Documenting the 2nd ANM training and deployment of West Bengal

NHSRC

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2nd ANM training and deployment of West Bengal:

About the Model:[1]

History:

The Health Sub Centres (HSCs) in the state are established at a density of one facility for every 5000 populations, which is norm prescribed by the planning commission and which is reiterated by the Indian Public Health standards of the National Rural Health Mission. . The number of HSCs are established based on 1991 census and requirements have not been revised for population rise over the two decades since then. The number of HSCs increased to 10,356 in 2004 to reach the density required for the 1991 population level. .[2] However there was no ANM output from 1993 to 2003 as ANM schools had been closed. The stated reason for this was that in 1993 there were no further vacancies. .[3] There is no documentation of this reason- but given the feature that it occurred across states almost at the same time, one needs to correlate this with the change of policy in 1993. Whatever the reasons for the shut down and schools and subsequent non availability and non recruitment of ANMs, the net result was that in the year 2003 existing ANMs served on average 8,000 - 10,000 populations to compensate for the vacant posts.[4] In 2002, the West Bengal government took initiatives to re-open the ANM training schools in the public sector, to fill the vacant posts in the newly sanctioned HSCs and fill up vacancies in existing institutions.

The requirement of for ANMs further increased following the launch of the National Rural Health Mission (NRHM) in 2006. One of the components of the mission was to increase human resources in health and a specific activity that was encouraged was to increase the number of ANMs in the HSCs to two. The reasons for the decision to increase the ANM were three fold: First the work description of the ANM was such that one person could just not achieve it. To give one example : an ANM had to make field visits and attend immunisation sessions away from her sub-centre on at least 15 days per month. If this were so, she could not combine this with providing midwifery services in the sub-centre on a 24 hour basis. If there were a second ANM and a male multi-purpose worker than the centre could be kept open. Another dimension of this same issue relates to population dispersion. Secondly in tribal and difficult areas, the 5000 could be dispersed around 7 to 12 habitations. Collecting the vaccine and reaching each habitation was thus not possible and coverage in practice reached only nearby hamlets. However in such areas if there were two ANMs, sharing the burden of work made it easier for them to reach every habitation. Secondly an ANM is a woman worker and we can expect them to be on leave at least 40 days in a year, not counting maternity leave. One ANM per sub-centre provides for no leave reserve, and as a system at least a 30% reserve is needed. Two ANMs per sub-centre is a more viable sub-centre. Thirdly a woman alone in a village is not a viable team. A group of three is a much more viable unit. The reasons why this thought had not

[1] Discussion with Special Sectary, Health and Family Welfare and Deputy Director of Health Services (Nursing) [2] GoWB (2004) Opening of New Sub-centers, Health and Family Welfare Department, Kolkata
[3] GoWB (2008) Annual out-turn of Nurses, 1990-2007. State Bureau of Health Intelligence, Directorate of Health Services, Kolkata, Table XI.11
[4] Information provided by DDHS, Nursing

occurred over two decades of health sector reform was probably became a victim of the philosophy of keeping the government small. Even today such is the reluctance to increase government employee strength that appointing them as contractual staff instead of as permanent employees is considered preferable. However in comparison with the international norm of having at least 250 professional service providers per 100,000 workforce, even with the entire IPHS norms being implemented the workforce would not cross 150 per 100,000.

Accepting this strategy of two ANMs per sub-centre meant a further increase of at least 10,356 ANMs. In the light of this, a fresh situation analysis of number of ANMs graduating currently and ANM training schools in the state was undertaken by the nursing division of the department of health and family welfare,. West Bengal is one of the few states to have a fully developed nursing division in the state directorate. A plan was drawn up to meet the entire requirement of 10,356 ANMs in three to four years. This involved the following five steps:

1. Increase the capacity of the existing training institutions, utilise the un-utilised spaces/infrastructure in exiting training centres
2. Develop innovative partnership with the private sector to expand the capacity to train ANMs such that the total deficit is met.. Once this backlog is met, the number of training centres can be cut back to replacement levels.
3. Innovate on the selection process of the ANM so that there was clear preference given to those ANMs who wanted to work in that specific village. Involve the panchayats in their selection.
4. Post the ANMs after training directly back to their place of selection and as an employee of the local government, and not as part of the state cadre.
5. During the training keep her as close to her community as possible- and also tailor the course curriculum to meet her immediate work needs.
6. Provide for strengthening the sub-centre especially the accommodation for ANMs, so that those trained could be retained there.

