CHAPTER: 1
INTRODUCTION

1.1 Meaning of NRHM

Every year, about millions of children around the world die before the age of one and millions die before the age of five. Two third of these deaths are preventable. Nearly many women die of complications related to pregnancy and childbirth .For India, the comparable estimates are unflattering. Progress on reducing infant and child mortality has been slow . The country's record on reducing maternal mortality was more encouraging – in the past years. Indian women died during pregnancy, delivery or in the six weeks after delivery. But now number had come down to deaths per live birth (See Registration Survey, 2008). Still, India retained the ignominy of being one of the six countries contributing to more than 50 per cent of the maternal deaths worldwide in 2008 (the others being Nigeria, Pakistan, China, Ethiopia, and the Democratic Republic of the Congo) (Hogan et al 2010).

Recognizing child and maternal health as a critical concern, the Government of India launched the National Rural Health Mission (NRHM) in 2005 in the country, with a special focus on 18 states identified as having poor outcome indicators. The idea behind the Mission is to provide universal access to equitable, affordable and quality health care through an integrated approach as well as to bring about institutional changes such as decentralization of the public health system; integration of organizational structures; community participation and ownership of assets; and convergence in services which co-determine health outcomes (e.g. food, nutrition, water and sanitation.[1]

From a social point of view, good health is a pre-requisite for human productivity and the development process. It is essential to economic and technological development. Individually, health is a man's greatest possession, for it lays a solid foundation for his happiness. Improvement in health would make a positive impact on economic development. Better health can increase the number of potential man hours for production reducing morbidity and disability as well as by reducing mortality. Better

[1] www.cbgaindia.org/files

health may result in more productivity per man as well as more men available for work. India is the world's second largest population country after china, as per estimate it will be most populous by 2020. But if we look at its demography then we will find that more than 60 percent of total population is of youths means (age between 15 to 35 years), which has been seen as a plus point to India and also Labelle as "Young India". But as recent studies comes out in news most of teenager are malnutrition which is not a good sign to emerging India. , because this young population can strengthen India only when it convert in human capital and for being human capital they should be physically well fit . Otherwise they will be burden on our economy.

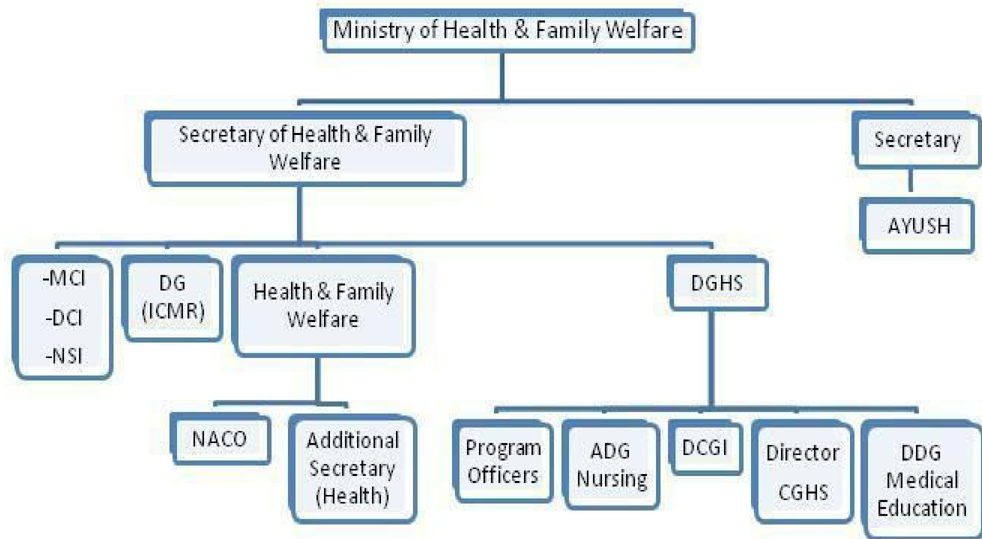
To use this large strength of young population to convert it into human capital Indian government launched a scheme i.e. called National Rural Health Mission (NRHM). Widely_accepted definition of health is that given by the WHO, Accordingly positive health is described as "health is a state of complete Widely_accepted definition of health is that given by the WHO, Accordingly positive health is described as "health is a state of complete physical, mental, and social well- being and not merely an absence of disease or infirmity"...... "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"..

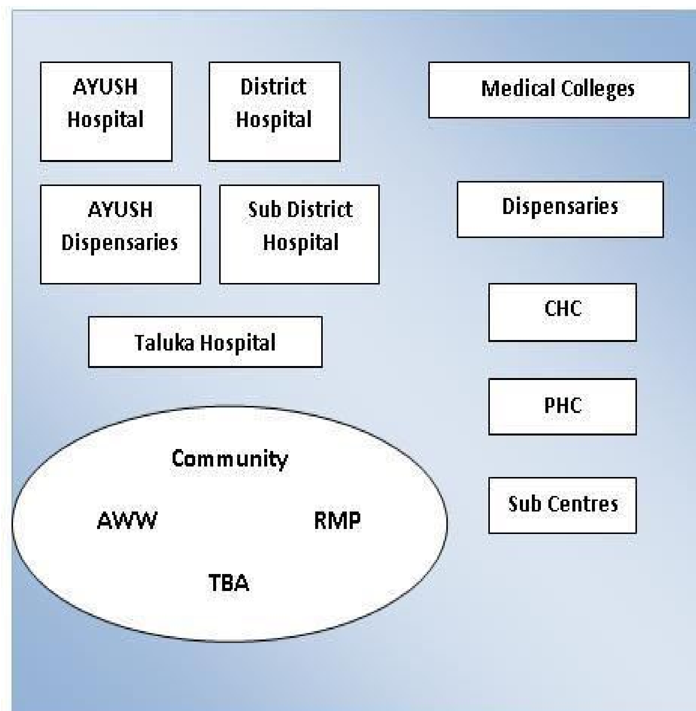
A recent internal Planning Commission review of National Rural Health Mission (NRHM). based on secondary data from the Ministry of Health and Family Welfare, as well as independent institutional sources (Gill 2008), confirmed the paucity of evidence-based material and systematic analysis of the delivery of health care in rural India found by other academics.

