaria control activities. This worker was to support the ongoing health activities and work as Multipurpose Health Worker at the village level (Chadha Committee, 1963).

Mukerji Committee 1965:

This committee was constituted in 1965 by the Central Council of Health, under the chairmanship of Shri Mukerji, who was the Secretary of Ministry of Health and Family Planning. The purpose of this committee was to make an assessment of the family planning programme. In order to improve a strategy for the control of Child Birth Ratio

[18] Priyadarshini, C. (26th June 2015). Health Committee Reports. Retrived from http://www.authorstream.com/Presentation/cpdarshini-1309376-19-8committee-reports/ as accessed on 26th June 2015.

(CBR) During this period, the CBR was 41 per thousand and it aimed at reducing this to 25 per thousand in 10 years. It also aimed to review the staffing pattern and financial provisions for the programme (Mukerji Committee, 1966).

The committee recommended a target oriented programme for family planning and also develop community awareness programmes in order to take the involvement of other organisations. It also suggested establishing a powerful implementation agency in the Health Directorate offor state governments which will handle the family planning initiatives. Formally basic health worker used as a multipurpose health worker for public health service and delink malaria programme and family planning programme activities (Mukerji Committee, 1966).

Mukherjee Committee, (1966)

This committee formed by the central council of health in 1966 to review public health services and suggest staffing pattern under the National Malaria Eradication Programme, tuberculosis, smallpox eradication, trachoma control and leprosy programmes. The committee recommended that, to strengthen general public health service at a higher level that there is a need to appoint basic health worker at the block level for vigilance task. It also recommended the need to develop separate grassroots health staff for the various national health programmes. It recommended for an integrated approach strategy that can be used for the implementation public health and medical care at the grassroots field level. The Committee did not address and work out any details of the organisation structure above district level for integration. Committee had given state government powers to desire organisation pattern (Mukherji Committee, 1966).

Jain Committee (1967)

A committee was established in 1966 under the leadership of Shri A. P Jain to study the medical care services of India The committee reviewed the working of various hospitals all over India to develop standards of medical care. The major recommendations were to strengthen the district hospitals with the provision of specialist healthcare. It also emphasized on developing the capacity and coverage of the PHC to provide maternity care services (Islam and Tahir, 2002)

Jungalwalla Committee (1967)

The Jungalwalla Committee was constituted by the Central Council of Health in 1964. This committee was headed by Dr. N. Jungalwalla, the Additional Director General of Health Services of India. It is also known as the Committee on Integration of Health Services. The aim of this committee was to study the problems of the health services and elimination of private practice. The committee submitted a detailed report in 1967. It defined health integration service as,

> "a Service with a unified approach for all problems instead of segmented approach for different problems and medical care of the sick and conventional public health programmes functioning under a single administrator and operating in a unified manner at all levels of hierarchy with due priority for each programme obtaining at a point of time" (Jungalwalla, 1967, p.i).

It proposed the integration from highest to lowest level in services along with the integration of preventive and curative services. It described the integration of health services in three main components; one is health services of functions and methods of delivery, second their organisation structures and third was the personnel providing these services & their administration. The main steps towards integration were through unified manpower cadre, seniority status, acknowledge extra qualifications, special pay for specialized work, equal pay for equal work, no private practice, and good service conditions remaining states developed their strategy (Jungalwalla, 1967).

Kartar Singh Committee (1973)

This committee was formed by the Central Family Planning Council in 1972 and was headed by Kartar Singh, who was an Additional Secretary of Ministry of Health and Family Planning. This committee reviewed the multipurpose worker under health and family planning programme and it submitted its report in 1973 to the Government of India. It suggested a redesign of multipurpose workers and developed a single cadre system developed for both male and female workers. ANMs were interchanged with family health workers. Basic health workers were replaced with multipurpose health

workers. The committee recommended for a clearly structured responsibility of health workers and supervisors. It also made suggestions regarding primary health centre population norm and recommended one PHC for 50.000 population. One sub-centre to have appointed one multipurpose health worker and one family health worker. One male and female supervisor, each one supervises four health workers. Medical Officer of PHC was in charge of all supervision work (Kartar Singh Committee, 1973).

Srivastava Committee (1975)

The Srivastava committee was formed by the Ministry of Health and Family Welfare, Government of India in 1974. This committee worked in the area of medical education and support manpower. The Committee submitted its report to the Government of India in 1975. This committee reframed the structure of medical education according to national needs and priorities. It developed a pedagogical design for health assistants to bridge the gap between the medical officer and multipurpose worker. It recommended making para-professional and semi-professional health workers from village level. It suggested the formation of three cadres of health workers system for multipurpose health workers on the similar lines of health assistants and the community level workers and doctors. It also created a "Referral Services Complex". It recommended the formations of a Medical and Health Education Commission for planning and executing health and medical education changes with University Grants Commission. The recommendation of the Srivastava Committee led to the establishment of the Rural Health Service in 1977. Under the rural health service, it developed the Re-orientation of Medical Education (ROME). This was undertaken for working with selected medical colleges with an objective of reorienting the medical education according to rural people's needs. It also suggested starting an internship programme for undergraduate students at PHCs (Malik, 2009).

The Working Group on Health for All (1981)

India was a signatory country of the primary health care declaration which promised universal Health for All by 2000 A.D. The Planning Commission of India formed the working group on health for all, to review health status in India, under the leadership of

Dr. Kripa Narain. He was Secretary, Ministry of Health and Family Welfare and also the President of All India Institute of Medical Sciences (AIIMS). This group submitted its report in 1981. This group analyzed the health situation in India and outcome of various health programme implementation and it developed a planning framework from 1980 to 1986 for the health sector. It also designed programmes for rural, tribal and marginalized sections and critically analyzed the minimum needs programme. This working group recommended a Revised Minimum Needs Programme. It comes below district health care structure. At the district level, it suggested health centre with a specialist and public health expert and the sub-division of the health centre for five lakhs population along with an epidemiology department. Block level Community Health Centre (CHC) was proposed to provide specialist services and serve around one lakh population. The PHC population norm proposed changes to reduce the population under each PHC to hilly (15,000) and non-hilly areas (30,000). PHC should provide preventive, promotive and curative health services. For sub-centre 5,000 population norms for non-hilly areas and 2,5oo in a hilly area and sub centre to have a male and female multi-purpose worker and one part-time attendant. At village level one health volunteer for every village (Karkal, 1982).

Bajaj Committee (1987):

The Bajaj Committee known as the 'Expert Committee for Health Manpower Planning, Production, and Management' was set up in 1985 under the leadership of Dr. J.S. Bajaj. He was a Professor at AIIMS. This committee helped in the formulation of national policies such as the National Medical and Health Education Policy, the National Health Manpower Policy. It proposed an Educational Commission for Health Sciences (ECHS) like the University Grants Commission, setting up of Health Science Universities in states and organising health manpower cells at the Centre and State levels. One of the significant contributions of this committee was a realistic health manpower survey (Bajaj Committee, 1987).

The National Commission on Macroeconomics and Health (2005)

The National Commission on Macroeconomics and Health was set up by the Government of India. This commission was headed by the Finance Minister of India Mr. P. Chidambaram and Health Minister, Dr. Anbumani Ramadoss. As the report pointed out, there was inequity in the health status of the population and the household expenditure on health was very high in the estimation of health spending. In order to overcome this situation in India, the commission suggested bringing in alternate models of health financing. It should also strengthen accountability mechanisms in the existing primary health care system. It also urged for developing institutional structures to improve governance of health. It was also supposed to suggest mechanisms for new health technology and manpower development. It should also set monitoring and evaluation system for health service system (GOI, 2005).

Recommendations of Committee and Governance Issue:

These various committee and commission and number of experts contributed in the process of establishment of Indian public health service system. The Bhore Committee report provided the first blueprint for the primary health care unit concept in the development of health system. Till date, this committee has been referred to in the decision-making and planning process. Bhore committee gave a systems approach and tried for the involvement of other actors. Historically, at the initial stage of health systems development, malaria and family planning programmes got the prime attention in the committees (Qadeer, 2011). The restructuring of the health system was the agenda carried forward throughout processes visible in all subequent committee recommendations. The grassroots level human resource issues were dealt with by most of the health committees. There was also overlap in the recommendations of primary level care issues. The recommendations of the male and female workforce in the health services development of India as suggested by the Kartar Singh Committee in relevant in today's context. Despite this, the Indian health care system is in the developing stage and there are lots of hopes from various committees and commissions.

However, the initial flaw in the blueprint and the systems approach created the divide between the public health services and the people. The minimalist approach to ISM&H

was more of lip service and all recommendations over subsequent plans such as the 10ht and 11th, for revitalization of local health traditions and people's local knowledge were completely ignored. The CDP closed down, the CHW scheme withered away, and the panchayat village committees were given no respectable place in any decision making about the health services (Banerji, 1992, Priya, 2005).

Contemporary Indian Responses to Governance:

In the Indian context, the constitutional pillars of governance in public affairs consist of elected representatives constituting the parliament, an executive government led by political representatives, an independent judiciary, a free media and active civil society.. There is a federal system with distinct responsibilites and jurisdictions of the centre and states, as well as concurrent subjects. It is to function through mechanisms of decentralization and devolution of power through a three-tier system of governance at national, state, district and sub-district levels (IIPA, 2013). All these processes are being subjugated to the globalization and liberalization led changes. International ideas of governance have sidelined constitutional procedures.

Though the policy reform had started during the mid-1980 in India, the Congress government led by Prime Minister Narasimha Rao formally adopted structural adjustment policies in the early 1990s. This government initiated decentralization and neoliberal reforms in the development sector. In the beginning, the neoliberal reforms were associated with the realm of trade, finance, and commerce. Later, it was implemented in the social sector (Kamat, 2004). However, financing is a backbone of the social sector. Reform in the economic sector also has a large effect on the social sector. The major challenge to governance in India is political and administrative powers concentrated at the top. During this period economic and political reforms through decentralization was going hand in hand. Political reforms in the system by the government were expressed in the 73rd and 74th amendments. These two amendments were considered to be able to bring a revolutionary change in the political system (Bandyopadhyay, 1996). Through these amendments policy decision-making, space and power were meant to be shared

with women, tribals and dalits. These marginalized sections of society were to get the power in political institutions to influence policy-making processes.

During this period, three major changes happened, i.e.; there was a change in the configuration of political leadership, restructuring of public institutions with changes in service delivery and administrative reform through new management. These systemic reforms created space for the small private sector, corporate sector, and NGOs (Mukundan and Bray, 2006).

The Indian government had justified through official documents that, since there is a crisis of governance, there was a need for administrative reforms through new good governance.

In the health sector, it responded by opening up the health services to formally supporting provisioning by the private sector, initially cutting back on budgetary allocations to public health services and introducing user fees, strengthening/restructuring management structures and financing processes, decentralizing the control of rural health services to panchayati raj institutions and opening up to integration of the other systems of health knowledge in the mainstream health services. However, it had to pull back on some of its initiatives due to the public response as well as evidence of their negative impacts. For instance, it went back to strengthening of public services once international and national evidence on market failure in health was acknowledged. It was in this context that, since the mid-2000s, it attempted changes in decision making structures and processes through the NRHM and subsequent planning and policy efforts.

This section focuses on governance issues as included in the National Rural Health Mission (NRHM), the High Level Expert Group (HLEG) and the Twelfth Five Year Plan (Draft Policy debate).

Governance under NRHM

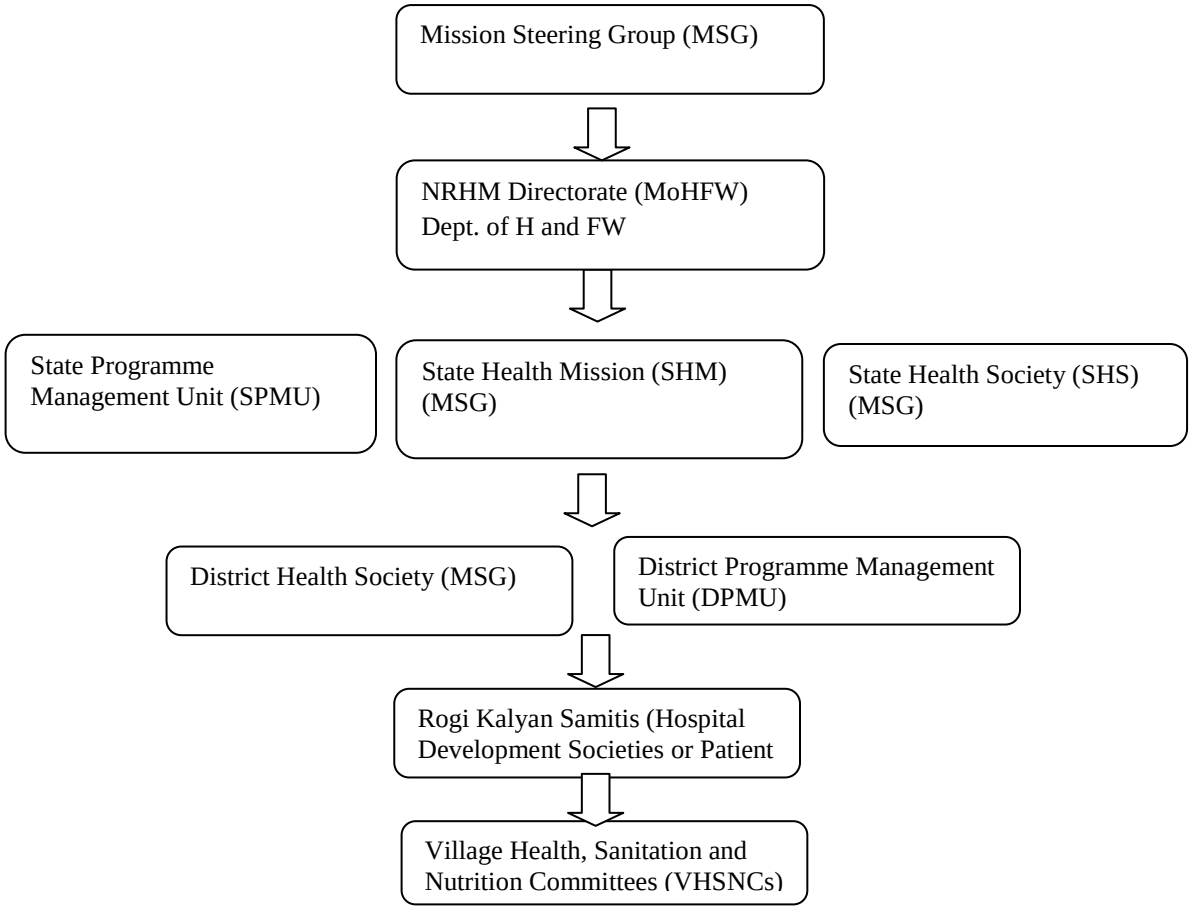
The National Rural Health Mission (NRHM) had adopted the new public organizational and management models to deliver primary health care in rural India (Kalita, and Mondal 2012). This model incorporates multi-stakeholder and new models of management.

Health policy planners have introduced new goals and values. However, the NHRM governance model has not been explored adequately, including its role, function, and structures. With increasing awareness of the significance of governance, it has introduced some critical debates and normative suggestions about 'good governance'. NRHM has framed a new institutional structure for public healthcare governance. It was supposed to make 'Architectural Correction' of the health service sector to improve the provision of services with assured quality and equity in rural India (Priya, 2011). NRHM is the largest health program in the world, and it has attempted to implement a New Public Governance (Dasgupta and Qadeer, 2005).

The various ideas and themes of NPG may broadly be seen in the NRHM. On the one hand, there are those ideas that are derived from managerialism that emphasized on management in government. This originated from the new institutional economics for promoting markets and competition, as a way to ensuring that users are able to access services through what it called as promoting efficiency in service delivery (Larbi, 2003).

A third component was inclusiveness through participatory approaches to planning at all levels. One of the key concerns during the design phase of NRHM was how to build institutions of governance to professionalize the management of public health systems so that it could not only absorb the increased flow of funds but also convert this investment into improved health outcomes (Sarma 2013). In parallel to improvements and innovations in management, there was also need to put in place a monitoring and accountability framework to ensure that funds are used effectively, efficiently and appropriately for what they meant (NHSRC, 2012)

Institutional Framework for Governance for the NRHM



The national level Mission Steering Group (MSG) chaired by the health minister, with the representation of other key ministries at both the ministerial and secretary level. The MSG also included well-known public health experts from both academia and civil society. At the state level, there were three structures the State Health Mission (SHM) at the central, the State Health Society (SHS) for administered decision making and planning, the State Programme Management Unit (SPMU) for implementation program. The SHM is a consultative body at the ministerial level. The SHS has a Governing Board chaired by the Chief Secretary or equivalent and the Health Secretary as the Secretary. It also has an Executive Committee with the Health Secretary, as Chair and the Mission Director as Member Secretary. The SPMU functions as the Secretariat of this Executive Committee and reports to the Mission Director (NHSRC, 2012).

It has a mix of management, and financial professionals hired on a contractual basis, and regular program officers who are part of the Directorate of Health Services (DHS). The Governing Board is a governance institution, which meets once a year, both the Executive Committee and the SPMU, as the executive body, meets more often and is the management organization that is accountable and meant to ensure adequate coordination and participation of the Directorate of Health Services (NHSRC, 2012).

At the district level, the Governing Board of the District Health Society exercises governance functions and the Executive Committee and the District Programme Management Unit (DPMU) are the management organizations. The DPMU is composed of both contractual specialist management staff and regular program officers who come under the Directorate. The district Panchayat members are usually represented and in some states, serve as chairpersons or vice-chairpersons of the Governing Board (NHSRC, 2012).

Rogi Kalyan Samiti (RKS) / Patient Welfare Committee/ Hospital Management Committee

NRHM has proposed Rogi Kalyan Samiti (RKS) / Patient Welfare Committee/ Hospital Management Committee (HMC) for efficient management of health institutions. The objective of this initiative was building community ownership of public health services in rural India. Kumar (2003) has traced the history of RKS. He discusses the Madhya Pradesh scheme of Public Private Partnership (PPP). It was unique because it was a process of translating PPP as a patient's welfare society. This society was taking initiatives for raising funds at the local level for the management of health services. The initial structure of RKS included charitable organizations, donors, leading citizens of the area, people's elected representatives as well as hospital staff. "This partnership has sought from market forces (excepting the areas where NGOs are being involved). The RKS seeks the direct involvement of the users (people) and service providers (Doctors, paramedics) in running the public hospitals. Thus, if the motivational factor in the case of the former is profit, the latter instance is about meeting the social goal and, by extension, raising the social capital" (Kumar, 2003, p. 3041).

Under the NRHM, in health service structure, RKS is an autonomous registered society. It is also known as the Hospital Management Society (HMS). The RKS was meant to supervise the use of untied funds and funds from other sources and thereby work as a community monitoring mechanism for ensuring financial transparency. It is composed of a governing board and an executive committee. The RKS composition includes members from local Panchayati Raj Institutions (PRIs), local elected members, officials from government, representatives of Non-Governmental Organizations and patient group representatives (Adsul and Kar, 2013).

Basic Structure of RKS

The suggested composition of RKS / HMS is as follows[19]

- RKS / HMS is a registered society set up in all District Hospitals / Sub-District Hospitals / CHCs / FRUs. It may consist of the following members: -
- People's representatives MLA / MP
- Health officials (including an Ayush doctor)
- Local district officials
- Leading members of the community
- Local CHC/ FRU in-charge
- Panchayati Raj representative
- Representatives of the Indian Medical Association
- Leading Donors

The RKS is not fully a government agency, but a quasi-governmental agency as far as its functioning is concerned. It has been given special powers. It may use government resources and also impose user charges. It may also raise funds additionally through donations, loans from financial institutions, grants from the government as well as other donor agencies (NRHM, 2014)[20]. Moreover, funds received by the RKS / HMS have not to be deposited in the state exchequer but if available to be spent by the Executive

[19] The basic structure of RKS taken from http://nrhm.gov.in/communitisation/rogi-kalyan-samities/basic-structure.html as accessed on 20th October 2014.

[20] National Health Mission Website (2014 August, 11). Retrieved from http://nrhm.gov.in/communitisation/rogi-kalyan-samities/basic-structure.html as accessed on 20th October 2014.

Committee constituted by the RKS/HMS. Private organizations offering high-tech services like pathology, such as MRI, CAT SCAN, Sonography, etc. can be contracted to establishsuch units in hospitals and rate of service will be fixed by the RKS (Das and Bhatia, 2006). Rogi Kalyan Samitis have been established to facilitate inter-sectoral coordination and increase public participation in decision-making (Lakshminarayanan 2011).

Village Health, Sanitation and Nutrition Committees

Village Health, Sanitation and Nutrition Committees (VHSNCs) have been constituted at the revenue village level and include the elected member of Panchayati Raj Institutions (PRI), Anganwadi Workers, ANMs, and ASHAs as well as community members from SHGs, and vulnerable communities. VHSNCs were meant to play an important role as part of community monitoring and accountability mechanisms as well as planning for health activities in the village. They are also an important element of decentralized planning, though due to limitations in capacity, village health planning has had limited success (Das and Bhati, 2006).

Based on the description of the governance structure under NRHM given above, it can seen that the NRHM structures make a distinction in governance and management. For governance, they have developed the governing boards for decision making in local management committees and the executive committees for taking day-to-day administrative actions. There was setting up of new management organizations under the NRHM and the Programme Management Units at each level to monitor different program components and increased fund flow.

Decentralized Planning under NRHM:

Decentralized planning is envisaged as the core aspect of the NRHM implementation framework. States were required to prepare their Programme Implementation Plans, focusing on their special needs and innovations to fulfill the objectives of the NRHM. District plans and district societies were meant to act as vehicles of decentralized governance. According to NHSRC report (2012), 636 districts prepared plans in 2011-12,

as compared to 310 in the first year of the NRHM. The plans have helped to integrate the activities of vertical programs and different departments including Disease Control, RCH, HIV/AIDS and AYUSH. Even though these programs have integrated, there is a need for larger convergence of vertical programs under NRHM.

There are many challenges put forth by various levels of decentralized governance such as resource allocation, panchayat raj involvement, and community health planning as the integration of democratic methods. Jacob (2010) has analyzed data on NRHM and indicated that there are variations among states as well as within regions. These variations are observed regarding utilization of funds, delivery of health services and people's involvement. Regional variations have shown that there are improvements in the regions that already have good health indicators whereas the regions with poor health indicators have shown less improvements. This is despite the fact that there is much focus of the NRHM on poorly performing states. There is a mandatory need for development of the overall governance of states and regions for improvement in governance within NRHM (Jacob, 2010)

Thus, the HLEG and 12th plan are only building upon the governance changes that the NRHM had initiated. Therefore, implementation of NRHM since 2006 provides a good example to examine the nature and outcomes of New Public Management and New Public Governance in the health system of India. In the next chapters this study attempts to examine the changes brought about by the NRHM by undertaking an empirical study to understand the implications of these changes in the state of Maharashtra. Since the context of the State is crucial in this regard, the following chapter describes the administrative structure and developmental history of Maharashtra in brief and then moves to health governance.

Universal Health Coverage process in India:

While the NRHM was ongoing, the government of India setup The High-Level Expert Group of Planning Commission of India on Universal Health Coverage (UHC) to suggest the roadmap to UHC by 2020. Report on Universal Health Coverage (UHC) has acknowledged the contribution of New Public Management (NPM) that there were

structural changes being made in the existing Indian public health system mechanisms under the NRHM. It analyses that the idea of NPM has entered in the development discourse in 1980-90s decade and has redefined the role of the state, the power of government with stewardship, oversight, and regulation being used for service provision in the public system (Government of India, 2011). The implementation of the NPM approach has both successes and weaknesses. The crucial success of NPM is viewed in how to use multiple resources, facilitate processes and negotiation with actors to fulfill policy and program goals. The HLEG report points out that the NPM has improved management techniques and regulation frameworks. It concludes that it will help for convergence of public and private sector to achieve Universal Health Coverage (Government of India, 2011, p.231).

The HLEG's report has defined Universal Health Coverage as

> Ensuring equitable access for all Indian citizens resident in any part of the country regardless of income level, social status, gender, caste or religion. To affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) As well as public health services addressing wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services (Government of India, 2011, p. 3).

Sen (2012) pointed out that there are challenges to achieving the goal of universal health coverage in the Indian context because there has been different transition which affects the outcome of the health system. These transitions are an epidemiological transition and demographic transition that has an impact on the social determinants of health. This has increased apprehensions about the issue of equity and access. The multiple dimensions of economic, caste, gender, rural-urban and across states have an effect on the health system (Sen, 2012, pp. 46-47).

According to Phadke (2011), HLEG suggested a strategy for Universal Health Coverage and not Universal Health System. Universal Coverage may mean merely covering the entire population through a system, which will continue dominated by the logic of the market in health care. The issue of finance is an important factor in the HLEG report. It suggested tax based funding for health care, but there is no clarity on the

operationalization of this element for universal financial protection that covers inpatient and outpatient care under the National Health Package (NHP) of essential primary, secondary and tertiary health care services (Phadke, 2011). This kind of protection is to ensure that all aspects are fully financed through pre-payment and actual provide cashless services at point of service, with the public and the private sector collaborating to do this within a well-defined regulatory and contracting framework (Ibid).

On the provision of the health care question, the Report recommended a mix of public health services with regulated, 'contracted in' services of those private providers who accept certain conditions. For the provisioning of Health Entitlements, Smart Cards have been seen to play a major role. A card that can be used to access the public services and contracted in private providers without the need for using insurance led purchasing models or purchaser-provider splits. Critical analyses of HLEG proposals argues that this cashless model is not taking into account the out of pocket expenditure on health care. The role of private voluntary or community-based insurance plans seems to be given a significant role (Phadke, 2011).

Baru (2012) has pointed to the role of the private sector in the HLEG report. According to her, there is a political silence in HLEG recommendations on the growing role of the private sector in the various sub-systems. The greater challenge was the regulation of the private sector and corporate sector in India, as it has been growing as a powerful lobby in policy decision-making processes (Baru, 2012).

On the issue of medicine procurement, HLEG suggests the Tamil Nadu Medical Services Corporation's model of centralized tendering and purchase of drugs for procurement and distribution of medicines as the model (Singh, et al., 2012; Phadke, 2011). It is a quasi-governmental structure adopted by Government of Tamil Nadu to deal with drugs and medicine procurement and distribution issues.

On the issue of Planning and Governance, the HLEG Report emphasizes the participation of communities, local elected bodies and NGOs as a prerequisite for successful implementation of UHC. It also acknowledges the role of ASHAs, and other Community Health Workers at the village level and proposes urban community health workers on

similar lines. Some initiatives suggested by the report for social responsiveness includes "*Jan Sahayata Kendra"* for the provision of risk-free grievance redressal and information services and "*Swasthya Panch*" to conduct periodic social audits or hearings on health issues, also giving importance to the preparation of the National Health Act (MFC, 2011). The HLEG report sees the management of the health system as systemic and institutional management reforms to rationalize the management of the Public Health system.

Phadke pointed out "Systemic management reforms would apply to the entire private sector, to ensure the quality of care, rational interventions, and medications, as well as safeguarding of patients' rights and ethical practices. Here one would add that the regulation should not be thrust from above by bureaucratic means, but it has to be participatory, multi-stakeholder" (Phadke, 2011, P. 17). Srivatsan and Shatrugna (2012) has put forward the issue of political challenges of universal access to health care generated by the different forces and interests that come into play to shape and reconfigure administrative policy and its implementation.

The Medico Friend Circle (MFC) concept note paper (2011) points out that the improvement of governance for Universal Access to Health Care (UAHC) through three mechanisms. Firstly, there is a need for 'adequate law', secondly 'institutional structure' means how the members of various participatory decision-making structure formation, the process empowerment of representative. Third is the 'culture of citizen's participation'. It highlighted some of the crucial aspects of the governance of health systems.

To improve governance mechanisms following steps were taken into consideration.

- There is a necessity to create a 'culture of Universalism' between all the health system actors.
- The governance value framework must guarantee accountability of the key stakeholders in the system and also to the users.
- The policy process is enabling the interplay of the key competing interest groups to influence policymaking on a level playing field. Adequate state capacity, power and recognition legal to administrated the policy-making processes meritoriously,

and to planning and develop programmatic interventions, to implementation health policy decisions.

- Develop a institutions structure that will guarantee people's participation, accountability. Also, developed the governance mechanisms for creating ownership of the community There is a need to invest in healthcare management capacity building in developing countries
- Governance depends on upon the engagement and efforts of non-state actors in the policy arena, as well as in service delivery partnerships and oversight and accountability (Shukla, Phadke and Gaitonde, 2011, pp. 342-344).

Ritu Priya (2011) highlights the limitations of the Universal Health Coverage model. She argues that this current model is based on a biomedical, technocentric and expert knowledge paradigm that excludes the lay people in the provisioning and financing of the UAHC. She raises a question "In our people-oriented model for universal access to health care (UAHC), is the vision one of the people's roles as 'participation' in pre-designed services, or should the model itself keep 'people center-stage'" (Priya, 2011, p.10).

Health Planning Under Twelfth Five-Year Plan (2012-17):

The direction of health planning under the twelfth five-year plan was influenced by the HLEG report on Universal Health Coverage. Health is being spelled out in the Twelfth Plan as process and pathways for Universal Health Coverage. The plan focused on creating mutual consensus among health system stakeholders. It is seen as a long-term challenge to bring architecture changes (Nambiar, 2013). The plan just focused on achieving long-term systemic goals. The twelfth five-year plan suggested that the National Rural Health Mission be converted into a National Health Mission (NHM) that would cover all villages and towns in the country. NRHM has to be strengthened under the umbrella of NHM, and that must have universal coverage as the prime objective of implementation framework. The rural health care also developed one of the prime agenda under the framework. The NHM is targeted both in rural and urban areas to promote universal health access (Patel, et al. 2015). The special programmatic strategy developed for urban areas is to enable easier access. All the services would be cashless from primary to tertiary level care. The focus is on developing primary, secondary and tertiary levels of

health care under the health system strengthening. The role and responsibilities are clearly defined for center and state governments in the plan (Planning Commission, 2013).

The Twelfth Five-year Plan document suggested Key elements of decentralized planning under the National Health Mission.

- District was to be the primary unit for decentralized planning. Every district was to set the framework to improve community participation. Health action plan would be prepared for prevention and service provisioning and management. It also developed transparency in resource allocation processes. It focused on strengthening social audit at the local level to build the trust of the community over the system. Accountability mechanism was to be set through community-based monitoring.
- Health action plan includes an integrated approach for service delivery from the district to the village level to reach out to the last section of society. Proposed district planning process focus on all the determinants of health and health care. The convergence approach is undertaken to address determinants of health and health care.
- These plans can influence the midday meal program for addressing issues of child malnutrition and anemia at the school level. Joint training of AWWs and ASHAs would promote to build camaraderie and clarity on mutual roles and responsibilities. Anganwadi Centers has been used as a base station for ASHAs and upgraded into health posts for the delivery of essential health services. Essential Health Services Package would be delivered under the NHM.
- Innovations in service delivery to improve coverage, quality of care, health outcomes and reduce costs would be encouraged and recognized.
- Prepare sector-wide plans to address special needs of health and health care. State takes the prime responsibility for co-ordination of sector-wide planning and funding. Convergence of different segments of health under state health plan (Ibid, 2013).

Health Governance Structure under the Twelfth Five-Year Plan:

The Twelfth Five Year Plan document envisages a broad and flexible governance structure for the National Health Mission. Under this, the structure for governance was developed for the involvement of sectoral organizations and non-state actors for determining demand and planning. An integrated approach is used to include the civil society for quality service delivery of social sector programs. Through Panchayati Raj institutions, to allocate all the financial and human resources and make multi-sectoral social plans to address the challenges collectively (Ibid, 2013).

To address the gaps in management capacity at state level, the following detailed course of action is mentioned in the plan. It focused on developing a cell for medicine procurement, logistics, and human resource management. It emphasized on the use of advanced information technology for financial management and quality control. It also stressed for a developed referral transportation system, program monitoring and evaluation system (Ibid, 2013).

It also focussed on greater efforts at community involvement in planning, delivery, and monitoring. It also adopted the internal and external monitoring and evaluation strategies from the NRHM such as community-based monitoring, social audit of health services, a well publicised citizen's charter for a guarantee of services, public hearing for creating a dialogue with community and a developed grievance redressal mechanism (Ibid, 2013).

The Rogi Kalyan Samiti model of facility management launched under NRHM was extended under the plan. It will help to improve the autonomy matched by greater accountability for the management of the facility for timely and quality care, and availability of essential drugs. This needs stringent regulation to ensure that mismanagement of funds, drugs, and equipment does not happen (Ibid, 2013).

Thus, one can see that the NRHM has created models that espouse the New Public Management (NPM) and New Public Governance (NPG) approaches, which have been taken up by the planners for the future development of health services.

Chapter-V

Health Governance Transformation in Maharashtra

Chapter- V

Health Governance Transformation and the NRHM in Maharashtra

Introduction

The formation of Maharashtra state has a long political and historical context, which shapes the governance structure and development initiatives in the state. Maharashtra is one of the developed states in India. However, it is also known for inequalities in the distribution of resources within the state as the outcome of regional imbalance (Mishra, 2008, Paranjape, 2007). Maharashtra has adopted various governance strategies and approaches to deal with regional imbalance and inequalities. In the case of public health services regional and district planning and decision-making has been the approach that has been used under NRHM.

This chapter focuses on the development of health services in Maharashtra over a period. It explores the health governance transformation in the context of the evolution of health services. The developmental policies and programs, provisioning, infrastructure and services in Maharashtra have a political context, which shapes its governance structure. The chapter is divided into five sub-sections. The first section discusses a brief history of state formation, which has set out the basic structure of public administration and had a major impact on the development of the state. The second section highlights details of demographic, administrative and health profile of the state. The third section addresses the issue of intra-regional inequalities in Maharashtra. The fourth section discusses health services and governance development in Maharashtra. The fifth section of the chapter focuses on challenges of health governance in the state.

Formation of State Maharashtra

Maharashtra has a long historical background of various rulers, from kingdoms of Maurya Empire to Peshvas of Pune. The historical texts showed the Maharashtra also had Yadav rulers in many regions. The historical monuments of Mughals in Marathwada regions are marked evidence of rule of the Mughal kings in Maharashtra. Buddhist caves in Maharashtra manifest the roots of Buddhism in the state.

The history of Maharashtra is known for the dominance of Maratha's and Peshvas legacy. There are many historical personalities from Maharashtra such as Mahatma Jyotiba Phule, Savitiribai Phule, Ramabai Rande, Balgangadhar Tilak, Agarkar, Dr, B. R. Ambedkar. Shree Shivajiraje Bhosale considered as historical figures of Maharashtra who have shaped people's politics. During British rule, the region of Maharashtra was divided into various provinces. The western part of Maharashtra was under the Bombay Presidency during British rule (Vanamore, 2013)[21].

Before the independence of India, Indian National Congress had assured to introduce linguistic states formula for new states formation. However, post-Independence of India Jawaharlal Nehru and Sardar Vallabhbhai Patel unalterably opposed the idea of linguistic states. They perceived linguistic states idea as a threat to the integrity of India. After independence, many provinces united on the basis of language and region. The idea of the linguistic state was prominent during this era. In the context of Maharashtra, Gujrat (Saurashtra and Kotch region) and Western Maharashtra joined together under Bombay state basis of political negotiations. Bombay as capital was the central issue of the dispute for the Saurashtra region and Samyukta Maharashtra Samiti. The Bombay state is dissolved in 1960 after a long political struggle. This lead to the formation of Maharashtra and Gujarat states on 1 May 1960 (Schoenfeld 1965). This formation took place based on a linguistic line of Marathi and Gujarati. Formation of Maharashtra state was a long mass protest history and political contestation with Indian National Congress. Formation of Maharashtra was a national political issue during 1956 to 60's. Samyukta Maharashtra Samiti was a major political opponent to Congress during this time in Maharashtra. Various political and social leaders (mainly socialist leaders from Pune and Mumbai) were against the idea of joint state Gujrat and Maharashtra. Pune was the hub of Samyukta Maharashtra Movement during the 1960s. The United struggle took place under Samyukta Maharashtra Movement. The major demand of Samyukta Maharashtra Movement was Maharashtra state formation along with Bombay as capital for

[21] Vanamore, H. S. (2013). *Geographical Personality of Maharashtra*, (Chapter III) Retrieved from http://shodhganga.inflibnet.ac.in as accessed on 17th July 2014. Full thesis could not be obtained.

Maharashtra (Jadhav, 2010)[22]. The committee also fought for Belgaum and Karwar region for Maharashtra. This committee endorsed dismantling of the bilingual State and creation of separate Gujarat state. Prime minister of India, Indira Gandhi accepted the demand that Mumbai remains as capital for Maharashtra. The parliament passed a resolution in May 1960 creating a separate State of Maharashtra consisting of twenty-six districts and two hundred and twenty-nine taluks (Thakare, 2015). The widespread discontent among people mounted and made Congress agree to the Samiti's demand. Maharashtra was created as a new state on May 1, 1960, with Mumbai as capital. Goa, Belgaum, and Karwar kept out, and this does lead to political heat during every election (DNA, 2014)[23]. Till now, Maharashtra and Karnataka have the border dispute issue of Belgaum and Karwar region. Today's Maharashtra is thus, only a fifty-year-old state.

After formation of Maharashtra state, Indian National Congress was major political ruler party in Maharashtra. Yashwant Rao Chavan was the first Chief Minister of Maharashtra. His tenure was from 1 May 1960 to 19 November 1962. His major contribution to Maharashtra's development is in founding cooperative movement in rural areas. He is one of the founders and propagators of the cooperative movement in Maharashtra. He contributed to the establishment of eighteen cooperative sugar factories, water irrigation projects on a cooperative basis, and hydroelectric power project on Koyna dam. He restructured village level governance structures through cooperative movement. The cooperative movement in Maharashtra was first framework or model used for decentralization of governance at local level (Chithelen, 1985; Baviskar, 1969).

Maharashtra has a unique caste composition of chief ministers. Legacy starts from Yashwant Rao Chavan. Maharashtra prominently had Maratha Chief Ministers mostly from Indian National Congress party, such as Marotrao Kannamwar, Shankarrao Chavan, Vasantrao Naik, Vilasrao Deshmukh, Sharad Pawar, Vasantdada Patil, Babasaheb

[22] Jadhav R. (2010, April 30). Pune Pioneered Samyukta Maharashtra Movement. *The Times of India*. Pune. Retrieved from http://timesofindia.indiatimes.com/city/pune/Pune-pioneered-Samyukta-Maharashtra-movement/articleshow/5874479.cms as accessed on 10th May 2014.

[23] DNA. (2014, May 1). What is the Samyukta Maharashtra Movement. *Daily News and Analysis* (Dainik Bhaskar Group). Retrieved from http://www.dnaindia.com/mumbai/report-what-is-the-samyukta-maharashtra-movement-1983811 as accessed on 19th May 2015.

Bhosale, Ashok Chavan, Prithviraj Chauhan and Narayan Rane. Besides, Marathas one Muslim A.R. Antulay and one schedule caste Sushil Kumar Shinde from Indian National Congress Party became chief ministers of Maharashtra. Along with this two Brahmin Chief Ministers Manohar Joshi from Shiv Sena and Devendra Fadnavis from Bharatiya Janata Party (BJP) became chief ministers of the state. This clearly shows the dominance of upper caste leadership in the democratic electoral politics. The larger governance shift has taken place in the sphere of economic development. However, the social characteristics of leadership have not changed (Palshikar and Deshpande, 1999; Dahiwale, 1995).

Thus summing up the argument, before independence Maharashtra was ruled by various leaders and had domination of different sects. After independence Maharashtra, electoral politics has been dominated by upper caste political leaders who even happen to assume the role of chief-ministership

Present Brief Demographic Profile of Maharashtra

In terms of population, Maharashtra is second largest State in the country with about 9.29 percent of the country's population. This makes the rate of growth 15.8 percent and 16.2 percent for males and females respectively. Due to the slightly higher growth rate of females, the sex ratio has increased from 922 to 925 during 2001-11. The sex ratio is 940 at the national level (Govt. of India, 2013).

In the State, 82.91 percent are literates in 2011, which is higher than 74.04 percent at the national level. Sex-wise literacy rates show that it is 89.82 percent for males and 75.48 percent for females. At the nationwide, it was 82.14 percent among males and 65.46 percent among females. Maharashtra has improved the male literacy rate from 85.97 percent to 89.82. and the female literacy rate increased from 67.03 percent to 75.48 percent during the period 2001-11 (Govt. of India, 2013).

Agriculture Pattern in Maharashtra

Maharashtra's economy has a large agrarian share. The net state domestic product share of Maharashtra agriculture has declined from 36% in 1961-62 to 18.7% in 1992-93. In 2007-08 it was 8.57 % and 2009-10 it was 14.62 %. The workforce engaged in

agriculture was as high as 83 percent even in 1991, nearly half of the agricultural workers being laborers. In the state's total domestic product, agriculture contributes nearly 17.00 percent (Government of Maharashtra, 2012).

The cropping pattern in Maharashtra is seasonal (Kharif and Rabbi) and regional. During monsoon season crops include Rice, Jawar, and Bajara. Other crops include pulses, vegetable Wheat, and onions. The Cash crops in Maharashtra include cotton, sugarcane, turmeric, and numerous oil seeds including groundnut, sunflower, and soybean. The state has massive areas under fruit cultivation of which mangoes, bananas, grapes, and oranges are the main ones. The regional variation in cropping pattern in Maharashtra is reflected in Konkan region being considered Paddy region. Along with rice, there is a large production of Cashewnut and Mango, mainly Alphonso and coconuts. The Western Maharashtra & Khandesh major cropping pattern is Sugarcane, grapes, turmeric, Banana and Soybean. Vidarbha and Marathwada regions are known for the production of Cotton, Oilseeds & Pulses, oranges, mangoes & banana (Sawant, et al. 1999).

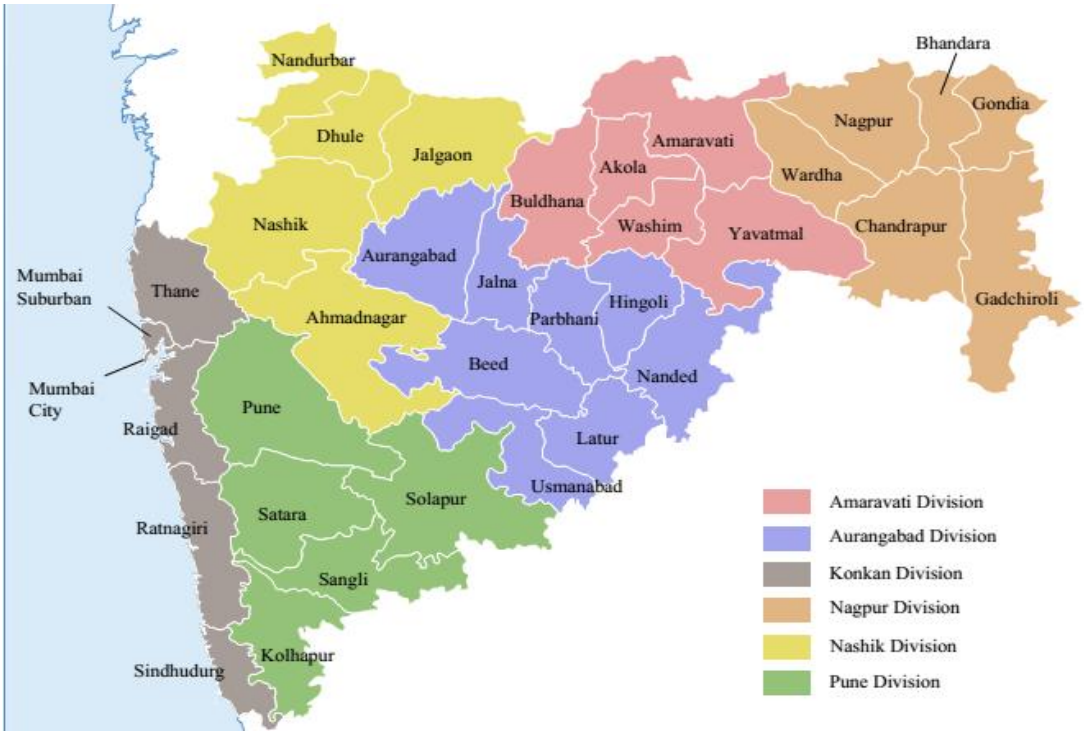
The regional inequalities also reflected into regional agriculture imbalance. The cooperative movement in Maharashtra has linkage with agriculture development. In the 1960s, the Green Revolution has developed agriculture in states like Punjab. However, in Maharashtra cooperative movement had also played an important role (Baviskar, 1969). It decentralized decision-making and model of agricultural financing. It set the new democratic mode of governance pattern in Maharashtra (Vandeplas, Minten, and Swinnen, 2013). The cooperative movement in Maharashtra was established in western Maharashtra due to political leadership from this region. There are limitation and strength of these models of functioning in Maharashtra. The growth and development of the state economy was highly concentrated in some districts. It has not trickled down to many other districts. Due to plenty of rich natural resource and viability of agro-climate throughout the year, the region of Western Maharashtra and Konkan is well ahead in social, economic and educational development as compared to the two other regions (Mohanty, 2009).