Details of each of these steps are given below

1. Strengthening Existing Institutions in the public sector.

This had two components- The first component was to establish new nursing schools in the existing infrastructure, and the second, was to augment the capacity of the existing nursing schools and thirdly, to engage in partnership with the private sector.

A detailed survey of the existing health facility at the secondary level hospitals with more than 100 bed size was considered for inclusion in the survey.[5] This is important for the training of ANMs requires a hospital setting where there are many institutional deliveries ongoing. Accordingly, 11 new sites were recognised and given permission to start new nursing training schools. The certificate of recognition as NTS was provided following the inspection of the facilities by West Bengal Nursing Council (WBNC) and subsequently by Indian Nursing Council (INC). The additional support for

[5] GoWB(2006) Opening of New ANM (R) training school, increase of intake in the existing NTS, department of health and family welfare, Kolkata

equipments, materials, and infrastructure was made available by the department of health services, nursing division on a priority basis. The main criterion for recognition was availability of classrooms, accommodation and laboratory as first priority along with availability of security and mess facility.

The second component was to augment the existing NTS following the inspection based on availability of classrooms and infrastructure. If more faculty was needed they were provided. The existing intake capacity in 38 NTS was at 520 students and augmentation lead to increase in the number to 2026. The entire process was done with an expenditure of Rs 8.17 Crore and Rs 2 crore assistance for teaching aids.[6]

2. PPP Model:

The National Health Policy 2002, had proposed to engage private sector for better delivery of health care services. Therefore, the state policy for public private partnerships (PPP) in the health sector, aims at strengthening of public sector as well as private sector with due concern to build on each other's weakness without deviating from the commitment to provide health care for the poor.[7] The state government had also adopted a similar policy on PPPs.

An effort was made to engage private sector hospitals to provide ANM training.

An advertisement calling for an expression of interest was placed in leading news papers in 2006. Of 270 applications received 49 were found suitable. These shortlisted institutions were visited by a team comprising of members from department of health services, nursing division; west Bengal nursing council and Indian nursing council. The criterion was infrastructure, availability of class rooms, laboratory, teachers, vehicles and accommodation. Based on these criterion 11 institutions were selected in the first phase. The selected institutions entered with memorandum of understanding (MOU) with the government, wherein they undertook the task of offered training for a specified grant. They were to train only those whom the government sponsored. Their accounts would be audited by an auditor appointed by district health and family welfare samity.[8]

Selection of Students:

In the first phase 141 blocks were selected which had around 4393 HSCs. The blocks prioritised for the first round of selections, were those which had the lowest Reproductive and Child Health indicators (RCH), lowest literacy indicators, and a higher tribal population.. In the first phase training was planned for 3527 trainees, the maximum that could be managed even with the expansion of nursing training school capacity.

Then the recruitments for the second ANM was announced through advertisements published in respective districts in local news papers as well as state level news papers as well as by information passed on within the districts from all government offices, panchayat offices, and public hospitals.

[6] GoWB(n,d) Training of Second ANM, The West Bengal Experience, Health and Family Welfare Department, Kolkata

[7] GoWB (2006) Policy for Public Private Partnerships in the Health Sector, Department of Health and Family Welfare, Kolkata.

[8] GoWB (n,d) Memorandum of Understanding, Government of West Bengal and Non-government Organization, for the purpose of setting up the continue training of ANMs in training centers.

Pamphlets were also distributed. The advertisement carried information about the availability of 2nd ANM posts in the HSC, minimum education requirement details as well as necessary documents that to be posted along with the application form. The applications from respective candidates had to be sent to sub-divisional officer- the senior most administrative officer of a group of three or four blocks.(the block is an administrative unit of about 1.5 lakh population. A district has about ten blocks). The applications were screened based on their marks obtained in the "mahdhyamik" board exams (10th standard), the marital status of the applicant(ever married women being preferred) , age limit of 25 to 35 yrs with relaxation for SC/ST (5 yrs) and OBC women (3 yrs), and finally proof of residence in that locality from respective panchayat office.[9] A committee comprising of Sub-divisional Officer, Assistant Chief medical officer for the distict and the district public health nurse officer were members for screening of committee at the sub-divisional level along with block development officer (the highest officer of the block), the Karmadhakshya of the Sthayee Samiti of the panchayat samity(this is the key functionary of a statutory committee under the local elected government) and the block public health nurse. This large team would process each application received against the HSCs and candidate with the highest marks amongst those who fulfil these criteria is selected for training. Some HSCs which had high population of SC/ST or OBC population were kept reserved for the candidates applying from these communities. The final list of candidates against the 2nd ANM post of the respective HSCs would be sent to Deputy Director Health Services (Nursing) who places them in the nearest nursing school, but given the uneven distribution of seats, could potentially place them wherever needed. A well established mechanism was set in place for proper independent verification of the candidates following the admission. In this process, 3017 candidate ANMs were admitted for training in the first batch and 822 were admitted for second batch and 2620 admitted in the third batch. The admitted candidates would undergo 18 months training in the recognised NTS in the state (table 2).