(Banerjee, Deaton_and Duflo **2004).**

NATIONAL RURAL HEALTH MISSION

Structure in India





MCI - Medical Council of India
DCI – Dental Council of India
NCI – Nursing Council of India
DG – Director General
DDG – Deputy Director General
ADC – Asst. Director General
DGCI – Director Controller General of India

1.2 REVIEW OF LITERUTURE

There are reasonably good literature in the subject of public health in India. Many books, papers and reports have been published from time to time by national and international organizations like ICMR, WHO, UNICEF, UNDP and World Bank. The National Rural Health Mission has been described as one of the largest and most ambitious programmes to revive health care in the world and has many achievements to its credit. It seeks to provide health care which is affordable, equitable and of good quality. It has increased health finance and has improved infrastructure for health delivery. The National Rural Health Mission has been described as one of the largest and most ambitious programmes to revive health care in the world and has many achievements to its credit. It seeks to provide health care which is affordable, equitable and of good quality. It has increased health finance and has improved infrastructure for health delivery. It has trained health care staff and has provided technical support. It has facilitated financial management, assisted in computerization of health data, suggested centralized procurements of drugs, equipments and supplies. It has revived and revitalized a neglected public health care delivery system. Challenges and Solution: The National Rural Health Mission has injected new hope into the health care delivery system .In India however it continues to face diverse challenges, which needs to be addressed if their goals are to be achieved in the near future.

The location of health in the state list rather than the concurrent list creates major problems for the service delivery because National Rural Health Mission funding is from the centre while the implementation is by the state governments. Regions with prior good health indices have shown marked improvements, while those with prior poor indices have recorded much less change. Health care costs for the average Indian usually results in Catastrophic out of pocket expenditure and is well recognized cause of indebtness in the country. The total health budget for India is about 1%of the country GDP. Most developed nation prioritized health care and provides 5 to 10% of GDP. The 12th five year plan should increase funding for health to the tone of 2 to 3% as promised by the UPA (Union Progressive Alliance).The diversion of funds through private health insurance schemes for the care of rare disorder to be treated in corporate hospitals takes away funding from the public health care system. The injection of such money into the public system would allow for the

provision of universal health care, improve government health care system and provide for common health conditions benefiting large numbers.

The National Rural Health Mission has focused on rural health, many parts of the urban health care needs and currently has glaring deficiencies The National Rural Health Mission should be accorded the same status as the National Rural Health Mission both efforts should be coordinated and combined into a National Health Mission.

The major focus of National Rural Health Mission is on maternal & child health. While this is vital, there is a need to expand the vision to the other common general health problems .There is evidence to suggest that other crucial government programmes (Eg. blindness) have taken a back seat. The National Rural Health Mission has provided for infrastructure personnel and training for health management information systems. However these are optimally not utilized. There is need to improve the information system as a part of process of monitoring health indices of populations and functioning of the public health care system.

Social determinants and public health approaches ; The goal of the N.R.H.M. clearly state the need to impact on the social determinants of health by coordinating efforts to provide clean water , sanitation, nutrition , housing, education and employment. It should in conjunction with other government programmes, work together for the reduction of poverty, social exclusion and gender discrimination all of which have a significant impaction health. There is need to increase the synergy and coordination between the government programming eg. (Integrated child development schemes, the mahatma Gandhi national rural employment guarantee act etc and the NRHM.

Improvement in health of population contributes to economic development and vice versa. This bidirectional relationship justifies increased investment in health. The NRHM should become an integral part of the five year plan and the health budget should be increased to 2-3 % o GDP.

The National rural urban health mission should receive equal funding priority and to be coordinated with NRHM. Strengthening of health information community monitoring and social audit to assess its impact on health outcome indicator is necessary. Improved funding for the public health sector to treat common health condition, rather than providing private health insurance for uncommon disorder is

mandatory. State government also needs to prioritize health and increase their share of health budget. Politician and government are also unable to see the ethical issues related to equity and lack the conviction to provide services for the poor.

Health a human right and universal health care should not remain an aspiration but should become operational in the near future.[2]

The root cause of ill health is inequality and poverty. Inequality in health care is interpreted as compromise in "Right to life". Training of paramedical staff is essential to improve the health care system. In the same way family physician can also help in preventing care Introduction During the middle of 18th century, the British government in India established medical services which were mend for the benefit of the British nationals, armed forces and civil servants. Service which was available in general hospitals located in big cities and commercial centers were largely curative. But neither health planning nor medical education was related to the health needs of the people. This strong western bias was largely responsible for blind adoption of modern medicine for a few, neglecting the vital interests of vast majority. In independent India, keeping in view the all shortcoming the government of India planned several approaches for the health care delivery. The basis for organization of health services was laid by the recommendation of health survey and development committee. (Bore committee) in 1946.

In the last two decades there has been growing concern over the performance of the health care delivery system. In India as per the government of India's NRHM. Document (2005) , only 10 % of Indian have some form of health insurance and around 40 % of Indians have to borrow money or sell their assess to meet their health care expenses. Nearly 25% of Indians slips below the poverty line because of hospitalization due to single bout of illness.

States of health in India maternal and infant mortality rates in India poorest district are worse than the sub Saharan Africa.

India represent 21 % of the global diseases burden with the largest burden of communicable diseases in the world .The projected cumulative loss of national income for India due to non communicable diseases morality for 2006-2015 was USD

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[2] Journal(Professor KS Jacob is an faculty of the Christian medical college Vellore)

237 billion countries with a high rate of HIV infected patient. Diarrheal diseases are the early cause of infant mortality.

These diseases are caused by poor sanitation and inadequate safe drinking water in India poor sanitation and inadequate safe drinking water, lack of access to basic needs contributes health burden of the nation. As more than 122 million households have no toilets, 33% lack access to latrines, over 50% of the population defecates in the open. The Indian health care sector is characterized by the presence of system such as government, not for profit, charitable organizations, corporate hospitals and smaller private clinics. There is not well defined forward or backward linkage between these. India's public health infrastructure it is grossly underfunded under staffed and poorly equipped. Allopathic physicians sector which is more affordable, offer services of varying quality often by under qualified practitioner.

It has been observed that private health sector expenditure is increasing While the public health expenditure is shrinking. Public spending on health care in India is as low as 0.9 % of the GDP in contrast to a total health expenditure of 5% 0f GDP . Decreasing public health expenditure has adversely affected the health outcomes .Unregulated private health sector: both urban and rural house hold tends to use the private medical sector .more frequently the public sector. Various studies show that private sector accounts over 70% of all primary care .However private sectors' focus is on curative care. Several reasons are cited for relying on private rather than public sector , the main reason at the national level is poor quality of care in public sector other major reasons are distance of the public sector facility, long wait times and inconvenient hours of operation .

Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups. It means there should be availability of health care to all sections of society. capability to cover different socio economic groups and geographic regions, technical competence and skills of individual health worker and motivation with which they perform their jobs – all contribute in important ways to improve health system performance and population health. Strengthening public sector: public sector must become the dominant player to lead the health sector rather than the private sector. It is only than that all health care can be ensuring if poor and downtrodden class gets better care. We need to find ways to treat poor patient at subsidized rates in private hospitals. If proper treatment is not

available in government sector. For this private and public sector must join hands in ensuring inclusive health services for the population.