The agrarian crisis in the state has taken adverse shape resulting into continuous and unabated farmer's suicides. Malnutrition related deaths and severe under-nutrition are rampant amongst children and women of the tribal groups (Birdi, et al. 2014).

Administrative and Governance Profile of Maharashtra

Maharashtra has been distributed into six divisions for administrative purposes. These divisions are Vidarbha (Nagpur Division), Vidarbha (Amravati Division), Marathwada (Aurangabad Division), Konkan (Konkan Division), Khandesh (Nashik Division) and Western Maharashtra (Pune Division). The aim of divisions is to help improve governance and decentralize administrative decisions and policy implementation processes. However, it is significant to mention that the administrative divisions have a socio-cultural basis and long political struggles by local people.

Map-5.1
Administrative Divisions of Maharashtra



Source:(Google Map from wikimedia)[24]

These administrative divisions in Maharashtra has strong political interconnection too. Every region had special development needs and required distinctive resource

[24] Map of Maharashtra- Retrieved from http://upload.wikimedia.org/wikipedia/commons/5/5f/Maharashtra_Divisions_Eng.svg as accessed on 14th December 2014.

allocations. To tackle this issue Government of Maharashtra came with regional governance approach through six administrative divisions. The rationale behind these divisions was to help in decision making, planning, and fund allocation as per their diverse conditions.

Regional Governance and Accountability Mechanisms

The regional governance is a historical demand in the context of Maharashtra. The 'Report of The High-Level Committee on Balanced Regional Development Issues in Maharashtra 2013', has shown the historical roots of these divisions. It also shows steps that have been taken by the Government of Maharashtra (GOM) to improve regional governance. See-Box-5.1

Box-5.1

Regional Governance Mechanism

- The government of Maharashtra has reorganized the Regional Development Boards for regional governance. They are administered under the chairmanship of Chief Minister of Maharashtra.
- Appointment of Additional Chief Secretary rank officer designated as 'Additional Chief Secretary & Regional Development Commissioner' (ACS & RDC) to head the Regional Secretariat and be the Member Secretary of the Regional Development Board.
- Regional Boards to prepare comprehensive Five Year Perspective Plans and Annual Plans of the Region. Plan resources devolved to the Districts and Blocks.
- Regional Boards entrusted with the responsibility of planning, supervision, and monitoring of development plans of that Region.
- An Empowered Group of Ministers from that region is to be formed in each region for faster decision making on the region specific problems
- Equitable distribution of Key Ministries amongst the three regions to promote the spirit of the Nagpur Agreement.
- Block Planning Committees (BPC) to be constituted for planning and implementation purposes.

- State Government will establish a Project Appraisal Board for management of the State's large PPP projects as well as for management of specific project borrowings.
- A new agency, State Statistical Board, to strengthen the statistical systems in the State will be established at the earliest.
- New Public Policy Platforms in the form of a Policy Institute and the Maharashtra Development Research Council at State level and Regional Institutes of Governance at the regional levels are to be established for a systematic and sustained institutional framework.
- State Assembly of Maharashtra (Mantralaya) will shift to Nagpur for a fixed period in December every year, to address the special needs of Vidarbha and Marathwada.
- Several Directorates are to be shifted to Nagpur and Aurangabad as per the spirit of the Nagpur Agreement.
- The royalty earnings from mineral resources of Vidarbha should be 'ring-fenced' for local area development. Also, the royalty rates should be rationally set on the ad-valorem[25] basis and be periodically revised.
- The power produced in the province is to be made available at village level with minimum rates. Likewise, a part of the revenues earned from the export of power to other regions will be used for local development

Source: Government of Maharashtra, 2013, Pp.189 -203.

This constructive measure of regional governance has been taken to deal with underdeveloped regions development such as Vidarbha and Mharathawada being the primary focus.

Governance Initiatives in Maharashtra

The Regional governance framework was adopted in Maharashtra since its formation. These governance mechanisms were initiated in the period since the formation of

[25] It is commonly applied to a tax imposed on the value of property. Real property taxes that are imposed by the states, counties, and cities are the most common type of ad valorem taxes.

Maharashtra. This has set the framework for governance of Maharashtra. The regional governance in Marathwada, Vidarbha, and the rest of Maharashtra was a political strategy for United Maharashtra (Kumar, 2001). However, the main issue of regional imbalance along with larger deprivation of some regions of Maharashtra had people discontented in these regions since mainly western Maharashtra benefited through the regional governance mechanisms. That had to be addressed through policy decision-making processes to foster better regional growth. It was important to develop a governance framework that permits region specific decision making and accountability to address the regional needs and priorities. Efforts for removal of backlog and equitable distribution of resources to regions were attempted (Phansalkar, 2005).

The historical Nagpur Agreement (1953) and Akola pact articulated the principles of governance. It takes into consideration the varied development levels of three regions, Vidarbha, Marathwada and rest of Maharashtra. The debate of regional imbalance since the Nagpur Agreement has led to a formal recognition of the three regions as units of governance. The Nagpur Agreement has been considered as the guiding principle for governance under Article 371 (2) of the Constitution. (Government of Maharashtra, 2013a).

In fact, the issue of governance seems to be the most important aspect of Nagpur Agreement. Important decisions contained in the Nagpur Agreement, which pertain to governance, are as follows:

Box-5.2

Regional Governance Mechanism under Nagpur Agreement

1. "For the purpose of all types of development and administration, the three units, namely, Vidarbha, Marathwada and the rest of Maharashtra will be retained as such.

2. Subject to the requirements of a single Government, the allocation of funds for expenditure over the different units would be in a share of their population however Marathwada needed special attention to promote the all-sided development of that area. A report in this behalf will be placed before the State Assembly every year.

3. The three units will be given representation in proportion to population in (a) the composition of the Government, (b) the admission to all educational institutions having

training facilities in vocational and scientific professions or other specialized training, and (c) the services, of all grades, under Government or Government controlled enterprises.

4. The High Court of the new State will have its principal seat at Bombay and the second seat at Nagpur. The Bench at Nagpur will ordinarily function for Vidarbha area. While making recommendations of High Court Judges, it shall be seen that Vidarbha and Marathwada areas get adequate representation in respect of appointments from the services and the bar.

5. Subject to the efficient conduct of the administration of a single State, the advantages derived from the people of Vidarbha from Nagpur as the capital of their State shall be preserved to the extent possible. The Government of Maharashtra shall officially shift to Nagpur for a definite period and hold at least one session of the State Legislature every year in Nagpur.

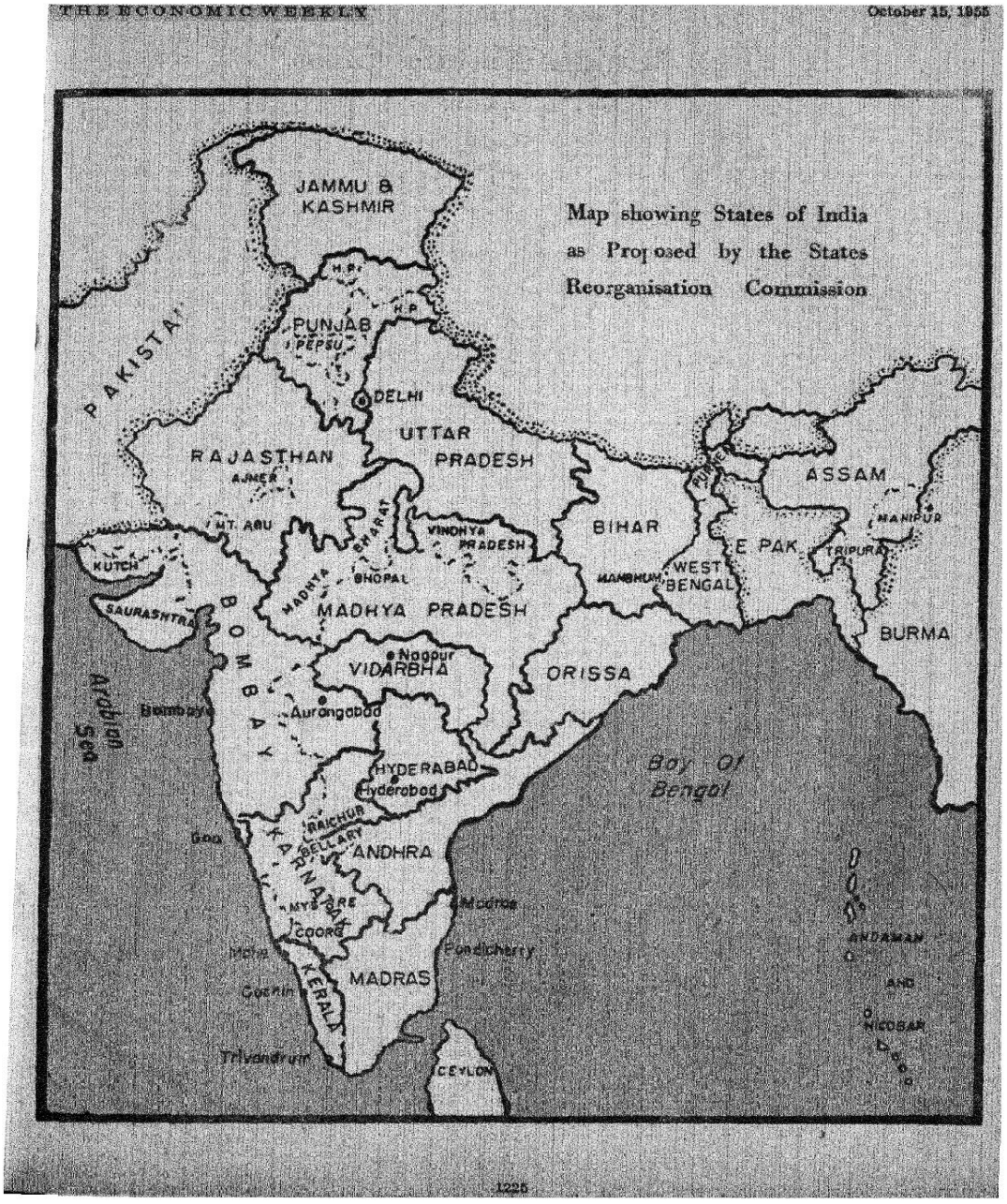
6. The administration will be decentralized as an effective means of better associating the people of different units with the administration."

Source: Government of Maharashtra, 2013a, pp 172

The States Reorganization Commission (1955) report had suggested the formation of a separate Vidarbha State, however the Parliament of India did not approve it. The Nagpur Agreement has given constitutional recognition to the inclusion of Article 371(2) in the Constitution Ninth Amendment Act, 1956. In Article 371 (2) (Annexure I), the demand for regional governance has been constitutionalized. Map of India provides insight on this issue.

Map-5.2

Map of India Proposed by the Reorganization Commission



Source: The Economic Weekly (1955)[26]

[26] The Economic Weekly (1955). Reorganisation of States the Approach and Arrangements. *The Economic Weekly*. Retrieved from http://www.epw.in/system/files/pdf/1955_7/42/reorganisation_of_statesthe_approach_and_arrangements.pdf as accessed on 28th July 2015. Page no and volume no. is not available.

Map-5.3

States and Union Territories: Map of India

Source- http://www.mapsofindia.com/maps/political.htm

Later, Sanyukta Maharashtra Movement also stands for regional governance, in 1960, the reorganization of provinces led to the formation of Sanyukta (unified) Maharashtra. The stand of the Sanyukta Maharashtra on the regional governance reflected in the speech of first Chief Minister of Maharashtra Shri Yashwantrao Chavan.

> "Likewise, I wish to assure the people of Vidarbha that they need have no apprehension that their legitimate interests will not be protected; on the other hand, they will be zealously guarded and will be treated as a sacred trust of the future Maharashtra Government. The terms of what is known as the Nagpur Pact will be honored and wherever possible something more will be done" (Government of Maharashtra, 2013a, pp. 102-103).

Shift of Focus from Regional Governance to District Governance

A Governance shift has taken place during the 1970s, from region to the district as the unit of planning and development. The Union Planning Commission issued guidelines for the preparation of district plans. It directed the formation of District Planning & Development Committees (DPDCs) and a separate District Annual Plan. The Panchyati Raj movement in Maharashtra had correspondingly contributed to the processes of decentralization. That has given a basis for the shift from regional to district governance. The important factors contributed to the shift are recommendations of the Balwantrai Mehta Committee (1957) and P. B. Patil Committee on the establishment of Panchayati Raj system. The 73rd and 74th Constitutional Amendments of 1992 further reinforced the efforts for democratic decentralization and made the district a key unit of administration, local governance, planning and implementation (Mohanty and Parigi 2004).

To address the issue of backlog and imbalance in development, Shri Vasantdada Patil established a Fact Finding Committee under the chairmanship of Shri V. M. Dandekar in 1984. It assessed the level of development in Marathwada, Vidarbha and rest of Maharashtra and recommended that 85 percent of the yearly budgetary allocations be used for removal of the backlog. This recommendation was not implemented by the State Government (Government of Maharashtra, 1984).

In 1994, the government of Maharashtra had established Regional Development Boards. It was mandatory under Article 371(2) for the establishment of separate Boards for Vidarbha, Marathwada and the rest of Maharashtra. Under this Article, the Governor has power, and he is bound for the allocation required for removal of backlog among the three regions. Funding has been the key issue of development. The state government received funding from Government of India. These funds were mainly for the centrally

sponsored program and schemes. Funding and backlog are major issues in this region. The District Planning Committees prepare the district sector plan. It assumed that the present processes of decentralization and transformation of power would lead to adequate resource allocation following in all district. However, the issue of state pool and district pool needs reexamination for balanced regional development.

District Planning Mechanism

Maharashtra has followed district planning from a long time, even as part of regional planning. In 1960, Government of Maharashtra had constituted District Planning and Development Councils (DPDCs) in every district. In the seventies, the Government of Maharashtra had implemented a policy of district as a unit for the formulation of Annual Plans. As per Article, 243 ZD of the 74th Amendment to the Constitution replaced District Planning and Development Councils (DPDCs) with District Planning Committees (DPC). However, the power of DPC was distributed among elected members and state bureaucracy actors[27]. The District Guardian Minister is the Chairperson of DPC whereas the District Collector is its Member Secretary. The Government of Maharashtra has admitted 50% reservation for women representatives in DPC. As per the policy of decentralization, DPC is expected to facilitate the preparation of participatory plans by the rural and urban panchayats and then consolidate those plans into an Integrated District Plan. The plan consolidated by DPC was to be finalized in state-level meetings held under the chair of Hon. Minister (Planning). The approved outlay of district plan was included in the State budget. These approved district plans were consolidated and submitted to Legislature. Provision of funds for on-going works were made on priority and then new works are proposed. Works taken under the district plan need to be complete within two years (Government of Maharashtra, 2013a).

Summing up the argument, equal regional development is the basic objective of Government of Maharashtra. However, it has seen the standard of regional development and priority of the region has changed. Western Maharashtra has taken a large share of development benefits. That has led to regionalism within Maharashtra. The Congress and

[27] For more information see http://aurangabad.nic.in/htmldocs/About_Planning_Br.htm accessed on 23rd July 2014.

the Nationalist Congress Party government in Western Maharashtra have pooled development resources to their regions. Now it has been the same happening in Vidarbha due to present Chief Minister of Maharashtra being from Nagpur. Most of the important institutions have been establishing in Vidarbha region. Political leaders from Marathwada are dissatisfied with the all these political decisions. It is wrong governance practice in the name of development since the goal of equal development has been sidelined in practice. Regionalism is dominate than development in Maharashtra's governance practice, because of the ruler's attitude towards development. They have given preference to the region mainly by-election constituency of the CM than the state of Maharashtra. While Vilasrao Deshmukh and Ashok Chavan were Chief Ministers of Maharashtra from Marathwada region, they target pooled resources in Latur and Nanded region, not gone ahead towards integrated development of Maharashtra. After the creation of the state, the political rulers did not give attention to equal or integrated development and that has reflected in the emergence of regionalism in Maharashtra. Today it is visible in a separate Vidarbha campaign; tomorrow Marathwada will demand the same. If standards of governance are not followed, it will always question the integration of the state's regions.

Modes of Administration Units in Maharashtra

There have been different modes of administration units in Maharashtra. The state consists of 35 districts, 34 Zilla Parishads, and 353 Tehsils. Maharashtra has 27,873 Gram Panchayats, 351 Panchayat Samitis, 226 Municipal Councils, 26 Municipal Corporations, 13 Nagar Panchayats, 7 Cantonment Boards, 41,095 inhabited villages.

Table-5.1

Types of Administrative Units in Maharashtra

Item	1960-61	1970-71	1980-81	1990-91	2001-01	2010-11	2013-14
Revenue Divisions	4	4	6	6	6	6	6
Districts	26	26	28	31	35	35	35
Tehsils	229	235	301	303	353	355	355

Inhabited Villages	35851	35778	39354	40412	41095	40959	40959
Un-Inhabited Villages	3016	2883	2479	2613	2616	2706	2706
Towns	266	289	307	336	378	534	534
Panchayati Raj Institutions							
Zilla Parishads	25	25	25	29	33	33	34
Gram Panchayats	21636	22300	24281	25827	27735	27913	27873
Panchayat Samitis	295	296	296	298	321	351	351
Municipal Councils	219	221	220	228	228	222	226
Municipal Corporations	3	4	5	11	15	23	26
Nagar Panchayats	-	-	-	-	3	4	13
Cantonment Boards	7	7	7	7	7	7	7

Source: GoM (2015), Economic Survey of Maharashtra 2014-15

Mumbai is the main capital of Maharashtra whereas Nagpur is its winter capital. There are 35 districts, 358 talukas and 43,722 villages in the State.

Table-5.2

Profile of Pune District Administrative Unit

Administrative Units in Pune District		
Units	2001	2011
Number of Sub-districts	14	14
Number of Villages	1866	1877
Number of statutory towns	16	16
Number of Census Towns	9	19

Source: Census of India, 2011, Pune District Profile

The Government of Maharashtra is making continues efforts to make administrative sub-divisions for better governance. It has been seen as administrative and Panchayati Raj Institutional structure will make the balance of power through a combination of bureaucracy and people's representatives. These units of governance have a certain degree of autonomy to manage their affairs at each level. Another benefit of this structure was it would increase the access of public institutions for people. The Panchayati Raj Institutions function as self-governing units at the local level. Decentralization of governance has strengthened the local level public institutional structure.

Health Services Development in Maharashtra

The health services development in Maharashtra has historical roots. The formal medical health service was started under British rule. During this period Maharashtra was part of the then Bombay presidency. Bombay presidency was an important geographical location for trading and commerce activities for East India Company. The large military settlement got placed for the security of goods and protection of trade activities in this coastal area. In 1835, the first medical college was established in Bombay in accompaniment with Calcutta and Madras. After this, over the years, a number of hospitals were established in Bombay, for example, the J. J. Hospital, the St George Hospital, Gokuldas Tejpal Hospital, Cama Hospital, etc. The major purpose of this clinical establishment was catering to the health needs of the military. These hospital establishments have initially served the military interests rather than the general population (Mushtaq, 2009). Apart from Bombay, in 1867 David Sassoon, a philanthropist contributed to the construction of the hospital in Pune. However, rural areas of the state got grossly neglected as the majority of hospitals developed close to military settlements in urban areas, like Bombay and Pune. Missionary health care work in rural parts of Maharashtra helped to deliver medical services in remote areas such as Ahmednagar, Chandrapur, Gadchiroli and Nagpur (Budhkar, 1996).

After the independence of India, the formation of Maharashtra state was the central issue and agenda in the political domain of Maharashtra. The government of Maharashtra gave preference for the prevention of diseases and for providing curative services to the people. Till the time programmatic health services were delivered in Maharashtra, the

government of Maharashtra was pioneer implementer of National Family Planning Programme in Maharashtra. The first decade after independence family planning program was given priority. Post formation of Maharashtra, initial priority has been given to creating public health infrastructure. The government of Maharashtra was a pioneer in decentralized public health governance through Panchayat Raj Institutions in 1960. They have initiated public administration of primary health care under Zilla Parishads, where both people's representatives and medical staff were involved in the decision-making and planning of primary health care (Duggal, et al., 2005).

The Third Five-year Plan (1961 to 1966) had taken the extension and target oriented approach to development, especially in rural areas. The government of Maharashtra had taken initiatives for health service development in socially marginalized areas. Under the Fifth Five-year Plan, under the Minimum Needs Programme (MNP) of the central government Maharashtra came up with infrastructure development approach at the bottom level. Maharashtra is one of the first states to fulfill the essential requirements mandated for primary health centres, sub-centres and Rural Hospitals (Duggal, et al. 2005). The following achievements were made under the Minimum Needs Programme

Table-5.3

Health Services Infrastructure and State Achievements in Maharashtra

Sr. No.	Indicator	National Norms		Achievement by State	
		Non tribal	Tribal	Non tribal	Tribal
	Rural Population covered (1991)				
1	Sub Centre	5000	3000	5383	3271
2	Primary Health Center	30000	20000	28795	20413
3	Community Health Center(R.H.)	120000	80000	160000	107000
4	No.of Sub Center per PHC	6		5.5	
5	No of PHC per R.H. / CHC	4		5.49	
	Rural Population covered (1991)				
6	MPW Female	5000	3000		4976
7	Ratio of H.A. female to MPW female	1:6		1:3.15	
	Average Rural area covered by (in km)				
8	Sub Centre	22.89			31.67
9	Primary Health Center	136.39			174.21
10	Community Health Center(R.H.) Average no.of villages covered	1156.52			956.52
11	Sub Centre	4.29			4.24
12	Primary Health Center	25.57			23.33
13	Community Health Center(R.H.)	216.85			128.10

Source: Government of Maharashtra (nd) Health Status-Maharashtra. p. 47[28]

Table-5.3 shows that Maharashtra had closely achieved all the targeted goals under the Minimum Needs Programme. It helped to build basic infrastructure in Maharashtra.

Baru (2006) has pointed that 1970s was a period of private nursing homes growing in number in urban areas and in agriculturally wealthy states such as Maharashtra, Andhra Pradesh, Karnataka, Punjab, and Gujarat. There has been a substantial development in private health sector between 1970's and 1980's. For example, the number of private hospitals increased from 68 in 1973 to 682 in 1983 and beds increased from 8300 in 1973 to 26,024 in 1980. The decade of the 1990s further witnessed a rapid spurt in the growth

[28] Government of Maharashtra (nd). *Health Status-Maharashtra*. Director General Health Services, Maharashtra. Retrieved from http://hetv.org/pdf/maharashtra/maharashtra-health-status.pdf as accessed on 27th March 2015.

of private health sector in the state. The number of hospitals increased to 3023 and beds increased to 42,046 (Baru, 2006).

Table-5.4
Growth in Health Infrastructure in Maharashtra

Health Institutions	Sixth Five Year Plan 1981-85	Eight Five Year Plan 1992-97	Till September 2004	Till October 2010	Till March 2013
SCs	6391	9725	9727	10,579	10580
PHCs	1539	1695	1780	1816	1816
CHCs	147	300	382	365	361

Source: CBHI http://cbhidghs.nic.in

Table 5.4 shows, from the mid-1980s there has been development in rural health infrastructure including SCs, PHCs and Rural Hospitals (CHCs). The total number of beds in government medical sector increased from 41,624 in 1980 to 57,126 in 1990. It declined to 39, 350 in 2001, but in 2014 total government hospital beds are estimated around to be 53,168 (Roy, 2007).

Table-5.5
Health Infrastructure and Population In India and Maharashtra

State	Rural Hospital (Govt.)		Urban hospital (Govt.)		Total Hospital (Govt.)		Provisional/ Projected population	Average Population Served per Govt. Hospital	Average Population Served per Govt. Hospital Bed
	No	Beds	No	Beds	No	Beds			
India	15398	196182	4419	432526	19817	628708	1223581	61744	1946
Maharashtra	440	11302	613	41866	1053	53168	115697	109874	2176

Source: CBHI National Health Profile (2013), Reference period 01/01/2014

General Hospitals, Women Hospitals, Medical Colleges are available in Maharashtra to support this rural-based health infrastructure. National Health Profile 2013 of CBHI

shows total licensed blood banks in Maharashtra is 289 within private is 199, and the government is 90. There are four Regional Mental Hospitals in Maharashtra, based in Nagpur, Pune, Thane, and Ratnagiri along with 49 functional eye banks (CBHI, 2013).

Presently, Maharashtra has the following medical and allied educational facilities, and along with the rural health services infrastructure, is among the leading States in addressing the preventive as well as curative needs of the people.

Table-5.6

Medical Educational Institutions in Maharashtra

Facilities	No
Medical Colleges	33
Dental Medical Colleges	13
Ayurvedic Colleges	39
Homeopathic Colleges	36
Pharmacy Colleges	45
Occupational Therapy Institutions	4
Psycho Therapy Institutions	8
Audio Therapy units	2

Source- Government of Maharashtra (nd) Health Status-Maharashtra. P. 2 [29]

This infrastructure helped to grow medical education and Indian system of medicine. Data has shown that the Maharashtra state had a properly well-developed health infrastructure. Maharashtra along with other states like Kerala, Punjab, Tamil-Nadu, Karnataka have emerged as the most advanced states in the health care provision (Kurian, 2000) Apart from the state government and private sector in health care, non-governmental organizations are also providing healthcare services to reach out to the remotest corner of the state. Some studies have observed different types of NGOs

[29] Government of Maharashtra (nd). *Health Status-Maharashtra*. Director General Health Services, Maharashtra. Retrieved from http://hetv.org/pdf/maharashtra/maharashtra-health-status.pdf as accessed on 27th March 2015.

involved in the delivery of health care services. Maharashtra has the largest number of such agencies in the entire country (Nandraj & Duggal, 1996)

Thus, in the 1990s, Maharashtra initiated the phase of consolidation of health institutions, to improve the existing health services in all corners of the state with very little growth of health institutions being planned for the coming years (Budhkar, 1996).

Table-5.7

Health Profile of Maharashtra

Item	1960-61	1970-71	1980-81	1990-91	2001-01	2010-11	2013-14
Hospitals	NA	299	530	768	1102	1368	1395
Dispensaries	NA	1372	1776	1896	1544	3012	3087
Beds Per Lakh	NA	88	114	114	106	103	107
Birth Rate@	34.7	32.2	28.5	26.2	20.7	16.7	16.5
Death rate@	13.8	12.3	9.6	8.2	7.5	6.3	6.2
IMR @	86	105	79	60	45	25	24

Source: - Government of Maharashtra, 2015, P.5

At the initial stage government has taken the programmatic approach for governance of health service system; later it has focused on the basic infrastructure development approach.

The development of health service system in Maharashtra can be categorized into five distinct phases:

(1) In the early phase post-1947 to 62, Maharashtra as the state was not formulated. Till the 1960s all activities operated under Bombay state. The initial priority of development was not health. Under health, implementation of national health programmes was the main area of work. First five year plan gave more attention to agricultural and industrial development which has come through Nehru's vision of Nation building. However, most of the health service initiatives were urban centric, with hospitals and medical colleges being the main focus (Priya, 2005).

(2) In the second phase of 1960-80, these two decades focused on health service infrastructure development. Health service system expansion in rural areas enhanced the access to publicly funded primary health care, facilitating the expansion of health facilities in rural areas through National Health Programmes.

(3) In the mid-1980s to 1990s, the central level policy changes happened. The government of India introduced support to private enterprise for healthcare service delivery and enhanced private sector investment in healthcare infrastructure through subsidies.

(4) The third phase, post-2000, has endorsing a further shift with broadening of focus on private sector through the current phase addressing key issues such as public-private partnership, liberalization of the insurance sector, and government as a financier. Simultaneously, the National Rural Health Mission (NRHM) was initiated in 2006 with the perspective of right to health care. A number of internationally aided projects for the health sector were also undertaken preceding the NRHM.

(5) Post-2015 agenda for health, saw several policy shifts: from NRHM to NHM, from the right to health to universal health care via health insurance, end of MDGss in 2015 and shift into SDGs, and a government of India health policy draft 2015

The Programmatic Approach in Maharashtra

The Programmatic Approach was adopted to address the health needs in Maharashtra, as in the rest of India. The following major national health programmes have been implemented[30].

Major Health Programmatic interventions in Maharashtra

- National Family Planning Programme (1952) and Community Development Programme (1952), both programmes started simultaneously, however there was

[30] This timeline of programme has been taken form Health Education to Villages website. Retrieved from http://hetv.org/india/mh/healthstatus/index.html as accessed on 28th March 2015.

separate implementation of both programmes according to their purpose and goals. Family Planning Policy adopted in Maharashtra. Maharashtra was the first state who implemented the family planning policy in 1957.

- The important two strategies of Community Development Programme such as extension approach and target orientated approach were implemented under third five-year plan 1961-66.
- The National Malaria Control Programme was executed in Maharashtra from 1953 to 1958. With the success achieved, the programme was converted into eradication programme from 1958. However, due to various reasons, there was a rise in the Malaria cases, during the period 1964 to 1975. As a result, an improved plan of operation was announced in the year 1977. This has caused a decrease in the rate of malaria cases till 1986, while the later prevalence of malaria cases are increased. During 1995, there was an epidemic in Thane, Nasik, and Mumbai. To deal with the epidemic situation Government of India formed an expert committee. The committee recommended the "Malaria Action Plan 1995". This strengthened the programmatic approach in the state (Kalra, 1979).
- The National Leprosy Control Programme was set up in the year 1954-55. After the availability of a more effective combination of Anti-Leprosy Drugs, the programme was redesigned as National Leprosy Eradication Programme in 1981-82 With the multidrug therapy (MDT). The World Bank contributed to a Project from 1993. The programme was monitored by the Joint Director of Health Services, located at Pune.
- National Filaria Control Programme (NFCP), Filaria was one of the major Public Health Problems during 1957 in India. one man commission appointed for assessment the Filaria. The commission findings helped to set-up The National Filaria Control Programme in 1957. This programme also was monitored by the Joint Director of Health Services (Malaria) which was located at Pune.
- National Tuberculosis Programme (NTP) was initiated in Maharashtra in 1962. The RNTCP is implemented in the State as per the guidelines of Govt. of India since 1998-99 under the Revised National Tuberculosis Control Programme. Maharashtra had covered the entire population under RNTCP in India. With good the quality of services.

- Medical Termination of Pregnancy (MTP) Act (1972) was implemented in the State. There were plenty of issues associated with maternal and child health care, abortion being one of them. Abortion act come with justification that failure of contraception, social and economic disparities, no regulation on quality of service provision, hazardous abortion practices which lead to morbidity and mortality in women from unsafe abortion. (Gupte, Bandewar, and Pisal, 1997).
- 1975-80 Fifth Five Year Plan period came with Minimum Needs Programme, Family Planning to Family Welfare, Community involvement, Dai Scheme, Rural Health Scheme, Village Health Guide Scheme
- Multipurpose Worker Scheme 1977, National Malaria Control Programme has been implemented since 1953 in India. This programme reviewed time to time. Multipurpose health worker is an essential component under Malaria Control programme. It was revised in 1977 and formulated separate multipurpose worker scheme for strengthening human resources under public health system.
- Epidemic Control Programme: The Epidemic Control Cell was established in the year 1985 in Pune. The Bureau is also supervising the State Health State Public Health Laboratory (SPHL), Transport Organisation SHTO), and Health Intelligence & Vital Statistics (HIVS).
- The Child Survival and Safe Motherhood (CSSM) programme was started 1992 in India. The aim of this programme was to improve the health status of women and children. Reduce overall maternal mortality rates MMR and infant mortality rates (IMR). In 1997 the Government of India converted this programme into Reproductive and Child Health (RCH) programme. RCH used Community Need Assessment Approach (CNAA) a participatory planning approach used involvement of the community to reduce MMR and IMR.
- National Surveillance Programme for Communicable Diseases (NSPCD) initiated in the year 1997-98. The programme is for strengthening the disease surveillance capacity to respond to emerging & reemerging infectious diseases.
- National Rural Health Mission (NRHM) launched in April 2005. In Maharashtra from 2006 actual implementation started. In 2013, NRHM programme culminated into National Health Mission (NHM) 2013.

Externally Aided Projects in Maharashtra

The post-1990's economic policy changes created space for international actors under liberalization and globalization processes. Many bilateral aided development health programmes were implemented by the government of Maharashtra. The following programmes have been implemented in Maharashtra[31].

- **Integrated Population and Development Project**

This Project was funded by United Nations Population Fund (UNFPA) and the implementation agency was Government of Maharashtra, through District/Corporation Societies. It was implemented in the year was 1998-2002. It focused on selected districts such as Thane, Dhule, Nandurbar, Chandrapur, Gadchiroli, Wardha and Corporations of Thane, Pune, Kalyan, Ulhasnagar, Bhiwandi. The goals of the project was to enable individuals and couples to achieve their personal reproductive intentions and to ensure survival and development of their children through the delivery of quality reproductive and child health services. These services included family planning, and improving the educational and social status of women in project areas.

- **World Bank Assisted - RTI/STI Sub-Project Nasik**

The project period was from April 1997 to March 2003 and covered only Nashik District. The financial outlay of this project was Rs. 13.78 Crores.

The objective of this project was to sensitize the community about RTls/STls and the grievous consequences of these infections and improve the treatment seeking behaviour of the patient. Besides this, the programme focused on improving access to an essential package of services under RTI/STI and to reduce the incidence of RTI/STI in the community.

- **Maharashtra Health Systems Development Project (MHSDP) World Bank**

The objective of this programme was to improve efficiency in the allocation and use of health resources through policy and institutional development. The second objective was

[31] The details of all the programmes has been taken from Health Education to Villages website as retrieved form http://hetv.org/india/mh/healthstatus /index.html as accessed on 28th March 2015.

to develop the performance of health care system through strengthening the quality of health services; these services developed at the first referral level with selective coverage of the grassroots levels for marginalised sections.

The major Components under this project were management system development, institutional establishment, Improving the institutional setup for policy development through making a strategic planning cell.

New systemic structures were created such as a project Governing Body, Steering Committee, Project Management Cell, District Management Committees and Hospital Visiting Committee. It helped to improve management and capacity level for programme implementation.

At the State level, this project focused on enhancing staffing, providing training, financial management, and auditing arrangements, enhancing capacity for procurement of goods, works and services, improving capacity for equipment management.

At the Facility level, it concentrated on strengthening service delivery management and equipment management. It also focused on strengthening the present surveillance system for communicable diseases and developing HMIS for monitoring. The project insisted on improvement and effectiveness of service quality of the district, sub-district hospitals and CHCs. It targeted focus on 25 district hospitals for up-gradation and under 29 districts developed hospital training systems, in 23 CHCs increased bed capacity as 100 bedded and 53 CHCs as 50 bedded sub-district hospitals. It also devloped clinical and support services, and created procedures for health care waste management.

Improving access: Through efficient referral mechanisms, provision of extension services, lEC activities, provision of essential civil works and physical inputs to 35 CHCs and developing innovative schemes for closer co-operation between the public and private sectors.

- **Sector Investment Programme: funded by the European Commission**

The Project period was from May 2001 to September 2004. Project Area was Satara District & Aurangabad Corporation. Total Budget Rs. 7.12 Crores. Expenditure, monitoring agency State RCH Society and Implementation with the Jt. Director (Project) SFWB, Pune. State Facilitator Agency BAIF, Pune.

This project focused on developing a vision for the Health & Family Welfare Sector in Maharashtra. Through developing a vision of the sector, empowering committees, empowering staff, increasing the outreach of services and improving quality of services. The core agendas at the central level were modifying the 'MIS' along with promoting private sector participation through involving it in public services. The Maharashtra Nursing Home Act was implemented.

- **Indo-German Development Cooperation (GTZ), Basic Health Programme (BHP)**

Project implementation period was from June 1996 to June 2001, but this project was extended in Dec. 2002 and March 2004. This project implemented in Pune, Raigad, Ratnagiri, Sindhudurg district. The project goal of this programme was a consistent improvement of the health of the people, particularly women and children in the project area.

The activities carried forward under this programme were Community Mobilization, Capacity Building, Rehabilitation of Health Institutions, Health Systems Research and Management Information System.

- **Border District Project (BDP): funded by UNICEF**

The programme started in January 1999 for Four Years. Its coverage areas include Latur, Nanded and Osmanabad districts. The project goal was to reduce the maternal mortality and infant mortality by half at the end of the project.

The Government of Maharashtra invited foreign aid to finance for development projects. In the health planning in Maharashtra external assistance played important role in financing public sector investment. The external aid project having a selective approach to develop health service system and project-specific. These investment funds were interconnected with commonly agreed goals between state and external agencies. It has periodic commitment with terms and conditions. It developed schematic pattern of planning and decision-making. Many times these projects became an additional burden

on system or disturbed the governance structures. They also provided ideas for formulation of the NRHM.

National Rural Health Mission in Maharashtra

Maharashtra is known as one of the better-developed states of India. However, there is still a large gap in health outcomes of Maharashtra as compared to some other States. There are considerable disparities across districts, necessitating setting up of district-specific targets[32]. The NRHM has provided the opportunity to address these issues. As per the order from Government of India, State Health Mission was constituted under the chairmanship of the Hon Chief Minister on 15th October 2005. The Maharashtra state cabinet approved the Memorandum of Understanding with the Central Government with some modifications and the MOU was submitted to the Central Government in 2006.

The State Health Society was constituted under the Chairmanship of the Chief Secretary and District Health Missions and District Health Societies were constituted in all districts. All the vertical programme related societies at the state and district level were merged into the State Health Society and District Health Societies respectively.

State Level Planning and Decision Making Mechanisms[33]

The State Health Mission of Maharashtra adopted a collective approach relating health to the determinants of good health through nutrition, sanitation, hygiene and safe drinking water and health services development. It proposes mainstreaming of the Indian systems of medicine to run health services. The plan of action includes improving public expenditure on health, reducing regional imbalances in health infrastructure, pooling resources through integration of organizational structure, optimization of health management**,** decentralization of district management of health programmes**,** community participation and operationalization of community health centers into functional hospitals meeting Indian Public Health Standards in each block of the State.

[32] National Health Mission, State Health Society: Maharashtra Website. Retrieved from https://www.nrhm.maharashtra.gov.in/history.htm as accessed on 30th August 2013.

[33] The structure of governance under NRHM has been taken from PIP 2008-09 of Maharashtra. National Health Mission, MOH&FW, GOI. NHM in State : State Program Implementation Plans (PIPs) : Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013.

The implementation of the National Rural Health Mission with architectural correction was under active consideration of the government of Maharashtra. In this regard, Government of Maharashtra has passed the Resolution. The Government is pleased to constitute a State Health Mission on the lines of the National Rural Health Mission.

The Government of Maharashtra set out an organizational structure for the state health mission in line with the national framework. The composition of the state health mission is as follows:

The Chief Minister is the Chairperson, Dy Chief Minister is Co-Chairperson, and Minister of Public Health is Dy. Chairman. The Chief Secretary is the Member Secretary. The State Health Mission has also nominated Non-Officials and representatives of development partners such as UNFPA, and UNICEF as members.

The State Health Mission meets at least once in every six months. The agenda of the Mission meeting is as follows.

- Providing Health System oversight
- Consideration of policy matters related to health sector (including determinants of good health). Reviews of progress in the implementation of NRHM.
- Inter-sectoral coordination
- Advocacy measures required to promote NRHM visibility.

State Health Society- the State Health Society was constituted on 24th Oct 2005. State Health Society comprises of Governing body and Executive Committee which serves in an additional managerial and technical capacity to the Department of Public Health for effective implementation of National Rural Health Mission / RCH-II.

A) The Governing Body has the Chief Secretary as the Chairperson, Principal Secretary Planning department as the Co-chairperson and Additional Chief Secretary Health as the Vice Chairperson. Mission Director is the Member Secretary of the Governing Body. These committee has also nominated NonOfficial members and a representative from Development Partners as members.

The Governing Body takes decisions on the following issues:

- Approval / Endorsement of Annual State Action Plan for the NRHM.
- Consideration of proposals for institutional reforms in health and FW sector
- Review of implementation of Annual Action Plan
- Inter-Sectoral coordination: All NRHM related sectors and beyond (e.g. administrative reforms across the State)
- Status of follow-up action on the decision of the State Health Mission.
- Coordination with NGOs / Donors / other agencies / organizations.

B) The Executive Body has Additional Chief Secretary Health as the Chairperson, Commissioner Family Welfare as the Co-chairperson and Director Health Services as the Vice Chairperson. Mission Director is the Member Secretary of the Executive Body. This committee has also nominated Non-Official members and a representative from Development Partners as members.

The Executive Body has taken decisions on following issues:

- Detailed implementation and expenditure review
- Approval of proposals from district and other implementing agencies / District Action Plan
- Execution of the approved State Action Plan, including release of funds for programmes at State level as per Annual Action Plan
- Release of funds to the District Health Society
- Finalization of working arrangement for intra-sectoral and inter-sectoral coordination.
- Follow up action on the decision of the Governing Body.

State Programme Management Support Unit:

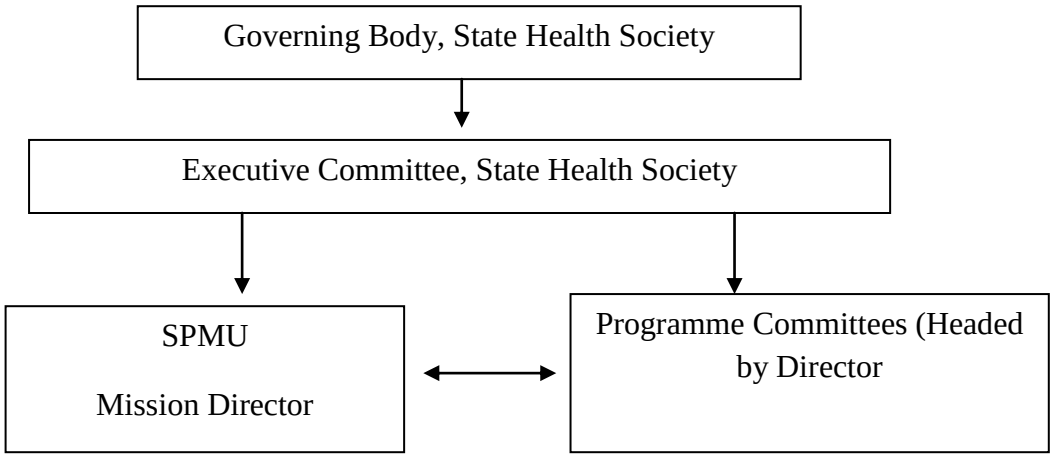
The State Program Management Support Unit (SPMSU) is established to ensure smooth implementation of NHRM /RCH. It is composed of key officers from the State Family Welfare Bureau. The State Family Welfare Bureau works in close coordination with State Program Management Unit (SPMU). The state programme management support units

have taken the appointment of consultants and supportive staff. The appointment decision is to be taken by the executive committee to prevent accreditation of society staff**.**

The SPMSU acts as the secretariat to the State Health Mission as well as the State Society. It is headed by the Mission Director and has experts from various areas. The SPMSU provides the technical support to the State Health Mission.