As the first batch of trainees completed their course, the West Bengal Nursing Council and Deputy Director of health services (Nursing) (DDHS) made re-assessment of the infrastructure, training, boarding and food facilities at these centres. Following which two of the previous recognised NTS started up by non-governmental organisations were de-recognised and 4 new NGOs were added to the pool. The training of the second batch started in the month of March 2008 and third batch in February, 2009. In the first phase applications had been submitted to block development office, but as there were numerous court cases, and the capacity of the BDO office came into doubt, the applicants of subsequent batches had to submit the application at the sub-divisional office. (Candidates of the first round had not been given a receipt of acceptance of the application from the BDO officer and this lead to discrepancies which had been contested in courts.)

Table 2. Number of Blocks, HSCs and detailed status of ANMs

	Blocks	HSCs	Allotted for Training	Admitted in NTS	Passed Students	Total
First Batch	141	4393	3527	3017	2730	2730
Second Batch	103	941	958	822	na	822
Third Batch	209	3202	3029	2620	na	2620
Total	453*	8536	7514	6459	2730	6172

*341 blocks in the state and some blocks were repeated for the reason of drop-outs.

[9] The 2nd ANM position was reserved for only married/widow/divorced and spinster applications were rejected. Secondly there was no cut-off point in marks obtained for selection of candidates.

The selection process of the first "regular" ANM as compared to this second "contractual" ANM in the state deviates from that of this model.[10] For the first regular ANM, the cumulative numbers of vacant posts in HSCs are gathered based on vacancy assessment exercise carried out by DDHS (nursing). Following this there are advertisements in the state newspapers for which applications are sought. The applicant eligibility differs in that marital status is not insisted on, and age of applicants is from 18 to 35, and the candidate should be resident in any of the areas where the HSC are located. The screening committee was of a district team in contrast to second ANM where the selection committee was by officers from the block and divisional level. This district level selection committee was made up of the senior most medical officer, the president of the elected district local government body (Zilla Panchayat) and the district Social Welfare Officer, Sc/St Officer, representative of DDHS (Nursing) and principal of the nursing institute of the respective district acting as convener. Choice of training institution also priorities the institution within the same district or at best neighbouring district- but not a random district.

The name of the successful candidates are then put up in the respective HSCs from where the applications were received and with due date of joining along with the assigned NTS. In case a candidate fails to admit within the due date, her selection is "withheld" and further enquiry is made into the matter following which the candidate is allowed to admit or removed from the list. A bond to complete the training is required of them.

None of the candidates have to pay any fees admission or tuition fees but they have to take care of their food expenses and expenses on books as well as the examination and certification fees.

4. Course Content:

The course module of the 2nd ANM programme has been redesigned with greater stress on serving the community. The 1st ANM programme has been designed with more of clinical skills and less of community orientation. Therefore there is a general perception among the trainers that the 2nd ANM cannot be employed in any hospital other than at the community level. The course modules are translated in the local language (Bengali) with approval from Indian Nursing Council and then distributed "one each" to NTS. There are many gaps here- the schools often getting photocopies distributed as there are no printed books as yet. Many trainers, newly recruited in these schools were not able to cope, as reported in interviews with students and trainers. Only those faculty who are retired as trainers and experienced faculty members in the government run institutions were able to provide better understanding of new course material to students. One NGO training school administrator stated "new faculty recruited for the purpose of 2nd ANM training are unable to train them, therefore we have deputed our experienced BSC nursing training faculty to train them." Such reports were absent in the government schools reported The dearth of faculty in the public sector was managed by posting of regular experienced nursing staff from the health system to provide clinical training for trainees and faculty in the institutions were requested to perform additional responsibility of training additional number of trainees. The department of health services provided incentive of Rs 2000 in both the cases.[11]

[10] To be read hence forth as first ANM or 1st ANM

[11] GoWB (2006) Posting nursing personnel as faculty in NTS to receive honorarium in to their normal pay and allowance, Health and Family Welfare department, Kolkata.