India's public spending on health is much less than those of the developed countries in absolute terms but even as a percentage of GDP. The government of India's recent decision to increase health expenditure to 25% of the GDP by the end of twelfth five year plan (2012-17) from the current 1.4%is good news for the sector. Government has to spend more on infrastructure development of the health sector something as basic as providing proper sanitation and safe drinking water to all citizens. The reduction in mortality and morbidity due to primary prevention and improved health education is well documented.[3]

The NRHM is a major under taking by the newly elected United Progressive alliance government to honor its commitments under the common minimum programme. The Political commitments to rural health and access to primary health care that the CMP clearly expressed was itself a matter of considerable cheer. Its most advertising features had been the sanctioning of six AIIMS like institutions, the promotion of medical tourism and the introduction of tele medicine – all highlighted as features of an Indian shining nevertheless the announcement of such a mission drew a number of stakeholder into defining it almost immediately. The central health ministry itself was by then in a high level of evolution of the grand RCH 11 programme is a programme that had been carefully negotiated though donors: world bank, European union, department for international development, WHO and UNICEF notably . The three main issues that this communication addresses are targeted sterilization, the retreat of state and the privatization of health service. All these concerned were largely highlighted by the representative of NGOs active in the field of heal then and how it was the hidden agenda arose from the initiative description of accredited social health activist (ASHA) scheme. The central task of ASHA would be motivating women for sterilization. In the discussion about targeted one needs to note the changed the contest of the discussion during emergency (1975-1977) every employee of the government was set the target for the cases to be secured , the failure to which attracted penalize d. However sterilization camp

[3] Journal National rural health mission Hopes and Fear Concern about targeted sterilization retreat of state and privatization T Sundararaman, Kamlesh Jain , V R Raman, Premjali Deeptisingh.

continued to be the main form of achieving fertility control and getting people to come to the camps remained the major preoccupation. A series of incentive and disincentives were devised to persuade the public.

The concern about the retreat of the state is based on ideological readings of the context of the mission. These refers to a set of policies based on the neo-liberal world view that growth and development were best left to the play of market forces with the state playing a minimal role. The key structural adjustment to achieve the growth are globalization – the polices that enable the free movement of commodities and capital across national borders.

The RCH[2] and the donor community had already identified public private partnership as a major innovation that made to improve access. The most important stated reason was that the private sector accounts for the major part of health care provisional but it needs to held accountable and to be utilized for public health goals as well. State commitments by number of states and centre to draw up a policy of public private partnerships.

1. The need to involve the private sector in the provision of the affordable service s for the poor and to contribute to national health goals is appreciated.

2. The flourishing unregulated and illegal (RMP) sector is symptomatic of the breakdown of the health care system and this must not be projected as the solution to rural health problems.

3. The formal qualified private sector is also almost completely unregulated in pricing of services in quality of services and in ethics.

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[4] Journal Strengthing of primary health care : Rajiv Yeravdekar

programme is a programme that had been carefully negotiated through donors: world bank, European union, department for international development, WHO and UNICEF notably. A Paper on Public Management and Essential Public Functions, published by World Bank[5] provides an overview of how different approaches to improve public sector management relate to essential public health functions such as disease surveillance, health education, monitoring and evaluation, work force development and health policy development. Managerial autonomy is important for promoting adaption and innovation. Strengthening hierarchical accountability within public health system is essential and requires not only changes in the capacity, autonomy and behavior of service managers, but also requires change in monitoring systems. Social Science and Medicine Journal[6]examines the patterns and determinants of maternal health care utilization across different social settings in south India: in the States of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. Results show that utilization of maternal health care services is not only associated with a range of reproductive, socio- economic, cultural and program factors but also with the State and type of health service. The interstate differences in utilization could be partly due to variations in implementation of maternal health care program as well as differences in availability and accessibility of services between States. In case of antenatal care, there was no significant rural–urban gap, thanks to the role played by the health workers working in rural areas to provide these services. The findings of this study provide insights for planning and implementing appropriate maternal health programs in order to improve the health and well-being of both mother and child. Another paper published by Public Health Foundation of India,[7] deals with the quality in health care in terms of safety, efficiency, timelines, responsiveness, equity, and human and physical resources. The study is based on outcomes assessed over time in safe delivery and maternal and neonatal mortality.

[5] Khaleghian and Monica Das Gupta - Public Management and Essential Public Health Functions, World Bank, 2005.

[6] Navaneetham K and A Dharmalinga: Utilization of Maternal Health Care Services in Southern India – Asia Metacentre of Population and Sustainable Development Analysis, Institute of Asian Research, Singapore.

[7] Dr. Clar, Chrisitine, Dr. Bilal Iqbal Avan: Evolution of the concept of quality of care with respect to clean delivery in health system in high, middle and low income countries.- Public Health Foundation of India, 2010.

The study was carried out for Malaysia, India and Ethiopia. In case of India, the study identifies the persistence of high proportion of maternal and neonatal deaths and low institutional delivery. Further, it is observed that issues such as poor access, poor infrastructure and facilities, ineffective treatment due to poor skills, corruption and lack of responsiveness as major problems.

A working paper by Planning Commission of India[8] aims to evaluate quantity and quality of service delivery in rural public health facilities under NRHM. The former is assessed on the static and dynamic condition of physical infrastructure; by number of paramedical, technician and medical staff employed; by the supply, quality and range of drugs; by availability and usage of maintenance funding of centers; and by actual availability of laboratory, diagnostics and service facilities. Quality is defined in relation to the condition of the above tangibles, and also supplemented by subjective data on intangibles, such as patient satisfaction, gathered from exit interviews. The findings across four States of Uttar Pradesh, Bihar, Rajasthan and Andhra Pradesh, resulted in reflecting context-specific driving factors and identifying problems where implementation is less than desirable. Thus, while the study attempts to identify factors which affect implementation of NRHM, it falls short of assessing the underlying management practices and the mechanism for delivery of health care services. There are many challenges and opportunities for health care managers which are discussed in the book, “Strategic Issues and Challenges in Health Management”[9]which should be used to stimulate action, thought, reflective practice and service provision. Health system has to respond to issues relating to management.

This includes potentially new health systems structures with greater emphasis on quality and performance of management. Information management is becoming more important with the explosion of information. The lowest income groups in

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[8] Gill, Kaveri: A Primary Evaluation of Service Delivery under the National Rural Health Mission: Findings from study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan – Planning Commission of India, Working Paper 1/2009 – PEO, May 2009.

[9] Fleming Fallon, L Jr., and Eric J Zgodzinski: Essentials of Public Health Management – Jones and Bartlett Learning, - ISBN-13: 978 1-4496-1896-4.

India receive the smallest share of subsidies for curative health care[10]. To reduce inequity and make services pro-poor, programs and facilities must be targeted better and made more accessible to poor. A judicious combination of supply and demand side strategies will be required for this. Supply-centric strategy practiced for a long time without any parallel demand from the community has failed to reach the poor. This is because of lack of awareness about availability of services or lack of access due to social barriers. A demand-driven approach requires improvement in availability of essential services, accountability mechanisms and empowerment of clients. Leadership in health care management has to adapt to changes in terms of style, process and structure. With transition from feudalistic and paternalistic society towards knowledge society, the leader is expected not necessarily to have all right answers but all right questions. People and technology management will be important issues. Leaders of future should think of integrating internal processes and systems to external needs. Organizational structures will move from pyramidal to spherical structures within which the locus of control will continually shift. With rapid changes in information technology, leaders of future should perceive change; conceive change and; deliver change, thus leading change with change.