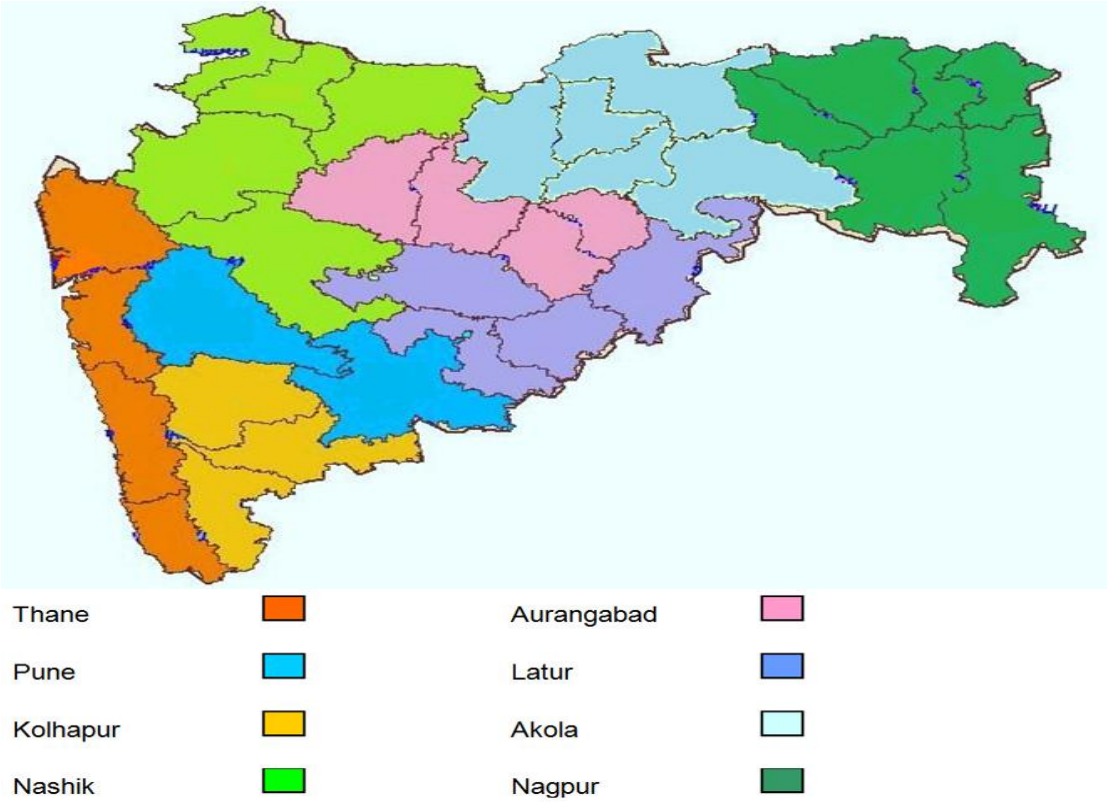
After sanction of State Action Plan by the Governing Body of the State Health Society and of District Plans by Executive Committee, funds are released through joint signature of 2 authorized signatories.

Organogram of State Health Mission and State Society



Map-5.4

Administrative Unit under NRHM in Maharashtra

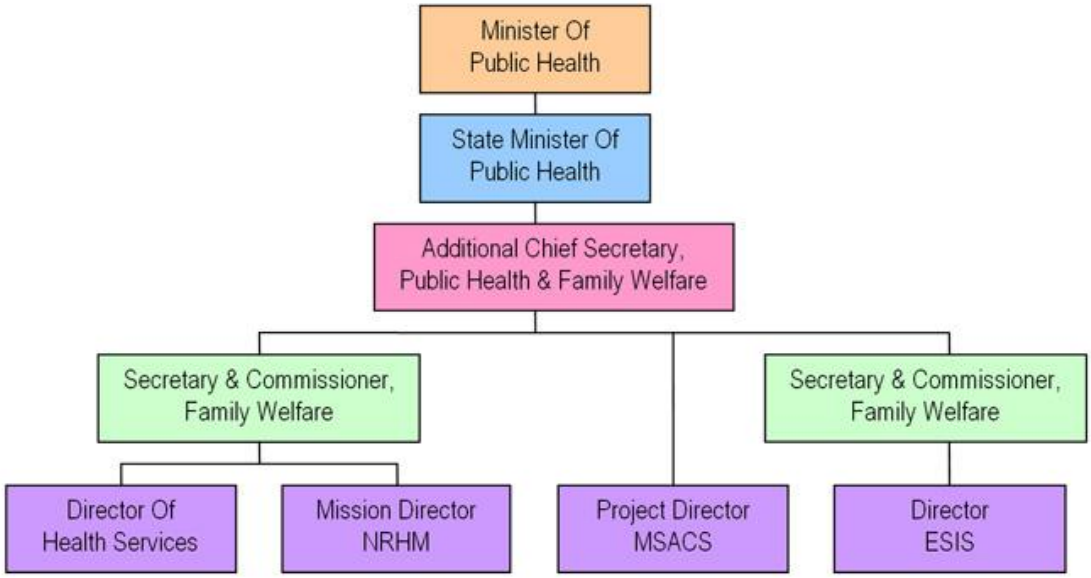


Source: NHM: Maharashtra, Government of Maharashtra[34]

The Government of Maharashtra has six main administrative divisions. NRHM tried to make this system more effective, and so the State Health Mission has formed eight administrative divisions for better governance. Criteria for this regional division was establishment of training centres according to regions, it would have helped to manage resources and helped to overcome burden on Mumbai, Pune institutions.

[34] National Health Mission, State Health Society: Maharashtra Website. https://www.nrhm.maharashtra.gov.in/history.htm as accessed on 30th August 2013.

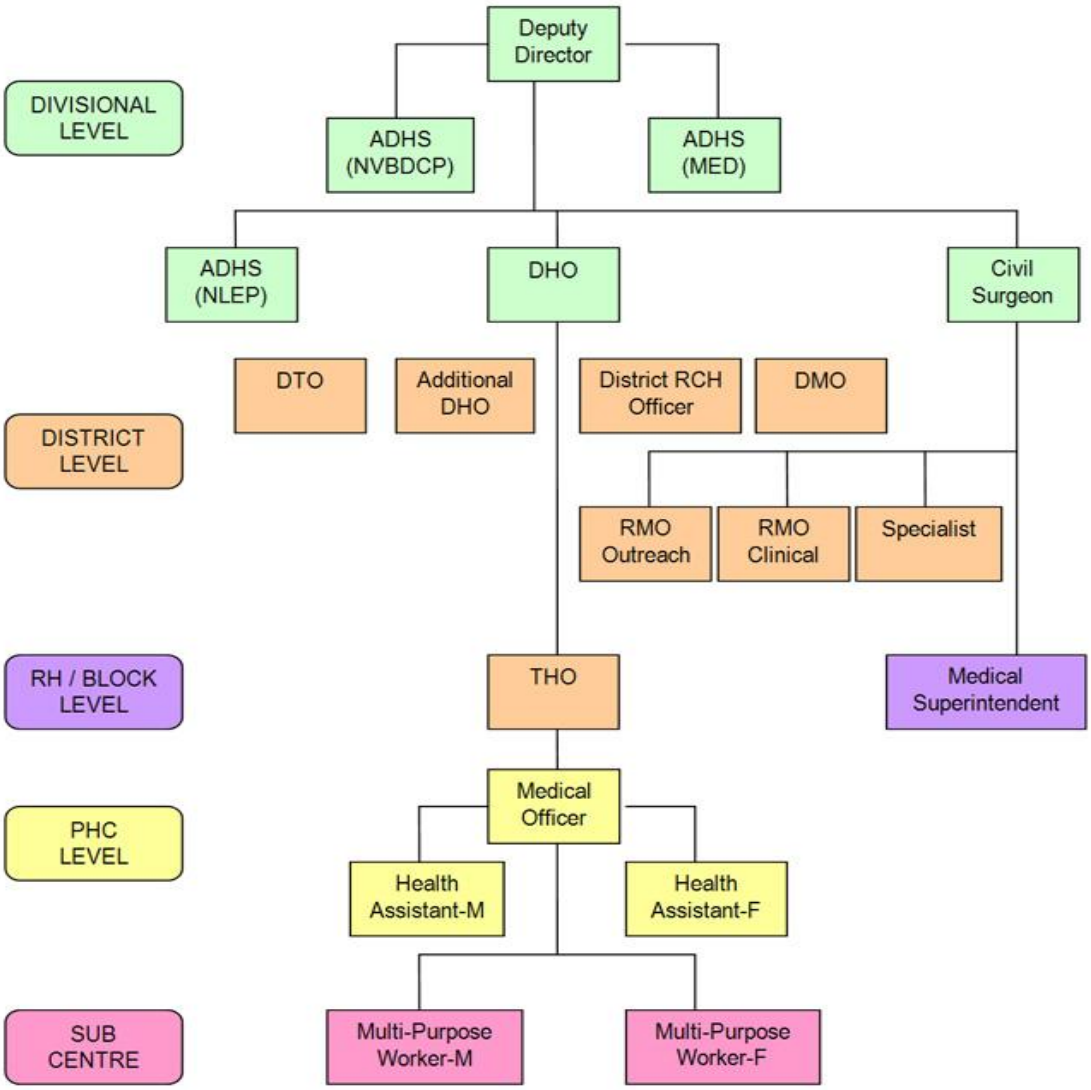
Health Service Organization Structure in Maharashtra



Source: GOI, NHM, MOH&FW, State wise Information: Maharashtra[35]

[35] NHM Website, MOH&FW, GOI, State Wise Information: Maharashtra. Retrieved from http://nrhm.gov.in/nrhm-in-state/state-wise-information/maharashtra.html#organogram as accessed on 30th August 2013

Health Service Infrastructure in Maharashtra



Source: GOI, NHM, MOH&FW, State wise Information: Maharashtra [36]

E-Governance in Maharashtra

The establishment of e-governance process in Maharashtra started in 1970. The government of India set up the Department of Electronics along with the National

[36] ibid

Informatics Centre. Maharashtra was the first state who adopted e-governance policy. In 1980, government offices introduced limited computer facilities with word processing capacity only. Later, in 1987, the government of India set up the National Satellite Based Computer Network (NICNET) which geared the digital processes in India. The District Information Systems of the National Informatics Centre (DISNIC) were formed at the district level, state governments set up computerized administrative structures at all district offices. The globalization processes further changed models of information technology and mode of communication pattern. To assess this new changes at India level government formed a task force on information technology and communication in 1998. Later it resulted in formation of the Union Ministry of Information and Technology.

The implementation of a twelve-point agenda programme developed by the ministry to channelize new information technology and larger e-governance processes was started. In 2006 the government of India developed an official e-governance plan. Later various state specific initiatives were carried forwarded by the government of India (Keruwala, 2015)[37].

In Maharashtra, the state government announced, "Sarkar Apalya Dari" (the government at the citizen's doorsteps) initiative to reach grassroots level. Under this initiative government of Maharashtra focused on linking technology initiatives with administration processes. The government made an effort to build confidence among people that new digital processes are socially inclusive. At the village level computerized information centres were developed. The e-governance policy for Maharashtra was drafted under the chairmanship of Dr. Vijay Bhatkarand by a 10-member committee. The policy was formally approved and published in 2011 and implementation started from 2012. In 2015, new processes began under banner of 'digital India' with the new elected government (Government of Maharashtra, 2011)[38]

[37] Keruwala N. (2015 April). History of E-Governance in India and Maharashtra. Retrieved from http://netpehchaan.in/internet-inclusion/history-of-e-governance-in-india-and-maharashtra.html. As accessed on 10th July 2016

[38] Government of Maharashtra (2011, September 23). Maharashtra E-Governance Policy. (Marathi version) Retrieved from https://www.maharashtra.gov.in/PDF/e_governance_policy.pdf as assessed on 13th April 2013

In the context of health, health information management system was poor and unorganized in Maharashtra. There was no formal structure for a health service information collection and utilization system. The government of Maharashtra made an effort to make more collaborative and structural e-governance for NRHM. A new set up of information communication technology to strengthen public health services was developed (Kamlakar, et al. 2014).

The following list of e-governance initiatives taken by Government Public Health Department for the management of health service system show the focus it has been given.

'Medical Officers Master'

It is a software-based application used for generating a database of medical officers which shows availability of medical officers in the state. It has helped in processing the Transfer Requests and Medical Officer Certification Program. Transfer request application is online with recording and tracking of the requests for transfers.

'Search ASHA'

This application was used for tracking the individual information, training, recruitment, performance and payment details of all registered ASHAs in the state. It was implemented from 2011 in Maharashtra. This application generated an online Database of 60,000 ASHAs in Maharashtra.

'Construction Tracker' for Public Health and NRHM

Construction Tracker Software was used from 2012 to track the physical and financial progress of construction related activities of health services of Public Health Department and NRHM. It helped upload photographs of construction works and their progress.

Drugs Inventory: Drugs Inventory application is to help the medicine procurement system. It was also introduced in 2011 to track purchase, distribution, and availability of medicines across all medical institutions. Besides tracking, it manages Purchase Orders, Receipts, Distribution, Stop-use, Loans, Wastage, Audit and Annual Requirements.

PCPNDT Application: There was malpractice involved in implementation of the PCPNDT act. Case recording system was very weak at all levels. This software records the details of all registered Sonography Centres and patients undergoing Sonography

Tests at those centres. It has also ensured adherence to the norms laid down under the PCPNDT ACT 2003 for Form A and Form F.

Rajiv Gandhi Jeevandayee Arogya Yojana: The government of Maharashtra developed an online system for Rajiv Gandhi Jeevandayee Arogya Yojana. It was a government insurance scheme. This application tried to generate all the database of this scheme.

Mother and Child Tracking System (MCTS): MCTS is a reporting software developed to generate data on pregnant women and Children registered in the health system. It also tracks the health services delivered to them.

Hospital Management Information System (HMIS)

The government of Maharashtra has implemented the HMIS system with the primary objective of creating a unique health Identification ID and permanent medical number for every patient visiting a hospital. It is to help to reduce registration waiting times and make all reports and images instantly available to clinicians on-screen. Patient records are stored electronically so the government can access them from any hospital. This programme has been implemented in J.J. Hospital and Grant Medical Collage, Mumbai.

Health Advisory Call Centre

This service scheme was developed to make easy access to information and guidance of health services. Health Advisory Call Centre was established at Pune Chest Hospital, Aundh Pune The callers (ANM, ASHAs, and Medical Officers etc.) calls on Toll-Free number 104, from where the caller gets connected to the specialists as per need (Government of Maharashtra, 2013b).

Advantages and Challenge of E-Governance

Following are the advantages and challenges of E-Governance in Maharashtra.

The traditional processes are time-consuming and process speed has been increasing with these mechanisms. A new mechanism such as the internet, landline phones, mobile phones, have developed faster communication patterns within the system. This has helped to connect and speed up decision-making processes.

E-governance is a one-time investment but it helps to reduce cost on administrative processes. Use of Information Communication Technology makes the governing process

at one level transparent. People are accessing government online information through the internet. A variety of information is being uploaded by the government departments on their websites. E-trending and application submission is available through e-governance processes. Once the governing procedure is made transparent by Government, it is expected that it will be made more accountable. Major challenges with e-governance are security concerns and misuse of publicly available information by users or external actors. In Maharashtra, e- governance is in developing stage, system capacities are limited to adopt new mechanisms. The large multiple administrative database generated by these processes is very difficult to manage, coordinate and synchronize. The community is not getting friendly with these mechanisms. It is still in hands of bureaucracy and not sufficiently transferred to the grassroots level.

Planning Processes under NRHM in Maharashtra

Community-based Monitoring and governance change in Maharashtra[39]

NRHM envisaged three branches of the accountability framework which included internal monitoring, Common Review Missions, periodic surveys and studies, and community based monitoring. Community-based monitoring (CBM) was piloted with involvement of civil society groups in nine states, but has survived after the initial years only in two states, Maharashtra and Tamil Nadu, where civil society groups took a pro-active role.

The adoption of a comprehensive framework for community based monitoring and planning at various levels under NHRM is based on monitoring and planning committees at PHC, block, district and state levels. This framework seeks to locate people center-stage in the process of periodically assessing the extent to which health rights of the community are actually being fulfilled.

The NRHM was designed with the understanding that this would be possible only when the community is sufficiently empowered to take leadership in health matters. The

[39] All the CBM processes activities information retrieved from Maharashtra programme implementation plan (PIP) to see community monitoring and planning under NRHM in Maharashtra.

Panchayat Raj Institutions (PRIs) and community members, right from villages to district level, would have to take ownership of the public health delivery system in their respective jurisdiction. In this regard, the state of Maharashtra has given the responsibility of providing primary health care to PRIs. Adequate representation of the disadvantaged social groups such as women, Schedule caste and Schedule Tribe categories was also given emphasis in communitization of health services.

The planning and decision making under the NRHM was to be conducted through following structures and processes:

- Creating a Village Health and Sanitation Committee in every village in the rural areas.
- Accountability of the Sub-Centre to the Gram Panchayat and various local committees for its management.
- Rogi Kalyan Samitis for the PHC, Rural Hospital and District Hospitals to manage these health centres and hospitals.
- Involvement of Gram Panchayats in the functioning of the PHCs.
- Zilla Parishads to have direct responsibility of planning people's health needs and budget for health in the district
- Community based Monitoring

Community based monitoring and planning of health services under NRHM is a participatory, multi-stakeholder process for increasing accountability and responsiveness of public health services while improving their implementation. This process was launched at state level in Maharashtra in mid-2007. After a series of initiation, selection and capacity building processes at state and district levels, field level implementation started in early 2008. Field level implementation of community monitoring was initiated in five districts of Maharashtra, initially on a pilot basis, and then as a component of the State Programme Implementation Plan. Significant expansion of these activities took place in two further phases, with addition of new blocks and villages in five districts in mid-2009 and then addition of 8 new districts in early 2011.

Coordination of state level events, along with training, technical inputs and capacity building inputs for NGOs at various levels would continue to be managed by SATHI as the existing State Nodal NGO. Major activities:

1. **Pilot phase of CBM**

Community based monitoring and planning process was being implemented in certain areas since early 2008 in 5 districts where 39 PHCs were covered and under these PHCs a total of 195 villages were being covered. The overall strategy for partial phasing out of external inputs by civil society organizations. The plan was that the organizations shall continue with lower scale of inputs but would sustain core community monitoring activities. The emerging activity of community based planning which was initiated since 2010 was to be continuously developed. Financial inputs for these areas would be reduced in scale to approximately half of the scale for the previous year (2011-12).

The core community monitoring activities such as meetings of Community based monitoring and planning committees at different levels, selective data collection and periodic dialogue between VHSC members and health care providers continued. In most of the existing areas, elections of PRI members at different levels were taking place, so training and orientation workshops for newly formed VHSCs as well as elected PRI members at different levels were to be conducted. Based on initial experiences in 2010-11, workshops would be conducted for RKS members as well as CBMP committees regarding decentralized planning. The objective of these workshops would be to enable RKS members to properly understand their role and responsibilities in planning the appropriate use of various flexible funds at facility level, with a clear focus on patient welfare and addressing issues identified through the community monitoring process.

Table-5.8
Budgetary Provision of Community Based Planning & Monitoring (CBPM) in Maharashtra (2012-13)

(in lakhs)

Year of starting the scheme/initiative	Budget sanctioned for year 2010-11	Budget sanctioned for year 2011-12	Budget proposed in PIP 2012-13	Budget approved in NPCC
2007-08	292.22	292.1	241.10	234.320

Source – Maharashtra PIP 2012-13

Expansion phase of CBM

Community based monitoring and planning process had been conducted in 14 blocks of 5 districts since mid-2009. In these areas, total number of PHCs covered was 33 and total of 245 villages as well as 93 Sub-Centers are covered by CBMP. Further since end-2010 Community based planning has also been initiated, wherein community based processes are now informing local health planning, through people's participation and decentralized inputs.

In 2011, CBM was expanded to cover eight new districts. In these new districts, the selection and approval of District and Block Nodal NGOs was completed and activities have been initiated during 2011. In these eight districts, total number of PHCs covered are 48 and under each PHC five villages are covered i.e. total of 240 villages. Similar to districts of earlier phases, in these districts key monitoring levels would be at the Village, PHC, Block and District levels.

The core activities such as regular meetings of monitoring and planning committees, next round of data collection, Jan Sanvad /Jan Sunwais at different levels were conducted in these expansion areas. In this phase attempt was made to conduct activities for facilitation of systematic monitoring of ICDS services.

District level workshops were organized with participation of diverse civil society organizations active in the district, regarding community awareness building, collection

of information on functioning of health services, participatory dialogue and intervention in decentralized planning.

Activities to involve and sensitize additional stakeholders and initiating Community based planning at village and PHC/RH RKS levels - Awareness and capacity building workshops would be conducted for different stakeholders.

Thus, in 2012-13, taking all districts together, a total of 13 districts, 37 blocks, 120 PHCs and 680 villages would be involved in Community based monitoring and planning activities.

The collective preparation of a health service report card was a strategy used to identify the systemic issues. These issues were then to be resolved through a public dialogue (Jan Samwad) with all health system stakeholders at all levels. The periodic public dialogues were organized to address time-bound issues. A CBM report was then collectively prepared. Under the CBM programme, in one year around 400 Jan samvads (Public dialogues) were organized in the state of Maharashtra (Rath, 2014)[40].

It has been reported that there has been reduction in private practice by government doctors. It has resulted in greater response to local needs, such as provision of diabetic medication for twenty-two areas in Pune district through Panchayati Raj institution funds Zilha Parishad; (Shukla, Kakade, and Scott 2011)

Thus, the community-based monitoring processes introduced another accountability and transparency framework under NRHM. It is claimed that the power structure within the health service system has been challenged by democratization powers under CBM. The need of governance has been viewed as for improving efficiency, but through CBM it has become a political governance initiative (Shukla, 2013). The democratization of health service system is one of the goals of the CBM processes. Civil society works with the understanding that democratization is possible through addressing four aspects: (i) Direct

[40] Rath, P. (2014). *Transparency and Accountability in the Social Sector: Pedagogy, Theory of Change and Showcasing Key Success Stories* (Conference Report) (pp. 1–50). Pune: National Centre for Advocacy Studies, National Foundation of India and Centre for Budget and Governance Accountability.

democracy is possible if it linked with reality. (ii) Planning, decisions, and governance have to develop from people. (iii) Going beyond the beneficiary, the approach should take people's involvement in planning and decision-making. (iv) Governance and development processes should empower the policy implementer agent (Shukla, Khanna, and Jadhav 2014; Rath, 2014). CBM provides a potential structure for implementing direct democracy in the delivery of health services. Such governance mechanisms have very context specific outcomes, and therefore cannot be generalized.

Involvement of Panchayati Raj Institutions

Involvement of Panchayati Raj Institutions in planning and decision making is one of the important aspects of NRHM. In Maharashtra state, PRIs are involved in implementation of NRHM activities right from village level onwards. Important aspects of PRI involvement in Maharashtra seen under NRHM as follows according to NRHM guidelines.

i. **Selection of ASHA**: Scrutiny of ASHA applications were carried out by the Village Health Committee and final selection was done by the Gram Sabha. Sarpanch and other Gram Panchayat members were expected to take active part in this process. VHC also reviewed the progress of ANM, MPW and ASHA on regular basis.

ii. **Village Health Committee**: Sarpanch was the Chairman for majority of VHCs. PRI members were given due weightage along with other village members in the committee.

iii. **Sub-Center Committee**: Sub-Center committee was chaired by Sarpanch of the village. Other members of committee were Sarpanch and VHC chairman of villages under Sub centre.

iv. **PHC RKS:** Zilla Parishad Member was the Chairman of PHC level RKS. Panchayat Samiti members of the area were members of the PHC RKS.

v. **Planning of NRHM Activities**: Village Plan is approved by Gram Sabha. PHC Plan is approved by PHC RKS. Block Plan is approved by Block Health Mission

headed by Chairman Panchayat Samiti. Similarly, District Plan is approved by District Mission.

vi. **Monitoring of NRHM Activities**: Special committees of PRI members and MLA/MLC (Member of Legislative Assembly, Member of Legislative Council) were established to monitor the progress of the NRHM. At the block level, committee headed by MLA/MLC of block was to monitor the NRHM progress. Members of this committee included the Zilla Parishad and Panchayat Samitis representatives. Similarly, at district level, monitoring committee was established under chairmanship of Guardian Minister. Members of these committees include ZP President and Chairman of Subject Committees. Monitoring of health service through community participatory initiative was also implemented under NRHM. Monitoring committees were formed at all levels under the NRHM with the participation of PRI representatives, user groups and Civil society organisation and Non-Government organisations (CSO/NGO) to facilitate their inputs in the monitoring and planning process and to enable the community to be involved in broad based review.

To strengthen community involvement structures following initiatives were taken by government of Maharashtra.

Orientation of Community Leaders workshops

The committees were constituted at all levels by 2008-09 but members of committees were not aware about the role and responsibility. To fill this knowledge, gap the orientation workshop, training and capacity building of the PRIs at state, district health societies and PHC level was initiated in the year 2011.

RKS orientation training

Similar to the training of RKS and other committees, it was proposed to carry out orientation training of District and State Members with the technical support from PHFI, UNICEF and UNFPA.

PRI members visit to health facilities

MLAs, MLCs and MPs were also the members of various monitoring committees for NRHM activities. Many of those selected took keen interest in NRHM activities. It was

proposed to organize one orientation camp plus guided tour for them in one of the districts of each circle.

As MLAs were busy in Panchayat Elections, the tour programs were postponed many times. The plan was to conduct these programs at regional level but MLAs insisted to see facilities of the district only. Total 6 tour programs were organized and 19 MLAs attended the program. The program was completely revised in 2012.

Preparation of District Health Action Plans

NRHM envisaged that in order to make the programme fully accountable, the district health action plan was the principal instrument for planning, implementation and monitoring. It was to be formulated through a participatory and bottom up planning process. District Health Mission constituted as per guideline is responsible for the planning for the district.

The NRHM activities and norms has published and utilized per district for surveys, workshops, studies, consultations, orientation in the process of preparation of District Health Action Plans.

Considering the bottom up approach being used by Maharashtra and also the funds utilized during preparation of PIP of 2011-12, it was proposed to request for the budget as mentioned below for preparation of PIP of year 2012-13.

Table No- 5.8-1
Budgetary Provision for District Planning

(₹ in Lakhs)

Year of starting the scheme/initiative	Budget sanctioned for year 2010-11	Budget sanctioned for year 2011-12	Budget proposed in PIP 2012-13	Budget approved in NPCC
New	0	137.8 1	317.70	176.500

Source: Maharashtra PIP 2012-13

However, what was found during the study was that the preparation of state programme implementation plans incorporated district plans only as a financial allocation format. Interviews at district level revealed that the PIP preparation was undertaken based on a

needs assessment format filled by each district. The sub-district levels, from village to block, were also required to only fill the needs assessment formats as part of the 'participatory planning', as found from workers and officials at each respective level.

Thereby, with little bottom up planning in terms of any needs or innovations other than RCH services, even the PRI members and the CBM process could hardly influence the preparation of PIPs.

Operational Strategies and Outcomes to Strengthen Health Service Delivery[41] :

Maharashtra NRHM Programme Implementation Plan Analysis:

Operationalising the various NRHM strategies was a complex task, and each one unfolded incrementally in the 'mission' mode. The various processes could be reconstructed by analyzing the annual PIPs, which showed what was planned for the year and the next one showed how much of it had been achieved. Some selected areas of major importance are presented here.

1. **Improving Human Resources**

Historically there was evidence of non-availability of the ANM, Medical Officer and specialist at the Sub centre, Primary Health Centre (PHC) and Community Health Centre (CHC) but NRHM and IPHS come up with a blue print to increase the availability of these health services on contractual basis. There were many schemes to provide the specialist services to the needy community but majority of them were not having any impact.

NRHM addressed the issue of availability of critical manpower in the rural areas through various initiatives, such as introduction of a trained voluntary community health worker known as the Accredited Social Health Activist (ASHA) in every village and tribal areas and link workers (Arogya Tai) in remote, inaccessible villages of non-tribal areas,

[41] All the data content of Operational Strategies and Outcomes to Strengthen Health Service Delivery section were retrieved form Maharashtra programme implementation plan 2008-to 2013, The purpose of this section was see how governance initiatives improve the performance and operationalization of health service system under NRHM in Maharashtra.

appointing of additional ANMs at Sub Health Centres, three staff nurses at Primary Health Centers (PHC) and specialists at Community Health Centers (CHC). Along with this integrating of AYUSH officers into public health institutions would be discussed in the AYUSH section[42].

In addition, supportive mechanisms were also developed, such as improving the condition of residential accommodation for local health service staff. Shortage of ANMs and the availability of nursing staff was a big challenge. It was difficult to get local ANMs and staff nurses in tribal and remote health institutions. Special efforts were made to make nursing staff available in these areas by strengthening of nursing schools. Maharashtra has 1817 Primary Health Centres (PHCs). The PHCs in Maharashtra are currently sanctioned on the population norm of 1 per 20,000 populations in tribal areas and 1 per 30,000 populations in non-tribal areas of the state. All the PHCs in the state have been provided two doctors from state funds. The 2012-13 Programme Implementation Plan (PIP) pointed out that there is no PHC in the Maharashtra without doctor. But specialist staff at CHCs and nursing staff are inadequate at present.

NRHM implementation framework set the timeline targets (2007 to 2010) to tackle critical manpower issues. This includes ASHA workers for both tribal and non-tribal villages, additional ANMs for 10,579 Sub-Centers, three staff nurses and one Lady Health Visitor for 1816 PHCs and staff nurses for hospitals upgraded to Indian Public Health Standards (IPHS) (PIP, 2008-12).

The manpower requirements laid down for year 2009 was considered for planning of critical manpower in PIP 2008-09. Therefore, following critical manpower was planned for the year 2008-09:

- ASHA – in tribal and Naxalite affected areas of the state
- Link Volunteer – in non-tribal remote uncovered areas of the state
- Additional ANM per SHC – in 60% SHCs of the state
- Three Staff Nurses per PHC – in 60% of PHCs for 24 hours services
- One Supervisory Nurse per PHC – in all PHC for quality supervision of health programs

[42] AYUSH officer and manpower issues would be discussed in detail in the AYUSH section.

- Two Medical Officers – in all PHCs for providing round the clock health services
- Staff Nurses as per IPHS requirement – at RH to provide quality specialty services
- Specialists – at all IPHS hospitals as per bed norm to provide specialty services

Out of the above-mentioned critical manpower, two Medical Officers in PHCs and some of the specialists were provided through state funds. Staff Nurses and Specialists mentioned for Rural Hospitals were also a part of the upgradation of health institutions (PIP, 2008-09).

1.1 Development of ASHA Programme in Maharashtra

Maharashtra is one of the non-high focus states as per central NRHM framework categorization. At the initial stage ASHA programme was concentrated on high focus states and tribal areas in the non-high focus states. Later it was expanded to non-high focus areas as well, due to this demand by states such as Maharashtra.

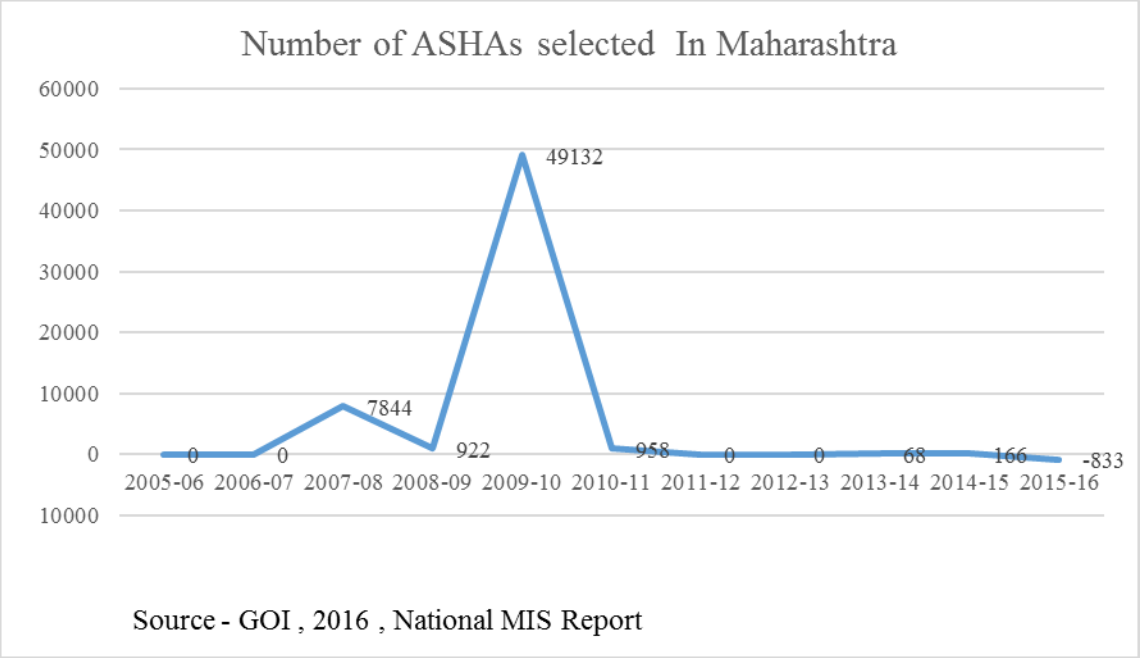
In Maharashtra the ASHA programme was started in the year 2007 in tribal areas. Training modules and support mechanisms were developed accordingly. By 2009-10, a total of 8,607 ASHAs were in place in tribal areas of the state. However, Maharashtra decided to expand the programme to all parts of the state. It was expected to appoint 51,450 ASHA in non-tribal areas of state by March 2008. There were some technical issues that were faced at the initial stage because this did not have approval of the centre, but later the central government agreed to such extension in all states and hence all the villages were covered. The total budget planned for ASHA scheme under NRHM 2008-09 PIP was Rs. 1633.968 lakhs. Performance based compensation to ASHA was provided through PHCs during monthly orientation meetings.

The support mechanisms for ASHA were planned in 2009-10 when, during the discussion while reviewing the state PIP at the NRHM secretariat at the centre, the Joint Secretary (RCH) Government of India suggested to carry out training and support mechanism of link workers in non-tribal areas from RCH-II funds. Accordingly, requirement was made through the RCH Flexi-pool and Mission Flexi-pool. The total requirement of funds under Mission Flexi pool under ASHA program was Rs. 1786.91 lakh. for year 2009-10. In 2010, Block Level Supervisors were appointed for every 10 ASHAs in tribal areas. Support mechanisms were in place from PHC to district level.

The actual functioning of the ASHA at the ground level started during the end of 2009. Compilation of one round of Training for ASHAs. PIP 2010-11 has shown, the medical kits for ASHA were provided in 2009. Data have shown that the ASHA had treated 1221 patients and referred 1113 patients to higher centers by January 2009.

In the PIP for 2010-11 was observed that many of the ASHAs who have educational qualification of 7th standard had difficulty in understanding the module. For them one illustrated module was prepared with the help of a Pune based NGO. This organization also supported conducting the ASHA trainings at some places in Maharashtra.

Figure-5.1



Source - GOI , 2016 , National MIS Report

The PIP for 2011-12 pointed out that the first five module training of ASHAs in tribal areas and first three module of non-tribal areas were completed by March 2011. As per the initial experience of three years, these kits were not sufficient for the ASHA. This issue was discussed in the ASHA mentoring committee meeting. It was decided to revise the kit contents and quantity of kits as per the needs of the state. Consequently, kit contents were reviewed in 2009-10 and modified kits were purchased during 2010-11.

At the end of NRHM the target achieved of ASHA selection in programme till 2012-13

Table-5.9

Selection Status of ASHA's in Maharashtra (2012)

Area	Target	Appointed	% Appointed
Tribal areas	9523	9523	100
Non-tribal areas	49861	49766	99.80
Total	**59384**	**59289**	**99.28**

Source: Maharashtra PIP, 2012-13

As mentioned above a total of 59,289 ASHAs were appointed in Maharashtra by December 2012. Almost all the targeted indicators of ASHA programme such as selection and training was completed in 2012-13.

To strengthen Asha programme at ground level the best performance awards for ASHA and ASHA mentoring groups establish.

Best Performance Awards for ASHA

There was lack of motivation factor observed in the implementation processes. To motivate the ASHAs performance based Awards scheme was announced by the Government of Maharashtra. It proposed to give awards to good functioning ASHAs.

For provision of awards the criteria were, ASHA with good record keeping, consistent performance and higher compensation. In one district, 3 ASHAs at district level and 2 ASHAs per block were to be given awards. The award giving function was organized under the chairmanship of President Zilla Parishad.

Establish ASHA mentoring groups:

NRHM guidelines instructed to establish ASHA mentoring groups at the state, districts and block level. State level mentoring group was responsible for policy decisions regarding ASHA. District level group was involved in planning, implementation and monitoring of the ASHA program for the district. Block level group was mainly responsible for implementation and monitoring of the program.

Thus, according to government of Maharashtra, appointment of ASHA workers was completed in both in tribal and non-tribal areas of Maharashtra by revision of central guidelines and full budget. Almost all the ASHA workers completed training. The target set for ASHA programme was achieved in Maharashtra.

The performance based intensives used to strengthen the programme are a component of the New Public Management approach. However, it is not fully accepted by ASHAs. It was clear from the views expressed by ASHAs in all ten villages that, without a minimum wage the incentive mechanism cannot work at ground level. This factor did not get reflect in the PIPs.

2 Nursing Staff improvement under NRHM Maharashtra

2.1 Additional ANM at Sub Health Center

Maharashtra has 10,535 Sub-Centres based on the approved population norms of 1 per 3000 populations in tribal areas and 1 per 5000 populations in non-tribal areas. One post of ANM is sanctioned at each of the 10,535 Sub-Centres through regular budget. This ANM has to visit every household in the village and provide outreach services. She has to conduct home and institutional deliveries. In such condition, it is almost impossible for ANM to remain present round the clock at the sub-centre head-quarter which has resulted in an inadequate availability of health services. Therefore, NRHM has sanctioned one additional ANM to each Sub-Centre as the second ANM on contract basis. Both the ANMs are supposed to provide services guaranteed as per IPHS. According to NRHM time-line, 60% of Sub-Centres were to be provided with the additional ANM by 2009. As per the NRHM time-line, 100% of Sub-Centers were to be provided with an additional ANM by 2010. Thus, all the 10579 Sub-Centers were to be provided additional ANM by

2010. However, only 5009 (47%) ANMs were appointed till 2009. Therefore, in 2009-10, it was proposed to implement all possible measures to make maximum possible ANM trained nurses available for Sub-Centers in the state. It was mentioned that about 2000 new ANMs will join the Sub-Centers as contractual second ANM in 2009-10. Thus, out of 10,535 Sub-Centres, 6321 Sub-Centres were to be provided additional ANM by 2009 and all the sanctioned additional ANM posts were not filled because of non-availability of trained ANMs. This non-availability of ANMs has not been a uniform problem throughout the state. In a few districts there were waiting lists of ANMs whereas some districts were not able to fill up even 30% of the posts. In this situation, the decision was taken to allow the districts with waiting list to fill up ANMs beyond 60% limit so that maximum numbers of ANMs are retained with health services (PIP, 2010-11). Following measures were taken to fill up maximum posts of additional ANMs at SHCs.

- Clearing all the waiting list ANMs where they are available to retain them in health services
- Walk-in-interview on fixed dates every month at all the district head-quarters in the state and advertisement for walk-in-interviews periodically.
- Campus interviews in private nursing schools
- Doubling the admission capacity of government nursing schools
- Requesting all the private nursing schools to increase their capacity and requesting the Maharashtra Nursing Council to sanction the proposals as soon as all the MNS criteria are fulfilled.
- Recruiting retired nurses who were less than 65 years age and were physically fit to discharge the duties.
- Enhancing remuneration to ANMs to be proposed in deficit districts, tribal and Naxalite affected areas (PIP 2010-11).

The total budget planned in 2008-09 for provision of additional ANM services in PHCs was Rs. 4320.0 lakh.

Table-5.10

Availability of Contractual Second ANM in Sub-Centers (2010-11)

Sr. No.	Area	No. of posts	No. filled in	% filled in	No. expected during 2010-11	Total by end of 2010-11
1	Non-tribal, Non-LEA area	8283	4405	53.2	2102	6507
2	Tribal area	1637	995	60.8	503	1498
3	Naxalite area	659	321	48.7	164	485
	Total	10579	5721	54.1	2769	8490

Source- Maharashtra PIP 2010-11

The same target was set for 2010-2011. It was proposed in 2010-11, to implement all the possible measures to make maximum possible trained ANMs available for Sub-Centers in the state. It was expected that about 2000 new ANMs would join the Sub-Centers as contractual second ANM during the year 2010-11. But this target was not achieved end NRHM. Which was seen in the PIP 2011-12.

2.2 Supervisory Nurses (LHV)

Government of India recommended the appointment of one supervisory nurse per PHC. Accordingly, each PHC in the state is to be provided one Lady Health Visitor (LHV). As there were 1817 PHCs in the state, the total requirement of LHVs was 1817. Thus, 903 (49.6%) posts of the LHV were filled in 2008 and till 2009, 1129 (62%) posts of LHV were filled. Status of availability of LHV is mentioned in the table below

Table -5.11

Availability Status of Contractual Supervisory Nurse (LHV)

Area	No. of posts	No. filled in	% filled in	No. expected during 2010-11	Total by end of 2010-11
Non-tribal, Non-LEA area	1468	664	45.2	300	964
Tribal area	242	120	49.6	50	170
Naxalite area	106	25	23.6	25	50
Total	1816	809	44.5	375	1184

Source: Maharashtra PIP, 2010-11

All the sanctioned posts of LHV could not be filled in because of non-availability of trained LHVs in the state. Important strategies were adopted to improve the availability of critical manpower such as increase in salary, appointment of retired nurses, decentralization of appointment and re-appointment system to the Taluka level. Walk-in-interview system were introduced to attract nursing candidates to join goverment health services (PIP 2011-12).

2.3 Staff Nurses at PHCs

PHCs are expected to provide health services for 24 hours, particularly through the nursing staff. To provide the services overt the 24 hours, it was proposed to appoint 3 Staff Nurses at PHC as per the time line of NRHM activities. All the three staff nurses were to be filled in on local criteria and on contract basis. Availability of these staff nurses within the PHC premises would address the health needs of rural population in very significant manner.

As per the NRHM timeline target was that 60% of the PHCs are to be provided with 3 Staff Nurses by the year 2009. Thus, in 2008 status, 526 (16%) Staff Nurses have been appointed by end of January 2008. PIP 2008-09 planned the total budget for provision of 3 staff nurses to provide 24 hours' services was Rs.1632.0 lakh. Out of 1817 PHCs, 1090 PHCs were to be provided 3 Staff Nurses total 3270 Staff Nurses by 2009. In 2009, at the end 784 (24%) staff nurses have been appointed. (PIP 2010-11) PIP proposed in the year 2009-10, was expected that about 1600 Staff Nurses would be available in PHCs.

As per the NRHM time line, 100% of PHCs were to be provided with 3 Staff Nurses by the year 2010. Thus, all the 1816 PHCs are to be provided 3 Staff Nurses by 2010. Therefore, total 5448 Staff Nurses were to be appointed in PHCs by year 2010. As against this, position of availability of staff nurses is as follows in 2011, ie not even half the posts were filled:

Table-5.12

Availability of Contractual 3 Staff Nurses in PHCs (2010-11)

Sr. No	Area	No. of posts	No. filled in	% filled in	No. expected during 2010-11	Total by end of 2010-11
1	Non-tribal, Non LEA area	4269	701	16.4	1000	1701
2	Tribal area	843	125	14.8	250	375
3	LEA area	336	34	10.1	100	134
	Total	5448	860	15.8	1350	2210

Source – Maharashtra PIP 2011-12

It was proposed to implement all the possible measures to make maximum possible Staff Nurses available for 24 hours PHCs in the state. It was expected that about 2500 Staff Nurses were available in PHCs by end of 2010.

All the sanctioned Staff Nurses could not be filled in because of non-availability of trained Staff Nurses who are ready to come to the public system.

