



Case Study

Inclusive Governance and National Rural Health Mission: A Case study of Pulwama (J&K)

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Abstract

Background: Inclusive governance signifies both processes and outcomes in developmental strategies across the world. More inclusive states are more prosperous, influential, and vibrant. Process-based inclusion refers to the decision and policy-making processes and how, why, and whose voices are considered. Outcome-based inclusion refers to the disbursement of developmental outcomes. One of the government's programs that it has launched is the National Rural Health Mission (NRHM). This programme is functional all over the Union Territory of Jammu and Kashmir. District Pulwama is part of this region. **Objectives:** whether this programme meets the area-specific needs and whether there is a need for any modification in the healthcare administration to make the programme more inclusive and efficient. **Methods:** Sampling, literature review, interviews, questionnaires, and focused group discussions are employed. The sample size of participants is one hundred, including doctors, patients, common citizens, paramedical staff and administrators. **Results:** Results were drawn which showed that the strategic convergence of healthcare and other related programs from village level upwards, context-specific alterations, and workable resources allocation elevate this program's dynamicity. 80% of respondents favoured area-specific modifications needed to reach all society sections. **Conclusion:** To meet Sustainable Development Goals within the prescribed time limits, the program can result in a remarkable change in the overall healthcare system. It needs to be in sync with the current healthcare scenario, like the outbreak of pandemics like COVID-19. Suggestions are provided to make it more effective, result-oriented, and in sync with the existing ground realities.

Keywords: Inclusive Governance; Rural Health; National Health Mission; Pulwama; Jammu and Kashmir

Introduction

Governance means not just "government," but it consists of structures and the rules of the game that govern the various political structures and processes that influence voters and the people who run them (Grindle, 2004). On the opposite hand, inclusive governance refers to "a normative sensibility that stands in favour of inclusion because of the

benchmark against which institutions are often judged and also promoted." Inclusion is a process that makes a difference in development outcomes, is an integral part of ongoing discussions on governance and development. It is inclusive when it serves and engages all sections of society and when institutions, policies, and services are accessible to everyone. Fostering inclusive governance is an integral

part of building a society that is tolerant of diversity, respects human rights and the rule of law. Governance is a dynamic concept that lies at the core of relations between state and society, comprising all the processes and interactions of governing over a social organization – whether undertaken by the state, the market, social groups and networks, or a mixture of these (Acharya, 2015). Despite strong agreement on the centrality of inclusive governance in current discourse around Sustainable Development Goal (SDG) 16, considerable debate and disagreement remain within the international development community on how best to support it. Some actors specialize in inclusive governance as an honest with intrinsic value (Buuren, 2009). Others take an instrumental approach and see inclusive governance not as an end but rather as achieving more inclusive development outcomes (Rose-Ackerman, 2016). At its core, inclusion, in terms of

both process and outcome, is meant to strengthen social cohesion and, therefore, the fabric holding a society together. Therefore, the SDGs and the 2030 Agenda commitment to go away from nobody behind the focus on giving voice and influence to those traditionally marginalized, enhancing their well-being, and fostering prosperity that’s more broadly shared (Sustainable Development Goals Report by UN, 2015). This means inclusive governance is additionally necessary to realize more inclusive development outcomes. National Rural Health Mission is a revolutionary programme in the health sector by which every section of society is touched. In the district, Pulwama, the manpower of the health department associated with this programme is shown in Table 1.

The number of personnel belonging to the family welfare section of the Health Department are shown in Table 2:

Table 1: Healthcare personals posted in the district

S.N.	Designation of posts	Sanctioned	In-Position	Vacant
Gazetted				
1	Sr. Consultant	02	01	01
2	Consultant	38	34	04
3	Medical Officer	131	115	16
4	Dental Surgeon	27	25	02
5	Administrative Posts	08	07	01
Total		206	183	23
Non-Gazetted				
1	Paramedical/Other Staff	513	432	95
2	Class-IV	254	222	32
Total		767	654	127