A recent edition of book on public health, "Essentials of Public Health Management",[10] discusses the theoretical models, day to day activities and realities in public health management. Management is the art of using all available resources to accomplish a given set of tasks in a timely and economical manner. Its success depends on ability to understand local organizational milieu as well as larger environment in which it exists. Governance is a critical component of all aspects of public endeavor and is oriented to both process and outcome. An important aspect of public health leadership is monitoring activities of practitioners. Governance is the oversight in the public health system, whereas the management implements the activities to make the system effective. The organization of public health varies from state to state in United Sates of America. The most common structure is a local public health department with six basic service areas: collecting and analysing vital statistics, sanitation, communicable disease control, maternal

[10] McGregor D- The Professional Manager, New York: Mc Graw Hills, 1967.

and child health, health education and laboratory services. The leadership for the majority of health departments is provided by board of health. The most familiar form of organizational structure is the classic bureaucracy which is widely used in Government, militaries and churches. This was first systematically described by Max Weber in bureaucratic theory in which bureaucracy follows a rational code of conduct. Three major theories describe the attitude and behaviour of individuals towards subordinates in the organization. In his book, "The professional Manager", by Douglas McGregor[11] discusses Theory X which gives a traditional view of direction and control.

A more humanistic Theory Y integrates individual and organizational goals. Theory Z[12] is a recent theory of management, based on management practices in Japan. In this, management makes long term commitments to the employees Organizations are affected by interpersonal and intergroup factors where positional authority has to be accompanied by the need to understand political factors. From the perspective of public health professional, organizational behaviour can be defined as the study of how groups function and the psychological underpinnings contributing to that behaviour. Some key tenets concerning individual behaviour are significant components of organizational behaviour. Causality is forces acting on people are responsible for human behaviour. These forces can be internal or external to an individual and include influence of genetics, experience and environment. Directedness means human behaviour is not only caused, it is also pointed towards something. This is referred to as goal directed. Motivation: As a result of underlying behaviour, a push, need, drive or motive can be found to explain most rational actions taken by individuals. Abraham Maslow made major contribution to the understanding of individual behaviour with five level of hierarchy of needs: physiological; safety; love and belonging; esteem and self-actualization. Sociologist Homans characterized social behaviour as being an exchange. When in groups, people interact to receive a reward. Each person communicates with others in the group, and each tries to make contribution to the group. Groups usually refer to small number of individuals in which membership is related to both technology and pace of work.

The status within the group is an outcome of internal and external factors. Internal factors refer to titles, job, perquisites, offices, work schedules,

mobility and methods of evaluation. External factors refer to influences that are brought to work place like age, gender, race, education and seniority. In the increasingly complex nature of modern public health organizations, the use of complex technological tools and concepts, and the need to increase productivity have contributed to the growth and importance of profession. The district health administration is considered the bridging administrative unit between National and State Government and the community at village level. Given the poor health indicators in the country, the book "Primary/Rural health Care System and Hospital Administration" suggests three urgent reforms[11]. First, it is time to accept that the Government has at best limited capacity to deliver health services and hence a radical shift in strategy that gives the poor greater opportunity to choose between private and public providers is needed. Second, the Government must introduce one year long term training courses for practitioners engaged in treating routine illness. Finally, there is urgent need to accelerate availability of qualified doctors to displace the unqualified doctors who operate in both rural and urban areas. As primary health care approach is people-oriented, the organization of health care starts with the people, individuals and families and communities. The book compares the national rural health mission initiative with health initiatives in countries like Democratic Republic of Korea, Singapore and Sweden. According to Jeffrey D Sachs[12], NRHM is the single largest mobilization of public health measures in the world.

Half-million young women have been hired as health workers to link impoverished households and public hospitals. This has broken three common myths: First, the burden of disease among the poor is somehow inevitable and unavoidable. Second, it breaks the myth that the aid from rich countries is wasted. Poor countries are capable of establishing effective health care programs rapidly when they are helped. Thirdly, there is myth that saving poor people will worsen the population explosion. But in reality households have many children because of fear of high childhood death rates. This declines since families feel confident that their children will

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[11] Goel, S.L: Primary/Rural Health Care System and Hospital Administration, Deep & Deep Publications Private Ltd, New Delhi, 2010.

[12] . Sachs, D Jeffrey: The Healthier Poor – Economic Times, 3rd September, 2007.

survive.

The report by the World Bank[13] defines six core performance domains: quality, efficiency, utilization, access, learning, and sustainability and provide a compendium of metrics that have been used to measure organizational performance in each of these six domains. Based on this, the report identifies seven major strategy areas potentially useful for improving performance among health care organizations: 1) standards and guidelines 2) organizational design 3) education and training 4) process improvement and technology and tool development 5) incentives 6) organizational culture and 7) leadership and management. It also provides illustrations of facility-level interventions within each of the strategy areas and highlight the conditions under which certain strategies may be more effective than others and proposes that the choice of strategy targeted at organizational level to improve performance should be informed by the identified root causes of the problem, the implementation capabilities of the organization, and the environmental conditions faced by the organization. Human Development Report for Gujarat[14] published in 2004 focuses on the link between economic growth and human development and suggests modifications to achieve higher levels of human development. The report studies the growth in agriculture, industry, labour and expenditure on social sectors and links it with development in education, health, poverty, gender and weaker sections like tribal people.

A detailed analysis of books, papers and reports shows that there have are both macro and micro level studies and scholarly works on health sector. These works cover theory and practice of public health delivery system, national health policy, health functions, inter-state comparison, human development at state and country level, improving accountability of public health managers and performance evaluation. However, it is observed that no significant research has been undertaken to study and assess management of public health delivery. Huge financial and other resources are committed for RCH program under NRHM

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[13] Bradley H Elizabeth, Sarah Pallas, Chhitj Bashyal, Leslie Curry and Peter Berman: Developing Strategies for Improving Health Care Delivery: A User's Guide to Concepts, Determinants, Measurement, and Intervention Design by World Bank, June 2010.

[14] Hirway, Indira and Darshini Mahadevia: Gujarat Human Development Report, 2004 – Mahatma Gandhi Labour Institute, Ahmedabad

to bring time-bound health care outcomes. Already under implementation for 5 years, the mission needs to be rigorously evaluated to make meaningful policy interventions. From the recent report of UNDP in 2011[15], the achievement in comparison to MDG in the area of child and maternal health can be ascertained. Though IMR for the country as a whole declined by 30 points (rural IMR by 31 points vis-à-vis urban IMR by 16 points) in the last 20 years at an annual average decline of 1.5 points.