One of the key strategies under NRHM was to strengthen the health system through better human resource management. NRHM provides opportunity for hiring additional manpower at different levels. The state had opted for giving contractual placement for an additional ANM at the sub-centre, staff-nurse and health supervisor at the level of PHC and appointment of staff nurses according to IPHS standard in hospitals. However, NRHM trided support to increase manpower, the state has been facing the issue of large scale vacancy of contractual nursing posts due to non-availability of trained nurses.

The criteria of local residency were followed to section of staff which helps to stay at the place of their postings. Though, in context of nursing staff, it has been becoming difficult to appoint local Staff nurses in remote tribal areas. Special componats were made to make nursing staff available in these areas which were described in strengthening of nursing schools.

Special steps for improvement of Staff Nurses

More than 40% of contractual nursing posts are vacant due to the non-availability of trained nurses. Increasing the capacity of nursing schools, opening new schools, supporting the private nursing schools and incentive to nursing students in the form of stipend and fees on loan basis are being tried to overcome this problem. In addition to this, appointment system for nurses has also been decentralized. The Chairperson of the Executive Committee can appoint nurses in their jurisdiction. Government of Maharashtra have also increased the monthly salary in tribal leftist extremism affected districts and in districts where not more than 25% nursing posts are filled in.

New integrated approach in the form of Public Private Partnership has also being tried to provide subsidized delivery services, ANM training and specialist training.

Steps for strenthagening of Availability of Critical Human Resource

Special initiaveis were taken to develop condition of human resounce Manpower in public health institutions. such as impovement in salary stucture of health nursing staff. Salary of nurses increased by approximately Rs. 1000 to non-tribal, Rs. 2000/- to tribal and Rs. 3000/- to tribal leftist extremism areas.

reincorporation of retired nurses, Retired nurses with good physical capacity were appointed in PHCs and hospitals on contract basis. Many of the retired LHV have accepted the appointments.

decentralize Machanisums developed for appointment and re-appointment processes. power of appointment has been givern to distirct health socirty and RKS. Decentralized postings have led to improvement in filling up of vacancies in state particularly the nurses and specialists.

Started an appointment system to make it conveniet for potential candidates and attract them, such as the walk-in-interview system at block level. Advertisements were published in all the leading newspapers indicating that there would be walk-in-interview for all the vacant posts on 2nd and 4th Thursday of every month at 3 pm in the office of the appointing authority. This resulted in getting the appointment at earliest. The above measures have resulted into very good effects and more than 1500 nurses have joined the

health services due to these measures out of which many have come from jobs in the private sector (PIP 2011-12).

Contractual Specialists

Availability of specialists was another crucial part of providing services to the community. Out of 231 hospitals being considered for upgradation, situation of availability of specialists in state is as follows:

Table 5.13
Status of Specialists in IPHS Hospital in Maharashtra (2009-10)

Sr. No.	Specialty	Regular	On contract (IPHS)	Total available	Not available	% available
1	Surgeon	85	46	131	98	57.21
2	Physician	70	31	101	129	43.91
3	Gynecologist	118	40	158	69	69.60
4	Pediatrician	106	49	155	72	68.28
5	Anesthetist	97	53	150	78	65.79
6	Total	476	219	695	446	60.91

Source:- Maharashtra PIP 2009-10

About 300 specialists have joined the post of Medical Officer in 2009. This increased the availability of specialists in the public system. Efforts are being made to convince the specialists to join public hospitals. It was expected that remaining hospitals also start providing specialty services.

In Maharashtra state, specialists were required in Rural Hospitals, Sub-District Hospitals, General Hospitals, Women Hospitals and District Hospitals. Specialties required in Rural Hospitals are for basic specialties such as General Physician, General Surgeon, Pediatrician, Gynecologist and Anesthetist. Requirement of specialties increased based upon number of beds certified for that hospital.

The intervention of IPHS to hospitals in Maharashtra changed allocation of specialties according to IPHS standards. The specialists were appointed as far as possible from regular doctors. if regular medical officer are not available, then specialists available locally in the areas are considered. Appointment of contractual specialists where regular specialist is not available was adopted as possible solution. Powers for appointment of

specialists in hospital are handover to RKS of that Hospital. Payment stucture to specialist were based on the performance of their work. Higher remuneration was given to contractual specialists in tribal and left extremism affected areas (PIP, 2011-12).

However, the efforts resulted in filling up only 55% of posts, no. of specialists appointed till 2010-11 in the state being as given in table below:

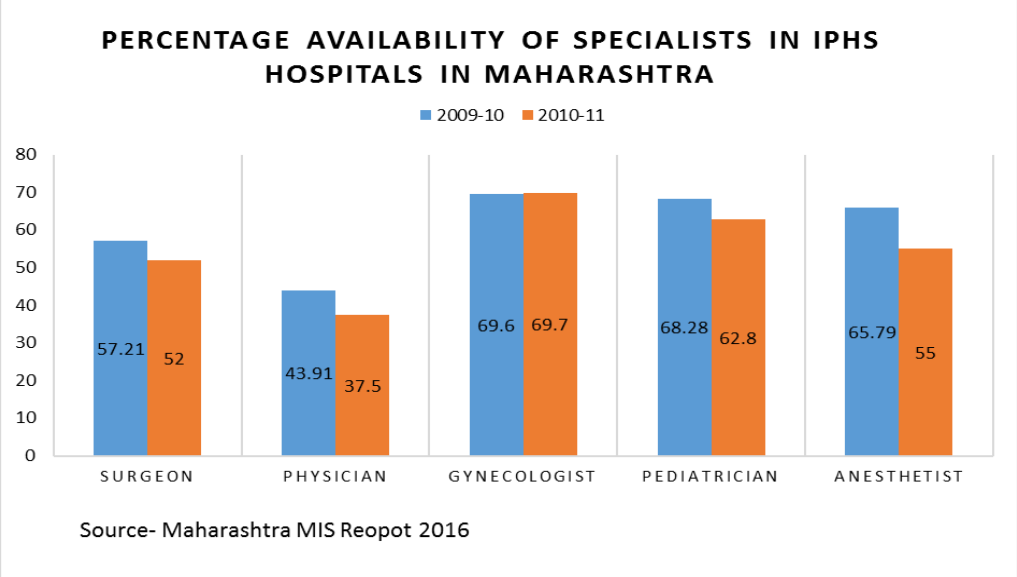
Table-5.14
Status of Specialists In IPHS Hospitals In Maharashtra (2010-11)

Sr. No	Specialty	Regular	contract (IPHS)	Total available	Not available	% available
1	Surgeon	109	64	173	160	52.0
2	Physician	76	49	125	208	37.5
3	Gynecologist	177	55	232	101	69.7
4	Pediatrician	154	55	209	124	62.8
5	Anesthetist	118	65	183	150	55.0
6	Total	634	288	922	743	55.4

Source - Maharashtra PIP 2010-11

Remuneration to contractual specialists has been paid from IPHS funds. Therefore, additional budget was not required in this section. There was no any progress mentioned in PIP 2011-12 about contractual specialists.

Figure-5.2
Availability of Specialist in IPHS Hospital in Maharashtra (%)



The above comparison of availability percentage of specialist shown decreasing trend in within one year in public health system. It systemic failure that the adoption capacity of public system is very low with regards to specialists.

Contractual Doctors (Medical Officers)

In Maharashtra, there are 1816 PHCs. Two doctors (Medical Officers) are appointed per PHC. Thus, total 3632 doctors are required for PHCs. As these are regular posts, appointment to these posts are made by Government. However, till the time Government appointed doctors join the posts, Deputy Director of circles can appoint MBBS doctors and CEOs of Zilla Parishads can appoint BAMS doctors on purely ad-hoc basis. The requirement of additional medical office to PHC is a constant demand. NRHM made contractual doctors provisoining in Primary Health Centers.

Although there was a shortage of MBBS doctors, there was no PHC left without doctors in the state. As appointment process of MBBS doctors was decentralized, any MBBS doctor can get posting immediately. Therefore, there was no need of additional contractual doctor to be posted in PHCs and hence there was no demand for budget under this activity.

Thus, despite several special efforts leading to increase in manpower in the system even by 20011-12, serious shortage of nurses, ANM and specialist doctors persisted. The ANM services needs at the village level were partly fulfilled by the new ASHA. BAMS doctors filled the gap of MBBS doctors and provided specialist services where there were vacancies. The NRHM provided support for these through its flexible mechanisms that allowed local level innovations.

Table-5.15
Present Status of Human Resources under NRHM (2016)

Number of General Duty Medical Officers (GDMOs) in position	At PHC level	0
	Other than PHC	95
	Total	**95**
Paramedics in position as on date		1280
Specialist at CHCs	Required (RHS 2015)	1440
	Sanctioned (RHS 2015)	823
	In Position (RHS 2015)	578
Specialist at level other than CHC	In position at start of NRHM (31/3/2005)	0

Specialist in position as on date	At CHC level	631
	Other than CHC	594
	Total	**1225**
Staff Nurses (SN)	Required at CHC	0
	Sanctioned at CHC	0
	In Position at CHC at start of NRHM 31/3/2005	0
Staff Nurses in position as on date	At CHC level	1319
	Other than CHC	1449
	Total	**2768**
ANMs in position as on date		5321

Source - NRHM MIS Report 2016

There were attempts to increase the availability of the ANM to at sub centres, but these were not coordinated with the number of education institution. This created a necessity to open for the walk in interviews and contractual basis. This created a pressure to open up the nursing education to private sector and poor quality of education. There were optimistic objectives to fill the various post of ANM and staff nurse in the various levels. Institutions were not capable to supply demands created by NRHM till 2009-10 hence they allowed public private partnership module, increasing private stakeholders in the education.

NRHM had allowed recruiting the human resources on contractual basis for the temporary period of the mission. This number was huge in a given state and created a work conflict between the regular and contractual on the basis of financial and non-financial benefits. At one level workers right to equal pay for equal work was violated and secondly, the selection process was undermined. Most of these contractual posts were directly filled by the Rogi Kalyan Samiti, without any proper procedure. This reduced the regular worker's faith in the public health system.

2 - Strengthening of physical infrastructure and facilities under NRHM

Maharashtra improved the infrastructrue of health institutions throughout the state under the NRHM. From the plan funds of the state, construction, repairs and routine

maintenance of these institutions was carried out on a wide scale. It has to be noted that the Public Health Department often does not get sufficient funds for these purposes. This led to the poor condition of health infrastructure by the year 2005 in most of the districts of the state. However, after getting additional support under NRHM, most of the health institutions were repaired and they had water supply, drainage and electricity facilities.

There is need for good physical infrastructure with a focus on cleanliness, availability of water and drainage system and other basic facilities as this is important while admitting patients and in providing basic obstetric services. Hence, emphasis was given to functioning of the health institutions. As felt need of health institutions was in order to improve the physical infrastructure as well as to strengthen the repairs, AMG and RKS funds were used for this purpose. Considering this situation, major part of new construction was sanctioned under the budget received as Mission Flexi-pool. It is also important to provide all PHCs/RHs with telephone for communication and ambulance services. The 2007-08, the PIP assessment showed that there is an urgent need for providing telephone to a total 1045 of PHCs. There was also emphasis on providing computers and internet facilities to PHCs to improve the Management and Information System (MIS) and for making all the records computerised. This would help to reduce the burden on health staff and improve the quality of reporting. Initially computers were provided to 2-3 PHCs per block and then extended to all (PIP 2008-09).

Maintenance and strengthening of physical infrastructure was carried out with the help of funds from following sources.

1. Annual Maintenance Grant
2. Grants for improving physical infrastructure
3. IPHS funds

Annual Maintenance Grants

Annual Maintenance Grants are distributed for maintenance of physical infrastructure of health institutions. Government of India directions were to use this grant for regular

maintenance of physical structures of health institutions including provision of water, toilets, their use and maintenance.

During the year 2007-08, the Annual Maintenance Grant (AMG) was distributed to all the PHCs (Rs. 0.5 lakh) and RHs (Rs.1.0 lakh). The pattern of utilisation of the AMG as observed in the state up to January 2008 as below.

Maximum expenditure from AMG was carried out on minor civil repairs. As mentioned in the Government of India guidelines, the distribution of AMG was proposed in Sub-Centres, Primary Health Centres and Rural Hospitals of the state as per norms prescribed under NRHM. In the year 2007-08, major part of AMG grants were utilised for repairs because it was immediate need of hospitals. As almost one third of 2008-09 year construction grant was utilised for repairs, the RKS was encouraged to utilise AMG for regular maintenance of hospital and staff quarters.

Repairs and New Construction:

In Maharashtra, out of 10535 Sub-Centres 6927 SCs, out of 1817 PHCs, 1331 PHCs and out of 453 RHs 342 RHs carried out additional construction work to the existing health care institutions during year 2007-08. Thus, more than half health institutions in all types of facilities were constructed. Further, many of the constructed buildings were old and required extensive repairs to make them fully functional. Thus, along with new construction, it was equally important to repair the existing physical infrastructure. Following actions was taken during 2007-08 to speed up the repairs and construction activities.

<u>Strengthening administrative structures</u>

- Infrastructure Development Wing (IDW) was established in all the districts of the state. One Junior Engineer for every four blocks and one Deputy Engineer for every district were sanctioned. Accordingly, 33 posts of Deputy Engineers were sanctioned out of which 32 were in place and 92 posts of Junior Engineers sanctioned out of which 91 are filled in.
- The IDW offices at block and district level were established

- Powers of administrative and technical sanctions were decentralised and delegated to District Societies. Accordingly, District Health Officer/Civil Surgeons were given powers to sanction new constructions of up to 15 lakhs and Chief Executive Officers of Zilla Parishads had full powers for administrative sanctions of works to be done in their district.
- To save time for fixing the agency for carrying out civil works, panel of contractors was developed by advertising in newspapers. Total 553 panel members have been established in the state. These panel members are allotted works by District Society through a competitive bidding process.
- Instructions issued to all the districts to construct new buildings as per state plans of hospitals and quarters.
- Public Works Department of Maharashtra State uses DSR for preparing and sanctioning work estimates. Districts were permitted to use same rates for NRHM.

Considering the situation of the presently available buildings, it was decided during 2007-08 that major part of grants for new construction may first be used for major repairs of the existing physical infrastructure.

Accordingly, a total of 4825 health institutions have been surveyed and 1467 buildings were started for repairs till January 2008. Out of total budget of Rs. 5200.00 lakhs, it was expected that budget up to Rs. 2627.07 lakhs were utilised for major repairs of the exiting physical infrastructure and new construction of health institution buildings. As to repairs of buildings, instructions have been given to undertake these works after conducting facility survey of the buildings to be repaired.

Following are the sources of funds for construction:

- Plan grants of the state
- Grants from Regional Imbalance fund
- Grants from Tribal Welfare Department for tribal areas
- NRHM grants

Plan grants utilised for all the institutions. Tribal grants were restricted to the geographical area, so these grants were used in that area on priority. NRHM grants have two sources. First was the RCH Flexible Pool in which 14% of outlay was utilised to

repair the labour room, operation theatre, water supply system and drainage facility. Second source was NRHM Flexible Pool in which 25% of outlay was utilised for repairs and new construction of health facilities including staff quarters.

Districts were advised to consider all these grants and prepare plans considering the restrictions laid down for utilisation of particular grants so that all the grants were optimally utilised for construction activity.

Provision of Important Facilities

It was important to provide basic important facilities. The health institutions needed support in vital areas such as communication, record keeping and dissemination, alternative power arrangements, transport facility, etc. The 2008-09 PIP proposed all the RHs required internet facility and solar back-up system. Regarding facilities at PHCs, out of 1817 PHCs, 1085 PHCs did not have a telephone and almost all the PHCs did not have computers. Accordingly, it was proposed to provide telephones to all remaining 1085 PHCs and computers to 2-3 PHCs per block during year 2008-09. Government had sanctioned a laboratory technician to all PHCs, with sufficient space for laboratory and provided Laboratory Refrigerator of 100 litres capacity and provided them Solar Power Back-up.Considering the importance of availability of essential facilities including solar backup system in health institutions, it was proposed to utilize the savings from other activities for this purpose subjected to permission by the State Health Society.

Ambulance services for PHC/CHCs:

All the hospital and PHCs in the district should have ambulance services available for 24 hours. This is important for mobility and referral of serious patients particularly the pregnant women in labour. The Government of Maharashtra had provided ambulances to majority of health institutions in the state. However, many of the ambulances require large sums for repairs. It was proposed in 2008-09, that at the places where the ambulances are not available, either the ambulance is hired on contract basis for transport of serious patients on fixed rate or new ambulance be purchased as per requirement. The decision about this was taken by District Health Societies. New ambulances were purchased where the post of driver was sanctioned from state budget.

The 2008-09 PIP assessment had shown improved availability of ambulances and their conditions as mentioned in the table below:

Table-5.16
Number and Availability of Ambulances in Maharashtra (2008-09)

Sr No.	Institution	No. of institutions requiring ambulance	Ambulance available	
			Yes	No
1	PHC	1817	1555	262
2	RH	453	418	35
3	DH	23	23	0
	Total	**2293**	**1996**	**297**

Source: Maharashtra PIP, 2008 -09.

The 2009-10 PIP assessment had shown, availability of telephone facility at 1072 PHCs, 341 Rural Hospitals and all Sub District hospital (SDH) (78), General Hospitals (3) Women Hospitals (8) and District Hospitals (23). In 2010-11 year, this has resulted into availability of telephones in 1510 (83%0 PHCs and 407 (89%) CHCs. Few health institutions were remaining only because there were technical problems in the availability of telephone lines at these places.

In 2009-10 year, ambulance services were available at 1633 (90%) PHCs, 402 (91) RH/SDH and all the General, Woman and District Hospitals. Similarly, in 2010-11 Ambulance services were available at 1600 (88%) PHCs, 402 RHs/SDHs and all the General, Women and District Hospitals.

MIS system strengthening was one of the priorities under infrastructure development. The MIS system of state was totally computerized and thus it was also important to provide computers and internet facilities to PHCs to improve the MIS. The computerized records also reduce the burden on health staff and improve the quality of reporting. By 2009-10, computers were available in 663 (36.5%) PHCs, 348 (95 %) RHs and all the Sub-District, General, Women and District Hospitals. It was proposed to provide computers to all PHCs where internet facility had been made available during year 2009-10.

Laboratory services that are also important for functioning of health institutions were one of the weakest services in Maharashtra state. The state government has recently sanctioned one laboratory technician to each of 1816 PHCs. These posts were filled up by 2010. Training of these technicians and providing deficit laboratory equipment was done through Mission Flexi Pool.

Annual maintenance grants (AMG) were utilized mainly for the maintenance of building, equipment and instruments. The health institutions were not allowed to purchase new items or new construction from AMG. Many of the health institutions hired electricians, carpenters and masons from these grants for regular preventive maintenance of main building and quarters. The 2008-09 maximum expenditure of the SCs was on repairs of equipment/instruments followed by civil works and repairs, whereas PHCs have spent maximum AMG funds on civil works followed by electricity/telephone bills and water supply. Regarding hospitals, maximum expenditure of RH/SDH was on repairs of hospital furniture whereas maximum expenditure of District Hospitals was on electrical repairs.

In 2009-10, it was proposed to provide AMG grants to Primary Health Units and Dispensaries. These institutions have one doctor and nurse and they provide health care delivery services mainly AYUSH to the community. During the year, it was also proposed to streamline the AMG expenditure of health institutions and make it more need based. More emphasis was given on preventive maintenance, particularly equipment, instrument and other hospital supplies.

Repairs and New Construction

Construction status of health institutions till 2009 in the state is given in table below

Table-5.17

Construction Status Of Health Service Institutions In Maharashtra (2009-10)

Sr. No	Institution	Total numbers	Main building		Quarters	
			No	%	No	%
1	Sub-Center	10579	7442	70.3	7442	70.3
2	PHC	1816	1518	83.6	1368	75.3
3	Rural Hospital	366	244	66.9	176	48.2

4	Sub-District Hospital	81	81	100	81	100
5	Women Hospital	8	8	100	8	100
6	District Hospital	23	23	100	23	100
	Total	12872	9316	72	9098	71

Source:- Maharashtra PIP, 2009-10.

In 2009-10, actions were taken to speed up the repairs and construction activities. This includes make functioning of Infrastructure Development Wing (IDW). Accordingly, all the posts of sanctioned out were filled in. Instructions issued to all the districts to construct new buildings as per state plans of hospitals and quarters. Public Works Department of Maharashtra State for preparing and sanctioning work estimates. Districts were permitted to use the same rates for NRHM.

Repairs and new constructions work done by Infrastructure Development Wing for the years 2007-08 and 2008-09is given in table below:

Table-5.18
Work Done by Infrastructure Development Wing

Sr. No	Type of institution	2007-08		2008-09		Total	
		Repair	New	Repair	New	Repair	New
1	SC	942	67	1220	304	2162	371
2	PHC	653	0	1490	90	2143	90
3	RH/SDH/WH	87	1	133	5	220	6
	Total	1682	68	2843	399	4525	467

Source: Maharashtra PIP, 2009-10.

The above table indicates that the Infrastructure Development Wing have been carried out in more than four thousand health institutions, five hundred repairs work and 467 new constructions, out of which 371 were Sub-Centers.

During year 2009-10, it was proposed to give more emphasis on repairs of health institutions which were maximally utilized.

Common Review Mission Suggestions

The Common Review Mission (CRM) visited Maharashtra state in 2010. Regarding civil works, CRM advised the state to concentrate on repairs of main building, wards and quarters, water supply, provision of toilets, repairs of medicines stores, availability of

laboratory, etc. Accordingly following priorities were considered while preparing the plans of new construction and repairs.

- Repairs and new construction of water supply, Sanitary and drainage system (working toilet with 24 hours' water supply to hospital as well as quarters)
- Repairs and new constriction of labour room and operation theater for delivery and FW services
- Repairs and new construction of staff quarters (MO, two nurses, one pharmacist and one HA on priority to stay important staff at HQ).
- Remaining repairs of main building
- Repairs or new constriction of compound wall for security to hospital and internal roads
- Repairs of medicine stores
- Repairs or new constriction of laboratory
- New construction of institution

In the 2009-10 PIP, districts have been given detailed guidelines regarding planning and execution of repairs and new construction grants. As per the recommendations of the second CRM, it was decided to provide 24 hours' water supply to at least 90% of health institutions by end of 2009. Similarly, operation theater, labour room and toilet blocks were also to be repaired or newly constructed if not available for providing services in health institution.

New construction was considered where land was available within the village. New construction includes main building, essential staff quarters, compound wall, internal road, water supply, etc. Priority was given in areas with poor coverage of health services.

Table- 5.19
New Construction Of Health Service Institutions (2009-10)

(Rs.in lakhs)

Sr. No.	Type of health institution	Total no. in state	No. not construction	No. proposed for construction	Budget required
1	Sub-Center	10579	3137	429	6156.90
2	Dispensary	836	195	76	1335.0

3	PHC	1816	298	86	6618.0
4	RH/SDH/WH	455	38	11	2445.0
7	District Hospital	23	0	0	0
	Total	13709	3668	602	16554.9

Source: Maharashtra PIP, 2009-10

Budget proposed for repairs and new construction of health institutions was Rs. 49719.74 lakhs. Out of this, budget for repairs and new construction of water supply system, operation theater, labour room and drainage (Rs. 9432.2 lakhs) was requested from RCH-II construction grants. Out of remaining budget of Rs. 40287.54 lakhs, budget of only Rs. 15000.00 lakhs were made available because of ceiling limit of 25% for new construction and repairs grants. Therefore, prioritization was made while considering the sanctioning budget for civil works.

Following priorities was made for utilization of civil works budget in state

- Works which were started in year 2008-09 but could not be completed before 31st March 2009. This was committed budget and should be provided to the districts.
- Repairs of main building where deliveries were conducted and patients were admitted
- Repairs of quarters where staff is staying at HQ
- Repairs of quarters where staff is likely to stay if quarters are repaired
- New Construction of health institute which has been provided space in the village

The total budget proposed for civil works is Rs. 7076.0 Lakh in 2009-10 PIP. In case of savings from other activities, more funds were provided to civil works within the limit of 25% of mission flexi pool.

As MIS of state is totally computerized, it was also important to provide computers and internet facilities to PHCs to improve the MIS and for computerized of records to reduce the burden on health staff and to improve the quality of reporting. State Health Society had taken this issue on priority basis and now computer and internet address is available in all the 1806 PHCs of state.

construction status of health institutions

Construction status of health institutions in the state is given in table below

Table-5.20
Construction Status of Health Service Institutions (2010-11)

Sr. No.	Institution	Total numbers	Main building		Quarters	
			No	%	No	%
1	Sub-Center	10579	7442	70.3	7442	70.3
2	PHC	1816	1518	83.6	1368	75.3
3	Rural Hospital	366	244	66.9	176	48.2
4	Sub-District Hospital	81	81	100	81	100
5	Women Hospital	8	6	100	6	100
6	District Hospital	23	23	100	23	100
	Total	12873	9314	72	9096	71

Source: Maharashtra PIP, 2010-11

During last three financial years, priority was given to repairs of health institutions because this resulted into making the health institutions functional with minimum budget.

New construction of quarters in existing PHCs

In 2011-12 there were 150 PHCs in the state in which main building was constructed but quarters were not available. Out of these, 38 PHCs were functioning well. It was proposed to construct quarters in these PHCs so that MO and nurses were available for services delivery.

3. Upgrading Health Institutions to Indian Public Health Standards (IPHS)

Non-availability of quality services is one of the main reasons for patients preferring private health facilities. Provision of quality services is affected by non-availability of specialists, absence of staff, insufficient supply of essential medicines, poor laboratory and investigation capacity, inadequate physical infrastructure, etc. To bring the quality and accountability in health services, Indian Public Health Standards (IPHS) have been set up for the health institutions such as SHCs, PHCs, RHs and District Hospitals. IPHS is a concept that emerged to fix benchmarks of infrastructure including building, manpower, equipment, drugs and quality assurance through introduction of treatment

protocols. Most important, they also define the level of services that health institutions are expected to provide (PIP-2008-09).

Government of India has fixed separate IPHS standards and time lines for various facilities as one of the components under the NRHM.

Services Assurance by IPHS at various level:

Sub-centre:

In the public health sector, Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Therefore, success of any health program depends upon well-functioning sub-centres providing effective services of acceptable standards to the people. The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of community. IPHS standards for Sub Centres aimed towards providing basic primary health care to the community, achieve and maintain an acceptable standard of quality of care, make the services more responsive and sensitive to the needs of the community. The IPHS has laid down assured services to be provided at the Sub-Centre. Important and prominent services among them are ANC care, normal delivery, essential new-born care, immunisation, family planning contraception, disease surveillance, adolescent care, etc. Also stated in the IPHS is the cultivation of local medicinal plants and herbs in the Sub-centre compound as part of 'revitalisation of local health traditions'. However, neither disease surveillance nor growing of herbal garden was found in the study area.

Primary Health Centre:

Primary Health Centre serves as the first port of call to a qualified doctor in the public health sector in rural areas providing a range of curative, promotive and preventive health care. While it serves as a referral unit for Sub-Centres, cases are referred out from PHCs to RHs. A PHC providing 24 hours services and with appropriate linkage, plays an important role in improving the institutional deliveries thereby helping to reduce maternal and infant mortality.

Objectives of the IPHS for the PHCs are:

- To provide comprehensive primary health care to the community through the PHCs

- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of community

Assured services at PHCs meeting IPHS includes Medical Care, Maternal care including 24 hours delivery services both normal and assisted delivery, child health care including new-born care, MTP, treatment, Adolescent health and Disease Surveillance, etc.

Also stated in the IPHS is the co-location of AYUSH services at the PHC, with one doctor and compounder, with medicines of that system. Cultivation of local medicinal plants and herbs in the PHC compound as part of 'revitalisation of local health traditions' was another activity. While the AYUSH doctor was posted at the PHC, there were no AYUSH medicines supplied, and he was expected to provide allopathic services. Growing of herbal garden was also not found in the PHCs of the study area.

Rural Hospital (RH):

Secondary level of health care includes Rural Hospitals of various bed capacity called as First Referral Units (FRUs). The RHs were designated to provide referral health care for cases form primary level and for cases in need of specialist care approaching the centre directly. In order to ensure quality of services, the Indian Public Health Standards are being set up for RHs so as to provide a yardstick to measure the services being provided there.

Objectives of Indian Public Health Standards for RHs:

- To provide optimal expert care to community
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the need of community

Services delivery in RHs

Every RH has to be provided assured services such as care of routine and emergency case in medicine and surgery, caesarean section and other medical interventions, implementation of National Health Programs, blood storage units, essential laboratory services, etc.

IPHS Standard Implementation:

IPHS in Maharashtra was initially introduced in Rural Hospitals. During 2006-07, out of 453 RHs in state, 105 were identified to upgrade to the IPHS standard. External Facility

Survey was carried out with the help of reputed agencies and disseminated to all the RHs in first quarter of 2007-08. All the selected RHs were instructed to start actions for up-gradation as per the gaps identified in the institutions. Regular follow-up of these institutions was carried out. In majority of the institutions some gaps were identified, which was related to availability of speciality services, blood storage units, civil works, medicine, equipment, instrument and support services. Out of these most important gaps difficult to meet were availability of speciality services and establishment of blood storage units. Procedure and rates for hiring of specialists were published and circulated to all the institutions. (PIP 2008-09) Because of these continuous efforts, 37 out of 105 RHs had all the required specialists and functioning Blood Storage Unit by the end of January 2008. Additional 47 units were expected to provide these services by the end of March 2008. During 2007-08, additional 66 RHs and 23 District Hospitals were identified for up gradation to the IPHS standards. Rapid surveys of these institutions were carried out with the help of Joint Director (Medical) and institutions were allowed to fill up the gaps in expenditure to the priorities decided. Meetings of all Medical Superintendents and Civil Surgeons were carried out, detailed guidelines and appropriate delegation of powers were issued to institutions in 2007-08. As NRHM has specified that external assessment survey carried out for all the institutions prior to up gradations as per IPHS, selection procedure for External Assessment Survey of newly selected institutions during 2007-8 and SHCs, PHCs, to be selected by 2009 as per NRHM time line was started in January 2008. Advertisement for procurement of Consultancy services had appear in newspapers in 1st week of March indicating district wise number of health institutions to be surveyed. The Plan of Action for 2008-09 was, in the time line of activities, NRHM has specified that 60% of SHCs, PHCs and 50% of RHs should provide services guaranteed as per IPHS by year 2009.

Total of 7665 institutions were identified for up-gradation. Out of which 1354 (18%) institutions were included for up gradation during 2008-09.

Following actions were taken during the year 2008-09 for up gradating these institutions as per IPHS.

i) Completion of External Assessment Survey

Procedure for procurement of agency for External Assessment Survey was started in April 2008. Twenty-five teams were expected to start External Assessment Survey. The teams comprised of Public Health Specialist, Civil Engineer, Bio-medical Engineer and Management Person. External Assessment Survey was carried out based on the Government of India guidelines. Survey were carried out considering block as a unit. Once survey of block was complete, report disseminated to institutions and procedure for up gradation work. It was expected to complete the External Assessment Survey of all health institutions by October 2008 and state report ready by December 2008.

ii) Gap identification and plan for filling up of gaps

Once the External Assessment Survey was complete, Workshops of Medical Officers and Medical Superintendents of concerned institutions was arranged in each district with the help of Directorate Officers and Health and Family Welfare Training Centres. Plan for filling up of gaps in Civil Works, Medicine procurement, Equipment and Instrument procurement and maintenance, Specialist services, etc. developed a IPHS wing of the district and monitored the progress of activities. Release of grants as per the external assessment report: plans were prepared for up-gradation and Grants were released to districts as per the expenditure proposed for up-gradation during year 2008-09.

iii) Procedure to be followed up for procurement for up-gradation

The Government of Maharashtra had delegated powers to all District Societies for up-gradation of health institutions as per IPHS. The health institutions were requested to get administrative and technical sanctions to the procurements as per the delegations and procure the material, services or construction as per the laid down procedure. It was also proposed to develop guidelines based on the difficulties faced by 105 institutions which were up-gradated.

iv) Demand generation for utilisation of the IPHS health institute

Once the hospital/Centre was upgraded as per the IPHS one inaugural program involving local PRIs and other community based organisations was organised by RKS to declare the up gradation of institution and services now available to community. Intensive BCC

activities were carried out in catchments area with the help of local media, local cable network, interpersonal communication, etc.

v) Setting up of IPHS Monitoring Wing

Up-grading the health institutions to IPHS and assuring the health services as per IPHS was viewed as very critical to provide quality services and to reduce infant and maternal mortality. Considering the quantum of work to be carried out and impact of this work on health care delivery, it was proposed to establish IPHS wings at district, circle and state level. These IPHS Wings monitor the progress made by each institution in three aspects. Firstly, the physical infrastructure, equipment and services procurement, secondly it assured medical services provided by the institute and thirdly it focused on the utilisation of the services by community.

Budget requirement for the year 2008-09:

Budget was required for following purposes:

- One time cost for upgrading of hospital as per External Assessment Survey – Civil Works, procurement of instrument, equipment, etc.
- Recurring cost such as cost of specialist services, medicine to be procured only when there is short supply from state medical supplies, maintenance of medical equipment, blood storage centres, etc.
- IPHS Monitoring Wing: Budget for salary, travel and contingency of contractual staff to be appointed for IPHS monitoring.

As information on External Assessment Survey of proposed institutions was not available in 2008, it was difficult to demand exact budget for up-gradation of health institutions. However, based on External Assessment Surveys carried out by external agencies and Internal Rapid Surveys,

Total budget required for IPHS up gradation was thus Rs. 7531.32 lakhs. Although, the time line of NRHM has mentioned upgrading of 50% PHCs and SCs by 2009, it was proposed to upgrade the number of institutions as stated above during year 2008-09.

During 2009-10, IPHS up gradation of health institutions was selected as one of the core activities of the NRHM. Therefore, remarkable progress has been made during the year

2009-10. In the time line of activities, NRHM has specified that 100% of SHCs, PHCs and Hospitals should provide services guaranteed as per IPHS by year 2009. Considering this, status of up gradation of health institutions in Maharashtra state was as follows:

Table-5.21
Status of Up-Gradation of Health Service Institutions As Per IPHS Standard (2009-10)

Sr. No.	Type of Institution	Total no. in state	External Facility Survey done (by Dec 09)	Upgraded up to Dec 2009	% Upgraded
1	Sub-Centre	10579	6347	1194	11.29
2	PHC	1816	1090	465	25.61
3	RH/SDH	455	310	49	10.77
4	DH/RRH	23	23	18	78.26
	Total	12873	7770	1726	13.41

Source – Maharashtra PIP, 2009-10

Considering the time line for IPHS up gradation (100% by 2010), it was decided to upgrade all the PHCs and SCs functioning in own building in 2010. Accordingly, facility survey of remaining SCs and PHCs with buildings was to be completed during 2010 year.

Appointment of contractual specialists where regular specialist was not available:

Availability of specialists was another crucial part of providing services to the community. The status of availability of specialists in state in the year 2010 was as follows:

Table-5.22
Availability Of Specialists In IPHS Hospitals in 2010

Sr. No	Specialty	Regular	On contract (IPHS)	Total available	Not available	% available
1	Surgeon	109	64	173	160	52.0
2	Physician	76	49	125	208	37.5
3	Gynecologist	177	55	232	101	69.7
4	Pediatrician	154	55	209	124	62.8
5	Anesthetist	118	65	183	150	55.0
6	Total	634	288	922	743	55.4

Source - Maharashtra PIP, 2010-11

Efforts were made to convince the specialists to join public hospitals. It is expected that remaining hospitals would also start providing specialty services.

Performance of IPHS institutions

Most important limitations for achieving the IPHS standard by the SC is availability of second ANM and for RH/SDH, the availability of specialists and permission for Blood Storage Unit. Special attention was provided for these limitations. Although the state could not get enough number of specialists as mentioned above, quite a good number of activities were carried out by the available specialists. Table below will indicate this:

Table-5.23
Performance of IPHS Institutions in Maharashtra

Sr. No.	Indicator	IPHS Institute Performance		
		20007-08	**2009-10**	**% increase**
1	OPD	10396327	13985869	134.53
2	IPD	1181362	1731080	146.53
3	Hospital deliveries	133348	184983	138.72
4	Caesarean section	10656	23222	217.92

Source: Maharashtra PIP, 2010-11

The table above indicates that there was an increase in the utilization of all the services. Highest increase is observed for caesarian section. Given the focus on institutional deliveries, there was increase in number of hospital deliveries in IPHS hospitals. However, it is to be noted that the major focus for upgradation now was on the District hospital and much less at the primary level (PIP 2010-11).

In the time line of activities, NRHM has specified that 100% of SHCs, PHCs and RHs should provide services guaranteed as per IPHS by year 2010. Hence, the activities planned by Maharashtra for year 2010-11 were as follows:

- Considering the fact that major part of public health services is provided by network of Sub-Centers and PHCs, it was planned to concentrate on up gradation of PHCs and SCs during this year.
- All the PHCs and Sub-Centers functioning in its own building were be included for up gradation during financial year 2010-11.

- CHCs, SDH and Women Hospital where three basic specialties OBGY, Pediatrics and Anesthesia were available and hospital is functioning in own building were to be included for IPHS standard.
- All the District Hospitals in state were included for IPHS up gradation.
- External facility survey of remaining SCs and PHCs functioning in own building were to be completed and up gradation to be started immediately.

Table No- 5.24
Health Service Institutions Upgradation Plan As Per IPHS Standard (2009-11)

Sr No.	Type of Institution	Total no. in state	Institutions eligible for up gradation	Institutions actually upgraded by Dec 09	Institutions expected to be upgraded during Jan-March 2010	Total institutes to be upgraded by end of March 2010	Institutions to be upgraded during 2010-11
1	SC	10579	7551	1194	4000	5194	2357
2	PHC	1816	1553	465	500	965	588
3	RH	366	77	17	60	77	0
4	SDH - 50	56	17	11	6	17	0
5	SDH – 100	22	18	14	4	18	0
6	GH - 200	3	3	3	0	3	0
7	WH	8	6	4	2	6	0
8	DH	23	23	18	5	23	0
	Total	12873	9248	1726	4577	6303	2945

Source – Maharashtra PIP, 2011-12

During the year 2011, External Facility Survey (EFS) of majority of 7770 health institutions was completed and findings were also disseminated. EFS of remaining PHCs and SCs functioning in own building was completed. Plan for filling up of gaps in civil works, medicine procurement, equipment and instrument procurement and maintenance, specialist services, etc. were developed. Up gradation of health institutions carried out as per the gaps identified by survey. IPHS wing of district was monitoring of activities. Actual distribution of grant from district to health institution was done based on gap analysis.

Setting up of instrument / equipment repairs and maintenance system

Equipment's and instruments are required for health care delivery in all the health institutions. Sophisticated equipments such as sonography machine, dialysis machine, X-ray machine, etc. have AMC with the authorized service agents. However, for small instrument and equipment such as BP apparatus, suction machine, centrifuge, autoclave, etc. there is no effective infrastructure available in health department. As majority of health institutions are in remote areas, there is no private sector maintenance system available for repairs of these equipments. Therefore, tendency of Medical Officers was to purchase new equipment instead of repairs when old machine is not working. Considering the above fact, hence it becomes extremely important to develop responsive repairs and maintenance wing in health department.

Presently, state government has Health Equipment Maintenance and Repairs unit situated at all the Divisional Head Quarters. These units have staff paid under state government. If these units are upgraded and provided with mobility support, they can function effectively. In addition to this, wherever required, help of private sector workshops can be taken up for equipment maintenance.

In 2011-12 Additional resources were made available to selected health facilities to upgrade infrastructure and manpower to IPHS. After going through the data of three years (2008 to 2010) it was observed that utilization of health facilities had increased remarkably. Although this increase was slow for deliveries, there was improvement in IPD (in patient department) cases. The utilization of services of IPHS, for the PHCs as compared. The utilization of IPHS for PHCs over non-IPHS-PHCs was very high. Even in IPHS-PHCs, the utilization had increased by 36% for deliveries, 65% for new OPD and 149% for IPD. Although number of deliveries per PHC was lower than expected, efforts were made in 2011-12 to increase the average deliveries in IPHS PHCs to increase to 25 deliveries per month.

Similarly, for hospitals also there is increase in utilization of services as mentioned in table below:

Table 5.25
Increase In Utilization Of Services IPHS and Non –IPHS in Maharashtra

Sr. No.	Indicator	IPHS RH	Non-IPHS RH	Difference	% increase
1	BOR	52.7	13.48	39.2	290.6
2	New OPD	53729	19905	33824	169.9
3	New IPD	6968	1393	5575	400.1
4	Major surgeries	382	66	316	474.2
5	Deliveries	863	132	731	551.4
6	LSCS	59	4	55	1283.3
7	Lab test	26063.6	6221.93	19841.7	318.9

Source – Maharashtra PIP, 2011-12

In hospitals, all the indicators have shown remarkable increase in IPHS hospitals.

Following actions was taken for up gradation of health facilities during 2011-12:

- Systematic plans were prepared based on external facility survey to upgrade the health facilities to IPHS. During 2011-12, facilities having less then desired level of deliveries have been examined on case by case basis. In the places where the deliveries were not as per desired and where there was no possibility of further improvement, facility were discontinued from up-gradation. There are few non-IPHS facilities where the deliveries have substantially increased. These facilities were added for IPHS up gradation.
- Scheme of **'Free delivery-Free neonatal care-Free transport'** was introduced in all the IPHS health facilities. This was treated as one of the IPHS criteria and was closely monitored for progress.
- Scheme of **'Book your Bed (BYB)'** was introduced in all the health facilities upgraded to IPHS standards. In this scheme, all the mothers in areas were shown the health facility. Beds were booked in name of mother in advance willing for a delivery in hospital and were displayed at the entrance of female ward.
- First step towards IPHS up gradation for hospitals was compliance of FRU status. Therefore, hospitals where three basic specialties OBGY, Pediatrics and Anesthesia were available and hospital was functioning in own buildings only these hospitals being included for IPHS up gradation. Efforts were made to

increase the availability of other specialists and nurses to provide maximum possible specialty services mentioned in IPHS as per bed strength.

- Similarly, all the SDH and District Hospitals in the state were included for IPHS up gradation. Five specialties were provided to all the hospitals – Medicine, Surgery, Gynecology, Pediatrics and Anesthesia were provided on priority considering the goal of NRHM. In addition to this, maximum efforts were made to get available additional 9 specialties as per bed strength of District Hospitals.
- One government RH was run by an Non Government Organisation (NGO) under Public Private Partnership (PPP) mode catering to around 1.2 lakh populations at Sastur of the Osmanabad district. As this hospital had started specialty services and undergoing delivery, cesarean section operation, this hospital had included for IPHS up-gradation.
- Facility survey of hospitals included in up gradation was carried out by External Expert agency.

In year 2010-11, Initially priority was given to repairs of health institutions because this resulted into making the health institutions functional with minimum budget. Following policy decisions have been taken regarding Civil Works in the state:

- Henceforth minor repairs was carried out locally by the Rogi Kalyan Samittee from funds such as AMG, RKS and if necessary the IPHS funds.
- For repairs of institution, either State government or IDW budget was utilized for major repairs of health institutions
- RCH Flexi-pool (Part-A) budget were used for repairs of OT, Labor room, water supply and drainage and electrification of health institutions
- Mission Flexi-pool (Part-B) budget priority were given for construction of Sub-Centers, PHCs and quarters of critical staff.
- In one institution, no budget from two sources was utilized for civil works.

As mentioned above, during year 2011-12, it was proposed to give more emphasis on new constructions from Mission Flexi pool funds.