The duration of the course was for 72 weeks. There were courses on community health nursing, health promotion, primary health care nursing, child health nursing; in the first 12 months. Midwifery, health centre management, preparatory leave and examination followed by second round of community visits occupied the last 6 months. There were three types of training sessions- clinical, community level and class room sessions. All students are monitored and supported by respective faculty members and in the clinical sessions, most of the time "staff nurse" in respective institutions guide and monitor students as and when posted/visited. The clinical postings of NGO run nursing schools were are also done in district hospitals, medical colleges and other government hospitals available at an accessible distance from the training centres. The community level training included visits to rural hospitals and to villages surrounding these hospitals. They also visit the urban slums to understand about the urban health. As a part of the assignment they do household visits and prepare a geographic map of the entire village. Street plays, poster presentation, community health talk, at the community level; weighing new born, monitoring the growth of the new born with growth chart, etc. Is part of the community level training. At the clinical skill level; all the necessary requirements to be fulfilled by respective candidates as per the nursing council (INC/WBNC) norms for appearing in the exams are achieved. Each student had to complete 20 deliveries first few cases under assistance and later independently. The schools are directed to conduct internal examination and present them as internal assessment marks to the external examiner at the time of final examination. The examinations have both theory as well as practical. The theory would have more of objective type question followed by short answers. The first batch of students mainly had objective questions and the later batches are having both objective type as well as short answers. The 1st ANM exams in contrast have more of long essay questions and are considered more difficult. There are two exams, the first at the end of 12 months and the second at the end of the course. Each student has to pass first level to appear for the level 2 exams. The successful students are then given the certificate of registration as ANM under the Indian Nursing Council. Following which they report to the sub-divisional office and collect their letter of appointment as contractual 2nd ANM staff at respective health sub-centres from where they had applied for the training. At the end of the first batch 2730 ANMs out of the 3017 students admitted completed the course and were posted at their respective HSCs. The unsuccessful students were given second chance to clear the exam from their respective NTS centres. There was no clear understanding about the policy of addressing the drop outs. We assume that the drop out candidates post could re-appear in the subsequent advertisements. The number of those completing the course who are joining is reported to be almost 100%. It is still too early to report on long term retention, but the outlook is promising.

Most of this information gathered from the senior official interviews and documents were validated by interviews with students, trainers. In each of the eight nursing schools visited, three students were picked randomly from each of these institutions who provided information about the entire process of selection and training. All candidates interacted during the visit to respective NTS, expressed their desire to work as 2nd ANM in their own village. Most of them received the information about 2nd ANM through news papers and some received the information from gram panchayat. There were also efforts to dissuade them from applying from many sources for many reasons- power, gender, caste etc. There was little support from the family members, and most candidates report having themselves taken the initiative to respond to the advertisements. Overall, the role of panchayat was appreciated by the candidates in their respective villages. All students interviewed had followed the procedure that was mentioned in the letter of provisional admission

issued by the department of health and family welfare, Kolkata. The cross verification of certificates was done at the NTS by respective staff. Following which, students submit the original bond papers with declaration that they would complete the 18 months training course and would join the HSCs from where they were selected.[12] Students expressed difficulty in understanding the subject initially and they thanked faculty and the government for making the course modules subsequently available in the local language and this enabled them to learn faster. They also presented the views that the transportation arrangement for field visits was limited and often had to make their own arrangements for visiting the health facilities like the district hospitals, medical college etc. Diet as well as clothing, were to be arranged by students and they felt that the stipend was very low compared to the expenses that they had to bear for diet.[13] The average monthly expenses bore by each student was at Rs 1,000 - 1,500 but the stipend was only Rs 500 per month.

Overall interviewed students had very high impression about the programme. All most all of them narrated that the they had never anticipated that with only "madhyamik" schooling they are now getting trained as ANM for the health system. They also expressed their desire to serve the community which they often felt there was need of health worker mainly women in the community.

Posting of the Second ANM:

The posting of the second ANM as an employee of the panchayat is a big break with past practice. This rules the whole issue of transfer and posting except within a range of a three to five HSCs in 5 to 20 km radius. It also makes for much better accountability and responsiveness of the health sub-centre as an institution.