It declined by three points between 2008 and 2009.With the present improved trend due to sharp fall during 2008-09, the national level estimate of IMR is likely to be 45.04 against the MDG target of 26.67 in 2015. Similarly, in case of maternal mortality ratio, SRS data indicates India has recorded a decline in MMR of 35% from 327 in 1999-2001 to 212 in 2007-09 with a fall of about 17% during 2006-09. The decline in MMR from 1990 to 2009 is 51%. From an estimated MMR level of 437 in 1990-91, India is required to reduce MMR to 109 by 2015. At the historical pace of decrease, the country is expected to reach MMR of 139 per 100,000 live births by 2015, falling short of target by 29 points.

The National Rural Health Mission has been described as one of the largest and most ambitious programmes to revive health care in the world and has many achievements to its credit. It seeks to provide health care which is affordable, equitable and of good quality. It has increased health finance and has improved infrastructure for health delivery. It has trained health care staff and has provided technical support. It has facilitated financial management, assisted in computerization of health data, suggested centralized procurements of drugs, equipments and supplies. It has revived and revitalized a neglected public health care delivery system.

The National Rural Health Mission has injected new hope into the health care delivery system .In India however it continues to face diverse challenges, which needs to be addressed if its goal are to be achieved in the near future.

The location of health in the state list rather than the concurrent list creates major problems for the service delivery because National Rural Health Mission funding is from the centre while the implementation is by the state governments. Regions with

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[15] Millennium Development Goals in India: Country Report 2011- Central Statistical Organization, Ministry of Statistics and Programme Implementation, Government of India.

prior good health indices have shown marked improvements, while those with prior poor indices have recorded much less change.

Health care costs for the average Indian usually results in Catastrophic out of pocket expenditure and is well recognized cause of inedebtness in the country. The total health budget for India is about 1%of the country GDP. Most developed nation prioritized health care and provides 5 to 10% of GDP. The 12th five year plan should increase funding for health to the tone of 2 to 3% as promised by the UPA (Union Progressive Alliance).The diversion of funds through private health insurance schemes for the care of rare disorder to be treated in corporate hospitals takes away funding from the public health care system. The injection of such money into the public system would allow for the provision of universal health care, improve government health care system and provide for common health conditions benefiting large numbers.

The National Rural Health Mission has focused on rural health, Many parts of the urban health care needs and currently have glaring deficiencies The National Rural Health Mission should be accorded the same status as the National Rural Health Mission both efforts should be coordinated and combined into a National Health Mission . The major focus of National Rural Health Mission is on maternal & child health. While this is vital, there is a need to expand the vision to the other common general health problems .There is evidence to suggest that other crucial government programmes (Eg. blindness) have taken a back seat. The National Rural Health Mission has provided for infrastructure personnel and training for health management information systems. However these are optimally not utilized. There is need to improve the information system as a part of process of monitoring health indices of populations and functioning of the public health care system. The goal of the N.R.H.M. clearly state the need to impact on the social determinants of health by coordinating efforts to provide clean water, sanitation, nutrition, housing, education and employment. It should in conjunction with other government programmes, work together for the reduction of poverty, social exclusion and gender discrimination all of which have a significant impaction health.

There is need to increase the synergy and coordination between the government programming eg. (Integrated child development schemes, the mahatma Gandhi national rural employment guarantee act etc and the NRHM. Improvement in health

of population contributes to economic development and vice versa. This bidirectional relationship justifies increased investment in health. The NRHM should become an integral part of the five year plan and the health budget should be increased to 2-3 % o GDP.

The National rural urban health mission should receive equal funding priority and to be coordinated with NRHM. Strengthening of health information community monitoring and social audit to assess its impact on health outcome indicator is necessary. Improved funding for the public health sector to treat common health condition, rather than providing private health insurance for uncommon disorder is mandatory. State government also needs to prioritize health and increase their share of health budget. Politician and government are also unable to see the ethical issues related to equity and lack the conviction to provide services for the poor. Health a human right and universal health care should not remain an aspiration but should become operational in the near future. (Professor K.S.Jacob faculty of Christian medical college vellore) IPHS Journal The root cause of ill health is inequality and poverty, inequality in health care is interpreted as compromise in “Right to life”. Training of paramedical staff is essential to improve the health care system. In the same way family physician can also help in preventing care.During the middle of 18th century, the British government in India established medical services which were meant for the benefit of the British nationals, armed forces and civil servants. Service which was available in general hospitals located in big cities and commercial centers were largely curative. But neither health planning nor medical education was related to the health needs of the people. This strong western bias was largely responsible for blind adoption of modern medicine for a few, neglecting the vital interests of

vast majority. In independent India, keeping in view the all shortcoming the government of India planned several approaches for the health care delivery. The basis for organization of health services was laid by the recommendation of health survey and development committee. (Bore committee) in 1946.

In the last two decades there has been growing concern over the performance of the health care delivery system. In India as per the government of India’s NRHM. Document (2005), only 10 % of Indian have some form of health insurance and around 40 % of Indians have to borrow money or sell their assess to meet their health

care expenses. Nearly 25% of Indians slips below the poverty line because of hospitalization due to single bout of illness.

States of health in India maternal and infant mortality rates in India poorest district are worse than the sub Saharan Africa. India represent 21 % of the global diseases burden with the largest burden of communicable diseases in the world .The projected cumulative loss of national income for India due to non communicable diseases morality for 2006-2015 was USD 237 billion countries with a high rate of HIV infected patient. Diarrheal diseases are the early cause of infant mortality. These diseases are caused by poor sanitation and inadequate safe drinking water in India poor sanitation and inadequate safe drinking water, lack of access to basic needs contributes health burden of the nation. As more than 122 million households have no toilets, 33% lack access to latrines, over 50% of the population defecates in the open.

The Indian health care sector is characterized by the presence of system such as government, not for profit, charitable organizations, corporate hospitals and smaller private clinics. There is not well defined forward or backward linkage between these. India's public health infrastructure it is grossly underfunded , under staffed and poorly equipped Allopathic physicians sector which is more affordable, offer services of varying quality often by under qualified practitioner.

It has been observed that private health sector expenditure is increasing .While the public health expenditure is shrinking. Public spending on health care in India is as low as 0.9 % of the GDP in contrast to a total health expenditure of 5% 0f GDP. Decreasing public health expenditure has adversely affected the health outcomes. Unregulated private health sector: both urban and rural house hold tends to use the private medical sector .more frequently the public sector. Various studies show that private sector accounts over 70% of all primary care. However private sectors' focus is on curative care. Several reasons are cited for relying on private rather than public sector, the main reason at the national level is poor quality of care in public sector other major reasons are distance of the public sector facility, long wait times and inconvenient hours of operation. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups. It means there should be availability of health care to all sections of society .capability to cover different socio economic groups and geographic regions, technical competence and skills of individual health worker and motivation with

which they perform their jobs – all contribute in important ways to improve health system performance and population health.