Number of institutions upgraded

In year 2011-12, achievement of upgradation was decided by self-declaration of the facility that they have achieved IPHS. The figures of upgradation are as follows in 2012-13:

Table-5.26
Status of up-gradation of Health Service Institutions as per IPHS Standard (2012-13)

Sr. No.	Type of Institution	Total no. in state	No. of health facilities designated for up-gradation	24×7 PHCs/ FRU upgraded	IPHS Upgraded	Fulfilling criteria of delivery point
1	Sub-Centre	10580	2997		1755	1521
2	PHC	1810	1067	594	242	658
3	RH/SDH/GH	447	224	132	73	188
4	WH	9	9	9	6	9
4	DH	23	23	23	18	23
	Total	12874	4319	757	2094	2299

Source – Maharashtra PIP, 2012-13

For year 2012-13, the GoM established committees at District, Regional and State level and developing evaluation formats for each type of facility. Once the facility approaches District Health Society to inform about achievement of IPHS status, the committee was to visit this facility for certification. Budget requirement of upgradation was calculated on average basis till 2010-11. In 2011-12, individual planning formats were introduced and budget requirement was calculated based on gaps. The calculations were partially based on plans and partially on averages. However, for planning of 2012-13, IPHS planning workshops were conducted in each district with the help of IPHS Coordinators and submitted in PIP. Thus, in this year planning was individual center based except for Sub-Center, where plans are still on average basis. Facility wise gaps were identified and budget requirement submitted for information. As these plans were prepared in February, additional grants received after plans were prepared (Rs. 51.30 Crores + Rs. 53.8 Crores = 105.1 Crores). Some of the budget although mentioned in Plan is not completely utilized in planned year as it takes some time to get specialist and equipment required for services.

4. Mainstreaming of AYUSH and Revitalisation of Local Health Traditions

This was a strategy of the NRHM to make available the benefits of Ayurveda, Unani, Siddha, Yoga and Naturopathy and Homoeopathy (AYUSH) to the public at large, so that the people can exercise their choice in accessing these services. The objective was to build bridges across the medical systems by providing general and specialized therapies of Ayurveda, Unani medicine, Siddha, Yoga and Naturopathy and Homeopathy for utilization as an adjunct or better alternative to conventional medical treatment. It has been felt that this situation needs to be addressed with concerted efforts (PIP 2008-09). The NRHM intended to encourage setting up of general and specialized treatment centers of ISM&H (in allopathic hospitals and support the efforts of State Government to improve the supply position of essential drugs in dispensaries situated in rural and backward areas, so that the faith of people in ISM&H could be enhanced (Ibid).It was proposed that maximum possible number of District Hospitals, Rural Hospitals and 24 hours Primary Health Centers should be provided with the facility of AYUSH so that by the end of 2012 all such institutions emerging as referral units would have facility of AYUSH and alternative to conventional medical treatment.

Establishment of such units have to be provided with the facilities of the required staff, renovation, alteration, equipment furniture, reference book, medicine and consumables, training of staff, and contingency. The Department of AYUSH, Government of India provided a prescribed format for seeking financial assistance under components of the scheme. The required information of all institutions was being submitted to the Department of Indian Systems of Medicine and Homoeopathy at the centre. So that the expenditure for renovation, alteration, equipment furniture, reference book, medicine & consumables, training of staff, and contingency has been provided by the ISM&H (PIP 2008-09).

Proposed staff to the AYUSH center to be established is as follow:

Staff Proposed For AYUSH Centre In Health Institutions

1. Medical Officer, (Ayurved) specialist. (B.A.M.S)
2. Medical Officer, (B.H.M.S) Homeopathy wherever required
3. Medical Officer, Unani, (B.U.M.S) wherever required
4. Pharmacist
5. Massagist / Therapist
6. Attendant

Budget required for salary of doctors and support staff. Medicine required for AYUSH Centers procured from ISM Department/IPHS funds. Budget requirement has been mentioned in table below:

Table-5.27
Salary Structure AYUSH Centers In Health Service Institutions

Sr. No.	Particulars	Salary/PM	No. of Units	Budget for 2008-09
1	Medical Officer (Ayurved)	0.12	50	72.0
2	Medical Officer (Unani)	0.08	10	9.6
3	Medical Officer (Homeopathy)	0.08	10	9.6
4	Pharmacist	0.06	50	36.0
5	Therapist	0.06	50	36.0
6	Attendant	0.05	50	30.0
7	Consultant (AYUSH)	0.20	1	2.4
Grant Total				**195.6**

Source – Maharashtra PIP, 2008-09

For AYUSH centers situated at District Hospitals and Medical Colleges, two postgraduate doctors from Ayurveda were appointed. If ISM department sanctions AYUSH scheme for additional health institutions in the state, these institutions were to be provided with required manpower as mentioned above. The budget required for this purpose was to be met from savings of salary component of other contractual staff.
Following actions were taken for AYUSH scheme till 2009

- AYUSH facility was started in all the IPHS hospitals in the state.

- Bigger (8) district hospitals were provided with indoor and outdoor facility of AYUSH. For this AYUSH department grant was utilized.
- Other 15 district hospitals were being provided salary of doctors and staff from AYUSH grant sanctioned from additionalities. Medicines for these centers were to be procured from IPHS funds.
- SDH and other hospitals included for IPHS up gradation were directed to appoint part time doctors on contractual basis from IPHS funds along with the medicine required.
- All the hospitals were provided with list of medicines

Progress of AYUSH in IPHS Hospitals

AYUSH doctors are appointed in IPHS hospitals and they were provided with medicines. Following is the work done by AYUSH sections of hospitals:

Table-5.28
Appointment of AYUSH Doctors (2009-10)

Sr	Faculty	Appointment of Doctor		
		RH/SDH	DH	Total
1	Ayurveda	72	21	93
2	Homeopathy	28	19	47
3	Unani	14	13	27
	Total	114	53	167

Source – Maharashtra PIP, 2009-10

AYUSH facilities utilized by the community are mentioned in table below:

Table-5.29
Utilization of AYUSH Services (2009-10)

Sr. No.	Faculty	RH/SDH		DH		Total	
		OPD	IPD	OPD	IPD	OPD	IPD
1	Ayurveda	39683	66	17300	302	56983	368
2	Homeopathy	1159	11	9704	100	10863	111
3	Unani	3388	13	11823	202	15211	215
	Total	44230	90	38827	604	83057	694

Source – Maharashtra PIP, 2009-10

By 2009-10, the department of AYUSH at the centre streamlined the planning of financing of component. As per Government of India guidelines, there were two parts of AYUSH scheme, Part – A was regarding Mainstreaming of AYUSH and Part – B was regarding Core activities of AYUSH.

Part – A of the Mainstreaming had two sections. Section: I of the mainstreaming had three activities such as Manpower, Training and IEC. These activities were to be supported through Mission Flexi pool of NRHM funds. Section – II of the Part – A has been related to Centrally Sponsored Schemes of the AYUSH, to provide for construction, furniture, etc. Part – B of the Plan has been related to provision of Medicine and Equipment. These are also to be provided through department of AYUSH funds. Separate proposal was requested to be submitted to AYUSH department regarding construction, furniture, medicine and equipment to AYUSH.

Manpower requirement was major challenge. Manpower was required for AYUSH hospitals and for support of the AYUSH activities. It was proposed to provide Medical Officer of Ayurveda, Unani and Homeopathy to IPHS health institutions in the state. In addition to this, nursing and support staff will also be provided. AYUSH centers were to be established in all the IPHS hospitals in the state.

Table-5.30
AYUSH Centers in Health Institutions Unit Cost

Sr	Particulars	Salary (Annual)	No. of Units	Budget 2008-09
1	Medical Officer (Ayurveda) (□. 12000/PM)	1.44	104	149.76
2	Medical Officer (Unani) (□ 8000/plus)	0.96	104	99.84
3	Medical Officer (Homeopathy)	0.96	104	99.84
4	Pharmacist	0.72	23	16.56
5	Therapist	0.72	23	16.56
6	Attendant	0.6	23	13.8
Grant Total				**396.36**

Source – Maharashtra PIP, 2008-09

The table above shows that the Auyurveda doctors got a salary of 12,000/- pm under NRHM, while other AYUSH systems got 8,000. This salary structure has been much

lower than the MBBS medical officers under NRHM (contractual MOs get a consolidated 15,000/- pm). There were also differences in salary of doctors from various systems under AYUSH, with the Ayurveda doctor getting one and a half times that of Homeopathy and Unani.

Manpower required for implementation of program

Strengthening of District AYUSH Cell

In every district, Maharashtra has large number of Ayurveda Dispensaries and Ayurveda Medical Officers. Functioning of these dispensaries and manpower can be regulated by systematic monitoring. Under NRHM, it was proposed to establish one AYUSH cell in each district under the control of Medical Officer. This cell monitored all the AYUSH activities in the district.

It was proposed to provide refreshers and NRHM training to AYUSH doctors and AYUSH training to allopathic doctors.

Under PIP 2010-11, AYUSH doctors were appointed in IPHS hospitals and they are provided with medicines. Following was the work done till 2011 by AYUSH sections of hospitals:

Table-5.31
Appointment of AYUSH Doctors (2010-11)

Sr. No.	Faculty	Regular AYUSH doctors in PHC	Appointment of Contractual Doctor in IPHS institutions			
			PHC	RH/SDH	DH	Total
1	Ayurveda	1228	102	170	33	305
2	Homeopathy	0	23	130	23	176
3	Unani	0	37	71	19	127
	Total	1228	162	371	75	608

Source – Maharashtra PIP, 2010-11

Thus, almost 50% of existing AYUSH doctors at the PHC level were added under the NRHM at various levels of rural health service.

Utilization of AYUSH services

AYUSH facilities utilization by the community increased almost ten times over the year 2008-09 and 2009-10 as reported by under NRHM mentioned in table below:

Table-5.32
Utilization of AYUSH Services (2010-11)

Sr. No.	Faculty	Ayurvedic		Homeopathy		Unani		Panchkarma		Total	
		OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD	OPD	IPD
1	2008-09	56983	368	10863	11	15211	215	0	0	83057	594
2	2009-10	383626	3285	161589	1131	90685	398	5290	412	641190	5226
	Total	440609	3653	172452	1142	105896	613	5290	412	724247	5820

Source – Maharashtra PIP, 2010-11

Plan of Action for year 2010-11

AYUSH Center in PHC

It was proposed to provide Ayurveda facility to all the PHCs in state. In Maharashtra, there are two medical officers in PHC. If none of the two doctors are Ayurveda graduate, then one part time contractual doctor is posted to provide Ayurveda services. Acceptance of homeopathy is minimal in rural areas and Unani system is accepted in selected pockets of the state. Considering this, Homeopathy and Unani systems provided at PHC level. Budget required for AYUSH manpower in PHCs is as follows:

AYUSH centers in CHCs

All the CHCs have been proposed to provide AYUSH facility of Ayurveda, Unani and Homeopathy. These services were provided by graduate or postgraduate doctors. Postings of these doctors have been done on full time or part-time as per the response of the community to particular system.

AYUSH centers in District Hospitals

Full time post graduate doctors from Ayurveda, Homeopathy, Unani and Yoga have been proposed for the appointment in District Hospitals. AYUSH facility in District Hospital also have indoor facility. Services of pharmacist, Massagist, therapist, etc. was to be provided in District Hospital AYUSH centers.

Under 2011-12 PIP, the focus was placed on improved services by the AYUSH doctors in the system and of their better linkages with Allopathic doctors. In Maharashtra, Extension Officer (AYURVED) has been available in 19 districts. These officers were given responsibility of AYUSH mainstreaming in district. For remaining places (14) one postgraduate AYUSH doctor appointed on contract basis.Training of AYUSH doctors

has been also undertaken in various National Health Programs. They did not have opportunity to get training in AYUSH. It was proposed to provide training to these officers in Ayurvedic Colleges. Curriculum for the training were decided in consultation with Director (Ayurved). In addition to this, many of the allopathic doctors were also taken interest in Ayurvedic issues. It was proposed to provide one introductory training for such doctors.

Training under AYUSH

Training is an important component of AYUSH. It was proposed to provide training of mainstreaming to AYUSH doctors, as well as training in specialized subjects such as Panchakarma, Ksharsutra. It was also proposed to conduct training of Allopathic Doctors in basic AYUSH concepts and commonly used remedies in AYUSH. But it was not implemented at ground level.

IEC/BCC under NRHM – Mainstreaming of AYUSH

It is important to provide information of AYUSH to community. It was proposed to conduct AYUSH mela per one per district.

PIP 2012-13

Further innovations were introduced in addition to the ongoing activities.

Following actions are taken for AYUSH scheme in year 2012-13

- AYUSH facility – Ayurveda, Homeopathy, Unani, Yoga and Naturopathy facilities were started in all District Hospitals by appointing contractual doctors.
- 6 District Hospitals were provided an AYUSH Wing (indoor, outdoor Panchakarma and Ksharsutra facility and other AYUSH services). For this AYUSH department grant is being utilized.
- AYUSH OPD and IPD facility started in 17 District Hospitals and some SDH and RH
- Ayurvedic and Unani Doctors are appointed on regular basis and 509 contractual AYUSH doctors are appointed in Rural, Sub-District and District Hospitals.
- Medicines are purchased through IPHS, RKS, DPDC and other available funds as Maharashtra did not receive AYUSH medicine grants from Government of India.

- Budget at state level will be utilized for IEC, Training, Contingency, innovative and salary as per requirement.

Plan of action taken in 2012-13 PIP

- In year, 2012-13 'Suvarnaprashan Sanskar' facility was provided at few institutes as an innovative.
- It was decided to start 'Ayurved Gram' in selected grams on pilot basis.

Thus, there has been substantial progress under mainstreaming AYUSH strategy, with incremental improvements. The significant increase in utilization indicates that it was also fulfilling a felt need of the public. However, it must be noted that the hierarchy between Allopathy and AYUSH and within AYUSH, between Ayurveda and the other systems has also been being reflected in the doctor's salary structures.

Also while utilization of Homeopathy (OPD attendance per doctor) was higher than for others, it was perceived that "no one uses it in rural areas" and so less expansion support was given relative to Ayurveda. Thus, this indicates a discrepancy between people's response and system provisioning.

Revitalization of Local Health Traditions

This was another strategy of the NRHM as given in the framework for implementation, to promote the benefit of local health practices and to grow herbal medicinal plants in the SC and PHC compound. The State did not address this strategy at all and nothing was planned to operationalize it. This appears to be a gap, given that there are active efforts for commoditization, for VHSNCs, *Arogya-tais* as a new cadre etc. to bring the services closer to the people.

Chapter-VI

District Health Governance under the NRHM in Pune District of Maharashtra

Chapter - VI

District Health Governance under the NRHM in Pune District of Maharashtra

A major emphasis of the National Rural Health Mission was on improving governance to ensure better health and health care in rural areas. Decentralization, flexible financing through 'untied funds' given to facilities to improve their infrastructure and services, integration of various national health programmes at the point of service delivery, inter-sectoral coordination between different sectors such as nutrition, education, and drinking water, community participation and formation of local-level bodies were all stated in the NRHM Framework of Implementation.

This chapter attempts to understand the ways in which district health governance has actually been operationalised from the village to district levels in the Pune district of Maharashtra. After discussing the district and taluka (block) level structures and issues, it primarily focusses on two Primary Health Centres in the block of Purandar, different in that one PHC has had operationalisation of community-based monitoring and another in which there is no community-based monitoring.

The process of decentralization introduced during the early 1990s in India has given a new vision to the grassroots level decision-making. Decentralization was aimed at transmitting a power shift from the bureaucracy to the community (Sangita, 2007). In a federal set up, the centre and state governments were the locations of power and decision making. However, under decentralization, there is meant to be a shift of implementation responsibilities and planning processes from central to local authorities. The nature of planning has changed after implementation of the 73rd Constitution Amendment that made statutory the system of Panchayati Raj in the rural areas. It has come with a three-tiered system, with a district considered as the primary unit for planning and implementation, and emphasis on participation of women and the socially marginalized groups (Bryld, 2001).

Historically, in the Indian context, a village has been considered as a socio-economically self-regulating unit through effective functioning of village *panchayats*. This decision-

making role was undermined over the decades of bureaucratic and centralized controls. Under the 73rd amendment, special decision-making powers has been given to the statutory Panchayat Raj Institutions (PRI). These provisions envisage a pro-people system of accountability established under participatory democratic governance. The decisions of the Gram-Sabha, in which all the adults of the village are permanent members, are to be considered central in the entire process of district planning. Panchayat institutions have been given powers to plan and implement public health programs and other health-related activities through community participation, within the overall framework decided at national, state, district and block level (Isaac & Harilal, 1997).

Community Participation has become an important phenomenon in development planning and implementation world-wide post the 1990s. The Community participation approach was introduced in good governance by the World Bank. It was incorporated in the implementation of development programs under a participatory governance framework. Most of the social development programs such as health, education, employment schemes were grounded on the community participatory principle. The state of Maharashtra has adopted this participatory governance strategy in the implementation of most of the development programs to reach the ground level. The participatory approach has been previously used to solve the rural drinking water and sanitation problems (Devasia, 1998).

The National Rural Health Mission (NRHM) incorporated the idea of participatory governance in the contemporary context of health service delivery. The NRHM aims to empower the community and local bodies to take leadership in health and sanitation issues at the local level. Grassroots community bodies such as Village Health and Sanitation Committees (VHSNCs) are important steps in decentralizing policy formulation and community participation (Kumar and Prakash, 2013).

Before NRHM, the National Health Policy, 2002 and Reproductive and Child Health (RCH-II) have stressed on the issue of community participation. RCH-II introduced community participation processes for effective health service delivery. These programs

gave importance to participatory health planning and implementation of various health activities through village health committees of the gram panchayat. Later, this idea of community participation was formally constituted by the National Rural Health Mission (NRHM) in the form of a Village Health and Sanitation Committee. The NRHM Framework Document (2005-2012) mentioned decentralized planning and monitoring from national to the village level. Hence, it was decided to entrust village level committees of the users group and community-based organizations with the planning, monitoring and implementation of NRHM activities in the villages of the country (Sah et al., 2013). To mobilize the community and raise awareness about health and the various programmes and services, a village level Accredited Social Health Activist (ASHA), a resident young woman with class VIII education, was added under the NRHM, initially only for the backward states and districts, but later extended by the Maharashtra government to all of the State.

District Health Mission:

On the lines of the State Health Mission discussed in the previous chapter, every district has a District Health Mission headed by the Chairperson of the Zilla Parishad and District Collector as a Co-Chairperson and the Mission Director as the Chief Executive Officer. For the implementation of the NRHM activities, every district has a District Integrated Health and Family Welfare Society and all the earlier societies for disease control programmes and family welfare have been merged into it.

Box-6.1

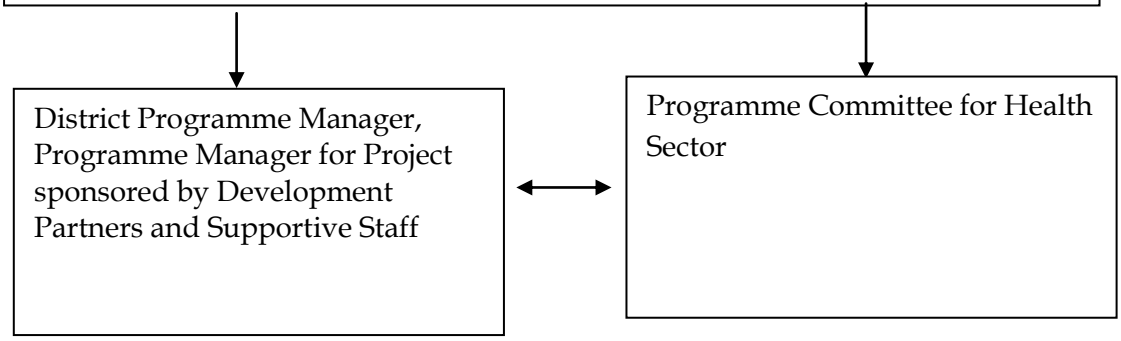
Structure of the District Integrated Health & Family Welfare Society

Governing Body

Chair	: District Collector
Co-Chair	: CEO, Zilla Parishad (District Development Officer)
Member Secretary	: District Health Officer
Members	: Project Officer (DRDA), DPM, AYUSH, Water and Sanitation, DPMSU, PHED, ICDS, Education, Social Welfare, Panchayati Raj, a State Representative, Sub-Divisional Officer, CHC (Rural Hospital) In-charge, Representative of Medical Association/MNGO/SNGO and Development Partners (International agencies).

Executive Committee

Chair	: CEO, Zilla Parishad
Co-Chair	: District Health Officer
Officer and Convener	: District Programme Manager
Members	: Superintendent-District Hospital, All District Programme Officers



Due to the formation of District Integrated Health and Family Welfare Society as an umbrella society headed by the district collector, there is good coordination in planning, implementation and monitoring of all activities under NRHM / RCH and other programs. Since the establishment of National Rural Health Mission (NRHM), the program wise grants are released to the District Integrated Health and Family Welfare Society. The performance under various programs including RCH is reported and monitored by the executive committee of District Integrated Health and Family Welfare Society.

The District Collector has been made the chairman of the umbrella society of District Integrated Health and Family Welfare Society, which includes malaria, leprosy, tuberculosis, and RCH. The District Development Officer i.e. Chief executive officer of the district level PRI, is the vice chairman and has been given powers for transferring Medical Officers within the district. The regional Deputy Director I/c circle is given powers for appointment of medical officers. Currently, every district family welfare bureau has a post of administrative officer and an accountant and/ or deputy accountant to look after the financial and audit matters. They are now fully involved in looking after financial management and audit of RCH II with the help of District Accounts Manager. The Zilla Parishads have full financial and administrative powers within their jurisdiction.

District Program Management Unit

A District Program Management Unit (DPMU) has been established for implementation of NRHM / RCH by pooling / redeployment of existing district level staff ***including the contractual staff at district level appointed under NHRM and RCH i.e. a District Programme Manager, Accountant, and Data Entry Operator.*** They have been oriented about their roles and responsibilities by organizing induction training and reorientation during monthly meetings.

The District Programme Manager (DPM) is seen as the key player not only in setting up and operationalizing the District Integrated Health and Family Welfare Society, but also providing managerial and logistic support to the district health administration. The DPM

sharing the Convenorship of both the Governing Body as well as the Executive Committee. In the Programme Committees, however, the DPM is one member.

Major roles and responsibilities of the DPM include following tasks:

Box-6.2

A: Management of DHS Secretariat

- Facilitate the working of the DHS as per the bye-laws of the Society
- Organize recruitment of personnel for the DHS.
- Maintain records of the Society.
- Organize meetings of the Governing Body and Executive Committee including preparation of agenda notes, circulation of minutes and compilation of action taken reports, etc.
- Organize audit of the society funds and preparation of the annual report of the Society.

B: Planning, Monitoring and Evaluation

- Generate and sustain district human resource database for the health sector, building, equipment, and other support infrastructure.
- Assist the Civil Surgeon and District Programme Manager in developing the "District Work Plan" based on the National and State needs and objectives.
- Undertake regular monitoring of initiatives being implemented in the district and provide regular reports and feedback to the society.
- Ensure compilation, analysis and presentation of relevant information in meaningful formats and assist the Civil Surgeon in making informed decisions
- Develop strategies /plans to develop the quality of services and present to the society for approval

C) Inventory Management, Procurement, Logistics

- Facilitate preparation of District Logistic Plan for maximum allocation of resources at each facility
- Ensure timely collection and compilation of demands and their timely dispatch to facilities in the district.

Institutional arrangement:

At district level there is an Integrated District Health & Family Welfare Society and District Program Management Unit (DPMU) which is part of the District Health Office. At present the District Health Office receives the reports of all programs. In the state of Maharashtra at the block level the structure has been created of a Block /Taluka Programme Management Unit with a Block Health Officer (Taluka Medical Officer (TMO)), who coordinates the programs and activities within the block with the help of health facilities available in the block. It is through his office the monitoring system is developed at the block level, and all the reports and returns are to be submitted to the District Health Office. Now, the reports pertaining to RCH, activities and financial, come to the DPMU. The analysis of the reports is carried out by DPMU and through the District Health Officer (DHO), who is the member secretary of the district, are submitted to the district society where necessary policy decisions and implementation guidelines are issued.

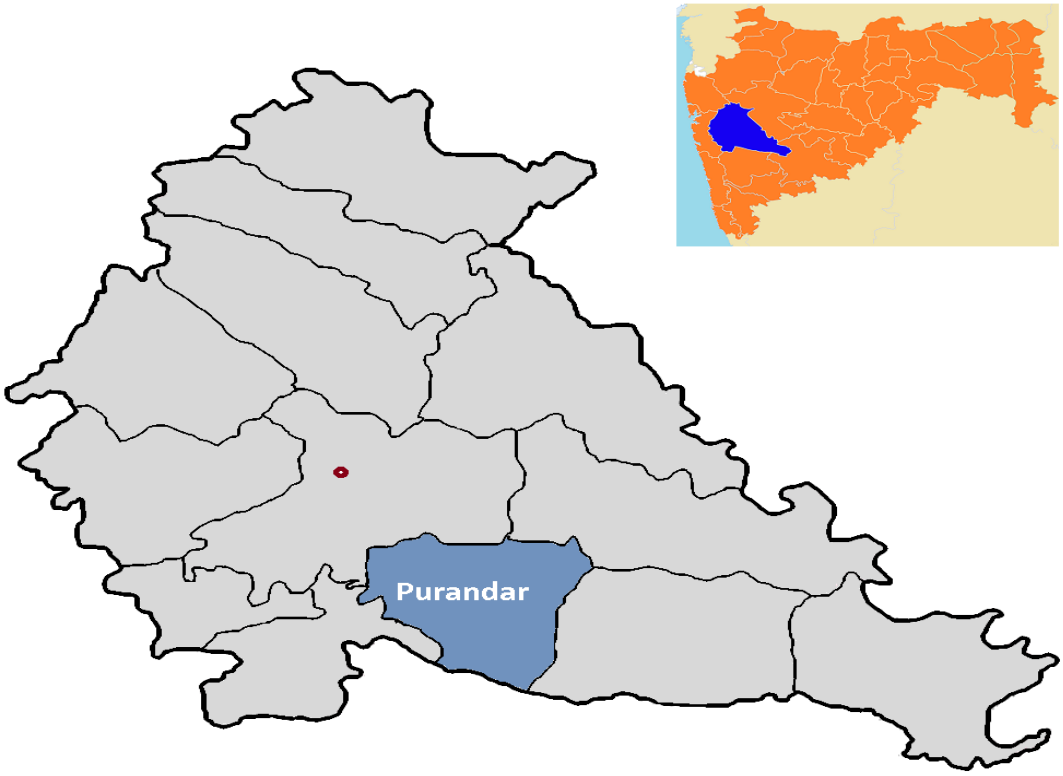
Block/Taluka Level Programme Management Unit (TPMU)

At Taluka level, the Programme Management Unit (TPMU) has been established for providing assistance to the Taluka Health Officer, who is a regular Medical Officer drawing salary and allowances from the State Budget.A Data Entry Operator Cum Accountant on contract basis assists the Taluka Medical Officer (TMO) to monitor the implementation of NRHM and RCH activities in their block besides tracking the physical and financial achievements.

Purandar Block Basic Profile

Purandar Taluka (Block) in Pune District of Maharashtra State was selected for this study. Purandar Taluka Administrative Head Quarters is Saswad town, and the name 'Purandar' has been taken from a historical Fort. All the administrative offices in Saswad. It is geographically situated in the Paschim (west) region of Maharashtra, administratively in the Pune Division. It is located 31 km from the Pune District headquarters.

Map-6.1
Location of Purandar block in Pune District



Map Source- Wikimedia.org (2015)[43]

Health Care Facilities

This block has both private and public health care facilities in the taluka headquarter town. The basic public health care service has been provided through the Rural Hospital in Saswad and a block PHC. This PHC area is presently attached with CBM PHC. Saswad town in Purandar block has a civil hospital. Both these public institutions play an important role in providing medical care and health information to the people. Surrounding villages have been depending on both on the public and private health care providers in the taluka town. Many steps have been taken by the block health department through the various programmes. These organizations also run numerous social

[43] Purandar Block in Pune District-Map retrieved from https://upload.wikimedia .org/wikipedia/commons/9/92/ Purandar_tehsil_in_Pune_district.png as accessed on 23rd December 2015.

awareness programmes. Besides Government facilities, private diagnostic facilities are available such as blood and urine testing, X-ray, ultrasound sonography in the study area[44].

Governance Issues at block level Under NRHM

Block level NRHM agencies have been working as a bridge between the village and the district. They play a mediator role in programme implementation processes.

NRHM envisaged the convergence of TMO and Civil surgeon of Rural Hospital in planning and decision-making at the block level. Block level rural health administration and programmatic activities under NRHM are run by the Block Health Mission Office under the charge of the Taluka Medical Officer (TMO)[45]. The administration of the Rural Hospital at the sub-district level is run by a civil surgeon. The TMO carries out more of a public health and administrative role, whereas civil surgeon performs both medical expert and administrative tasks. Along with monitoring, reporting and planning of health activities in the block, administration and management of PHCs (including their sub-centres) becomes the major routine task of the TMO. According to NRHM guidelines both are meant to work collectively for block level activities and report to the district level.

However, there was a tension and conflict between TMO and civil surgeon on the issue of health service decision making. TMOs role was seen as an administrative conduit between the district and PHC while the Civil Surgeon's role was seen as a clinical expert and administrator of clinical services. This created a status hierarchy, which is reflected in work culture at the block level. The Civil surgeon feels he is not answerable to the TMO office for reporting. All the decisions related to the Rural Civil Hospital are made

[44] The information is available on Shodhganga website but full reference could not be obtained. Retrieved from http://shodhganga.inflibnet.ac.in/bitstream/10603/79073/9/09_chapter2.pdf as accessed on 14th February 2016.

[45] Block Medical officer (BMO) and Taluka Medical Officer (TMO) is a same post only the names are different. In Maharashtra BMO is called as TMO and some health documents mentioned BMO and some mentioned TMO, hence, used both the names. TMO handles all the administrative responsibilities at the block level and it is considered as block health service administrator.

by the civil surgeon (together with the RKS), who interacts directly with the DHO. In an interview, the TMO said that

> "…..representing as block health service administrator I have to handle all the issues raised under CBM and there are power dynamics which affects the planning processes at the block level" (Interview conducted in Sasawad, Pune 15th March 2014)

Further, evidently, the major decisions for the blocks were taken at the district level. There is very less decision making or freedom to the authorities at the block level. The only significant decision making process at the block level was of the RKS of the Rural Hospital.

RKS has been functional in all Rural hospitals. The Functioning of RKS is controlled by the civil surgeon and local elected representatives, the local Member of the Legislative Assembly (MLA) and Zilla Parishad Member All the financial decisions of RKS are not made on a transparent basis. There was evidence of corruption in RKS functioning raised by a civil society representative in an interview.

The civil society organization led CBM processes at the block level. There was less active participation from the formal health service authority. PHC level functioning issues were raised at the block level. However, to take a final and concrete decision at block level needed higher level involvement. Block has very limited decision-making powers. Only minor PHC level issues are resolved with the help of TMO. Major issues are not in the hands of the TMO and were forwarded to the district level, such as if there is a new appointment of medical officer or transfer of medical officers which are out of TMO's role.

Most of the issues raised by civil society in public dialogues were about the functioning of the Rural Hospital. Over the years, the CBM process has continued to exert pressure on the Rural Hospital administration for improving the quality of services.

Basic Structure of Village Level Health Governance

The NRHM guidelines in its framework for implementation have mentioned the details of functions and responsibilities of the VHSNC. The 'Implementation Framework of the NRHM' provides the constitution and orientation of community leaders on Village Sub-Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC)

committees. It also stipulated the setting up of Village Health and Sanitation Committees at village level, with a fund annually of 10,000/- to undertake health activities[46].

The Village Health and Sanitation Committee

The basic structure of Village Health and Sanitation Committee (VHSNC) involves four different types of actors for health service governance. This includes local elected representatives such as the panchayat members, public healthcare providers, community-based organization or non-governmental organization representatives and non-official delegates from other village level committees for example from schools or the Self Help Group (SHG) members.

The composition of VHSNC has a major emphasis on women with the suggested composition of at least fifty percent representative members being women. Socially and economically marginalized sections such as the Schedule Castes (SCs), Schedule Tribes (STs,) and Other Backward Castes (OBCs) representation is also stipulated for the committee. This has been done to address the needs of weaker sections. Further, thirty percent representation has been given to the non-governmental sector in the formation of the Village Health and Sanitation Committee (VHSNC).

Box-6.3
Composition of the VHSNC

The Village Health and Sanitation Committee is constituted at the level of the revenue village. It involves members of the Gram Panchayat, the Accredited Social Health Activist (ASHA), the Anganwadi worker, Auxiliary Nurse Midwife (ANM), SHG leader, the member of primary teacher association, members of mother teacher association and representatives of any community-based organization working in the village as well as a user group representative. The chair would be a female panchayat member (preferably woman SC/ST member), and the convener would be ASHA; if ASHA is not in a position to take up the responsibility, then the Anganwadi worker of the village can be the convener.

Source – Sah et al., 2013, PP-114

[46] Government of Maharashtra Resolution- 6th December 2006/ no-1006.Pra. Kra.-369/ Pa. Pu. 07, this resolution on structural framework of NRHM

After the VHSNC is formed, efforts are then directed for its capacity-building. The VHSNC is trained, and orientation is given on its roles and responsibilities through training programs of the state government. This is primarily undertaken to equip the committee members to provide leadership skills. Further, it also helps to plan and monitor the health activities at the village level.[47]

Financial support: The VHSNC annually receives a sum of Rs 10,000 as untied funds for general village levels activities. This amount has to be utilized with the collective decision of the VHSNC on a priority basis. VHSNC has to maintain a bank account of village health annual funds, operated collectively with the joint signature of the ASHA or the Health Link Worker or the Anganwadi Worker along with the President of the Village Health & Sanitation Committee or the Pradhan of the Gram Panchayat.

Monitoring work- VHSNC performs important monitoring work that includes keeping track of the village health plan of the health care providers and ensures the fulfillment of NRHM indicators at the village level. (Garg & Laskar, 2010, Loewenson et al., 2011).

VHSNC implements various activities at the village level. The major role of VHSNC is to make villager aware about the essentials of health programs. VHSNCs have the power to develop a participatory village health plan with undertaking a participatory assessment of the village health priorities and identifies health needs. It helped to solves important issues related to health and nutrition at the village level and provides suggestions to relevant functionaries and officials resolve these health issues. VHSNC have to present annual health report of the village in the Gram Sabha and take its approval.[48]

[47] Government of India (nd). National Rural Health Mission: Meeting People's Health Needs In Rural Areas Framework For Implementation 2005-2012. New Delhi: Ministry of Health and Family Welfare. Retrieved from http://jknrhm.com/Guideline/Frame_Work.pdf as accessed on 13th December, 2014.

[48] Shib Sekhar Datta (2008, February 7) Village Health and Sanitation Committee (VHSNC) under NRHM. Seminar PPT, Retrieved from https://pglibrary-public**health**.wikispaces.com/file/view/**VHSC**.ppt as accessed on 17th May 2015.

Box-6.4
Major Role and Activities of VHSNC

It ensures that the ANM and MPW visit the village on the fixed days. IT also supervises the work of the village health and nutrition functionaries like the ANM, the MPW and the Anganwadi Worker (AWW). It has to obtain the bi-monthly health delivery report from the health service providers during their visit to the village. It has to take into consideration the problems of the community as well as the health and nutrition care providers and propose mechanisms to solve it. It has to discuss every maternal mortality or neonatal mortality that happens in their village, analyze it and suggest needed action to prevent such deaths. It has to get these deaths registered in the Panchayat. It also has to get involved in the management of the village health untied fund and to organize a village health and nutrition day once every month.[49]

Convergence of NRHM and and ICDS: VHSNC to VHSNC

The National Rural Health Mission (NRHM) interventions primarily aim to provide access to health services for the vulnerable and marginalized sections of rural societies (Singh, 2008). It focuses on the preventive and promotive aspects of health. The implementation of NRHM has enabled developing a link of the village community with the local governance institutions. According to Patro (2014), "the key to NRHM success are community ownership and inter-sectoral convergence directed through village level health agencies at the level of the gram panchayat" (Patro, 2014)

In order to achieve the objective of improving health status of the population, there has been an involvement of the different government departments in the delivery of public health services at the village level. For instance, there is a focus on the provision of safe drinking water, education, sanitation, nutrition, and health by involving their respective

[49] National Health Mission, MOH&FW, GOI. Communitisation:Village Health Sanitation & Nutrition Committee (VHSNC) -Retrieved from http://nrhm.gov.in/communitisation/village-health-sanitation-nutrition-committee.html 8th July 2012.

departments. The greatest link has been with the ICDS, given that the anganwadi centre provides the nodal point in each village for children below six and mothers coming for supplementary food as well as on the monthly Village Health and Nutrition Day for antenatal check up by the ANM. In this context, the government of Maharashtra has passed the resolution in 2011 under the NRHM to expand the role of Village Health and Sanitation Committee (VHSNC) to include 'Nutrition' within its ambit with the active participation of Anganwadi Workers, the ANMs, and the ASHAs. Therefore, as per the national level decision, the name of the committee was changed to Village Health Sanitation and Nutrition Committee (VHSNC) to facilitate this linkage and bring greater attention to the nutrition component. It has defined activities of VHSNC as per NRHM framework of implementation; including monitoring the status, issues and action related to nutrition. The committee preferably acts as a sub-committee of the gram panchayat and functions under its overall supervision accordingly, all the states have requested to consider notifying VHSNC as a sub-committee of the Gram Panchayat.[50] This was a strategy of convergence at the village level to ensure institutional, human resources and financial convergence.

However, there are parallel sub-agencies and bodies that operate at the village level. The NRHM framework has made an attempt for convergence of all these different actors under one umbrella in order to minimize the workload and avoid multiplicity of tasks. Throughout the convergence process, the Panchayati Raj Institutions (PRIs) have been central to the planning and implementation of policies. This has initiated a continuous process of dialogue between the actors. The PRIs also ensured the regular maintenance of records of the program.

Health Governance Issues and Challenges at the Village Level

One of the important objectives of the NRHM is to ensure inter-sectoral convergence by bringing together different programs such as drinking water, sanitation, hygiene and nutrition in the rural areas. This strategy of village level inter-sectoral convergence under the NRHM assumed importance to improve good governance at the village level. It is

[50] Government of India VHSNC order no- Z.18015/8/2011-NRHM-II, Ministry of health and Family Welfare, National Rural health Mission.

primarily through the VHSNC that the convergence is sought under the NRHM (Kulkarni et al., 2014).

This process of convergence began at the village level with a Government of Maharashtra (GoM) resolution. However, these processes have resulted in coordination at the higher level. There are major limitation and challenges to the issues of convergence at the formation level. While various agencies and bodies have clubbed together and form an institutionalized body. However, the convergence processes have merely remained on paper (Sah, et al. 2013). However, these processes have been failed to take an institutional form to operationalise activities at the village level. Sustained processes need financial support. However, the budgets pattern comes with the different heads for schemes. The various schemes have a different timeline for allocation of funds and implementation. There is lack of other recourses to build and sustain the processes (Semwal, et al., 2013)

Table-6.1
PHC Profiles Field Area

Name of PHC	Population	Sub-Centre	Number of Gram Panchayats	VHSNC Committee	Other Details
CBM 24+7 IPHS	24240	Total – 5	18	18	Additional area attached with this PHC. Now total 52000 population serve by this PHC
Non-CBM 24+7 IPHS	20402	Total - 6	8	11	3 separate revenue village have VHNWS committees

Source- FRCH CBM Documentation, File-2, page 15-16**.**

It was viewed in the study field under the NonCBM PHC that the idea of convergence has not been translated further, apart from formation of the committee. However, in practice, it is not effectively functioning at the ground level. There is not much

interaction between different actors. Except for the formation of the committee, there has been no other mode of interaction between the members and the community. Most often actors associated with different carry out their tasks independently.

Processes of Formation of VHSNC at the village level

This section presents the findings of the study undertaken in two types of study areas. In the first group, villages were taken from community-based monitoring (CBM) area; it has been undertaken from the year 2008. CBM processes were coordinated by the Foundation for Research in Community Health (FRCH). With an objective to ensure the linkage between community-based monitoring and effect on local governance process. In the second cluster of study villages, community-based monitoring was not present. Hence, a comparative exercise to understand the differences between the two villages enables to explore how there have been changes introduced in the process of health governance. Data was collected in both study areas. The main respondents were health providers such as ASHA, ANM, MPW, Medical officers, Administrative health officers, Anganwadi Worker, community leaders, PRI member, Civil society representatives, local CBO representative, Health committee members and villagers, who have been users of the health services.

There are a number of challenges that the VHSNC has been encountering as becomes clear from the findings of the study regarding the actual practice, the convergence strategy one way helped to improve governance at the village level. It made coordination processes easy at the village level. nonetheless, It is clear from the study that there are significant differences in the working patterns and mode of functioning of the VHSNC both in the villages where community-based monitoring was introduced and villages where there was no community-based monitoring

It is evident from the non-CBM study area that .in the non-CBM revenue villages the VHSNC was not formed in a formal Gram Sabha. Instead, it was only seen as an administrative procedure to be fulfilled as a part of the official requirement on paper. In terms of decision making, all the main decisions were taken by local political leaders, the

Sarpanch, and the Gram-Sevaks. It became clear from the interviews of the members of VHSNC in the non-CBM villages that majority of the VHSNC members in non-CBM villages were not aware of their roles and responsibilities as mentioned in policy documents. The VHSNC members have not undergone any formal training. ANM and ASHA have been told that all the functioning powers of VHSNC are to be controlled by village Sarpanch, local political leaders or Gramsevak of that revenue village. It is clear from the interviews of health service providers (ANM and MPW) that they have very little power. Further, the Anganwadi worker and the ASHA too hardly have any role in the decision-making. It is to be noted that these grassroots health workers are in a vulnerable position while working at the village level. Often their work reports are sanctioned by the Sarpanch and the Gramsevak. If they make any complaint regarding the VHSNC, this has negative consequences on their work. It is also clear that in some villages those grassroots health workers who have established links with the local political leaders do not perform their work. They have been using these established power equations to assert their own will.

The evidence from the CBM villages of formation of VHSNCs –

The process of formation of VHSNC under CBM villages followed the CBM policy document (Government of Maharashtra, 2006).[51] The VHSNCs was formed in the Gram Sabhas and Pada Sabha (Village cluster). The non-governmental organizations or civil society organizations in the area have played the role of facilitator of the processes. It also becomes clear that the composition of members of the VHSNC was discussed in the Gram Sabhas or Pada Sabhas. A majority of the members of the VHSNC have received formal training from local NGOs. It became clear from the interviews of the VHSNC members that they were very clear about their roles, and the functioning of the VHSNC was effective.

The other studies and reports on village health committees have highlighted or discussed various facts (Semwal, et al., 2013; Garg & Laskar, 2010; Sah et al., 2013; Dindod and Makwana, 2013). The research papers on member's knowledge regarding the functioning

[51] Government of Maharashtra (2006, December 6) Water and Sanitation Department. Mumbai: Mantralay. Retrieved from http://www.cbmpmaharashtra.org/cbmdata/GR/Gram%20aarogya%20swachhta%20samitee.pdf accessed on 6th May 2013

of Village Health and Sanitation Committees (VHSNC) concluded that the purposes and guidelines for utilization of fund were not clear to VHSNC members. Therefore, the fund was not utilized for its main purposes such as for the implementation of the village health plan or for undertaking any sanitation activity in the village. There was limited participation from a member as those from the PRIs or education department usually did not attend the meeting. So, there was a lack of interest from other sectors (Dindod and Makwana, 2013). Another VHSNC assessment report pointed that the knowledge about the objectives of the VHSNC was highest among the ASHAs, ANMs, members of the Self Helf Groups, and the least among the members of the PRIs. Lack of clear guidelines from the state level has affected the VHSNC formation process. The lack of institutional set-up at the village level affected the planning at the village level. The inter-sectoral coordination, the involvement of the panchayats and convergence indicates that even if the community is given the ownership of the plans, it will still be a matter of concern (Nandan, 2008). Similar finding on the study of the performance of the village health, nutrition and sanitation committee pointed out that, regarding the use of the fund, the majority of the VHSNC members were unaware of the areas on which the funds were utilized. Most of VHSNC members said that either president or secretary decided about the use of the funds without consulting other members (Sah et al., 2013). Community-based participatory procedures have emerged as a response to conventional approaches that historically have failed to make a notable improvement in health (Kumar and Prakash, 2013). On a parallel line, USAID evidence report pointed out that village level ownership by the Village Health Committee (VHC) is a long process. It would take time to understand the facilitation and ownership of the VHC and Village Health Plan. There are challenges, but the VHC can develop the functioning of the Government service delivery at the Primary Health Centers and Community Health Centers. The VHC may function better and have improved relationships with the government health services if the VHC is established and if it is able to help select their health and nutrition functionaries. Regular meetings of the VHC was associated with more successful outputs and outcomes (USAID, 2008).