Courtesy; Director Health Services Kashmir, Srinagar

Table 2: Personnel working with Family Welfare in the District

S. N.	Category of post	sanctioned	In-Position	Vacant
Gazetted				
1	Senior. Consultant	0	0	0
2	Consultant	0	0	0
3	Medical Officer	03	0	03
4	Dental Surgeon	0	0	0
5	Administrative Posts	02	02	0
Total		05	02	03
Non-Gazetted				
1	Paramedical/other staff	103	83	20
2	Class IV	05	0	05
Total		108	83	25

Courtesy: Director Health Services Kashmir, Srinagar

Significance of the Study

India is a rural country, and most of the population lives in rural areas. The significance of this study lies in providing impetus towards enhancing primary healthcare facilities. NRHM is one of the various tools to achieve Sustainable Development Goals related to health. This programme pertains to providing quality and affordable healthcare services to the people. It is a harbinger of a silent revolution in health administration. It has been more than a decade since its launch. Various shortcomings get reflected with changing socio-economic conditions. This paper tries to portray various achievements and provide suggestions for better implementation of the programme. District Pulwama is part of Jammu and Kashmir (UT). It has a 5.60 lac population (As per the latest Census), and 85.64 % population of Pulwama districts lives in the countryside. The male population accounts for 293064, and the female population is 267376. Child proportion (0-6 Years) was 17.37%. One hundred twenty-seven families, which account for 0.15% of the total population of Pulwama district, are without roof cover. 22607 (4%) are Scheduled tribes' population. National Rural Health Mission has been combined with other programmes National Urban Health Mission, and the whole scheme collectively is known as National Health Mission. Deputy Commissioner is the Chairman, while Chief Medical Officer is the Vice Chairman of the District Health Society under the National Health Mission. This region is a rural district; hence the NRHM is functional all over the district. This study is a sincere endeavour towards analyzing the role of this programme in promoting inclusive governance through easy access to health services to all sections of society.

Inclusive Governance in Healthcare

The National Health Policy 2017 increased India's healthcare spending by 2.6%, a phased increase of over 1%. It aims to provide free, comprehensive, and high-quality primary health care services to all citizens. The policy aims to promote human resources and infrastructure in the health sector to deliver health care services on a pro-bono basis. It also encourages the collaboration between the non-government sector and the government to provide access to a doctor of their choice. The policy also encourages the establishment of a comprehensive human resources development program and a logistics network to support the continuous improvement of healthcare services. It is also necessary to upgrade the facilities' infrastructures to provide comprehensive care. This policy aims to provide access to quality AYUSH healthcare services through a combination of documentation, validation, and research upon tribal medicines. Leveraging digital health technology for two-way systemic links between various levels of care would help ensure continuity of care. These measures could help achieve the targets set under the Sustainable

Development Goals regime regarding healthcare in the long run.

“Of all the sorts of inequality, injustice in healthcare is that the most shocking and inhuman.”

-Luther King Jr.

Health is a precious gift. Therefore, the first purpose of the health system is to enhance the health of its entire population. In India, the National Rural Health Mission (NRHM), was launched in 2005, to bring considerable modifications in India's health system by ushering in an era of development of infrastructure, financing innovations, and strengthening of health governance by increased investment within the public health system revolving around the concept of “communitization” which means health system's ownership by the community. It is one of the programmes which would help in the timely achievement of Sustainable Development Goals related to “Health.” There has been some research on the implementation and impacts of these changes, but there is not much systematic research on their integration into the health system (Rotberg, 2014). The National Rural Health Mission sought to ensure that everybody has easy access to basic standardised health care, especially in rural areas. The National Rural Health Mission was formulated to ensure that everybody has equal access to quality health care. It focused on improving the health standards, management capacity and financial flexibility of the health system. The building blocks of the NRHM setup are standards, governance, and community participation.