Public sector must become the dominant player to lead the health sector rather than the private sector. It is only than that all health care can be ensuring if poor and downtrodden class gets better care. We need to find ways to treat poor patient at subsidized rates in private hospitals. If proper treatment is not available in government sector. For this private and public sector must join hands in ensuring inclusive health services for the population. Increasing public spending on health care: India's public spending on health is much less than those of the developed countries in absolute terms but even as a percentage of GDP. The government of India's recent decision to increase health expenditure to 25% of the GDP by the end of twelfth five year plan (2012-17) from the current 1.4%is good news for the sector.

Government has to spend more on infrastructure development of the health sector something as basic as providing proper sanitation and safe drinking water to all citizens. The reduction in mortality and morbidity due to primary prevention and improved health education is well document.

The NRHM is a major under taking by the newly elected United Progressive alliance government to honor its commitments under the common minimum programme. The Political commitments to rural health and access to primary health care that the CMP clearly expressed was itself a matter of considerable cheer. Its most advertising features had been the sanctioning of six AIIMS like institutions , the promotion of medical tourism and the introduction of tele medicine – all highlighted as features of an Indian shining nevertheless the announcement of such a mission drew a number of stakeholder into defining it almost immediately. The central health ministry itself was by then in a high level of evolution of the grand RCH 11 programme a programme that had been carefully negotiated though donors: world bank , European union , department for international development , WHO and UNICEF notably.

The three main issues that this communication addresses are targeted sterilization, the retreat of state and the privatization of health service. All these concerned were largely highlighted by the representative of NGOs active in the field of health. Targeted sterilization: Then and how it was the hidden agenda arose from the initiative description of accredited social health activist (ASHA) scheme. The central

task of ASHA would be motivating women for sterilization. In the discussion about targeted one needs to note the changed the contest of the discussion during emergency (1975-1977) every employee of the government was set the target for the cases to be secured , the failure to which attracted penalize d. However sterilization camp continued to be the main form of achieving fertility control and getting people to come to the camps remained the major preoccupation. A series of incentive and disincentives were devised to persuade the public**.** The concern about the retreat of the state is based on ideological readings of the context of the mission. These refers to a set of policies based on the neo-liberal world view that growth and development were best left to the play of market forces with the state playing a minimal role. The key structural adjustment to achieve the growth are globalization – the polices that enable the free movement of commodities and capital across national borders.

The RCH 2 and the donor community had already identified public private partnership as a major innovation that made to improve access. The most important stated reason was that the private sector accounts for the major part of health care provisional but it needs to held accountable and to be utilized for public health goals as well. State commitments by number of states and centre to draw up a policy of public private partnerships (PPPs).

1. The need to involve the private sector in the provision of the affordable services for the poor and to contribute to national health goals is appreciated.

2. The flourishing unregulated and illegal (RMP) sector is symptomatic of the breakdown of the health care system and this must not be projected as the solution to rural health problems.

3. The formal qualified private sector is also almost completely unregulated in pricing of services in quality of services and in ethics. (National rural health mission Hopes and fear IPHS Journal) Female feticide and declining sex ratio

indicate female oppression in India Will Legal Action or Public health Education alone resolve the issue. In all income group, education group obsession of son is prevalent Why everybody prefer son? There are many reason behind this. Son is preferred for continuation of family Lineage and for performance of certain religions and social function. Son is also preferred to provide financial, emotional and social support at old age are some of the important factor some hard task like ploughing in field are very difficult for females but sons are important assets in such situations.

Who will look after them when the parents lose their strength with age. Gender disparity exists throughout the life cycle of individual from birth of death. At the birth of boy, whole family is excited and jubilant and sweets are distributed. Birth attendants get handsome rewards. But at the birth of girl nobody comes to celebrate and dance. There is over all atmosphere of gloom generally, especially, if it is second or subsequent girl child. If the girl survives then there is discrimination for nutrition, education recreational activities and for getting medical aid. Unwanted girl children are left to die. What can we do as a society and as a system to minimize this? Marriage is next important milestone in life. To what an extent freedom is given to girls for match selection? Girls have to show up in different dresses and have to exhibit her cooking and art/craft skills. Why all this is not applicable to boys. Boy may look ugly, may not have even good qualification, but if parents have good money or property then it is sufficient qualification. For girls all parameters are different many times the girls are rejected if she has no brother. After marriages, plight of women's status is not better. Working ladies has to perform dual role job task and household task. On reaching home She is expected to entertain and serve the in laws family. While others will sit relax and have fun. She cannot even take rest during illness. For seeking health call also women have to seek permission from their family. They do not have any say in the financial matter of the family. Whatever they earn, they just handover it to its family. A post graduate lady doctor despite earning handsome salary in government job cannot spend money even for her personal clothes. Thus important question is that what reform can be introduced in the system to make work conditions conducive and comfortable for women. Abuse and violence against women is another important dimension of this gender problem. Women suffer and tolerate tortures silently. Women do not take daring steps of divorce because husband's name matter a lot to protect them from the lusty eyes of society. Divorce or widowed lady is viewed as available to everyone. She could not take divorce because of her girl child. Thus we can say that gender disparities exist despite educational states and financial independency .Our system as a whole is inadequate and insufficient to deal with the problem. It shows that our society is still culturally very conservative. With education and legislation strong support system should be in place. Otherwise people will keep on aspiring for son and gender gap will remain. Women empowerment should begin from home. We should stopped distinguishing between the roles of girls and boys right from the beginning. Children observe parents

for their interpersonal relationship and roles. If current generation of young parents get determined, they can bring change a next generation by acting as role models. This all can supplement the practical implementation of PNDT act and education efforts in terms of sensitizing the communities and providing educational support to girls by providing uniforms, books and financial aid to girl a children property rights to women can also go a long way in empowering women and would prove to be useful strategy in long term. While India today is in the forefront of health care and we often here of health tourism begin a great revenue generator, the vast majority of Indians especially in the rural areas today lack even the basic health amenities. Even today "quacks" who are former compounder's of doctors or even the compounder's assistants rule the roost in such areas. Those in the government setup largely ignore such "quacks" as they are regularly paid off to turn a blind eye to their activities. It is common to have a person walking into a clinic and asking for a drip because of weakness. In a matter of 30-45 minutes dextrose is pumped into that person Along with injections of avil and dexamethasone he or she ends up paying some Rs. 250 or 300 and leaves satisfied at having been treated well even the auxiliary nurse midwives' (ANMs) and dais who are the doctorani have well educated persons utilizing their services for antenatal service and deliveries. Against the background the grass root level realities, the NRHM may have been launched to remove the dichotomy in health care.