Basic Functioning Task of the VHSNC

Financial Work: every revenue village VHSNCs receives 10000/- annual grant under the NRHM policy framework, known as the 'untied funds' of the VHSNC. This fund is utilized by VHSNC on different health care activities at the village level. For the purpose of this fund, a joint account in the name of the Sarpanch of the village panchayat and ASHA or the Anganwadi worker has to be opened. This fund has to be utilized collectively as per the decisions taken by the VHSNC.

.

In the non- CBM villages, it is evident that the Sarpanch had taken all the decisions about the spending of these funds. In most of the villages, the Sarpanch belongs to the dominant caste groups. They are very powerful at the village level. Initially, the Anganwadi workers and the ASHAs were not willing to create a joint bank account with the Panchayat Sarpanch. A major concern expressed by the Anganwadi Worker and ASHA was that it would lead to conflict between the panchayat members and the local health staff. Further, they also cannot oppose the Sarpanch regarding any financial malpractice in the utilization of these funds. In the initial years most often the untied funds remained utilized in majority of the study villages. As interviews with a VHSNC member and PHC administrative officer revealed, most of the VHSNC members were not aware of the utilization criteria and guidelines initially. Later the government issued a letter to all VHSNC and gave guidelines on how to utilize this fund. All the local administrative staff is used to spending as part of a 'heads' culture, ie funds come already designated under certain heads of expenditure items and they can use them only for that particular item. Untied funds was a newly introduce term to health system functionaries.

At the village level, formal and the informal organizations have an accumulation of power of rural elites or political and social leaders. VHSNC also becomes a part of this process. It is observed in the study villages (both in CBM and Non-CBM), that the composition of the VHSNC is mainly dominated in terms of decision-making by the rural leaders. They take all the financial decisions regarding the use of all the funds meant for developmental activities. It is to be noted that the village untied funds are very small part of the larger system. In one study village, Anganwadi worker and ASHA mentioned that

they were not aware of how these funds were spent by the Sarpanch. He hardly informed them before the utilization of the funds. As the passbook of the untied funds bank account is kept in the Sarpanchs home, he takes decisions on his own. The sarpanch only takes a signature from the committee members and withdraws money from the bank. However, while interviewing the Sarpanch of this same village, he claimed that all the financial decisions were taken collectively, and all the members were aware of the utilization of funds. In two villages, there are women Sarpanchs elected, but all the decision making powers were in the hands of their husbands. Further, while interviewing the woman Sarpanch about the VHSNC activities in the village, most of the answers were given by the husband. Iit was difficult to get to interview the woman sarpanch separately as the husband didn't give an opportunity to meet women sarpanch alone. She also depends on her husband for details of program implementation information.

In an interview of a male Sarpanch, he said, "I spend 2 lakh rupees during panchayat election. From where do I can recover that money?" Sarpanch does not give so much attention to untied funds because they consider this as a very small amount according to him. This kind of irregularity through informal patterns of financial decision-making affects the accountability and governance mechanism of the VHSNC. Though it is a small amount, it corroborates how the Sarpanch takes all the decisions regarding its use without even consulting any of the health workers or the committee members of the VHSNC.

Evidence of Untied Funds under CBM areas:

VHSNCs are more active in CBM study areas compared to the one in the non-CBM study areas. In these areas, the VHSNCs have utilized the untied funds according to the government guidelines. In the initial period, the VHSNCs faced problems of utilization of funds even in the CBM areas. This was because there were no such funds previously available at the village level and people were not aware of how to utilize untied funds. Thereafter, the State NRHM department issued a basic guideline for utilization of funds in order to solve this problem. These guidelines had set the path for spending the funds. Most of the committees follow this guideline rather taking any other village priorities into

consideration. The guidelines issue by Government of Maharashtra under NRHM to utilization of united funds. The main NRHM implementation framework suggested that people take collective decisions about united funds. In practice it was not happened. This has been one of the key limitations observed in the processes of utilization of the untied funds.

All the VHSNC committees in CBM villages have maintained their untied funds utilization registers and bank details. Utilization of funds is a collective decision. Most of the time fund utilization priorities have been decided collectively by members. There are also debates and arguments on the funds utilization issue. This is a a good sign of democratic processes. All the financial records were made available to the general public. This has produced a new level of accountability and transparency issues at the ground level. Still, there are other factors that also have an influence on these processes, such as the involvement of the local political actors. Interviews of VHSNC member show that some of the local political leaders feel threatened if community-based auditing was undertaken for the untied funds at the village level. This was because it revealed major problems in the initial utilization and the irregularities in the funds distributions at village level as all the committees followed the same initial NRHM guideline to distribute funds. Irregularities in terms of it utilized once in year. It was not utilized according to upcoming needs at village level.

Health Resources Mapping:

To improve the accountability and village health resources mapping is one of the components under the NRHM. It was believed that this process would create a demand for services through participatory community mobilization. It also creates a conducive environment for decentralized community managed programming (Shukla, 2013; Yashada, 2009).

Village micro-plans were a mandatory requirement for district planning as per Planning Commission's Manual for Integrated District Planning (Dongre, et al., 2009). The

resource mapping helps to identify needs and priorities of health services. It was conceptualized as a method of participatory stocktaking, problem analysis, solution seeking and intervention planning (Garg & Laskar, 2010). Health resource mapping and planning as a rights-based self-help approach are significant because micro-planning leads to community empowerment and self-reliance (Shukla, 2013; Shukla, Kakade and Scott, 2011). It strengthens the panchayat institutions in the rural areas and results in the active participation of women in decision-making. It is an active collaboration between communities and government agencies. It is Social Audit of the service delivery system and addresses the issue of social inclusion of underprivileged sections. It operates as a useful tool to strengthening administrative functioning through a resource optimizing Block Response Plan and District Plan. Under the NRHM, participatory planning and village health resource mapping are prime agenda of the VHSNC. The mapping has facilitated the making of the village action plan owned by the community. However, village level processes are not translated into practice. It has been generally found that VHSNC functioning has limits in terms of monitoring of health services. It has failed to do constructive health services planning due to systemic issues (Sah, et al., 2013). VHSNC members are not aware of methods of health resource mapping and its relevance.

In the study villages it was found that, the VHSNC conducted resource mapping in the CBM villages, the committee members knew the different methods of participatory resource mapping, while in the Non-CBM villages, committee members were completely unaware of this method. Whereas, the villages under the Community-Based Monitoring (CBM) program implemented these methods. VHSNC members of CBM village knows this method. They said these methods were introduced in VHSNC training program. However, implementation of these methods in villages (both CBM and non-CBM) is difficult for the VHSNC. These kinds of initiative remain as activities, because, health needs of village people and health service needs are different. It is one of the annual bottom-up planning activities and there are efforts for institutionalisation of processes. However, this planning is central only to medical service planning. It mainly focused on the RCH focused NRHM service-centric approach while other health related activities

were not considered, There are other practices of health care and institutions in villages that coem under the ambit of the NRHM framework but are not addressed by this process, such as the livelihood and food security programmes e.g. Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), or use of local medicinal plants at household or community level.

Community Score Card:

This is one of the accountability mechanisms suggested under the community-based monitoring program. The idea behind it is that all actors from public health service system (such as village level health providers, community member, PRI member, civil society representatives) will come together and grade the health service performance. It will generate dialogue between communities, service providers, and government functionaries and thereby lead to a more accountable service delivery. The findings from the scorecard have to be share in Gram Sabhas (Shukla, 2013; Garg & Laskar, 2010).

The VHSNC is a simple and effective management structure at the lowest level, comprising of the representatives from the village with PRI representative and government officials working at cutting edge (Aggarwal and Mathur, 2011). The experience of preparing village level health card shared by PHC community monitoring committee member. It has been a collective process of making scoring card of health services. However, challenges in these processes are that it has created conflict between health service provider and community member. In some cases, the health care providers are in the power position. Often they hide the facts, because the higher authority will blame them for bad performance. This kind of crisis has been created by the new changes. The soring results reach at the Jan Samwad (public dialogue) level. It should reach constructive decision making at higher level.

Citizen's Health Charter: -

Under the NRHM program every village should have a health charter at a public place. It is the responsibility of the VHSNC to draft a health charter. Citizen's health charter is a manuscript which signifies a systematic effort to focus on the commitment of the health service organization towards its Citizens, it bound for standard of services, access of

information, Non-discrimination while service delivery, grievance redress structure for denial of service. This also comprises expectations of the organization from the people for achieving the vision of the organization. It is also important to display Citizen health charter with the referral transport vehicle number and contact information of emergency services. These referral services are contracted out at the village level. At the PHC level, the citizens charter mechanisms are to establish linkages with the government systems and institutions. It was observed in the study areas, both in the CBM and Non-CBM villages that there was a citizens' charter board in all villages. The contact details of the private vehicle for emergency referral services have been written on the board.

However, at the village level, people have interpreted this citizen charter differently. There is a difference in the language of the citizen charter and local language of the people. In tribal region we find various kind of local languages. Within Marathi, there are different dialects people do speak. Translated Marathi doesn't match to the local language which mostly used for information dissemination. This creates a gap in understanding the purpose of this board. In most of the villages, people understood and interpreted this charter as only a referral service board. Some respondents interpreted it as a health scheme board as government PHC board, not as village board. This is a very small initiative at the village level and people were willing to provide some financial allocation to prepare the citizens charter for the village. However, the government administration has contracted out the service for painting the citizen charter in every village private agency. It was set format and not made collectively with the help of VHSNC.

Gram Sabhas:

Functioning of Gram Sabhas was a critical issue at the village level. According to Ministry of Health & Family Welfare Secretary letter. (D.O. No. 28013/1/2013-NRHM-IV) "the chairperson/ secretary of the VHSNC would also be responsible for informing the Gram Sabha regarding the creation of facilities, infrastructure and available benefits, the name of beneficiaries, etc. under the scheme during the bi-annual meeting of Gram Sabha and Gram Panchayat in their quarterly meeting"

As one of the respondent a common villager who was present outside of the Gram Panchyat Office in a Non-CBM village, expressed his opinion about the Gram Sabha.

> "…..the Gram Sabha's at the village level are not organized formally. They organized it on paper by collecting signatures. There is very limited space for the marginalized sections of society. Gram Sabhas have been dominated by elected members of the panchayat and panchayat officer. Most of the Gram Sabhas do not give any importance to women participation. Panchayat members do not pay any attention to health services issues in Gram Sabha. Health related issues are given second priority" (Interview conducted in non-CBM village, Purandhar, Pune on 28th March 2014).

Role of ASHA in Village Health Governance:

NRHM has important health care actors at the village level known as the Accredited Social Health Activist (ASHA). The concept of ASHA has been drawn from the Community Health Worker Program (Gopalan, Mohanty and Das, 2012). ASHA is supposed to act as a bridge between the community at the village level and health functionaries. The selection of ASHA worker is to be processed by the VHSNC and approved by the Gram-Sabha. ASHA is considered to be accountable to the VHSNC and community through the Gram Panchayat. She would be guided by the AWW and the ANM. She would report to the VHSNC of the Gram Panchayat. The significant role of ASHA is to work with the VHSNC under the panchayats.

An ASHA is expected to work with communities for social mobilization and improve access to services. She has to be located in every village. ASHA's role will be to facilitate care and serve as a depot holder for a package of basic medicines. The AWW, school teachers, members of local community-based organizations, such as SHGs, and the Village Health Sanitation & Nutrition Committee are expected to support the ASHA in her work. The role of the ASHA is important since she connects healthcare system and community (Mane & Khandekar, 2014). ASHA has a major contribution in the referral work. She is expected to identify patients needing services from the village and refer to health institutions for treatment. In the hierarchal division of work of health providers, first, comes the ANM, the male MPW, then the Anganwadi Worker, the Anganwadi

Attendant and at last comes the ASHA. All the village level public health care program interventions have directly or indirectly got associated with the ASHA.

There are lots of expectations from the role of ASHA. Primarily her role was conceptualized as a voluntary health mobiliser approved by the VHSNC and the panchayat. Interviews with the ASHAs at the study villages have made some facts clearer. It was observed that local PRI members mostly dominate nomination of the ASHA. Most of the times the selection of ASHA is done by the PRI members mainly of persons who are their political followers. Initially, the perception about ASHA was that it was a government job at the village level in the health department. Most of the ASHAs considered their job structure like Anganwadi worker or attendant. Due to this reason the PRI members influenced the process of selection of ASHA. Though the ASHAs were aware that they would receive incentive money as performance-based payment for their work, they thought that sooner or later the government will start formal payment as in the case of Anganwadi workers, and they will get formal payment from the state government. There has been a debate at the national level on the payment and incentive for the ASHA (Singh, et al., 2011; Jain, et al. 2016; Garg, et al. 2013). The government put forward success stories about ASHAs receiving more money via the incentive-based payment system to justify the incentive-based system. The incentive-based system in one of the components of the new public management that has been made operational through the ASHA (Singh, et al. 2011).

There are many challenges faced by the ASHA worker as it is expressed in interviews. The higher authorities don't recognize ASHA's work and doesn't give any importance to her work. There is no clear work profile for ASHA workers.

One of the ASHA workers in non-CBM village mentioned that,

> "…we are not covered under minimum wage. If I work under the MGNREGA, then I will get at least a minimum wage. As an ASHA, there is work from morning till evening. For working in the fields, there are higher wages. This work has no clear timeline. The villagers demand medicine whenever they need. Many times, I have to go with the patients for

institutional delivery at night" (Interview conducted with one of the ASHA worker in non-CBM village Purandhar, Pune on 13th April 2014).

There is a demand raised at the village level that there is a need for better governance of ASHA program as well as for clear work profile and minimum wage for the ASHAs work.

Group interaction with ASHAs revealed field realities about the ASHAs. Some ASHA workers joined the program and completed the ASHA training program. After completion of the training program they left the job. One of the main reasons for leaving the job is the issue of payment for ASHA worker.

Secondly, it was shared by some that the appointed ASHA worker has not been given adequate training. The empowerment of as health worker is a continuous process and training is one of the components of the capacity building. Many ASHAs expressed that the training programme improves their knowledge about health care and related issues. Knowledge of basic medicine gave the ASHA workers respectable position in the village. However, at the knowledge implementation level it limits mostly to only to referral cases to PHC.

Mostly the ASHA workers earns more incentive payment from institutional delivery, and therefore they focus more on institutional delivery. This also a source of conflict between the ANM and the ASHA. Increase institutional child delivery is one the targets of the NRHM. This has increased the work pressure of the ANM, which leads to work of ASHA. Promoting women for institutional child delivery ANM tasks shared with ASHA worker. Another target is child immunization in villages. Due to ASHA worker workload of ANM has reduced, and that has been recognized by ANMs.

However, in the process of improving the health of the village, the decision-making of ASHA has very limited space. Most of the health programme decisions are taken by the ANM, the MPW, the PRI Members and higher health officers. ASHA undertakes the workload of the paramedics for most of the health programmes. However, she has limited

power to influence decisions at the village level. ASHAs do not have a voice in village the Gram Sabha on health issues because gram sabha has been dominated by political people, particularly men of the village. Political representatives of the village treat ASHA as a person of government health worker not a member of the village. Education profile the ASHAs in the study area is that all the ASHAs were above eight standards passed. Three ASHAs were twelfth class passed.

ASHAs main role is seen only for the child immunization programme and institutional delivery. On other issues, people do not pay much attention towards the ASHAs. One of the ASHA workers expressed that, if an ASHA is from the lower caste then the upper caste people do not pay attention to her work. Rich from the village also donot have a good attitude towards government health institutions and personnel since they can access services from private clinics.

ASHA also complained that they had not received good treatment from the village Gram-Sevak (village level panchayat officer). Most of the time, the work of ASHA is negated by the panchayat officer of the village. She has been not considered for decision making process. There is no proper communication channel between panchayat officers and the ASHA worker.

Communitization Process at Village Level:

The communitisation of health care system is one of the objective of NRHM. It has been tried through to creating community ownership on health institutions. This processes lead by various health committees. The Village Health and Sanitation Nutrition Committees at the level of the Gram Panchayat is grassroots level step towards Communitization. Creating community ownership is a continuous process. (Gill, 2009). This processes involved social and cultural power dimensions which operates at village level through the class, caste, gender, position in the village, location, professional knowledge (in the context of health care). Though, it is to be noted that in the context of health care services, there is a hierarchical and domination relationship between different actors. Often there is a conflict between the two actors i.e. the health care providers and community. However, people have understood the health care institutions and

governance issues in a different manner. At the village level, different stakeholders and local institutions are involved in the village development planning and decision-making. This includes political actors, administrative personnel, community-based organization, service users, representation of the marginalized socio-economic sections were directly and indirectly associated with the governance process.

This chapter aims to understand how the decision-making processes have happened at ground level under NRHM. What were the factors that were influential and interconnected in bringing the shift in decision-making? The interviews of people in the villages both CBM and Non CBM villages taken to understand processes, who have shared their experiences through group discussions and informal conversations about the changes in the village institutions and political structure.

In one of the study villages, the Maratha and the Dhangar communities are in majority. One family from the Dhangar caste had control over the electoral politics and caste based voting since a long time. In this village, number of households of Dangar community are higher than the other caste communities. The gram panchayat, the local agricultural cooperative finance society, the cooperative dairy, agricultural water distribution society, the PDS shop, the library in the village were totally under their control. People from the Dhangar caste had domination over the village resources through these institutions. The agricultural co-operative and finance society, the cooperative dairy, and agricultural water distribution society have played an important role in the village. It was observed in the study village that the people from the Maratha caste have withdrawn their memberships and shares from the old cooperative institutions and established new cooperative institutions of particularly Maratha caste people. Marathas also contested local gram panchayat elections against the Dhangar caste, and they won the gram panchayat election for three terms continuously. The people from the village said these political differences played an important role in the village development activity. Due to these political differences, many villagers want to be neutral in the processes of peoples' participation. They do not want to be allied with any political group. Some other people participate in the local development activities to oppose the ruling party's activities. While interviewing the present political leaders in the village they said that the common people are not willing to participate in the village development activities. Many times we

called people to attend the meetings, but they do not participate in the processes. One of the reasons they pointed was that of lack of awareness about governance processes.

Gram Sabha:

The 73rd and the 74th Constitutional Amendments have formally given a statutory status to the Gram Sabha and Ward Sabha. The Gram Sabha is one of the grassroots structures of decentralized governance. It has created a space for decentralized participatory democracy, where elected people representatives and community together can build transparency and accountability mechanism for village development. The government has been demanding to make the panchayat system is truly self-governed and a bottom-up structure that has channelized decisions and planning through Gram-Sabha.[52] There is more expectation from the Gram Sabha. However, the Gram Sabha's do not become effective in practice. It has been determined by various social and political factors. The nature of Gram Sabha in study village is not at a satisfactory level. Gram Sabha's are not properly conducted at the village level. The call for Gram Sabhas is not given accurately in most of the study villages, both in the CBM and NonCBM villages. The kind of decisions taken in the Gram Sabha's is not transferred to the villagers. There is a lack of transparency in the Gram Sabha decision-making processes. Organizing the Gram Sabha has been observed more as a ritualistic activity in most of the villages. On record, the Gram Sabhas are conducted on the occasion of 26th January (Republic Day), 15th August (Independence Day) and 2nd October (Mahatma Gandhi Birth Anniversary).

People from one study village shared their experiences in a group discussion about the practice of decision making in the Gram Sabhas. In their village, on the occasion of 26th January (Republic Day) and 15th August (Independence Day) most of the parents visit the village school to attend flag hosting and their children's cultural programmes. During the cultural programme one worker of the panchayat circulated the Gram Sabha Attendance Register for signature. This is only a Gram Sabha attendance register without any agenda.

[52]The information is available on Shodhganga website but full reference could not be obtained. The name of the chapter is *Introduction*. Retrieved from http://shodh.inflibnet.ac.in/bitstream/123456789/1667/2/02_introduction.pdf as accessed on 15th June 2016.

Parents are not aware that this is a Gram Sabha attendance register. They consider this as a school register for parents' signature. After collection of signature, the village of Sarpanch and village administrative officer (Gram-Sevak) attach the agenda and minute of Gram Sabha meeting. This practice has continued and has not changed whoever was elected as village Sarpanch. There was local panchayat electoral power shift in the village. However, this has not changed the practice of decision making for village development. If someone was opposed to signing the Gram Sabha register, then later the panchayat members would target that person or the family while giving any welfare benefits of the government schemes. The opponent party at the local level also did not give any attention to this kind of practices of decision making. They also followed same kinds of decision making when they were in the power.

Gender Aspect of Gram Sabha's Decision Making Process:

Many study villages had women's reservation for the election of Sarpanch. It is a well-known fact that women Sarpanch's husband has dominated in village decision-making processes. He takes the hold of all the decision-making powers. While interviewing the woman Sarpanch, it has been realized that they are not aware of their role and responsibility in a democratic set-up. In all the villages, the women do not have much participation in the Gram Sabhas. Women were not even aware of the name of Gram Sabha. According to them, they considered any general meeting in the village they considered as Gram Sabha. The gram sabha according to the women was only for male members of the family. They believed that women speaking at the village public forum in any village meeting had been considered bad and those doing so are labeled as women with bad character. This fear is an obstacle for women to participate in political and development activity of the village. Many women from the village have never entered the Gram Panchayat office. They have a belief that panchayat office place is not meant for them; it is the only place for village politicians particularly male.

Women representation in the Gram Sabha is mainly composed of the ANM, ASHA and Anganwadi Worker (AGW) and some women panchayat members are present in the Gram Sabha. Even they do not have any say in the process of decision making in the

Gram Sabha. All the activities of ANM and AWW are controlled by the panchayat officer and Sarpanch of the village. Most of the decision regarding village Sub-center and Anganwadi center circulate through the panchayat. Due to this reason village, ANM and AWW support all the decisions in favor of the Sarpanch and other local political leaders.

Social Marginalization and Gram Sabha

To integrate all the sections of society has been mandatory to panchayat formation. It is also necessary that one Gram Sabha should be organized in the locality of the marginalized social community (such as *Dalit Basti*) residential area. This mechanism has been developed for the participation of the marginalized sections of the community in the democratic governance processes. People in the study villages have said that only on the panchayat record has this Gram Sabha been organized. In reality, it never takes place in the Dalit residential area. Village political leaders feel embarrassed to organize any formal program in Dalit residential area. If they want some kinds of political mileage from these communities, only then they visit Dalits residential areas, mainly during the various elections.

Gram Sabha is constituent for governance and decision making. People from the marginalized socio-economic community have been not included in the village decision-making processes. People gave an example of previous Sarpanch in one of the study village. She was from a Schedule Caste community. She was elected from the local Nationalist Congress Party NCP panchayat panel. The NCP local leader from upper caste had controlled this Dalit woman sarpanch. She was not able to take decisions independently. She was directed by this leader. In another study village, in a recent election in the village, there was reservation for Sarpanch from Nomadic Tribe or Schedule Tribe category. The NCP leader nominated a candidate from *Phase Pardhi* (Nomadic Tribe known as Criminal Tribe in Maharashtra) community, a most backward community in Maharashtra. This community carries a taboo of Criminal tribe till today (Abraham, 1999). Most of the people from this community are homeless, and they stay outside the village due to discrimination. The woman sarpanch was elected due to NCP mobilization. She is unaware of all the democratic processes in the election and the functioning of the panchayat institution. Though, she is Sarpanch on the official record,

in practice the upper caste local leader takes all the decisions on her behalf. Thus, there is an informal pattern of decision making that has been prevalent in the village. This has led to maintaining of status quo in terms of power equations and influencing decision making in the village. It has thereby undermined all the efforts at collective decision making and changing the mode of village governance.

Health Service Institutions and Community:

People have very different understanding of the government health service institutions. They believed that health institutions such as the Sub-Center and Primary Health Center belong to the government, not to the people. The operative ownership is viewed to be in the hands of the administrative officer. The notion of collective ownership as the village is not associated with government health service institutions. They consider the community temple and the *dharamshala* as owned by the village. The government health service institutions are considered to be in hands of the professionals and staff such as the medical officers, ANM, and MPW. The village people consider the function of the health institutions as a technical matter and beyond their understanding. Also, often the service providers at the village level do not consider it relevant to get any participation from the people to implement the health programme. This power hierarchy between the people and the service providers is an outcome of the social hierarchy, the administrative powers given through the programme implementation processes, as well as the perceived knowledge gap.

Thematic Analysis Of Governance Mechanism At Village:

A thematic analysis helps to understand issues related health care governance. Six themes have been chosen for analysis (Siddiqi, et al. 2009). This includes (Health Services, Health Human Resources, Health information, Medicine, Health Care Financing, Participation, and Leadership). These terms are broadly categorized only for analysis, often the themes overlap with each other and are interconnected.

Health Service: Under CBM village and Block

One of the primary health center (PHC) has been selected for the CBM programme. However, there are some issues that have emerged in the area.

The PHC is located in a remote and hilly area. It is 25 km from the block level health care facility. The PHC is a major health care provider for many villages, serving more than fifty thousand population.

The PHC, officially stated to be under 24*7 services scheme is not functioning for all the hours. It was found to be open only during the Outpatient Department (OPD) timing. However, keep the PHC functioning for 24*7 services there is need of the support staff and other elements that have not been developed at this PHC.

Due to the remoteness of this PHC, the Medical Officer of the PHC attends the morning OPD. He does not stay at night as he does not reside in this village. Many people face difficulties to access emergency medical care at night. There is no proper residential facility for the medical officer at the PHC despite it being mandatory that at least one medical officer should stay at the PHC. ANMs stay at the PHC campus. However, it is difficult for them to take a decision in emergency situations at night. Medical officers said that at the PHC level there was no proper accommodation facility for medical staff.

The medical test laboratory at the PHC is not functional. Thought there is a laboratory room, it is dysfunctional due to laboratory technician post being vacant at both the PHCs. Patients access basic laboratory checkup either in a private laboratory or at the block level. The PHC has contracted out this service with a private lab technician under Public - Private Partnership initiative. The same is the case with the operation theater of the PHC. Despite the availability of an operation theater, it is not functional even for basic operations or surgeries because their unwillingness. This PHC is situated in the remote area. However, the PHC does not have a functional vehicle for referral services. PHC had contracted out referral transport services to private vehicles under NRHM guidelines. In the interview with the private vehicle driver, he made a complaint about not getting proper and regular payments for his referral services from the block level.

There was an issue raised by village elders, as they need age certificate as a documentary proof for applying for many government schemes. This certificate should be issued by the PHC medical officer. But for this, the PHC medical officer charged money. People have reported that PHC staff's behavior with patient's relatives is not good, they have often used abusive language for the patient's time and rural state transport bus time did not match, affecting the access to the OPD services of the PHC from remote villagers.

Many villages face the problem of safe drinking water. There is no regular drinking water testing. The panchayat governs safe drinking water issue as they collect water taxes from the villagers, but there is no awareness about water testing processes in the villages. The technical responsibility of drinking water testing is of the MPW and ANM. However, no drinking water testing is being done by the MPW. At the village level, there is no proper collaboration between the gram panchayat and local public health service providers such as ANM and MPW on the issue of drinking water.

At the village level, assessment of PHC health committee shows that the number of diabetic patients is increasing in PHC areas. Basic treatment and medications are supposed to be given at the PHC. However, it is reported by a civil society representative that no proper treatment is received at the PHC level by diabetic patients.

Pune District Medical Officer has issued a circular for Anganwadi to purchase a weighing machine from the untied VHSNC funds and other materials for the Anganwadi. However, this was not the self-perceived priority issue in these villages. Under the CBM village, VHSNC demanded in Jansawand (Public Dialogue), to make available the Rogi Kalyan Samiti (RKS) funds for village wall painting of public health services information and awareness messages and referral information boards. Regular child health checkup of Anganwadi children had not taken place at villages in Purandhar block, as noted with concern by the villagers. Thus, this process of 'guidelines' on how to use the 'untied funds' took away the VHSNC's right to decide village priorities for spending it.

Collective Demand and voice of community to influence decision-making

The following collective demands were raised in the Jansawaad (Public Dialogue) in 2011:

- To access emergency medicines available at the village level health authority appointed Medicine Kit Depot holder for villages.
- A collective decision was taken, and there was a change in the OPD timing according to bus timing. Now long distance villagers can access services according to state transport bus timing.
- Source of drinking water will be cleaned with the help of Gram Panchayat and people's participation, and local health staff will collect the drinking water samples regularly
- Higher level medical offers promised that the Operation Theater of the PHC would be made functional as early as possible with a specialist.
- Basic surgery services were demanded by the people at the PHC level. They also demanded to build separate ward for women. Most of the time child delivery cases referred to Rural Hospital (RH) or district hospital but more should be dealt with at the PHC itself.
- The community demanded that for issuing age certificate, user charges should be stopped by the medical officer or higher authority should take formal action against the concerned medical officer.
- The PRI member had suggested that medicines for diabetes can be bought through RKS funds at all levels and made available to patients. This demand was raised by the people's committeeand a District Medical Officer promised to put forward this demand to the concerned officers at the State level. This suggestion was included in the PIP of Pune district.
- Community-based monitoring process documentation showed changes in accountability and governance. The general OPD rate at PHC level has increased from 20 to 60 patients per day. Availability of general medicines has increased at PHC level. OPD timing has changed, according to people's need. This documentation pointed out things that still needed to change at PHC level. Behaviour of public health service providers, who are very rude and discriminatory with poor patients still needs to be changed. The reach of the CBM program processes is limited to few villages. All revenue villages from that particular PHC should be included in this process.

Human Resources Related Issues

Major unavailability of government health services, there is no service provider at the sub-centres, small villages, and *padas*. Due to no new appointments on vacant posts there is a problem of lack of human resources at PHC and sub-center level. The CBM VHSNC member's major demand was to have a residential Medical Officer and appoint a Laboratory Technician for the PHC to the vacant post. People have reported in the jansunwai reports the experience of VHSNC training program.

The capacity building training programs have been organized at the PHC or block level to introduce functioning of VHSNC to all the actors. This includes government health institution representatives, the PRI members and representatives of civil society organizations / NGO members. The capacity building training program of VHSNC was attended by a Government Health Officer and PRI member, however they have not participated in the programme activities after that. The local NGO representatives suggested need for more participation from PRI and government officials to strengthen accountability processes.

Under Non-CBM PHC, two posts were vacant: one of an ambulance driver and of a helper. All ANM posts were filled up through a contracting system.

Health Service Awareness:

People say that the people's experiences of public health services at the community level was documented the first time under the Community-Based Monitoring (CBM) program. The information dissemination and health awareness messages were not new to the villages. The Department of Health disseminated awareness information every year in the villages. Village health committee members said, nowadays we understand these information messages in the right manner and understand the perspective behind that particular information. The Block CBM coordinator said that presently, under the CBM programme health service related Information is disseminated through posters and processes of organizing and conducting community meetings. These processes contributed to increased awareness about health services and their entitlement to services

has increased among peoples. This has helped to raise the bottom-up demands and issues with regards to public health services.

People have also started to ask information under the Right to Information (RTI) Act from the health committee of government health institutions. The evidence showed that, when people demanded health service related information through formal channels, the concerned government officer was not willing to share that information. They avoid sharing information with the community. The following experience of local RTI activist in study area, some government health officer shares information that is limited often provide misleading and half information. This issue also taken by Civil society organization that particular area at block level authority, This was shared by community peoples and health committee members.

There are now also new formal channels for accessing information by health and monitoring committees at various levels. The people have started accessing health service related information with the help of civil society organizations or local NGOs.
Thus, people have space to demand official information about health programmes from health service institutions. However, people faced greater difficulties to access information from local Panchayati Raj Officers. There is intervention from the village Sarpanch or local political leaders who largely denied any information to the villagers.

In one Non-CBM village, a resident filed an RTI application to seek information about SC/ST welfare funds. The local panchayat political leader threatened and got involved in physical violence forcing him to take back the RTI application. The RTI applicant was an educated young man from a Dalit family in the village. The panchayat political leader from upper caste felt offended. The leader was of the opinion that how can a Dalit from this village ask and question panchayat activities. The traditional social structure creates a barrier to access information.

Health Medicine Access:

The report of people's health dialogue of the CBM PHC have pointed out the following issues about access to medicine: The very basic drugs and vaccines such as Rabies and Tetanus toxoid were not available in the PHC. To access, these medicine people had to go to the block level which increased the burden on patients. In remote and hilly villages and padas (hamlets), no basic emergency medicine is available with local medicine depot holders. In some villages' additional Depot holders are needed other than the Anganwadi Worker. They do not have an adequate supply of medicines from the PHC.

Health Fund Utilization:

The untied fund is the main financial support at the village level under the NRHM. Every VHSNC, which is created for a revenue village, received Rs. 10,000/- as untied funds annually. Some issues were found during the interviews and examination of records. In 2008, the untied fund allocation started with the VHSNC in Pune district. Detailed assessment of VHSNC Bank Account documents showed that out of five VHSNCs, only one Committee had utilized all funds. Two Village health committees had utilized only 60% of funds, and two Village health committees had not utilized any funds at all. The reason for the non-utilization of untied funds is not having clarity about utilization of funds. The government issued circulars to the VHSNC to spend on particular heads in 2008. Presently, VHSNC untied funds were spent on equipment for the Anganwadi activities that should have been officially supplied by the ICDS. However, often the other health service related issues are missing in the utilization pattern of untied funds and only Anganwadi activities get priority in utilization. In both study PHC areas, the village panchayats cover ten to twelve hamlets (wadis and padas) under one village. The untied fund of Rs.10000/- is insufficient for larger villages as these villages include many hamlets under one village.

Another issue is of accountability and transparency of fund utilization. The ANM and Sarpanch have a joint bank account. The Sarpanchs often create problems in spending the money, whether of the VHSNC, or the Sub-centre funds. They want to utilize this money for a different purpose and does not want to be accountable to VHSNC members.

VHSNC committee members reported that the medical officer of the PHC utilized Rs. 96000/- for a water supply pipeline from the PHC welfare funds when there is already water facility availability for the PHC and there were other pressing priorities.

Another direct financial assistance at village level is the Janani Suraksha Yojana (JSY) scheme. JSY) scheme introduced under NRHM, Janani Suraksha Yojana was launched in April 2005 for assisting households in accessing institutional care for deliveries. Women getting home deliveries were also to be given. The financial assistance of Rs. 500/-. The funds were transferred to the woman's bank account.

At the village level, there were a number of confusions regarding the implementation of the JSY scheme. The opening of the bank account is one of the major problems faced by the beneficiaries, since women often do not have bank accounts, especially of the BPL households.

Secondly, there is a lack of obstetric services at the PHC level and so patients are referred to the private doctors who have obstetric care in their private nursing home/hospital. Charges of a private hospital are very high, often reported to be ten times higher than the JSY benefit (Rs. 1500/-). Patients have to pay the excess from their own pocket. This has raised suspicions about the real beneficiaries of the scheme, as expressed by a community member: maybe there is lobbying between government medical officers and private doctors to benefit the private.

Leadership and Participation:

VHSNC is one platform to encourage community participation in health service planning and decision making. Formation of the VHSNC had taken place in 2008 in Pune district. The members of the VHSNC are expected to be nominated through the village *Gram Sabha*. The Civil society representatives shared his insights on the process of formation of VHSNC Under CBM area. At the initial stage village visits were conducted for the initial contact. IEC (Information, education and communication) material such as poster and pamphlets used for the publicity of programs and to create health service awareness were distributed. People's mobilization was done through village notice board writings and house to house visits by the local concerned organization. Then they approached the health functionaries at the village level, and discussions were held with the SHG groups,

adolescent groups, youth clubs, village water committee, etc. There were difficulties in organizing a Gram Sabha on the issue of health services at the initial stage; it was a difficult task for the civil society organization. Mostly it was informal processes at village. For big villages, two-three meetings were conducted to mobilize the community. There were 12 to 14 members nominated to the village level committees. It has included representation from marginalized social groups such as (SC, ST and Women).

At day time, people were busy with agriculture activities; it was a good time to conduct a community meeting at the night time. During those days, the electric load shedding (power cuts) was a major problem when village health meetings were held at night. The Sarpanch is one of decision-making actors at the village level. Some village Sarpanch does not live in that village. They have a residence outside the village for many reasons. Hence, this is a problem for deciding dates and time of programme activities.

Positive Aspect of VHSNC Processes under CBM:

- 'Health Day' is regularly organized that provides an opportunity to share information with the villagers.
- Appointed depot holder in village for access to basic essential medicines
- Now JSY beneficiaries get their JSY benefit on time.
- Adolescent girls' health checkup is undertaken at the Sub-centres

Negative Effect of VHSNC processes CBM:

- In the initial stage old permanent staff of government health institutions opposed the process of CBM. They gave the excuse that they are not appointed as NRHM staff so they will not participate in the CBM programme under NRHM.

Preparation of Village Health Card:

- Five villages out of ten had prepared village health report s under the CBM PHC.
- Interviews and group discussions had taken place with Dalit and Non- Dalit residents to prepare the village health report card. After preparation of health report cards, final report findings were shared with government health officers and the following issues were put forward:
- At the PHC level, there is a lack of human resources
- Village people are not ready to participate in the government health programme.
- PRI representatives are not cooperating with government health service providers.

Positive Aspect after the Preparation of Health Report Card:

- ANM and MPW regularly visited the villages
- Registration of pregnant women for ANC and PHC care improved
- Behavior of government health service providers has improved
- The participation of village was enthusiastic in the preparation of village health report card. However, there was still a dependency on some external leadership.
- The presence of government health service providers during preparation of the report card had influenced the quality of information on the report card.
- Village Gram Sabha has not acknowledged the health report card findings in thr gram sabha meeting.
- Sometimes decisions at high levels officials in response to report card findings and improvement takes lots of time.
- Follow-up of Jan Samvad decisions was taken by the PHC and monitoring and planning committee
- Monthly two meetings were planned with the medical officer of the CBM PHC.

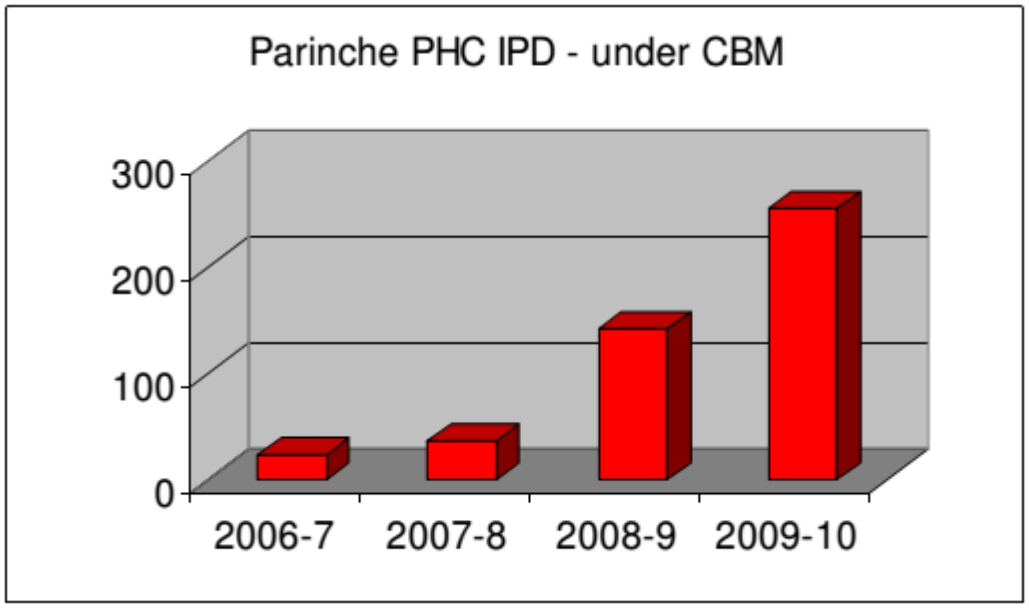
Suggestions to improve people's participation in health planning

- Information should be given on time to the community people.
- Take affirmative action on peoples' suggestions
- People-centered health planning and implementation
- Information should be in local language

Performance of CBM and non CBM PHC

To see the comparatives performance of the two PHCs, data on utilization was collected, as given in the table below. The community based monitoring system made any changes in the performance of PHC. Report on NRHM mentioned that "people had no idea about the (CBM) PHC, which was covered under community monitoring. They did not know that the PHC can admit patients, and it was almost non-functional. But after community monitoring, patient intake went up by 10 times and deliveries started taking place and people got admitted for health problems" (Parija, 2010, p. 22).

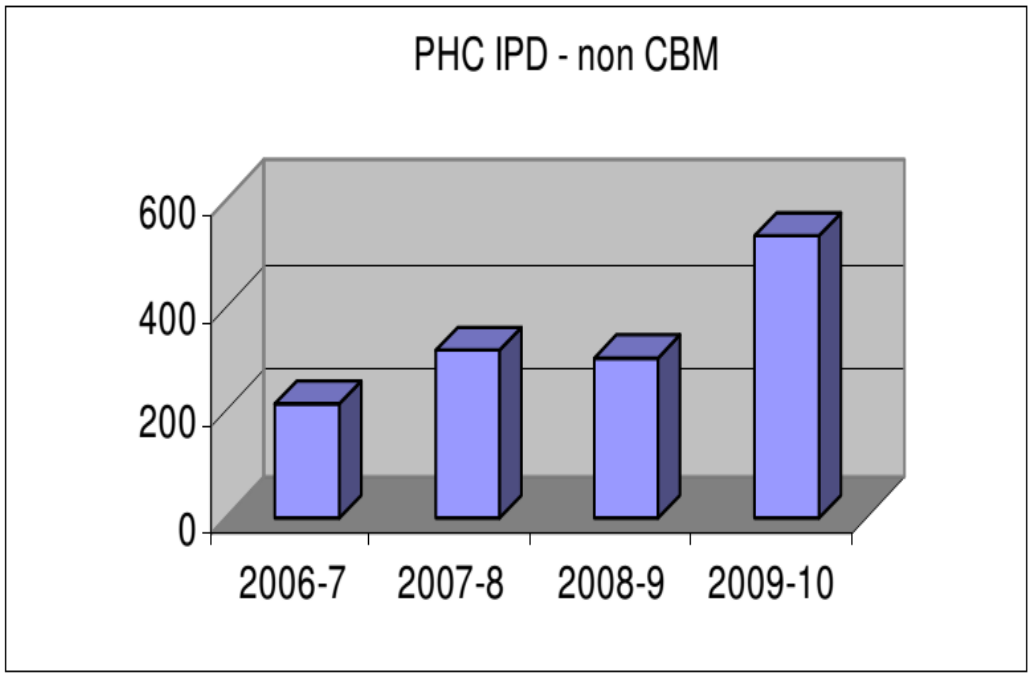
Figure-6.1
PHC-IPD Services Under CBM in Purandhar, Pune



Source – Shukla, 2010, p-23

Figure-6.2

PHC-IPD Services Under Non CBM in Purandhar, Pune



Source: Shukla, 2010, p.70.

However, they are not much quantitative difference found in the performance of both PHCs. Due to set targets for institutional deliveries, the IPD load increased in both. Both PHC don't have any significant infrastructural differences to handle such targets. However, there is a qualitative difference in the processes of decision making and planning at both PHCs.