A community-based accountability system was also incorporated into the communitization process (Sriram, 2019) . This component provided a framework for the effective management of various tasks and activities within a community. This component of community-based accountability included the formation of Locality based health and sanitation committees. Community-based monitoring has led to effective capacity building. Civil society organizations-built capacity and participated in monitoring the services at the first care level, as proposed. The government would ensure that all staff members were involved in the processes where monitoring results were shared, and plans were drafted or modified accordingly (Ramadi and Srinivasan, 2021). There is a decline in the Under Five Mortality Rate, India still has some of the highest maternal and child health mortality rates globally, posing a severe obstacle in achieving the UN set goals. Goal 3.2 of the U5MR aims to reduce the mortality rate for newborn babies globally by 2030. In India, the NFHS data shows that out of the country's population of over 10 million, approximately 68% of newborn babies do not receive basic health care within immediate 14 days after birth.

In India, the role of Frontline health workers (FHWs) has been studied empirically and shown to have a significant impact on maternal healthcare utilization and outcomes. In India's healthcare delivery system, Frontline Health Workers are an integral part of Mother-Child Healthcare services, particularly about providing the requisite information about the government's flagship programmes in the field of health care (Gaitonde, San Sebastian and Hurtig, 2020). The increasing number of maternal and child healthcare services has raised the awareness of the public about the importance of these services. This is, in turn, contributing to the overall improvement in the healthcare scenario in the country. The existing rural health networks Frontline Health Workers were strengthened in 2005 and 2013 under various government programs to bridge the skilled workforce gap and improve healthcare services for vulnerable groups. Target specificity of India's National Rural Health Mission (NRHM) has been remarkable, as in cohesion with NUHM, India reached close to health-related Millennium Development Goals and is marching on to achieve SDG targets regarding healthcare (Gopalakrishnan and Immanuel, 2017)

The foremost astonishing feat NRHM has achieved is that it has successfully placed quite ten lac grass-root community health activists (Accredited Social Health Activists) in villages of India. Despite this remarkable achievement, one critical area is the supply of specialist doctors at the peripheral levels. This programme has devised strategies to draw specialist doctors to rural areas by providing better incentives, handsome salaries, and versatile working conditions (Shukla, 2007 To date, these policies have not yielded positive results.

The quality of health services seems to have improved due to the up-gradation of labour rooms, newborn care facilities, and Operation theatres. In terms of availability/functioning of equipment, several District Hospitals and Sub District Hospitals have been working satisfactorily. However, in some instances, it needs augmentation of facilities like managing the rush of patients in Outpatient Departments. The absence of privacy maintaining measures for ladies hampers the effective use of obstetric care. Institutional

delivery procedures in some Public Health Centres are without proper privacy arrangements, proper equipment, water system and infection control of the labour room. Enhancements under NRHM and timely disbursement of financial resources have improved the standard of the service in Jammu and Kashmir. There is an urgent need to take remedial measures to correct the imbalance in human resource and physical infrastructure deployment. Accredited Social Health Activists (ASHA) who are 11916 in number within the Union Territory are trained in two segments or sessions and provided with drug kits containing essential medicines and pieces of equipment. However, these kits have not been replaced or upgraded. Most of them paid referral services from their own pockets to bring the patients to the health facilities. It has resulted in the loss of morale. Most of the ASHAs are aware of their responsibilities towards society. It is these workers who help in organizing health activities under the sub-centre. Incentive payments for ASHAs usually are getting delayed.

Being one of the districts of the gorgeous valley, Pulwama is surrounded by Srinagar from the North by Budgam and Poonch Districts in the west and Anantnag from the South and East. The district is inhabited by 5.6 lac people spread over 1090 Square Kilometre as per Census 2011. 85.65% of the population live in rural areas and 14.35% in urban areas. The district consists of 327 villages, including 08 uninhabited ones. For administrative convenience, the district is divided into eight tehsils of Pulwama, Awantipora, Tral, Pampore, Kakapora, Aripal, Rajpora & Litter, which have further been grouped into eleven Community Development Blocks which are Tral, Aripal, Dadsara, Awantipora, Pampore, Kakapora, Pulwama, Shadimarg, Achgoze, Lassipora and Newa. The healthcare administration is headed by the Chief Medical Officer and Block Medical Officers at Block Levels at the district level. There are four Medical Blocks: Pulwama, Tral, Pampore and Rajpora. The administrative offices of the district are situated at Pulwama, which is about 31 km from Srinagar. The infrastructure set-up is available in the District under NRHM (a subcomponent of the National Health Mission) is shown in Table 3.