As it stands even today, the NRHM could have revolutionized health care deliveries in India and been a role model for all third world to emulate. But this is not the case. The goal of missions is to improve the availability of and access to quality health care by people and especially for those residing in rural area, the poor women and children. It primarily aims to improve the following parameters: health sanitation and hygiene, nutrition and safe drinking water. It seeks to provide to rural people equitable, accountable and effective primary health care. Along with other national programmes like janani suraksha yojna the NRHM can go a long way to improve the mother and child welfare parameters in the country.

The NRHM work for comprises accredited social health activists (ASHA's), auxiliary nurse midwives' (ANM's) ,Multipurpose health worker along with contracts of "samvida" staff nurse, AUSH (Aurveda , Yoga, Unani, Siddha and homeopathy) and allopathic doctors. There is great emphasis on reviving the AUSH system of medical

treatment for which various measures have been incorporated in the mission. The ASHAs form the backbone of the NRHM and are meant to be selected by punchayat. They are to be provided with a drug kit including AUSH drugs for common ailments. The government has also allocated total support of Rs 1000 per ASHA for initial training. While the NRHM envisages three staff nurses in every P.H.C with residences it provide only for one samvida doctor with no provision for residence. If the samavida doctor does night duty the there will be no doctor to see the OPD and vice versa. So there is lack of vision in the provision of basic services. All contract doctors and staff are supposed to work for eight hours a day but permanent staff doctors try to exploit them by making them do their own work even during non duty hours.

The Janani Suraksha Yojana being a major thrust area for safe deliveries in hospital under the NRHM is the biggest source of corruption. A mother from rural area is paid RS 1400 and one from an urban area is paid Rs 1200 for delivery expenses. The vast majority of the deliveries are done by the ANMs who pose as doctors so whole things work flawlessly. Even home deliveries are shown having been done at P.H.C. so show a higher number of deliveries in the government set up. Samvida doctors under the NRHM are exploited who have no casual or earned leave and they have to work even on gazzeted holidays failing which their salary will be deducted. To expect these people to deliver under any scheme or mission would be like asking for the sun. A government set will always find ways to make money out of schemes as is already being done with pulse polio. The NRHM is yet another fail dream. BY Atul S Bhadur Recognizing the significances of health government of India launched National Rural Health mission (NRHM) in 2005. A lot of emphasis was given to strengthen the rural health infrastructure, including the physical manpower and other facilities, the current health conditions are one of the reasons for Indians poor rank in human development index. This programme has put rural public health care firmly on the agenda and is on the right track with the institutional changes it has wrong with in the health system, over the last several years in India there has been a drastic change in the national government is approach to the health sector. India was one of the pioneers in health service planning with a focus on primary health care. Most of the Indian Population lives in rural area and they are suffering from long standing health care problems. It is estimated that only one trained health care provider including a doctor with any degree is available per sixteen village Most of the health problem that people suffer from on rural community

and in urban slums are preventable and easily treatable . In view of the above issues NRHM was launched by the government of India in April 2005. It also seeks to revitalize Indian tradition of Ayurveda , Yoga, Unani , Siddha and Homeopathy.

Health is listed as a state subject in the Indian constitution while family welfare is in the concurrent list. NRHM envisages a significant role for communities in the delivery and monitoring of primary health care. NRHM is a joint mission steering group, headed by the union minister of health and family welfare and an empowered committee, headed by union secretary for health and family welfare. A mission directorate has been created for planning and implementation and monitoring day to day administration.

Lack of trained person and infrastructure is a major concern for proper implementation of NRHM. Presently at the district level and below there is a hurry to achieve targets which cannot be achieved In absence of trained personnel; and improvement in infrastructure. There is an acute shortage of all categories of staff in health sectors across the length and breadth of the nation. Most glaring are the lack of specialist doctors laboratory technicians and male health workers. A need for a second Auxiliary nurse midwife is felt in all the states. To improve the health care system in rural areas, the government should ensure proper arrangements of trained health personnel. There should be a fixed quota of the specialist doctors in the recruitment policy and some extra benefit should be given to these specialists.

Implementation of NRHM in many states like Jharkhand is very challenging .These states lack the very basic infrastructures for implementation of national health programmes and state health societies were not constituted here for long.

There is possibility of corruption in the implementation of this programme. Recent example of state uttar pradesh state indicate the possibility of corruption at higher level . The chief secretary of uttarparadesh conceded that it was the rampant corruption at various level in the execution of Rs 3000 crore under NRHM schemes that led to the murder of two successive chief medical officers in Lucknow. There should be check on the corrupt practices of the engaged bureaucrats. The official should engage civil societies and local peoples while making expenditure on health service under NRHM. Untied funds are not being released at proper time and most of the medicals officers and ANMs were unaware about the proper utilization of these untied funds, due to lack of training of panchayti raj institutions, there is lack of clarity how the funds will be

operated. There is provision of up gradation of PHC's and CHC's in the states but in some state these PHC's and CHC's not been upgraded. The quality assurance committee has not yet been constituted to maintain the medical services.

ANMs and AWWs are also not aware about their duties and responsibilities. Thus the state of NRHM is quite dismal in many states. it is suggested that proper training programmes should be organized. The ANMs and AWWS should be trained and held responsible for the quality assurances of medical services. Public private partnership process should not encourage the privatization of health service. Financing should be from public funds so that universal access to service is ensured. Other challenges hampering to better health services are hard to reach areas, low acceptance level in some areas, extremist prove areas, quality assurance in strengthening the village health Committee and Sahiya training lack of infrastructure and trained human resources and frequent transfer of health personnel. Village level planning should be introduced as soon as possible.

NRHM should welcome partnership with the Non Governmental sector in a fully transparent manner to ensure that quality services are available at affordable costs to communities. In emergency there should be provision of engagement of some specialist doctors working in the private hospitals under this programme. The overall health status is not well in some states the reasons for the poor health status of millions of people are not hard to find. Major factor hindering accesses to quality health services are lack of non existing inter linkages between different stakes holders. This phenomenon is also found between different Government Departments. There is also need of forging alliances with wider determinants of health. The factors that hinder proper implementation of NRHM from the beginning are not addressing existing problems in the health systems before initiating NRHM other reasons are lack of systematic coordination and implementation of various programmes and mechanism by states Governments; A theoretical frame work with special reference to Indian Rural Hospitals. A Mehta it observed that though the Indian Government has made efforts to set up a vast network of health centers in deep interior regions of rural areas, their importance is declining due to neglect of services quality. The pros and cons of this can be debated but something is better than nothing for the for the Indian's population which is predominantly rural and distributed across distant geographically locations.

Widely accepted definition of health is that given by the WHO accordingly positive health is described as "health is a state of complete physical, mental and social well being and not merely an absence of diseases or infirmity". The enjoyment of the highest at tamable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief economic or social condition.

Despite a renewed commitment to investment in primary care structures under the NRHM wide spread shortages of skilled health care professionals at lower level facilities remain while poor governance including historic lack of financial investment and poor supervision contribute to poor quality of services provided shortage of drugs and high level of staff absenteeism. The private sector is the most important source of health care services in India.