Box-6.5
Summarizing Major Differences in both CBM And Non CBM Study Area

Element	Non –CBM	CBM
Monthly planning	Each individual service provider prepared monthly work plan Submitted at the PHC level to MO	Each individual service provider prepared monthly work plan One copy of plan submitted to PHC Monitoring committee
PHC Committees	Committees exist on Board. It function or ruled by Medical officer and PRI member of particular areas. Members are not aware about their role and responsibility	PHC level committees nominated democratically Transparency in functioning Members are not aware about their role and responsibility
RKS	Registration of RKS Completed Technically on paper made distinction between governing board executive board All the financial decisions controlled by ZP member (District PRI Members) single handed. Minute of RKS meeting are not made public.	Registration of RKS Completed Technically on paper made distinction between governing board executive board All the financial decisions controlled by ZP member (District PRI Members) single handed. Minutes are made public, RKS member completed training programme with CBM members. CBM member put pressure on Medical officer for proper allocation of RKS funds
Mainstreaming of AYUSH	BAMS Doctors on Contract at 12000/-pm No Ayurvedic medicine Supplied	The Same experience CBM Study Area found

Box-6.6 Village level		
Themes	**Non –CBM**	**CBM**
Gram Sabha	Conducting Gram Sabha is a process dominated by the local traditionally politically powerful sections. It is influenced by social factors such caste, class and gender No Transparency in the decision making processes Administrative and PRI members controlled the whole Gram Sabhas	In CBM areas also the Gram-Sabha is political dominated by the local traditionally politically powerful sections It is influenced by social factors such caste, class and gender Intervention of civil society plays an important role as facilitator of accountability processes. Limitation is that the community developed dependency on external agencies for conducting programmes
VHSNC	In the study villages, the VHSNC members don't have the clarity of role and functioning VHSNC exists only on paper. Composition of VHSNC has not fullfilled Functions of the VHSNC are known only in very selective terms, to the Gram Sevak, ANM, Anganwadi worker and PRI member. No other members were aware about them.	All the VHSNC members have clarity of their role and functions. Decision making processes by village residents have started in some parts of CBM villages Only functioning around untied fund utilization and referral services. Marginalized sections have been incorporated in the structure of VHSNC, but decision making powers have not shifted into hands of marginalized sections. It is highly dominated by PRI members
Inter-sectoral Convergence	Not happened, not proper awareness of functioning (Three type of convergence, institutional, human-resource and financial level)	Not happened
Health Day	Immunization day celebrated as health day at village level. Women's signature collected	Immunization day celebrated as health day at village level. Some of the initiatives added by civil society

	by ASHA through home visit.	org., such as a women health talk.
Utilization of Untied funds	PRI member and Gram-sevak control the financial decision making No- transparency in Account details Other members role is merely as signatories. No other financial decision making power has been observed in practice.	All the financial transactions were democratic decisions of the VHSNC. Transparency in account details and utilization. Problem with how to set priority of utilization, and thereby largely followed the uniform guideline given by the higher medical authority.
Health Charter	No clarity about health charter	Only VHSNC members aware about health Charter through trainings inputs.
Trainings	Only Asha training completed VHC members not having training inputs.	Training inputs given to VHSNC members, PRI members, health staff and officials.
Revitalization of LHT	No action or even mention	Similar experience in CBM study areas

Source: Researchers own interpretation from the study

Chapter-VII

Discussion and Conclusion

Chapter - VII

Discussion and Conclusion: Democratizing Health Governance?

The meaning of 'transition' refers to the process or a period of changing from one state to another[53]. The transition in health care governance in India is a part of the new economic transition within the democratic value framework (Denhardt and Denhardt 2000). This transition has led to a shift from the conventional public health administration towards the new public management approach and lastly to new public governance. This transition in health system governance is one of the important issues in current attempts at strengthening of the public health service system.

In the Indian context, there has been a persistent demand to build a democratic, accountable and transparent health service system. However, 'health governance' in India has been viewed only in relation to the budgetary allocation on health by the government (Berman et al. 2010). In such an approach health financing is always been seen as the determining factor of governance. It was generally believed that the deficit of health governance can be addressed through a management and cost efficiency approach (Conrad and Shortell 1996). There was also a focus on creating structures for greater accountability and transparency through institutionalization of community involvement. Thus, health services development and governance of the health service system have been in transition, going through different phases.

The structural adjustment programme in India changed the private health sector and public health service development in India, both carrying different goals and value frameworks (Berman 1998). The health sector in India is moving towards a health industry business model. Over the years, it has seen growth of the private health care industry and an increasing shift towards involvement of the corporate sector in the health sector of India (Purohit 2001). While on the one hand, the role of the state in developing public health service systems has been declining, private health care providers have been increasing without a legal regulatory framework (Baru 2012). This growth in the private sector has been largely affecting the poor strata of society accessing health care from the

[53] The meaning of "transition" from online oxford dictionary http://www.oxforddictionaries.com/definition/english/transition access in Jan 2016.

private service provider. In order to provide basic health care services, the state is also involving non-state actors (Peters and Muraleedharan 2008). The private healthcare industry has developed powerful economic and political networks and interlinkages with pharmaceutical lobbies, corporate and private hospital corporations. These networks have been increasingly influencing state decision-making and policy planning (ibid). However, it is to be noted that the role of the state is to promote and restore the health of people and provide essential health services to citizens. In the Indian context, it has been largely the political and administrative bureaucracy which has kept the public sector and its objective of health care for all in focus. Civil society has acted as watchdog in this regard. Thus there have been conflicts in decision-making and planning processes. There is a rigid hierarchical structure of health services on one hand that does reach even remote parts of the State free of charge, but with limited services., On the other hand is a private sector that provides services of variable price and quality, remains unregulated by any democratic structure and influences the decision making processes through its powerful position in the health services sector as well as the international support that it receives. In this situation, to make decision making structures more conducive to strengthening of the public sector in a rights based framework, NRHM came with a structural correctional approach, influenced by the changing governance paradigm.

In 2005, the health sector witnessed an important change with the introduction of the National Rural Health Mission (NRHM). The NRHM was launched with a view to bring about dramatic improvements in the health system and health status of people living in the rural areas of the country, especially the most vulnerable sections. The mission attempted to provide universal access to equitable, affordable and quality health care through a system which is accountable and at the same time responsive to the needs of people. This was aimed to bring reduction in the child and maternal deaths as well as ensure population stabilisation. Some of the key features in order to achieve the goals of the Mission included making the public health delivery system fully functional and accountable to the community, human resource management, community involvement, decentralisation, rigorous monitoring and evaluation, convergence of health and related programs from village level upwards, innovations and flexible financing and also inter-

sectoral coordination for improving health indicators (GoM, 2008).[54] The present study examined how the process of decision making unfolds at the all levels under the NRHM in order to understand this critical element of health governance. The study findings lead us to the conclusion that the new structure and value framework developed through governance transition adopted under the NRHM influenced health governance as "soft authoritarianism with a democratic face" (Sampath 2015).

The study observes that there have been significant changes in the health sector with the implementation of the NRHM that emphasised on improved management and decentralisation of decision making and community participation in health care. It was found that the NRHM has incorporated the private sector as a provider of services silently through contracting-in and contracting-out arrangements of public-private partnership. Thus, NPM aspects of governance were brought in for instance in relation to new financial structure, managerial system, performance based incentive payment system, creation of quasi-public institutional structures such as RKS and a larger workforce on contractual basis.

It was also found that several new institutional mechanisms such as the District Health Society, Rogi Kalyan Samitis, Village Health Sanitation and Nutrition Committees and Community Based Monitoring have increased the scope of participation of multiple stakeholders to ensure increased accountability of the health services system. This indicates the potential for democratization of the health service system by the contemporary transition in health governance that is in accordance with the NPG approach. However, this potential was not adequately achieved in practice, the details of which we discuss in subsequent sections.

The study began by examining the conceptual shifts in health governance at global and national levels and then conducted an empirical enquiry into the changing processes of governance and their implications for decision making at meso and micro levels in one state of India. The history of governance in general and health services in particular in the state of Maharashtra was reviewed through available literature and data sets, to reconstruct the changing structures and value frameworks for governance. Locating the

[54] GoM, 2008, Maharashtra NRHM Project Implementation Plan, 2008-09,

empirical study in Pune district of the state of Maharashtra, this study explored processes of decision making that were actually undertaken under the NRHM, from village up to the state level. The study observed the implications of the governance changes at ground level.

Defining Governance

The idea of health system governance has been in the developing stage. Governance is not merely about efficient management. Governance is about social value frameworks to be adopted and decision making accordingly, power play between various social and sectoral segments, and the way structures of governance shape these processes. Historical social, political and administrative processes influence the functioning of governance structures. Hence, the work culture of institutions matters.

From the conceptual review of idea of governance, it becomes clear that governance has been in transit through different time and scope. Multiple typologies of governance have been used. For example, governance, health governance, good governance, global governance, global health governance, governance for health, governance of health, clinical governance, corporate governance, non-profit governance, collaborative governance, public sector governance, new public governance.

In this study, we used a Health Systems Governance Principles framework adapted from Siddique et al (2009) to guide the exploration. It includes ten domains: Strategic long-term vision with a comprehensive strategy for health and health care; Participation in decision-making processes with stakeholder identification and voice; Rule of law and regulation policy; Transparency in decision-making on technical content of services and allocation of resources; Responsiveness to regional and local population health needs; Equity and inclusiveness; Effectiveness and efficiency, with quality of human resources, communication processes and capacity for implementation; Accountability. internal and external; Information generation, collection, analysis, dissemination; An ethics framework.

The study was able to identify initiatives for measures addressing almost all the principles to a greater or lesser extent. However, there was no mention found of an

ethical framework, or even the need for ethics in practice, or in decision making, in any document of the NRHM or of the CBM.

In the Indian context the "idea of governance" transited through three paradigm shifts. Since India's independence, the first phase began with 'Public Administration', moved to Public Management, in the early 1990s it shifted to New Public Management and in the 2000s to New Public Governance. The shift in governance is not as one form being replaced by another form but more as new forms being added on to the pre-existing ones. This has brought about changes in the theoretical roots of discourse, nature of the state and its focus areas, as well as in the relationship with external actors and in the functional mechanisms and value frameworks. At the larger level, the transition in the discourse, the focus and emphasis of public administration was policy system change and emphasis was given on its policy implementation. The value framework of public administration was on a public sector ethos, which shifted towards efficacy of competition under the New Public Management (NPM). The focus under NPM was on intra-organizational management and emphasis was given on service inputs and outputs. Under the NPM approach, the market principles and value framework has been central to its discourse. New Public Governance (NPG) focused on inter-organizational governance and emphasis was given on service processes and outcomes.

The governance framework transitions in recent decades has been initiated through international agencies in development discourse. It was the World Bank that first introduced the concept of governance to national socio-economic development. The failure of its Structural Adjustment Programmes (SAPs) in African countries was seen mainly due to a "crisis of governance." Thereby it was emphasized that there was a need for good governance. However, the 'crisis of governance' was defined by the bank only in economic terms as the failure of accountability and transparency. There are differences in the mainstream discourse on the issue of governance. The new conception of governance reflected in NPM was also reframing the role of the state and silent on fundamental issues of equity, justice, gender, and non-discrimination, inequalities, poverty and resource distribution (Sampath, 2015).

Later, every international development agency made an effort to define governance for its own agenda, incorporating some of these issues as well. The United Nations and its concerned organizations focused on political and social governance. It must be noted that the conception of governance changes with its application, context, and the intent by who is applying it. It was altogether silent on processes with a democratic face (Denhardt and Denhardt 2000). Clearly, the idea of NPG in development is a post-structural adjustment programme agenda. It is multi-layered in nature and has serious implications for nature, structure and composition of health service systems.

The application of governance in practice was meant to realize the organizational and societal goals of problem solving through policy formulation, planning and implementation. To achieve the governance goals, strategies are adopted like institutional integration and fragmentation, formal and informal actors and norms, the use of administrative power and democratic values (Biersteker, 2009; Brinkerhoff and Bossert, 2013). The ideas and concepts of governance have tried to explain the problem. Nonetheless, it has remained unanswered in many ways, since the ownership and command of governance remains with the bureaucracy and political interests without actually shifting the command to people through deliberative democracy processes.

Issues of Health Governance

Health Services Development and its urban, internationalist, doctor-centered and techno-centric culture that shaped the actual implementation of programmes and delivery of services in India since the British period has largely continued under the NRHM and therefore, the hierarchy contained in the vision of the health services continues (Priya, 2005, 2013). Health knowledge is a basis for the hierarchy between the provider system and the users, and that remains completely unaddressed, and in fact only got further entrenched through the NRHM. The limitations of the public service system, and the large number of doctors being produced by the increasing number of medical colleges, resulted in the private sector becoming well entrenched in Maharashtra. It is believed to provide the doctors and technology in a better way than the public services. Being completely unregulated, it is also expanding very rapidly.

The implications of the change in governance in the Indian system have been manifold. Transitions in governance approach and value frameworks have been reflected in many health programmes, for instance in the flexible financing mechanisms of the NRHM based on trust in local collective decision making over the public administration mechanism of rigid rules and procedures. The shift from NPM to NPG is reflected in the return to strengthening public services for health in the 2000s.

The design of the Indian public health service structure was based on the recommendations of the Bhore Committee (1946), which was doctor-centered and institution based. Secondly, it was under the Community Development Programme (1952) that the rural administrative set up for service delivery was initially developed, but the CDP itself was inadequately implemented and remained weak on health service development and community involvement. In the initial period, the major focus was on infrastructure development of health service system and a large network of service institutions was built, but the spending by the government was very low. The poor coverage and quality of health services resulted in large scale denial of rural health care services. Increased financial allocation was the historical demand as this has had significant negative effects on the health system in India but has been a neglected subject within the political and state agendas. In the post 1990s, civil society organizations in health put forward these issues through a rights based approach at the national level. There was a collective demand for the right to health care. There was a hope that the National Health Care Act will help to improve health service governance. With a global recognition of the necessity of public health services due to 'market failure' in health, and the rights discourse, NRHM was framed with a new institutional structure for public governance to make 'Architectural Correction' of the health service sector and improve provision of services (Priya 2008). The two positive achievements under the NRHM were that it created infrastructure development for rural health service and financial allocation of funds flows for rural health service increased significantly in comparison to the previous years. At the larger level NRHM created the structures for new governance reform. Various ideas and themes of New Public Governance can be seen in the NRHM.

One of the major limitations of NRHM implementation has been that it focused more on building institutions of governance to professionalize the management of public health systems (NHRC 2012). The decision making structures created larger managerial authority in the rural health service system with only limited increase in decentralized decision making.

Though there was an increase in the financial flows for services, but it gave more focus on financial accountability through managerial methods and less on responsiveness to democratic decision making. The NRHM has increased the creation of semi-government bodies or autonomous bodies or quasi-government agencies to by-pass the rigid bureaucratic structures of the existing public system, with regular financial audits for accountability.

It has also emphasized on public private partnerships and outsourcing of various components of health service delivery. Human resources increased in the rural health system, but it was through contractual hiring of doctors, nurses and all other staff under the NRHM, thereby providing low social security to the workforce and therefore a high turn-over that threatens the sustainability of the public services.

The change from right to health of the NRHM to universal health coverage is one of the recent forms of governance shift. NRHM was merged with the NUHM to become the National Health Mission (NHM). The objectives and design of the NHM were also to create the path for Universal Health Coverage (UHC) in India. At one level there was a demand for right to health through public system strengthening which was merged into the universal health coverage discourse. Since the UHC discourse is related to the lobbying for an insurance based model for health care in India through which equitable access to services is now to be envisaged, it certainly reads as "neo–corporatism" with a democratic face.

In the Indian context, there have been various perspectives and positions on health system strengthening. One major issue is who is to be considered the 'owners' of the system, who therefore are to take part in the policy decision making. In a democratic political

system, are the citizens the 'owners', or is it their elected representatives, or the experts and officials of the executive structures?

Governance as Responsive and Accountable Decision making:

Governance shifts since the 1990s have meant an opening out of the inflexible public health administrative structures. In this era of globalization with LPG, this has allowed for greater public financing of private services.

On the other hand, it has created possibilities for decentralized decision making and greater responsiveness to local conditions, needs and demands by the health service system, thereby bringing the services closer to the people. Flexibility in fund utilization, innovative human resource policies, use of Information Technology (IT) for greater transparency and accountability in procurement systems, as well as in service provisions, greater responsiveness through interactive processes of the ASHA as well as IT help-lines, participatory committees at all levels, perspective planning and annual planning through a bottom up approach was visualized. CBM was to be piloted and then adopted as part of NRHM.

However, the developmental policies and programs, provisioning of services, and infrastructure in Maharashtra have evolved in a different political context which has shaped the governance structure and its functioning.

Broadly, governance in Maharashtra has been influenced by the regional diversity and associated political processes. The state of Maharashtra has also been a pioneer in the implementation of co-operative movement in rural areas. A democratic governance structure was first implemented through the cooperative movement in Maharashtra, which restructured the village level governance structures in the decade immediately after independence. Panchayat Raj and local governance in Maharashtra, followed the general structure of local governance in India that is broadly classified into Urban Local Governance and Rural Local Governance bodies. However, this model resulted in dominance of the powerful caste groups i.e. the Marathas, in the local structures of governance. This resulted in the accumulation of wealth in the hands of elite Marathas in the rural areas. Historically, the Marathas have dominated both the governance structures

in Maharashtra. They have not addressed the issue of inequalities within Maharashtra which lead to increase in the regional disparities as well.

Regional governance was the historical framework to address the regional imbalance and inequalities. After formation of the state of Maharashtra, the first Chief minister agreed for regional development focused on Vidarbha and Marathawada along with the rest of Maharashtra (GoM, 2013). However, Special Component Plans for these regions failed to address their issues. Hence, there were demands for a separate Vidarbha state as a result of the failure of regional governance in Maharashtra.

During the 1970s, there has been a shift from the regional to district governance and as the unit of planning and development. The Planning Commission issued guidelines for the preparation of district based planning across the country. The important factors that have contributed to the shift from regional to district were based on the recommendations of Balwantrai Mehta Committee and P. B. Patil Committee that focussed on the establishment of Panchayati Raj system (reference). The 73rd and 74th Constitutional Amendments in 1992 further reinforced the efforts for democratic decentralization and made the district a key unit of administration, local governance, planning and implementation.

The Government of Maharashtra has six main administrative divisions in the state. NRHM tried to make it more effective and state mission of Maharashtra formed eight administrative divisions for better governance. Under the NRHM both regional and district based decision making and planning processes were carried out. New structures for decision-making and planning were successfully created at all levels. At the state and district levels, multi-sectoral missions were to ensure inter-sectoral coordination for health at policy level, and societies were to manage all the administrative and planning processes. However, the study found that there was little change in the processes of decision making with no increase in the role of sectors other than Health and WCD under the NRHM. Other social determinants are still not adequately included in decision making or even addressed in the policy formulation.

Participatory Decision-making as a Governance Tool

NRHM incorporated the idea of participatory governance in the health service delivery, aiming to empower the community and local bodies to take leadership of health and sanitation issues at the local level. Grassroots community bodies such as the RKS and VHSNCs were important steps envisaged in decentralizing planning and increasing community participation.

It is to be noted that the State level is still where major policy and planning actually happens, while the regional level has limited powers. The district level has the responsibility of needs assessment and budgeting accordingly for RCH services and for the national health programmes within the given programmatic structure. However, it does have some flexibility to allocate funds for specific needs and innovations, which is denied to the block level. The block officials are given the responsibility to act as channels between the state and the village, but not given any powers. Despite this there have been some state level innovations in the formulation of the State Programme Implementation Plans. There has also been some representation of lower level priorities in higher level plans such as in response to issues raised through the CBM.

However, there is still little ownership developed amongst the community members. The culture of bureaucracy and political representatives acts as a major barrier in the implementation of community participation. For instance, the RKS decision making process is hindered by the involvement of only the political leaders by the medical and administrative officials, rather than the community level organizations. The social structure also acts as a barrier where the marginalized communities are hardly involved in the decision making process. Even now people's knowledge and its relationship with governance have not been recognized.

Community Based Monitoring (and Planning)

Though there has been increase in the accountability mechanisms with the community based monitoring, the larger system has not allowed translation of these into major shifts in the health services. Though the block level understands issues raised at lower levels and responds, but it has no powers of decision making. The coverage under the CBM has also been small for making any significant impact, including only one-third of the districts in the state and leaving out large pockets within these districts.

Village level

At the village level, the ASHAs and VHSNCs have been added in all villages across the state, with holding of monthly VHNDS at Anganwadis, and the JSY scheme, all leading to increase in the utilization of public services. The improvements in infrastructure and services is also being viewed as positive.

As the difference in functioning of services between the CBM and non-CBM PHC areas has shown, CBM has made a difference to the accountability and responsiveness of the local staff, with the utilization of services increasing markedly in both areas.

- In the CBM areas, the village level decision making and planning structures such as the VHSNC are getting input from civil society organizations about role, responsibilities and basic functionality. Local level actors are aware about their functions. Community representatives were creating pressure and demanding essential health services from local providers. Democratic decision making processes have begun in the CBM areas. In the Non-CBM areas, these structures exist largely only on paper. There is no clarity about their basic role and functions among actors. Socio economic and marginalized sections have been incorporated at the village level under CBM processes, whereas under the Non-CBM areas these sections are not actively participating in the decision making and planning processes.
- Financial transparency was made in terms of utilization of untied funds in CBM areas, and in the non-CBM areas untied funds are controlled by political actors at village level and tend to get diverted.
- Three types of convergence, i.e., institutional, human- resource and financial level and inter-sectoral convergence processes has been initiated on paper. However, at the implementation level, actors were not aware of the proper functioning of convergence in both the areas.
- Health Day event at village level was considered as a medium of community involvement for interaction between provider and community. But it remains as

the children immunization at village level. It has not moved beyond this in both the CBM and non-CBM areas.

- The Gram Sabha is a collective decision making body at the village level. Conducting Gram Sabha is a local socio-politically dominated process. It has been determined by social factors such caste, class and gender. At the village level, the socio-cultural factors have shaped the power of new governance structures. The traditional forms of decision making structures have been translated into new structures. There is still no transparency in the decision making processes, with the administrative and PRI members controlling the gram Sabha's processes. It has been not seen as a democratic space through which people's voice can be included in the governance processes.

- In CBM areas, community people have a dependency on civil society organizations in taking decisions and planning. The monitoring activities have not been not fully taken over by community actors.
- Community ownership of health care institutions has not happened at the grassroots level.

PHC level

- Both PHCs are having governance and executive mechanisms for decision-making and planning. Through, the CBM processes capacity building and strengthening, training of the RKS and PHC committees was given emphasis. This helped to demand guaranteed health services under NRHM via PHC committees. It has also enhanced the clarity about its functioning. Under non-CBM areas, committee members are not aware about functioning. Most of decision taken by medical officer with PRI member.
- CBM processes created pressure on Medical Officers for proper allocation of RKS funds.
- Monthly planning at PHC level has become a ritualistic task through filling monthly planner sheets. However, the tasks are being not carried out according to the monthly planner sheets. A village health calendar for activities is proposed

under the CBM for participatory community planning. However, it is not successfully implemented in the area.

Block Level

- Block level health care unit works as a bridge between the village and the district. It plays a mediator role in programme implementation processes.
- There is very less decision making freedom to the authorities at the block level. Management of PHC is major task in hands of TMO.
- CBM processes- Block level CBM processes were led by civil society organizations. There was less active participation from the formal health service authority. Most of the issues are about the functioning of rural hospital. CBM process has continued to exert pressure on rural hospital administration for quality of services. However, all the decisions related to the Rural Hospital are made by the civil surgeon in charge. Functioning of RKS is controlled by the civil surgeon and local PRI members and all the financial decisions are not made on a transparent basis. There was a tension and conflict between TMO and civil surgeon on issue of health service decision making. TMO role is seen as an administrator in processes and civil surgeon role seen as clinical expert and administrator which is reflected in the power balance at the block level.

  The minor PHC level issues are resolved with the help of TMO. Major issues are forwarded at the district level and are not in the hands of TMO.

Thus the CBM is still largely NGO driven and not owned sufficiently by the community. It appears that its coverage remains limited because the process is not taken up adequately by the community or owned by the state system. In the districts where it was started earlier, there is an effort to hand over the CBM process by the NGOs to the community, while also taking the process one step further towards community based planning.

However, the CBM is also not raising issues of knowledge hierarchy. It is not raising questions even about the implementation of the strategies of mainstreaming if AYUSH and revitalization of local health traditions that are components of the NRHM (Priya, 2013). Nor is it in a position to raise issues about regulation of the private sector.

Therefore, it remains to be seen how far it will lead to a sense of involvement or ownership by the community, especially as the NGOs phase out. Also, it has to be acknowledged that governance mechanisms have very context specific outcomes, and therefore cannot be generalized from this one small study.

In conclusion, one is still left with the question that there is need for changes in health governance both for strengthening the services and their coverage, as well as to make them more democratic, responsive and accountable to the people it is meant to serve. There is a prevailing mix of positive and negative processes, but shifts seem to be more in adding structures than in actual processes. People's empowerment has happened in the CBM areas in creating some ability to question the officialdom and service providers. However, clearly something more is needed, and so the exploration continues, with learnings from the experience of the multiple efforts so far.

Issues for further research

- What can people's ownership mean in health governance? Since healthcare is at one level an individual, family and community issue and on the other it requires expert inputs and access to technologies, how far can people be involved in making decisions about health and health care?
- What are the learnings about generating greater ownership and right to involvement in decision making form governance mechanisms in other context, such as Brazil and Thailand?
- Where representative democracy institutions seem to fail, can deliberative democracy processes be more effective?
- Does people's traditional health knowledge and its legitimacy or lack of legitimacy play any role in increasing ownership of governance in the health system?
- Is it possible to create a democratic 'health governance' process without such an ethos at the wider level of governance and society?

Bibliography

Bibliography

Abbas, S. M. and Baloch, Q. (2013). Decision Making & Good Governance: Theoretical Perspective. *Abasyn Journal of Social Sciences*, 3(1), 1-16.

Abdellatif, A. M. (2003). Good Governance and Its Relationship to Democracy and Economic Development. Workshop IV. *Democracy, Economic Development, and Culture*, Ministry of Justice, Republic of Korea. (2003, May 20-31).

Abelson, J., Pasic, D., & Grignon, M. (2011). *Health System Efficiency Project (HSEP): A Qualitative Study of Provincial and Territorial Health Ministry Perspectives*. Report submitted to the Canadian Institute for Health Information. Centre for Health Economics and Policy Analysis, McMaster University.

Abraham, S. (1999). Steal or I'll Call You a Thief: 'Criminal' Tribes of India. *Economic and Political Weekly*, 34(37), 1751–1753.

Adsul, N., and Kar, M. (2013). Study of Rogi Kalyan Samitis in Strengthening Health Systems Under National Rural Health Mission, District Pune, Maharashtra. *Indian Journal of Community Medicine*, 38(4), 223.

Afsharipour, A. (2011, April). A Brief Overview of Corporate Governance Reforms in India. In *Conference Board Director Notes No. DN-020*. UC Davis Legal Studies Research Paper No. 258. Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1729422 as accessed on 15th July2014.

Aggarwal M. and Mathur, T. (2011, July 7). Solution Exchange for the Maternal and Child Health Community, Solution Exchange for the Decentralization Community Consolidated. *Solution Exchange*. Retrieved from ftp://solutionexchange-un.net.in/public/mch/cr/cr-se-mch-decn-020511-01.pdf as accessed on 15th October 2015.

Ahluwalia, M. S. (2002). Economic Reforms In India Since 1991: Has Gradualism Worked? *The Journal of Economic Perspectives*, 16(3), 67-88.

Androniceanu, A. (2007). New Public Management, a Key Paradigm For Reforming Public Management In Romanian Administration. *Administratie Si Management Public*, (8), 154.

Annex, L. (2007). *What is Health System? Healthy Development, The World Bank Strategy for HNP Results*. Retrieved from

http://siteresources.worldbank.org/HEALTHNUTRITION_ANDPOPULATION/Resources/281627-1154048816360/AnnexLHNPStrategyWhatisaHealthSystemApril 242007.pdf as accessed on 15th May 2014.

Ansell, C., and Gash, A. (2008). Collaborative Governance in Theory and Practice. *Journal of Public Administration Research and Theory*, 18(4), 543–571.

Antia, N; Deodhar, S; and Mistry, N., (2004). *Developing An Alternative Strategy for Achieving Health for All: The ICSSR/ICMR Model-The FRCH Experience*. Pune: Foundation for Research in Community Health.

Atkinson, M. and Coleman W. D. (1992). Policy Networks, Policy Communities and the Problems of Governance. *Governance,* 5(2), 154-180.

Bajaj Committee (1987) *Report of the Expert Committee on Health Manpower, Planning Production and Management*. New Delhi: Ministry of Health and Family Welfare. Government of India.

Bajaj, J. L. (1992). *Externally Aided Projects and State Finances: State Finances in India*. New Delhi: Vikas Publishing House.

Banaji, J. and Mody, G. (2001). Corporate Governance & the Indian Private Sector. *QEH Working Paper Series*. No 73. Retrieved from http://eprints.soas.ac.uk/10919/1/qehwps73.pdf as accessed on 15th July 2014.

Banda, N. and Simukonda, H. (1994). The Public/private Mix in the Health Care System in Malawi. *Health Policy and Planning,* 9(1), 63–71.

Bandyopadhyay, D. (1996) Administration, Decentralisation and Good Governance. *Economic and Political Weekly*, 31(44), 3109–14.

Baru, R. (2006). Privatization of Health Care in India: A Comparative Analysis of Orissa, Karnataka and Maharashtra States. In Mehta, A.K., Sharma, P., Singh, S., Tiwari, R.K. and Panchmukhi, P. R. (Eds.), *Pro Poor Dimensions of Economic Reforms: Health, Agriculture, Services and Infrastructure*. Working Paper Series, New Delhi: Indian Institute of Public.

Baru, R. (2012). A Limiting Perspective on Universal Coverage. *Economic & Political Weekly*, XLVII (8), 64-66.

Baru, R. and Bisht, R. (2010). *Health Service Inequities as Challenge to Health Security*. Working Paper Series. New Delhi: Oxfam India and Institute for Human Development. Retrieved from http://www.ihdindia.org/IHD-

Oxfamworkingpaper-PDF/III.%20health _inequity.pdf as accessed on 14th July 2012.

Baru, R.; Qadeer, I. and Priya, R. (2000).Medical Industry: Illusion of Quality at What Cost? *Economic and Political Weekly*, 35(28/29), 2509–11.

Baviskar, B. S. (1969). Co-Operatives and Caste in Maharashtra: A Case Study. *Sociological Bulletin*, 18(2), 148-66.

Baziliana, M.; Nakhoodab, S. and Graaf, T. (2014). Energy Governance and Poverty. *Energy Research & Social Science*, 1, 217-225.

Berman, P., Ahuja, R., Tandon, A., Sparkes, S., & Gottret, P. (2010). *Government Health Financing In India: Challenges in Achieving Ambitious Goals*. Washington, DC: World Bank Human Nutrition and Population Discussion Paper, 59886.

Berman, Peter A. (1998). Rethinking Health Care Systems: Private Health Care Provision in India. *World Development*, 26(8), 1463-79.

Bert Hoffmann (2005). Global Health Governance: Conflicts on Global Social Rights. (Ed) German Overseas Institute (DÜI), Hamburg, Working Papers Global and Area Studies, No -7,

Bevir, M. (2009). *Key Concepts in Governance*. London: Sage Publication.

Bhore Committee (1946). *Report of the Health Survey and Development Committee*. Vol. I and IV. Delhi: Manager of Publications. Government of India.

Biersteker, T. (2009). Global Governance. In Myriam Dunn Cavelty and Victor Mauer (Eds.) *Routledge Companion to Security*. New York and London: Routledge Publishers.

Bingham, L. B., Nabatchi, T., and O'Leary, R. (2005). The New Governance: Practices and Processes For Stakeholder And Citizen Participation In The Work Of Government. *Public Administration Review*, 65(5), 547-558.

Birdi, T. J., Joshi, S., Kotian, S., & Shah, S. (2014). Possible Causes Of Malnutrition in Melghat: A Tribal Region of Maharashtra, India. *Global Journal of Health Science*, 6(5), 164.

Borrmann, A. (1999). Evaluating Development Co-Operation. *Inter-Economics*, 34(5), 255–59.

Bourgon, J. (2009). *New Governance and Public Administration: Towards a Dynamic Synthesis*. Australia: Centre for International Governance Innovation.

Bovaird, T. and Löffler, E. (2003). Evaluating the Quality of Public Governance: Indicators, Models and Methodologies. *International Review of Administrative Sciences*, 69 (3), 313–28.

Bradshaw, P. and Bryan, H. (2007). Non-profit Governance Models: Problems and Prospects. *The Innovation Journal: The Public Sector Innovation Journal*, 12(3), 1-22.

Brand, H. (2007). Good Governance for The Public's Health. *The European Journal of Public Health*, 17(6), 541-541.

Bridges, J. F. (2002). Stated Preference Methods in Health Care Evaluation: An Emerging Methodological Paradigm in Health Economics. *Applied Health Economics and Health Policy*, 2(4), 213–24.

Brinkerhoff, D. and Bossert, T. (2013). Health Governance: Principal–agent Linkages and Health System Strengthening. *Health Policy and Planning*, 29(6). 685.

Bryld, E. (2001). Increasing Participation in Democratic Institutions through Decentralization: Empowering Women and Scheduled Castes And Tribes Through Panchayat Raj In Rural India. *Democratization*, 8(3), 149–172.

Budhkar, U. (1996). Health Services Development: The Case of Maharashtra (Unpublished M.Phil dissertation). Jawaharlal Nehru University, New Delhi.

Cameron, W. (2004). Public Accountability: Effectiveness, Equity, Ethics. *Australian Journal of Public Administration*, 63(4), 59-67.

Caroline R. and Jose, R. (2008). *The Essential Public Health Functions as a Strategy for Improving Overall Health Systems Performance: Trends and Challenges since the Public Health in the Americas Initiative, 2000-2007*. Washington, DC: Pan American Health Organization/World Health Organization (PAHO/WHO). Retrieved from http://www1.paho.org/hq/dmdocuments/2008/EPHF_2000-2007.pdf as accessed on 15th September 2013.

Carver, J. (2001). A Theory of Governing the Public's Business: Redesigning The Jobs Of Boards, Councils, And Commissions. *Public Management Review*, 3(1), 53-72.

Central Bureau of Health Intelligence (2013). National Health Profile 2013. Directorate General of Health Services. New Delhi: Ministry of Health and Family Welfare.

Chadha Committee. (1963). *Report of the Special Committee on the Preparation for National Malaria Eradication Programme into the Maintenance Phase*, New Delhi: Ministry of Health and Family Welfare, Government of India.

Chand, M., & Puri, V. K. (1983). *Regional planning in India* (Vol. 1). Allied Publishers.

Chandra, S. (2008). *Introduction to Agricultural Extension: Rural Development Programme*. New Delhi: Indian Agricultural Research Institute. Retrieved from http://nsdl.niscair.res.in/jspui/bitstream/123456789/501/1/PDF%20Rural%20development%20programme.pdf as accessed on 22nd October 2013.

Cheema, G. S., & Rondinelli, D. A. (Eds.). (2007). *Decentralizing Governance: Emerging Concepts and Practices*. (pp.1-20) Brookings Institution Press. Retrieved from http://www.brookings.edu/~/media/press/books/2007/decentralizinggovernance/decentralizinggovernance_chapter.pdf as accessed on 15th May 2014.

Cheema, S. (2004). From Public Administration To Governance: The Paradigm Shift In The Link Between Government And Citizens. *6th Global Forum on Reinventing Government Towards Participatory and Transparent Governance*. 24 -27 May, 2005, Seoul, Republic of Korea

Chithelen, I. (1985). Origins of Co-operative Sugar Industry in Maharashtra. *Economic and Political Weekly,* XX(14), 604-612.

Chopra Committee. (1948). *Report of the Committee on Indigenous Systems of Medicine Technical Report.* New Delhi: Ministry of Health and Family Welfare, Government of India.

Christensen, T. and Laegreid, P. (1999). New Public Management: Design, Resistance, or Transformation? A Study of How Modern Reforms Are Received in a Civil Service System. *Public Productivity & Management Review*, 23(2), 169–193.

Conrad, D. A. and Shortell, S. M. (1996). Integrated Health Systems: Promise And Performance. *Frontiers of Health Services Management*, 13(1), 3.

Coskun, A. and Hayrettin OZLER (2008). Good Governance: A New Public Managerialism. *Review of International Law and Politics*, 4(14), 165-187.

Dahiwale, S. (1995). Consolidation of Maratha Dominance in Maharashtra. *Economic and Political Weekly*, 30(6), 336-342.

Das Gupta, M. and Rani, M. (2004). India's Public Health System: How Well Does It Function at the National Level? *World Bank Policy Research Working Paper*, (3447). Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=625325 as accessed on 13th July 2014.

Das, A. and Bhatia, P. (2006). *National Rural Health Mission A Promise Of Better Health Service For The Poor.* Advisory Group for Community Action. New Delhi: Population Foundation of India (PFI) and Centre for Health and Social Justice (CHSJ). pp-1-26

Dasgupta, R., & Qadeer, I. (2005). The National Rural Health Mission (NRHM): A Critical Overview. *Indian J Public Health*, 49(3), 138-40.

De Angelis, M. (2003). Neoliberal Governance, Reproduction and Accumulation. *The Commoner*, *7*, 1-28.

De Costa, A. and Diwan, V. (2007). Where Is the Public Health Sector? Public and Private Sector Healthcare Provision in Madhya Pradesh, India. *Health Policy*, 84(2), 269–76.

de Durand, E. T. (2016). Reframing The 'Rules Of The Game': Through Governance, Transparency And Fiscal Responsibility. *Journal of Public Governance and Policy: Latin American* Review, 1(2), 107–152.

DeLong, J. B. (2003). India Since Independence: An Analytic Growth Narrative. *In Search Of Prosperity: Analytic Narratives On Economic Growth*, 184-204.

Denhardt, J. V., & Denhardt, R. B. (2011). *The New Public Service: Serving, Not Steering*. New York: M. E. Sharpe.

Denhardt, R. B., & Denhardt, J. V. (2000). The New Public Service: Serving Rather Than Steering. *Public Administration Review*, 60(6), 549-559.

Devasia, L. (1998). Safe Drinking Water And Its Acquisition: Rural Women's Participation In Water Management in Maharashtra, India. *International Journal of Water Resources Development*, 14(4), 537–546.

Dindod, S. and Makwana, N. R. (2013) Knowledge of Members Regarding Village Health and Sanitation Committees (VHSC), *International Journal of Scientific Research*, 2(9), 331-332

DNA. (2014, May 1). What is the Samyukta Maharashtra Movement. *Daily News and Analysis* (Dainik Bhaskar Group). Retrieved from http://www.dnaindia.com/mumbai/report-what-is-the-samyukta-maharashtra-movement-1983811 as accessed on 19th May 2015.

Dodgson, R.; Lee, K. and Drager, N. (2002). *Global Health Governance: A Conceptual Review*, Discussion Paper, Geneva: World Health Organization and London School of Hygiene and Tropical Medicine. Retrieved from http://cgch.lshtm.ac.uk/globalhealthgovernance .pdf as accessed on 14th April 2013.s

Dongre, A. R., Deshmukh, P. R., & Garg, B. S. (2009). A Community Based Approach To Improve Health Care Seeking For Newborn Danger Signs In Rural Wardha, India. *The Indian Journal of Pediatrics*, 76(1), 45-50.

Douglas, Ian R (1999). Globalization as Governance toward an Archaeology of Contemporary Political Reason. In Aseem Prakash and Jeffrey A. Hart (Eds.). Globalization and *Governance*. (pp.135-160). New York: Routledge.

Drake, E., Malik, A.; Ying Xu, Kotsioni, I.; El-Habashy, R. and Misra, V. (2001). *Good Governance and the World Bank*. In Collingwood V. (Ed.). Nuffield College, University of Oxford. Retrieved from http://www.ucl.ac.uk/dpu-projects/drivers_urb_change/urb_economy/pdf_glob_SAP/BWP_Governance_World%20Bank.pdf as accessed on 27th April, 2014.

Duggal, R.; Dilip, T. R. and Raymus, P. (2005). *Health and Healthcare in Maharashtra: A Status Report*. Mumbai: Centre for Enquiry into Health and Allied Themes (CEHAT).

Eberlein, B., & Kerwer, D. (2002). Theorising The New Modes Of European Union Governance. *European Integration online Papers (EIoP)*, 6(5). Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=307521 as accessed on 29th June 2014.

ESTC (2005). *Health Research Data Processing, Analysis and Interpretation*. Training Module-3. Ethiopian Science and Technology Commission, Health Department, Ethiopian Public Health Association and Regional State Health Bureaus.

Fidler, D. P. (2001). The Globalization Of Public Health: The First 100 Years Of International Health Diplomacy. *Bulletin of the World Health Organization*, 79(9), 842-849.

Fidler, D. P. (2010). Asia's Participation In Global Health Diplomacy And Global Health Governance. *Asian J. WTO & Int'l Health L & Pol'y*, 5, 269-300.

Finkelstein, L. S. (1995). What Is Global Governance? *Global Governance*, 1(3), 367-372.

Fukuda-Parr, S. and Ponzio, R. (2002). Governance: Past, Present, Future Setting the Governance Agenda for the Millennium Declaration. Draft paper for Fourth Global Forum: *Dialogue and Partnerships for the Promotion of Democracy and Development* Morocco. (New York: United Nations Development Program).

Garg, P. K., Bhardwaj, A., Singh, A., & Ahluwalia, S. K. (2013). An Evaluation of Asha Worker's Awareness and Practice of Their Responsibilities in Rural Haryana. *National Journal of Community Medicine*, 4(1), 76-80.

Garg, S. and Laskar, A. (2010). Community-Based Monitoring: Key to Success Of National Health Programs. *Indian Journal of Community Medicine*, 35(2), 214.

George, A. and Nandraj S. (1993). State of Health Care in Maharashtra-A Comparative Analysis. *Economic and Political Weekly*, 28(32/33), 1671-1677.

Gill, K. (2009). *A Primary Evaluation of Service Delivery under the National Rural Health Mission (NRHM): Findings from a Study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan*. Working Paper 1/2009 PEO. New Delhi: Planning Commission of India, Government of India.

Goodsell, C. T. (2006). A New Vision for Public Administration. *Public Administration Review*, 66(4), 623–635.

Gopalan, S. S., Mohanty, S., & Das, A. (2012). Assessing Community Health Workers' Performance Motivation: A Mixed-Methods Approach On India's Accredited Social Health Activists (ASHA) Programme. *BMJ open*, 2(5), e001557.

Governance Handbook. (2002). *Excellence in Governance A Handbook for Health Board Trustees*. Government of Newfoundland and Labrador and Department of Health and Community Services. Retrieved from http://www.gov.nf.ca/publicat/excellence_health.pdf as accessed on 15th July 2013.

Government of India (nd). National Rural Health Mission: Meeting People's Health Needs In Rural Areas, Framework For Implementation: 2005-2012. New Delhi: Ministry of Health and Family Welfare. Retrieved from http://jknrhm.com/Guideline /Frame_Work.pdf as accessed on 13th December, 2014.

Government of India. (1981). Report of the Working Group on Health for All by 2000 A.D. New Delhi: Ministry of Health and Family Welfare, Planning Commission, Government of India.

Government of India. (2005). *Report of the National Commission on Microeconomics and Health*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Government of India. (2011). *The High Level Expert Group Report on Universal Health Coverage for India*. New Delhi: Planning Commission of India.

Government of Maharashtra (1984). *Report of the Fact Finding Committee on Regional Imbalance*. Bombay: Planning Department

Government of Maharashtra (2011, September 23) Maharashtra E-Governance Policy. (Marathi version) Retrieved from https://www.maharashtra.gov.in/PDF/e_governance_policy.pdf as assessed on 13th April 2013.

Government of Maharashtra (nd). *Health Status-Maharashtra*. Director HealtGeneral of Health Services, Maharashtra. Retrieved from http://hetv.org/pdf/maharashtra/maharashtra-health-status.pdf as accessed on 27th March 2015.

Government of Maharashtra. (2012). *Annual Plan 2012-13 and Five Year Plan 2012-17*. Mumbai: Planning Department, Government of Maharashtra.

Government of Maharashtra. (2013a). *Report of the High Level Committee on Balanced Regional Development Issues in Maharashtra*. Mumbai: Planning Department.

Government of Maharashtra. (2013b). *Status of e-Governance in Maharashtra*. Retrieved from https://www.maharashtra.gov.in/site/upload/WhatsNew/State%20of%20E-Governance%20in%20Maharashtra%20,%202013.pdf as Accessed on 14th September 2014.