Table 3: Infrastructure Availability in district Pulwama

Infrastructure under NRHM in district Pulwama	
District Hospital	1
Community Health Centre/Sub District Hospital	3
Public Health Centre	20
New Type Public Health Centre	27
Multi-Purpose Centre	4
Sub Centre	85
New Sub Centre	18
Newly Constructed GNM School	1
Total	159

Source: Chief Medical Officer Pulwama

To get the monthly patient load of the healthcare facilities within the Pulwama district, we collected the data of indoor/outdoor patient departments as well as the number of various diagnostic tests for December 2020 (As the data up to this month is readily compiled at Chief Medical Officer's office). It is shown in Table 4.

Table 4: Patient Load in December in 2020 in Pulwama District

OPD	94649
IPD	2006
Major surgeries	200
Minor surgeries	378
Delivery	283
ECG	3311
X-ray	5039
USG	2591

Source: National Health Mission, Pulwama

Discussions

Regarding targets, 80 per cent of participants believed that there should be area-wise or region-wise target settings. The geography and the socio-economic conditions of the area need to be considered during this process. Contextualize this programme within the ground conditions, including employment opportunities, food security, environmental concerns, living conditions and hygiene. There is a need for the further development of healthcare administration. The present hierarchy of administration needs to be modified with more emphasis on decentralization. Also, the use of Information technology is a necessity in present times. Healthcare workers working in peripheries of the Sangarwani belt cannot be compared with workers posted in an urban area.

ASHA workers form a vital component of this programme. There is an urgent need to enrich their job and provide better incentives. There should be a feedback mechanism where these workers can provide the requisite feedback to higher authorities which could help in better policy formulations. AYUSH services need to be made available at Block and other lower levels. Many areas of this district have a tribal population who feel more satisfied with indigenous treatments. It will enhance the reach and quality of healthcare services. There is also a need for having a vibrant communication strategy so that correct information reaches the masses. During the COVID-19 outbreak, we saw how confusion got created by fake statements through social media platforms.

Inputs need to be considered regarding health-seeking behaviour and expectations of individuals towards healthcare. There is a need to build new infrastructure in new primary health centres to help cover the whole population within the coverage of universal healthcare. There is a requirement of remoulding and refurbishing the existing structure of sub-centre, public health centres, community, and district hospitals. The Public Health Centre approach needs to be augmented further, where the first level acts as a regulator for availing the services from the upper levels. Universal norms of population coverage cannot merely govern human resources for health but need to be planned in sync with the local epidemiological scenario.

The public healthcare system can be more tempting for medical specialists through proper working conditions and other performance-linked incentives. Intake into medical college should considerately the doctors' social background concerning their entry and retention within the rural healthcare services. There is a need for area-specific planning of health services and their development, considering the ground realities about social groups and their influence on service delivery. There is a requirement to restructure the cadres of doctors. Doctors who have managerial skills should be posted on managerial posts like Block Medical Officer and Chief Medical Officer. The district being the focus of all basic health services, need to be headed by a Generalist physician with proven track record of good managerial skills because the Chief Medical Officer, Superintendent of the District hospital, is a group of specialists who have only technical skills. The present system of specialist dominated managerial posts needs to be reviewed, and measures need to be taken to posit people with better managerial skills.

Conclusion

NRHM has played a prominent role in enhancing healthcare services all over the country. District Pulwama has also received a boost in healthcare facilities. It has provided affordable and easy access to thousands of souls. It has resulted in participative governance by including all sections of the society within the ambit of public healthcare. A remarkable change is being witnessed in this area, still are various loopholes that could be plugged. Effective and responsible implementation of this programme will help this country achieve sustainable development goals in a time-bound manner.

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