A related fact is that nearly 75% of health related expenses are out of pocket and occur at the point of services delivery over the last few years there have been many initiatives to improve the efficiency, effectiveness and equity in provision of health care services in the country. Public Private Partnership is one such initiative. Over the years the private health sector in India has grown remarkably.

National Rural Health Mission represents an important link to address essential health needs of the country's undeserved population. For the mission to achieve its goal urban population needs to be included in its scope other factor contributing to inadequate reach of services are illegality, social exclusion of slums hidden slum pockets, weak social fabric lacking coordination among various stakeholders and neglected political consciousness. Opportunities for impacting urban health are several. National Rural Health Mission should be broadened to National Public Health Mission.

The National Rural Health Mission represents a renewal, communicable diseases control and health protection and promotion. NRHM approach reflects the growing realization among public health promotional. It provides an opportunity for health administrator to provide need based health care, ensure reach of Public health services to the undeserved segments through vitalized health system, enable socio-economically and educationally weak communities to take better care of their health and bring all pieces of the health and linked sectors to function in a harmonized and complementary manner to optimized impact.

While public health indicators (under 5 mortality, infant mortality) in India had improved measurably over the last few decades. Among several factors a notable

issue is that essential public health services have remained inaccessible owing to physical distance, affordability and other reasons for large segments of people in rural as well as urban. For NRHM to achieve its goals, the growing urban population needs to be included in its scope. Poverty is not merely a rural phenomenon one out of four poor persons of the country is now an urban residents. The reasons for urban poor population growing rapidly is that Migration into a city from villages and smaller towns owing to better opportunities diminution of rural agricultural lands and related livelihood opportunities and expansion of city boundaries to include peripheral rural area areas some of which get converted into slums as rural land is colonized for housing purposes.

The reason for poor health status of the urban in India is that slum dweller in cities suffer from adverse health conditions owing to insufficient services, low awareness and poor environment government efforts have been primarily rural centric , a few urban schemes have been implemented in the past. These include the urban family welfare scheme urban revamping scheme, sterilization bed scheme in urban areas. Why do primary health service not reach the urban poor? Lack of organized public sector infrastructure and survive in urban areas.

It means there is inequitable distribution of available resources for urban poor among different cities. Mega cities like Mumbai, Delhi, Kolkata, and Chennai have greater management and negotiation capacity that enables them to garner more support and resources. It means health survive provider often rough in behavior towards slum dweller this dissuades the latter from availing services.

It means slums dwellers are considered synonymous with pocket of dirty, diseased and gloomy people and wished to disappear for making cleanness in the city. Sometimes government demolish entire slums to clean up the city for meeting legal obligation . Due to this many population of urban poor become homeless.

Services do not reach hidden and missing pockets of urban poverty that are not part of official slum list. Bound to a specific industry, they are usually on some private land, unseen by most.

Existing policies need to be improved to make them more urban poor friendly, practical and measurable. Energetic policy implementation can be ensured through a) regular training of officer b) increasing information about various schemes to urban poor.

Health department could collaborate with other stakeholders (water and sanitation departments) and NGOs to provide basic environment and health service in slums.

Involve private sector: NRHM has clearly identified public private partnership as a key approach for implementation of various health programmes. Strengthening municipal functioning for getting better results while generating resources at the local level, better financial managements and effectively engaging with private sector partners. Need for dedicated focus on urban health within national rural health mission by S. Aggarwal.

1.3 Statement of Problems

However, this powerful instrument to strengthen good health of the people in the country may succeed only if the citizens have adequate knowledge about the provision of the NRHM. Having being enacted seven years ago, it would be appropriate time to know the awareness about the provisions of the NRHM. In the present study, and efforts has been made to know the level of awareness among the educated youth about the provisions of the NRHM and the study was conducted on the students of different colleges situated in Rewari town of Haryana state. Thus, the research problem under study may be stated as: Awareness of NRHM among college students: A study of Rewari town in Haryana .

1.4 Objectives of the Study

1. To known whether there exists a significant difference between the levels of awareness of male and female students about provisions of NRHM.
2. To known whether there exists a significant difference between the levels of awareness of students from rural and urban areas about provision of NRHM.
3. To known whether there exist a significant difference between the levels of awareness of students from arts and science streams about provision of NRHM.
4. To known whether there exist a significant difference between the levels of awareness of students from arts and commerce streams about provision of NRHM.
5. To known whether there exist a significant difference between the levels of awareness of students from arts and Professional courses streams about provision of NRHM.

6. To known whether there exist a significant difference between the levels of awareness of students from arts and Teacher Education streams about provision of NRHM.
7. To known whether there exists a significant difference between the levels of awareness of students from science and commerce streams about provision of NRHM.
8. To known whether there exist significant differences between the levels of awareness of students from science and commerce streams about provision of NRHM.
9. To known whether there exist significant differences between the levels of awareness of students from science and Teacher Education streams about provision of NRHM.
10. To known whether there exist significant differences between the levels of awareness of students from commerce and Professional courses streams about provision of NRHM.
11. To known whether there exist significant differences between the levels of awareness of students from commerce and Teacher Education streams about provision of NRHM.
12. To known whether there exist a significant difference between the levels of awareness of students from Professional courses and Teacher Education streams about provision of NRHM.

13. Hypothesis - Following have been the Main Hypotheses of the study :

13.1.There exists a significant differences between the levels of awareness of male and female students about provisions of NRHM.

13.2. There exists a significant differences between the level of awareness of

students from rural and urban areas about provisions of NRHM.

13.3. There exists a significant differences between the level of awareness of

students from arts and science streams about provisions of NRHM.

13.4. There exists a significant differences between the level of awareness of

students from arts and commerce streams about provisions of NRHM.

13.5. There exists a significant differences between the level of awareness of

students from arts and Professional courses streams about provisions of NRHM.

14. **Methods and Methodology**

The present study is an empirical study related to the college students of Rewari town in Haryana state. The studies under taken to observe and highlight the level of awareness among college students about the provisions of NRHM. As explained in the previous section , There are seven colleges in Rewari town with 4 degree colleges and 3 colleges of education and the number of students in all these colleges has been 9090. Degree colleges offer the following courses: B.A…, B.Sc., B.com, B.B.A, B.C.A., B.B.E., B.Sc., (Biotech.), M.A., and M.Com. In colleges of education, there are three streams: B.Ed., M.Ed., and D.Ed.

15. 1.7 Limitation of the Study

The researcher had to work under considerable limitations. The present study does not include the student of distance education because distance education students come once in a week and the researcher had lack of time. So, data was collected from the regular college students of different courses according to their propitiation in total population. Further, the researcher tried to know the difference between the level of awareness in male and female, and rural and urban. But male and female, and rural and urban students in the samples are not according to their proportion in the population-college students of Rewari town.