Government of Maharashtra. (2015). *Economic Survey of Maharashtra 2014-2015*. Planning Department, Mumbai: Directorate of Economics and Statistics.

Govt. of India. (2013). Census of India 2011: Maharashtra Release of Provisional Population Totals Report. Maharashtra: Director of Census Operations. Retrieved form http://pibmumbai.gov.in/English/PDF/E2013_PR798.PDF access on march 2014 as accessed on 16th August 2015.

Graham, J., Bruce, A and Plumptre, T. (2003). Principles for Good Governance in the 21st Century. *Policy Brief*, No.15, Ottawa: Institute On Governance.

Gupte, M., Bandewar, S., and Pisal, H. (1997). Abortion Needs of Women in India: A Case Study Of Rural Maharashtra. *Reproductive Health Matters*, 5(9), 77-86.

Guy, P. and Pierre, J. (1998). Governance without Government? Rethinking Public Administration. *Journal of Public Administration Research and Theory*, 8(2), 223–43.

Haas, P. M., & Haas, E. B. (1995). Learning to Learn: Improving International Governance. *Global Governance*, 1(2), 255-285.

Hanberger, A. (2001). What Is the Policy Problem? Methodological Challenges in Policy Evaluation. *Evaluation*, 7(1), 45-62.

Harlow, C. (2006). Global Administrative Law: The Quest for Principles And Values. *European Journal of International Law*, 17(1), 187-214.

Harrison, G. (2005). The World Bank, Governance and Theories Of Political Action In Africa. *The British Journal of Politics and International Relations*, 7(2), 240-260.

Hartley, J. (2005). Innovation in Governance and Public Services: Past and Present. *Public Money and Management*, 25(1), 27–34.

Haruna, P. and Kannae, L. (2013). Connecting Good Governance Principles to the Public Affairs Curriculum: The Case of Ghana Institute of Management and Public Administration. *Journal of Public Affairs Education*, 19(3), 493-514.

Hill Carolyn, J. and Laurence, E. Lynn (2004a). Governance and Public Management: An Introduction. *Journal of Policy Analysis and Management*, 23(1), 3-11.

Hill, C. and Laurence E. Lynn (2004b). Is Hierarchical Governance In Decline? Evidence from Empirical Research. *Journal of Public Administration, Research and Theory*, 15(2), 173-195.

Hood, C. (1991). A Public Management for All Seasons? *Public Administration*, 69(1), 3-19.

Hood, C. (2004). The Middle Aging of New Public Management: Into the Age of Paradox? *Journal of Public Administration, Research and Theory* 14(3), 267–282.

Hufty, M., Báscolo, E., and Bazzani, R. (2006). Governance in Health: A Conceptual And Analytical Approach To Research. *Cadernos de Saúde Pública*, 22, S35-S45.

Hunt, A. (1996). *Governance of Cons Passion: A History of Sumptuary Law*. Basingstoke: Palgrave Macmillan. Retrieved from http://ezproxy.depaul.edu/login?url=http://depaullaw.eblib.com/patron/ FullRecord.aspx?p=1040524 as accessed on 15th April 2013.

IIPA. (2013). *India Governance Report 2013*. New Delhi: Indian Institute of Public Administration.

IMF. (1997). *Good Governance: The IMF'S Role*. Washington, DC: IMF

International Fund For Agricultural Development (IFAD) (1999). *Good Governance: An Overview*. IFAD Document. Executive Board-Sixty-Seventh Session, Rome, 8-9 September. Retrieved from http://www.ipa.government.bg/sites/default/files/pregled-dobro_upravlenie.pdf as accessed on 29th May 2015.

Isaac, T. T., & Harilal, K. N. (1997). Planning For Empowerment: People's Campaign for Decentralised Planning In Kerala. *Economic and Political Weekly*, 32(1-2), 53-58.

Islam, A., & Tahir, M. Z. (2002). Health Sector Reform In South Asia: New Challenges And Constraints. *Health policy*, 60(2), 151-169.

Jacob, K. S. (2011, August 10). For a New and Improved NRHM. *The Hindu*. Opinion. Retrieved from http://www.thehindu.com/opinion/lead/for-a-new-and-improved-nrhm/article2333819.ece as accessed on 16th June 2014.

Jadhav, R. (2010, April 30). Pune Pioneered Samyukta Maharashtra Movement. *The Times of India*. Pune. Retrieved from http://timesofindia.indiatimes.com/city/pune/Pune-pioneered-Samyukta-Maharashtra-movement/articleshow/5874479.cms as accessed on 10th May 2014.

Jain Committee. (1967). *Report of the Study Group on Medical Care Services*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Jain, M. L., Chauhan, M., Chhabra, R., Saxena, A., & Dhonkeriya, M. (2016). Review of Online Payment System-Asha Soft. *International Journal of Health Sciences and Research (IJHSR)*, 6(6), 314-319.

Joshi, A. (2007). Producing Social Accountability? The Impact of Service Delivery Reforms. *IDS Bulletin*, 38(6), 10-17.

Jungalwalla Committee (1967). *Report of the Committee on Integration of Health Services*. New Delhi: Directorate General of Health Services, Government of India.

Kalita, A., & Mondal, S. (2012). Role Of Innovative Institutional Structures In Integrated Governance: A Case Study Of Integrating Health And Nutrition Programs In Chhattisgarh, India. *Journal of health organization and management*, 26(6), 758-777.

Kalra, N. L. (1979). National Malaria Eradication Programme, India-Its Problems, Management And Research Needs. *Journal of Communicable Diseases*, 10(1), 1-20.

Kamat, S. (2004). The Privatization of Public Interest: Theorizing Ngo Discourse in a Neoliberal Era. *Review of International Political Economy*, 11(1), 155-176.

Kambli, R. (2013, January 8). Maharashtra Needs to Increase Proper Healthcare Infrastructure. *Indian Express*, Retrieved from http://healthcare.financialexpress.com/sections/market-section/1160-maharashtra-needs-to-increase-proper-healthcare-infrastructure as accessed on 14th April 2014.

Kamlakar S., Gauda, N., Nitin, A. and Malik, M. (2014). *Public Health Department of Maharashtra 'Bringing Value Based E-Governance In Practice*. Retrieved From https://it.maharashtra.gov.in/PDF/eGovernance%20in%20Public%20Health%20Dept.pdf accessed on 24th March 2014.

Karkal, M. (1982). Health For All: A Review And Critique Of Two Reports. *Economic and Political Weekly*, 17(7), 249-253.

Kartar Singh Committee. (1973). *Report of the Committee on Multipurpose Workers*. New Delhi: Ministry of Health and Family Planning Programme, Government of India.

Karunaratne, G. (1976). The Failure of the Community Development Programme in India. *Community Development Journal*, 11(2), 95-118.

Kearney, J., Berkes, F., Charles, A., Pinkerton, E., & Wiber, M. (2007). The Role of Participatory Governance and Community-Based Management In Integrated

Coastal And Ocean Management In Canada. *Coastal Management,* 35(1), 79-104.

Kersbergen, K.V. and Waarden, F. V. (2004). Governance a Bridge Between Disciplines: Cross-disciplinary Inspiration Regarding Shifts in Governance and Problems of Governability, Accountability and Legitimacy. *European Journal of Political Research*, 43(2), 143-171.

Keruwala, N. (2015 April). History of E-Governance in India and Maharashtra. Retrieved from http://netpehchaan.in/internet-inclusion/history-of-e-governance-in-india-and-maharashtra.html. As accessed on 10th July 2016.

Kickbusch, I and Behrendt, T. (2013). *Implementing a Health 2020 Vision: Governance For Health In The 21st Century. Making it Happen*. Copenhagen: World Health Organization Regional Office for Europe.

Kickbusch, I., & Gleicher, D. (2012). *Governance For Health In The 21st Century*. Geneva: World Health Organization.

Kickbusch, I., Hein, W. and Silberschmidt, G. (2010). Addressing Global Health Governance Challenges Through A New Mechanism: The Proposal For A Committee of the World Health Assembly. *The Journal of Law, Medicine & Ethics*, 38(3), 550–563.

Kielmann, K. (2002). Theorizing Health in the Context of Transition: The Dynamics of Perceived Morbidity among Women in Peri-Urban Maharashtra, India. *Medical Anthropology*, 21(2), 157–205.

Klijn, E. (2002). Governing Networks in the Hollow State: Contracting Out, Process Management or a Combination of The Two? *Public Management Review*, 4(2):149-165.

Klijn, E. H. (2012). New Public Management and Governance: A Comparison. In David Levi-Faur (Ed.). *The Oxford Handbook of Governance*. (pp. 201-214). United Kingdom: Oxford University Press.

Kulkani, R. and Maniam, B. (2014). Corporate Governance — Indian Perspective. *International Journal of Trade, Economics and Finance*, 5(4), 364-368.

Kulkarni, A., Kotwal, A., Hiremath, R. N., Verma, A. K., Bhalla, S., & Singh, H. (2014). Role of Government in Public Health Issues. *Journal of Scientific and Innovative Research*, 3(2), 244-250.

Kumar, A. (2001). Statehood for Vidarbha. *Economic and Political Weekly*, 36(50), 4614-4617.

Kumar, G. (2003). Promoting Public-Private Partnership in Health Services. *Economic and Political Weekly*, XXXVIII (29), 3041-3045.

Kumar, S., & Prakash, N. (2013). Impact of the Village Health And Sanitation Committee On Health-Care Utilization: Findings From Propensity Score Matching in India. *The Lancet*, 381, S77.

Kumara, M. A. S., & Handapangoda, W. S. (2008). New Public Management: The Level of Preparedness and Implementation-A Study based on the Sri Lankan Context. *JOAAG*, 3(2).

Kurian, N. J. (2000). Widening Regional Disparities in India: Some Indicators. *Economic and Political Weekly*, 35(7), 538-550.

La Forgia, G., and Nagpal, S. (2012). *Government-Sponsored Health Insurance in India: Are You Covered? Directions in Development*. Washington DC: World Bank.

Lakshminarayanan, S. (2011). Role Of Government In Public Health: Current Scenario In India And Future Scope. *Journal of Family and Community Medicine*, 18(1), 26.

Lapsley, I. (2008). The NPM Agenda: Back to the Future. *Financial Accountability & Management*, 24(1), 77–96.

Larbi, G. A. (2003). Overview of Public Sector Management Reform. *United Nations Research Institute For Social Development.* Discussion Paper-112. Retrieved from http://siteresources.worldbank.org/INTROADSHIGHWAYS/Resources/338993-1115316483571/3-public_sector_mgmnt_reform.pdf as accessed on 15th July 2014.

Lewis, M. (2006). Governance and Corruption in Public Health Care Systems. Working Paper, no. 78. Washington DC: Center for Global Development. Retrieved from http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=984046 as accessed on 18th July2014.

Loewenson, R., Flores, W., Shukla, A., Kagis, M., Baba, A., Ryklief, A., ... & Kakde, D. (2011). Raising the Profile Of Participatory Action Research At The 2010 Global Symposium On Health Systems Research. *MEDICC Review*, 13(3), 35-38.

Lovan, W. R.; Murray, M. and Shaffer, R. (Eds.). (2004). *Participatory Governance: Planning, Conflict Mediation and Public Decision Making in Civil Society*. Burlington VT: Ashgate Publishing, Ltd.

Lynn, Laurence E., Carolyn, J. Heinrich and Carolyn, J. Hill. (2000). Studying Governance and Public Management: Challenges and Prospects. J*ournal of Public Administration Research and Theory*, 10(2), 233-262.

Maldonado, N. (2010). The World Bank's Evolving Concept of Good Governance and Its Impact on Human Rights. Doctoral Workshop on Development and International Organizations, Stockholm, Sweden, (May 29-30, 2010). Retrieved from www2.warwick.ac.uk/.../doctoral_workshop.../maldonado_nicole_paper-final_ii.doc as accessed on 15th May 2014.

Malik, G. (2009). Role of Auxiliary Nurse Midwives In National Rural Health Mission. *Nurs J India*, 100(4), 88-90.

Mane, A. B. and Khandekar, S. V. (2014). Strengthening Primary Health Care through Asha Workers: A Novel Approach in India. *Primary Health Care*, 4(149), 2167-1079.

Mark, R. (2015). *From Old Public Administration to the New Public Service Implications for Public Sector Reform in Developing Countries*. UNDP. Singapore: Global Centre for Public Service Excellence.

McQueen, D. V. and Jones, C. M. (2007). Global Perspectives on Health Promotion Effectiveness. In McQueen, D. V. and Jones, C. M (Eds.). *Global Perspectives on Health Promotion Effectiveness*. (pp.3-11). New York: Springer Science.

Mehta Committee (1957). *Report of the Team for the Study of Community Projects and National Extension Service*. Committee on Plan Projects. New Delhi: Ministry of Health and Family Welfare, Government of India.

Mehta Committee. (1983). *Medical Education Review Committee*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Milward, B. and Provan. K. (2000). Governing the Hollow State. *Journal of Public Administration Research and Theory*, 10(2), 359-80.

Mishra, S.; Duggal, R.; Lingam, L. and Pitre, A. (2008). *A Report on Health Inequities in Maharashtra*. Pune: Support for Advocacy and Training into Health Initiatives (SATHI).

Mitra, S. K. 2006. The Puzzle of India's Governance: Culture, Context and Comparative Theory. Vol. 3. Psychology Press.

Mohanty, B. (2009). Regional Disparity in Agricultural Development in Maharashtra. *Economic and Political Weekly*, 44(6), 63-69

Mohanty, P. K. and Parigi, V.K. (2004). *Inter-State Study on Rural Decentralization*. Hyderabad: Center for Good Governance.

Mudaliar Committee. (1961). *Report of the Health Survey and Planning Committee*. Government of India. Delhi: Manager of publications.

Mukerji Committee. (1966). *Committee on Basic Health Services*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Mukherjee Committee. (1966). *Committee to Review Staffing Pattern and Financial Provision under Family Planning Programme,* New Delhi: Ministry of Health and Family Welfare, Government of India.

Mukundan, M. V., & Bray, M. (2006). The Decentralisation of Education In Kerala State, India: Rhetoric And Reality. In Zajda J. (Ed.). *Decentralisation and Privatisation in Education.* (pp. 111-131). Netherlands: Springer.

Mushtaq, M. U. (2009). Public Health in British India: A Brief Account Of The History Of Medical Services And Disease Prevention In Colonial India. *Indian Journal of Community Medicine*, 34(1), 6.

Nambiar, D. (2013). India's "Tryst" With Universal Health Coverage: Reflections On Ethnography In Indian Health Policymaking. *Social Science & Medicine*, 99, 135-142.

Nandan, D. (2008). *Rapid Appraisal Of Functioning Of Village Health And Sanitation Committees (VHSCS) Under NRHM In Orissa*. New Delhi: National Institute of Health & Family Welfare.

Nandraj, S., & Duggal, R. (1996). Physical Standards In The Private Health Sector. *Radical Journal of Health*, 2(2/3), 141–84.

Navarro, V. (2009). What We Mean By Social Determinants Of Health. *International Journal of Health Services*, 39(3), 423-441.

Nettl, J. P. (1968). The State as a Conceptual Variable. *World Politics*, 20(4), 559-592.

NHSRC. (2012). *NRHM in the Eleventh Five Year Plan (2007-2012)*. New Delhi: National Health Systems Resource Centre. Retrieved from http://nhsrcindia.org/pdf_files/NRHM_Eleventh_Five_Year_Plan.pdf as accessed on 25th December 2014.

Oakes, Graham (2011, August 19). Governance: Nine Steps to Good Decision Making. *Econsultancy*. Retrieved from https://econsultancy.com/blog/7891-governance-9-steps-to-good-decision-making/ as accessed on 25th April 2013.

Orr, R. (2002). Governing When Chaos Rules: Enhancing Governance And Participation. *Washington Quarterly*, 25(4), 139-152.

Osborne, D. (1993). Reinventing Government. *Leadership Abstracts*, 6(1), 1-3. Retrieved from http://files.eric.ed.gov/fulltext/ED367424.pdf as accessed on 12th Feb 2013.

Osborne, D. (2007, June 26-29). Reinventing Government: What a Difference a Strategy Makes. In *7th Global Forum on Reinventing Government: Building Trust in Government* (pp. 26-27). Vienna, Austria

Osborne, S. P. (Ed.). (2010). *The New Public Governance: Emerging Perspectives On The Theory And Practice Of Public Governance*. London: Routledge.

Ottaway, M. (2002). Rebuilding State Institutions in Collapsed States. *Development and Change*, 33(5), 1001–23.

Palshikar, S. and Deshpande, R. (1999). Electoral Competition and Structures of Domination in Maharashtra. *Economic and Political Weekly*, 34(34-35), 2409–2422.

Pande, S. and Kaushik K. (2012). *Study on the State of Corporate Governance in India: Evolution Issues and Future*. New Delhi: Thought Arbitrage Research Institute, Indian Institute of Corporate Affairs and Indian Institute of Management Calcutta.

Paranjape, M. S. (2007). Uneven Distribution of Education in Maharashtra: Rural-Urban, Gender and Caste Inequalities. *Economic and Political Weekly*, 42(3), 213–216.

Parija, Elisa (Ed.). (2010). *National Dissemination Meeting: Community Monitoring Under National Rural Health Mission (NRHM)* (A Report). New Delhi: CHSJ, NRHM and PFI.

Park, K. (2009). School Health Service. In *Park's Textbook of Preventive and Social Medicine* (20 th ed). (pp. 498-501). Jabalpur: M/s Banarsidas Bhanot.

Patel, V., Parikh, R., Nandraj, S., Balasubramaniam, P., Narayan, K., Paul, V. K.,& Reddy, K. S. (2015). Assuring Health Coverage For All In India. *The Lancet*, 386(10011), 2422-2435.

Patro, B. C. (2014). Effective RCH Programme: A Key-Solution to the Spillover Population of India. *Health and Population-Perspectives and Issues*, 37(1-2), 15-26.

Peters, D. H. and Muraleedharan, V. R. (2008). Regulating India's Health Services: To What End? What Future?. *Social Science & Medicine*, 66(10), 2133-2144.

Pfiffner J.P. (2004), Traditional Public Administration versus The New Public Management: Accountability versus Efficiency. In sA. Benz, H. Siedentopf, and K.P. Sommermann (Eds.). *Institutionenbildung in Regierung und Verwaltung: Festschrift fur Klaus Konig*. (pp. 443-454). Berlin : Duncker & Humbolt. Retrieved from http://pfiffner.gmu.edu/files/pdfs/Book_Chapters/NewPublicMgt.doc.pdf as accessed on 15th May 2015.

Phadke, A. (2011). Planning Healthcare for All? *Economic & Political Weekly*, 46(21).

Phansalkar, S. J. (2005). Political Economy of Irrigation Development in Vidarbha. *Journal of Indian School of Political Economy*, 17(4), 605-632.

Planning Commission. (2013). *Twelfth Five Year Plan (2012–2017) Social Sectors. (Volume III)*, New Delhi: SAGE Publications India.

Pollitt, C. (1994). The Citizen's Charter: A Preliminary Analysis. *Public Money & Management*, 14(2), 9-14.

Pollitt, C. and Bouckaert, G. (2004). *Public Management Reform: A Comparative Analysis*. USA: Oxford University Press.

Priya, R. (2005). Public Health Services in India: A Historical Perspective. In Gangolli, L.; Duggal, R. and Shukla, A. (Eds.).*Review of Health Care In India*. (pp.41-74). Mumbai: CEHAT.

Priya, R. (2011). UAHC with 'Community Participation' Or 'People Centre-stage'? Implications for Governance, Provisioning and Financing. *MFC Bulletin*, 345-347, pp. 9-15. Retrieved from http://www.mfcindia.org/mfcpdfs/MFC345-347.pdf as accessed on 15th April 2013.

Purohit, B. C. (2001). Private Initiatives And Policy Options: Recent Health System Experience in India. *Health Policy And Planning*, 16(1), 87-97.

Qadeer, I. (2011). The Challenge of Building Rural Health Services. *The Indian Journal Of Medical Research*, 134(5), 591.

Raghavan, G. N. (2004). New Public Management: Chennai. New Delhi: Centre for Civil Society Research Internship Paper, 1-30.

Raju, C. U. K., Subramanyam, M., & Dasaraju, H. (2012). Emergence of Corporate Governance In India. *EXCEL International Journal of Multidisciplinary Management Studies*, *2*(5), 74-90.

Rath, P. (2014). *Transparency and Accountability in the Social Sector: Pedagogy, Theory of Change and Showcasing Key Success Stories* (Conference Report) (pp. 1–50). Pune: National Centre for Advocacy Studies, National Foundation of India and Centre for Budget and Governance Accountability.

Renuka Roy Committee. (1960). *Committee on School Health*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Rhodes, R. A. (1997). *Understanding Governance: Policy Networks, Governance, Reflexivity And Accountability*. Buckingham, Philadephia: Open University Press.

Rhodes, R. A. W. (1996). The New Governance: Governing Without Government. *Political Studies*, *44*(4), 652-667.

Risse, T. (Ed.) (2013). *Governance without a State? Policies and Politics in Areas of Limited Statehood*. New York: Columbia University Press.

Rodrik, D. (1997). Has Globalization Gone Too Far? *California Management Review*, 39(3), 29-53.

Rudramoorthy, B. (1964). Extension in Planned Social Change, the Indian Experience. Retrieved from http://eric.ed.gov/?id=ED022120 as accessed on 23rd July 2014.

Ruhanen, L., Scott, N., Ritchie, B., & Tkaczynski, A. (2010). Governance: A Review and Synthesis Of The Literature. *Tourism Review*, 65(4), 4-16.

Ruttan, V. W. (1984). Integrated Rural Development Programmes: A historical Perspective. *World Development*, 12(4), 393-401.

Sah, P. K., Raut, A. V., Maliye, C. H., Gupta, S. S., Mehendale, A. M., Garg, B. S., & Sewagram, W. (2013). Performance Of Village Health, Nutrition And Sanitation Committee: A Qualitative Study From Rural Wardha, Maharashtra. *Health*, 1(4), 112-117.

Sampath, G. (2015, July 6) Why Everyone Loves 'good Governance. *The Hindu*. Opinion. Retrieved from http://www.thehindu.com/opinion/op-ed/comment-g-sampath-on-modi-government-why-everyone-loves-good-governance/article7389373.ece as accessed on 16th June 2016.

Sangita, S. (2007). Decentralization For Good Governance And Service Delivery In India: Theory and Practice. *The Indian Journal of Political Science*, LXVIII (3), 447-464.

Santiso, C. (2001). Good Governance and Aid Effectiveness: The World Bank and Conditionality. *The Georgetown Public Policy Review*, 7(1), 1-22.

Santiso, C. (2002). Promoting Democratic Governance and Preventing the Recurrence Of Conflict: The Role Of The United Nations Development Programme In Post-Conflict Peace-Building. *Journal of Latin American Studies*, 34(03), 555-586.

Sarma, A. (2013). The National Rural Health Mission: An Ailing Initiative? *Asian Journal of Research in Business Economics and Management*, 3(7), 221.

Sawant, S. D., Kulkarni, B. N., Achuthan, C. V., and Satyasai, K. J. S. (1999). *Agricultural Development in Maharashtra Problems and Prospects*. Occasional Paper-7. Mumbai: National Bank for Agriculture and Rural Development (NABARD).

Schoenfeld, B. N. (1965). The Birth of India's Samyukta Socialist Party. *Pacific Affairs*, 38(3/4), 245-268.

Selsky, J. W., & Parker, B. (2005). Cross-Sector Partnerships to Address Social Issues: Challenges To Theory And Practice. *Journal of Management*, 31(6), 849-873.

Semwal, V., Jha, S. K., Rawat, C. M. S., Kumar, S., & Kaur, A. (2013). Assessment Of Village Health Sanitation And Nutrition Committee Under NRHM In Nainital District Of Uttarakhand. *Indian Journal of Community Health*, 25(4), 472-479.

Sen, G. (2012). Universal Health Coverage in India: A Long and Winding Road. *Economic & Political Weekly*, XLVII (8), 45-52.

Shukla, A. (2010). Increasing Accountability Among Providers And Improving Access And Quality Of Services – An Experience of Maharashtra. In Parija, Elisa (Ed.). National Dissemination Meeting: Community Monitoring Under National Rural Health Mission (NRHM). New Delhi: CHSJ, NRHM and PFI.

Shukla, A. (2013). People Reclaiming the Public Health System: Community-Based Monitoring and Planning in Maharashtra. *Social Change*, 43(2), 311–19.

Shukla, A. and Sinha, S. (2014). Reclaiming Public Health through Community-Based Monitoring: The Case of Maharashtra, India. Occasional Paper No. 27. Support for Advocacy and Training to Health Initiatives (SATHI). Municipal Services Project Retrieved from http://www.sathicehat.org/images/msp-paper.pdf. As accessed on 13th May 2015.

Shukla, A., Khanna, R. and Jadhav, N. (2014). Using Community-Based Evidence for Decentralized Health Planning: Insights from Maharashtra, India. *Health Policy and Planning*, 1-12. Retrieved from http://heapol.oxfordjournals .org/content/early/ 2014/09/21/heapol.czu099.full.pdf+html as accessed on 17th July 2015.

Shukla, A., Phadke, A. and Gaitonde, R. (2011). Towards Universal Access to Health Care in India: Concept Note for Medico Friend Circle, Annual Meet 2011. *Medico Friend Circle Bulletin*, 342- 344,

Shukla, A., Saha, S., Jadhav, N. (2013). Community Based Monitoring and Planning in Maharashtra-A Case Study. SATHI, India and COPASAH

Shukla, A.; Kakade, D. and Scott, K. (2011). Community Monitoring of Rural Health Services in Maharashtra. *Economic & Political Weekly*, 46 (30), 79.

Shukla, M., and Johnson Lassner, K. (2012). Governing for Better Health: A Targeted Literature Review. *Prepared for the US Agency for International Development (USAID) by the USAID Leadership, Management and Governance Project.* Arlington, VA: Management Sciences for Health.

Siddiqi, S.; Masud, T.; Nishtar, S.; Peters, D.; Sabri, B.; Bile, K. and Jama, M. (2009). Framework for Assessing Governance of the Health System in Developing Countries: Gateway to Good Governance. *Health Policy*, 90(1), 13-25.

Sigamani, P. (2011). *The New Public Management in Healthcare: A Case Study of Tamil Nadu Medical Services Corporation Limited in Vellore District*. (Unpublished Doctoral Thesis), Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, India.

Simms, C. (2008). Good Governance at the World Bank. *The Lancet*, 371(9608), 202-203.

Singh, K. (1973). Report of the Committee on Multipurpose Workers under Health and Family Planning Programme. *New Delhi, Government of India, Ministry of Health and Family Planning*, 21.

Singh, M., Kandpal, S. D., Negi, K. S., & Shikha, D. (2011). An Assessment of Performance Based Incentive System of Asha in Doiwala Block, District Dehradun. *Indian J Prev Soc Med*, 42(4), 399-02.

Singh, P. V., Tatambhotla, A., Kalvakuntla, R. R., & Chokshi, M. (2012). Replicating Tamil Nadu's Drug Procurement Model. *Economic & Political Weekly*, 47(39), 27.

Singh, S. (2008). National Rural Health Mission. *Rural Infrastructure: Sanitation, Housing, Health Care*, 213.

Sokhey Committee. (1948). *National Planning Committee Series (Report of the Sub-committee). National Health Report*. Bombay: Vora.

Srivastava Committee. (1975). *Health Services and Medical Education A Programme For Immediate Action. A Report of The group of Medical Education and Support Manpower*. New Delhi: Ministry of Health and Family, Planning Programme, Government of India

Srivastava, M. (2009). Good Governance-Concept, Meaning and Features: A Detailed Study. (December 26, 2009). Retrieved from http://papers.ssrn.com/sol3/papers.cfm? abstract_id=1528449 as accessed on 14th July 2013.s

Srivatsan, R., & Shatrugna, V. (2012). Political Challenges to Universal Access To Healthcare. *Economic and Political Weekly*, 47(8), 61-63.

Tandon, R. and Mohanty, R. (2002). *Civil Society and Governance*. New Delhi: Saṁskṛiti.

Tandon, R. and Mohanty, R. (2003). *Does Civil Society Matter? Governance in Contemporary India*. New Delhi: Sage publication.

Taylor, A. L. (2002). Global Governance, International Health Law And Who: Looking Towards The Future. *Bulletin of the World Health Organization*, 80(12), 975-980.

Thakare, A. N. (2015). Linguistic States and Formation of Samyukta Maharashtra. *IOSR Journal Of Humanities And Social Science*, 20(12), 80-82.

The Economic Weekly (1955). Reorganisation of States the Approach and Arrangements. *The sEconomic Weekly*. Retrieved from http://www.epw.in/system/files/pdf/1955_7/42/ reorganisation_of_statesthe _approach_and_arrangements.pdf as accessed on 28th July 2015.

Travis, P., Egger, D., Davies, P., and Mechbal, A. (2002). *Towards Better Stewardship: Concepts and Critical Issues*. (1-19). Geneva: World Health Organization.

UN. (2006). *Definition of Basic Concepts and Terminologies in Governance and Public Administration*. Committee of Experts on Public Administration, Fifth Session. New York: Economic and Social Council, UN. Retrieved from http://unpan1.un.org/intradoc /groups/public/documents/un/unpan022332.pdf as accessed on 15th May 2014.

UNDP (1997). *Governance for Sustainable Human Development: A UNDP Policy Document*. United Nations Development Programme.

United Nations Development Programme (2004). *Transparency and Accountability In The Public Sector In The Arab Region*. New York: UNDP

USAID (2008). Role of Village Health Committees in Improving Health and Nutrition Outcomes: A Review of Evidence from India. *Evidence Review Series*-4. Retrieved from http://www.intrahealth.org/files/media/role-of-village-health-committees-in-improving-health-and-nutrition-outcomes-a-review-of-evidence-from-india-/ER_Brief_VHC%204.pdf as accessed on 23rd May 2014.

Vanamore, H. S. (2013). *Geographical Personality of Maharashtra*, (Chapter III). Retrieved from http://shodhganga.inflibnet.ac.in as accessed on 17th July 2014

Vandeplas, A., Minten, B., & Swinnen, J. (2013). Multinationals vs. Cooperatives: the Income and Efficiency Effects of Supply Chain Governance in India. *Journal of Agricultural Economics*, 64(1), 217-244.

Veillard, J. H. M., Brown, A. D., Barış, E., Permanand, G., and Klazinga, N. S. (2011). Health System Stewardship of National Health Ministries in The Who European Region: Concepts, Functions And Assessment Framework. *Health Policy*, 103(2), 191-199.

Voxted, S., & Lind, J. (2010). New Principles of Management in Modern Organizations. In *IIRA, European Conference*. Retrieved from http://faos. ku.dk/pdf/iirakongres2010/track2/63 .pdf. As accessed on 1st August 2014.

Vyas, D. (2010). Corporate Governance: Issues and Concerns. *Corporate Governance: Issues and Concerns.* (February 17, 2010). Retrieved from http://papers. ssrn.com/sol3/papers. cfm?abstract_id=1554243 as accessed on 15th July 2015.

Weiss, T. G. (2000). Governance, Good Governance and Global Governance: Conceptual And Actual Challenges. *Third world quarterly*, 21(5), 795-814.

Westmeyer, P. (1990). *Principles of Governance and Administration in Higher Education*. Springfield, IL: Charles C. Thomas Publisher.

WHO (2010). *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: World Health Organization.

WHO, (2000). *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: World Health Organization. Retrieved From http://www.who. int/whr/2000/en/ whr00_en.pdf As accessed on 15th May 2014.

WHO, (2007). *Everybody's Business–Strengthening Health Systems to Improve Health Outcomes:* WHO's Framework for Action. Geneva: World Health Organization Retrieved from http://www.who.int/healthsystems/strategy/everybodys _business.pdf as accessed on 15th May 2014.

WHO. (2001). Report on WHO Meeting of Experts on The Stewardship Function In Health Systems. Meeting on the Stewardship Function in Health Systems, Geneva: WHO

William, J.; Mishra, U. and Navaneetham, K. (2008). Health Inequality in India: Evidence from NFHS-3. *Economic & Political Weekly*, 43(31), 41-47.

World Bank (2013). What is Governance? Retrieved from http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/MENAEXT/ EXTMNAREGTOPGOVERNANCE/0,,print:Y~isCURL:Y~contentMDK:2051 3159~pagePK:34004173~piPK:34003707~theSitePK:497024,00.html as accessed on 13th July 2015.

World Bank. (1992). *Governance and Development*. Washington DC: The World Bank

World Bank. (1994). *Governance-the World Bank's Experience*. Washington DC: The World Bank.

Yashwantrao Chavan Academy of Development Administration (Yashada) (2009). *Impact of Social Accountability Mechanisms on Service Delivery and Human Development Outcomes in Satara District of Maharashtra*. Paper presented in conference held in Jaipur on 16th December 2009.

Website

E-Gov. Feature News. Maharashtra is One of the Pioneer States. Retrieved From http://egov.eletsonline.com/2012/04/maharashtra-is-one-of-the-pioneer-states/#sthash.IJxXwDz7.dpuf as accessed on 22nd July 2013.

Government of Maharashtra (2006, December 6). Water and Sanitation Department. Mumbai: Mantralay. Government Resolution on Structural Framework of NRHM. Retrieved from http://www.cbmpmaharashtra.org/cbmdata/GR/Gram%20aarogya%20swachhta%20samitee.pdf as accessed on 6th May 2013.

Health Education to Villages website as retrieved form http://hetv.org/india/mh/ healthstatus /index.html as accessed on 28th March 2015

Introduction to Agriculture Extension - NISCAIR, Retrieved from http://nsdl.niscair.res.in/jspui/ bitstream/123456789/501/1/PDF%20Rural%20develop as accessed on 24th June 2016).

Maharashtra PIP (2008-09). National Health Mission, MOH&FW, GOI. NHM in State: State Program Implementation Plans (PIPs): Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013.

Maharashtra PIP (2009-10). National Health Mission, MOH&FW, GOI. NHM in State: State Program Implementation Plans (PIPs): Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013

Maharashtra PIP (2010-11). National Health Mission, MOH&FW, GOI. NHM in State: State Program Implementation Plans (PIPs): Maharashtra. Retrieved from.

http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013

Maharashtra PIP (2011-12). National Health Mission, MOH&FW, GOI. NHM in State: State Program Implementation Plans (PIPs): Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013.

Maharashtra PIP (2012-13). National Health Mission, MOH&FW, GOI. NHM in State: State Program Implementation Plans (PIPs): Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013

Map of Maharashtra- Retrieved from http://upload.wikimedia.org/wikipedia /commons/5/5f/ Maharashtra_Divisions_Eng.svg as accessed on 14th December 2014.

National Health Mission Website (2014 August, 11). Retrieved from http://nrhm.gov.in/communitisation/rogi-kalyan-samities/basic-structure.html as accessed on 20th October 2014.

National Health Mission, MOH&FW, GOI, State Wise Information: Maharashtra. Retrieved from http://nrhm.gov.in/nrhm-in-state/state-wise-information/ maharashtra.html# organogram as accessed on 30th August 2013.

National Health Mission, MOH&FW, GOI. Communitisation: Village Health Sanitation & Nutrition Committee (VHSNC) -Retrieved from http://nrhm.gov.in/communitisation/village-health-sanitation-nutrition-committee.html 8th July 2012.

National Health Mission, MOH&FW, GOI. NHM in State : State Program Implementation Plans (PIPs) : Maharashtra. Retrieved from. http://nrhm.gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/maharashtra.html as accessed on 30th August 2013.

National Health Mission, MOH&FW, GOI. NHM in State : State Program Implementation Plans (PIPs) : Maharashtra 2008-09. Retrieved from. http://nrhm .gov.in/index.php/nrhm-in-state/state-program-implementation-plans-pips/ maharashtra.html as accessed on 30th August 2013

National Health Mission, State Health Society: Maharashtra Website. https://www.nrhm.maharashtra.gov.in/history.htm as accessed on 30th August 2013.

Priyadarshini, C. (26th June 2015). Health Committee Reports. Retrived from http://www.authorstream.com/Presentation/cpdarshini-1309376-19-8committee-reports/ as accessed on 26th June 2015

Shib Sekhar Datta (2008, February 7) Village Health and Sanitation Committee (VHSNC) under NRHM. Seminar PPT, Retrieved from https://pglibrary-public**health**.wikispaces .com/file/view/**VHSC**.ppt as accessed on 17th May 2015.

The Community Development Programme of India. Retrieved from http://www.yourarticlelibrary.com/india-2/the-community-development-programme-of as accessed on 24th June 2016.

The information is available on Shodhganga website but full reference could not be obtained. The name of the chapter is *Introduction*. Retrieved from http://shodh.inflibnet.ac.in/bitstream/123456789/1667/2/02 _ introduction.pdf as accessed on 15th June 2016.

The meaning of the term "transition" referred from online oxford dictionary. Retrieved from http://www.oxforddictionaries.com/definition/english/transition access in 25th Jan 2016.

Webster's Third New International Dictionary (1986). This definition is cited in concept note on governance titled *Understanding the Concept of Governance.* as retrieved from http://www.gdrc.org/u-gov/governance-understand.html as accessed on 15th May 2014

WHO. Health Systems Strengthening Glossary. http://www.who.int/healthsystems/hss_glossary /en/index5.html as accessed on 13th June 13, 2016.

Annexures

Annexure - I

Siddiqi et al. framework

Analytical framework for assessing health system governance

Principle	Domains	Assessment level	Broad questions
Strategic vision	Long-term vision; comprehensive development strategy including health	National	What are the broad outlines of economic the policy of the government? Has health been recognized as a basic human right in the constitution of the country? What is the importance of heath in the overall development framework? How does health rank in priority in the overall development and plan of the country? What is the state's responsibility in the provision of health care and health?
		Health policy formulation	Is there a long-term vision and policy for health? Is there a national health policy/strategic plan stating objectives to be achieved with time frame and resources?
		Policy implementation	Are the implementation mechanisms in line with the stated objectives of health policy? What is the extent of implementation of the health policy?
Participation and consensus orientation	Participation in decision-making process; stakeholder identification and voice	National	Are the private sector, civil society, line departments and other stakeholders consulted in decision-making? How are decisions related to health finalized—cabinet, parliament, head of government or state?
		Health policy formulation	How are the inputs solicited from stakeholders for health policy? How does government reconcile the different objectives of various stakeholders in health decision-making? Are other state ministries involved in by the MoH in policies and programs to tackle health determinants?
		Policy implementation	What is the level of decentralization in decision-making? What is the extent of community participation in health services provision?
Rule of law	Legislative process; interpretation of legislation to regulation and policy; enforcement of laws, and regulations	National	Who initiates or where are initiated laws relevant to health? Are laws/regulations related health service provision, infrastructure, technology, human resources, pharmaceuticals in place? How are the laws translated into rules, regulations, and procedures?
		Health policy formulation	Is the MoH consulted for laws/regulations which relate to health? Does the MoH consult other line departments for laws/regulations pertaining to health? What is the relationship of MoH to the regulating bodies? What is the capacity of MoH for contracting, regulating, accrediting, licensing?

Principle	Domains	Assessment level	Broad questions
Transparency	Transparency in decision-making; transparency in allocation of resources	Policy implementation	What procedures are in place for redressing grievances of (a) consumers, (b) contractors? How are the relevant laws enforced? Are tools/instruments for various functions like accreditation, regulation, licensing for health related activities available and how are they enforced/used?
		National	Is information about financial and administrative procedures readily available? How transparent is the process of resource allocation?
		Health policy formulation	Are there monitoring mechanisms in place to ensure transparency of decisions? Who is involved in monitoring of the health services?
		Policy implementation	How are the district managers appointed/transferred? How soon is information from the financial audit available after the funds are disbursed?
Responsiveness of institutions	Response to population health needs; response to regional local health needs	National	Are health subsidies targeted? What is the targeting mechanism? Is needs assessment conducted as part of the policy process?
		Health policy formulation	Does the health policy address the health needs/burden of the local populations? Is the quality of health services and user satisfaction valued high by the MoH
		Policy implementation	How does the health system respond to regional/local priority health problems? How responsive are the health services to the medical and non-medical expectations of the population?
Equity	Equity in access to care; fair financing of health care; disparities in health	National	Are there any social protection schemes in place to address financial barriers for the poor?
		Health policy formulation	What policies are in place for identifying issues of equity in provision and financing of health services and rectifying them?
		Policy implementation	What are the differences in access to care by residence, income, gender, ethnicity, religion and others? Is allocation of public sector resources by states, provinces, districts equitable?
Effectiveness and efficiency	Quality of human resources; communication processes; capacity for implementation	National	What is the turnover/tenure of the leadership at the MoH? What is the quality of bureaucracy, technocracy (training, qualifications, career development)?
		Health policy formulation	How efficient and up to date are the communication processes at the MoH; extent, form, filing, timeliness? Is there an in-service training program for staff?

Principle	Domains	Assessment level	Broad questions
Accountability	Accountability: internal; accountability: external	Policy implementation	What is the capacity of MoH for implementation measured in terms of regulatory, monitoring, financial and human resource management? What is the level of utilization of services? Is there an in-service training program for staff? Are job descriptions available and followed by staff?
		National	What is the role of the press/media? What is the role of elected bodies (legislature)? What is the role of judicial system?
		Health policy formulation	Are mechanisms for overseeing adherence to financial, administrative rules in place?
		Policy implementation	What evidence is present about the effective enforcement of accountability processes?
Intelligence, information	Information: generation, collection, analysis, dissemination	National	What information is available about the health system and health in the country and how accessible is it? What is the reliability of information available for development of policies?
		Health policy formulation	What evidence is there for the use of information in the decision-making process?
		Policy implementation	How is the relevant information about health generated? How is implementation of health policies monitored?
Ethics	Principles of bioethics; health care and research ethics	National	What is the importance attached to ethics in research and services?
		Health policy formulation	What principles of bioethics are included in national health policy? Is there a policy on promoting ethics in health care and research?
		Policy implementation	What are the institutional mechanisms to promote and enforce high-ethical standards in health research and health care?

Source - Siddiqi, et al. (2009) pp 20-22

Annexure – II

Respondents Profile

At the village level, interviews were held with ASHA workers. In non-CBM, PHCs interviews of six ASHA were conducted. In CBM-PHC a group discussion was held with ten ASHAs. ANMS were also interviewed, of which two were from non-CBM PHCs and four were from the CBM-PHCs. Interviews were also held with Medical Officers of both the CBM and non-CBM PHCs. Administrative officer of the non-CBM PHC was also interviewed. Health workers such as MPWs were also interviewed. Three interviews of the MPWs were conducted. Two were from non-CBM PHCs and one from CBM-PHC. Six interviews were held with the Anganwadi workers, three each from CBM and non-CBM PHCs. RKS members were interviewed four from CBM-PHCs and three from Non-CBM-PHCs.

Panchayati Raj officials were also interviewed at the village level. This included Sarpanch, Gram Sevak and other panchayats members. Such as 3 Women and 2 men Sarpanchs. Two gram sevaks were interviewed one each at the CBM-PHC and non-CBM PHC. Civil Society Members such as the self-help group's members, nine interviews were conducted. These members had the contract of cooking food under the Integrated Child Development Scheme (ICDS) and Mid-Day Meal (MDM) schemes at the village level. VHSC members were also interviewed, 10 members from Non CBM and 11 from CBM study area. Interviews were also held of the block level officials such as Taluka Medical Officer (one), Administrative Officer of NRHM block office at Purandhar (one), RKS members (three) at the rural hospital, administrative officer of the Rural Hospital, Saswad in Purandhar block of Pune district. Three members of the Panchayat Samiti at the block were also interviewed. One of them was a woman member. At the block level three interviews were held with the civil society organization. This included one woman and two men.

At the district level, interview of one District Programme Manager was conducted. Two interviews were also held of Zilla Parishads members at the district level. One member of the civil society organization working as a District Coordinator for CBM was also interviewed. At the state level two interviews were conducted. One included the State Programme Manager-NRHM and another was the head of State Health Society under NRHM. Interviews were also held of state programme coordinators and health activists associated with civil society organizations in Pune. Two interviews were also conducted with media reporters who had been involved in reporting about NRHM issues.