Strengthening the Sub-centre

Along with this under the Health Systems Development Project (HSDI) assisted by DFID, 1023 sub-centre local in village panchaayat head quarters has been taken up for strengthening. Residential accommodation for both ANMs would be attached and as of now work is completed in 594 units.[14] Further construction of 248 non-GP head quarters was proposed under NRHM programme and an additional 340 would be completed in proposed in the 2008-09 financial year.[15] Making the availability of quarters at least at the GP head quarters was the main priority during this n period, as ANMs posted here are being insisted upon their staying there. This alignment of sub-centres with gram panchayat headquarters has been done to make them full time functional for access to skilled assistance at birth. Thus sub-centres in west Bengal have now become differentiated into two types, the GP HQ sub-centres and the others. The male worker is also required to stay there and medical officers encouraged to visit these GP HQ HSCs on fixed days.

Financing of the Programme:

[12] Drawn from the sample copy acquired from an institute for reference purpose only.
[13] The officials raise concerns over the low stipend and have approached the government for increasing the amount. However due to administrative hazels the issue of increasing the stipend was not addressed.
[14] GoWB (2004) Reporting and Feedback under health management information system, department of health and family welfare, Kolkata
[15] GoWB(n,d) The Plan Document - 2007-08, Department of Planning, Kolkata.

The 2nd ANM programme was completely financed under the National Rural Health Mission. The funds from NRHM was used for construction of additional class rooms, hostels, expansion of dining space, laboratory equipments. The second phase funds were utilised for surveying existing infrastructure in the vicinity of sub-divisional hospitals, and converting what was available into hostels and classrooms. In the third phase, selected NGOs were provided financial support under certain heads as shown in the table below. The extent of funding was based on the intake capacity. The budget formulation was separate for schools under government and those under PPP.. The total government allocation for NTS under government is Rs 2,20,18,168 for 38 NTS in government sector for the period of six months from 1st April 2008 for the first batch of 2nd ANM training.[16] The total NGO figures were unavailable for the same period. In the case of a nursing school in public sector and within the premises of the sub-divisional/district hospitals the funds were transferred to respective hospital development societies (Rogi Kalyan Samitis), who would then issue the funds for the institution based on the needs.[17] The NTS in public sector expressed advantages and disadvantage over the funds pooled into RKS. The main advantage was that additional equipments, materials, repairs, menial staff salary and security were adjusted from the RKS budget. The disadvantages was that the priority of the RKS were different than that of the NTS and the procedure would usually get delayed and thereby the budget sanctions. In the other form, the limited budget and expenditure under respective sub-heads was a major concern and the utilisation of unutilized funds from one head to other was not permitted. There were also concerns raised over utilization of the untied funds. The state had sent an order by which it was difficult for the NTS to utilise untied funds.

The budget sub-heads varied between an NGO, NTS and Government NGOs (see table). The budget for student stipend, student field visits, sweeper and menial staff were similar. However some budget heads were not applicable for NGO run NTS (eg. Untied fund) and some were not applicable for government run NTS (salary of staff). The budget was reduced for security as well as housekeeper in the NGO side. NGOs have raised the concerns over the dearth of teaching staff and have requested government to raise the budget under teaching head and have also requested to raise budget under student stipend, security and field visits.

Table 3. Financial breakups comparison with NTS-Government and NTS - NGO (Example)[17]

Name of the institution	Number of students	Cheques will be issued to	Purpose	NTS Government	NTS NGO
				Total cost for 6 months	Total cost for 2 months
A	100	Accounts Officer	Stipend for students Rs 500 x 100	Rs 3,00,000	Rs 1,00,000
			Lodging for students Rs 600 x 100	n.a	Rs 1,20,000
			Salary for principal Rs 10,000 x 1	n.a	Rs 20,000
			Salary for teachers	n.a	Rs 96,000

[16] GoWB (2007) Administrative approval and financial sanction, department of health and family welfare, Kolkata

			Rs 8,000 x 6		
			Additional expenditure for teachers Rs 2000 x 5	Rs 60,000	n.a
			Additional expenditure for clerk-cum-computer assistant Rs 1000 x 1	Rs 6,000	n.a
			Salary for accountant cum clerk Rs 5000 x 1	n.a	Rs 10,000
			Expenditure to house keeper Rs 4000 x 3	Rs 72,000	n.a
			Expenditure for menial staff Rs 2000 x 5	Rs 60,000	Rs 12,000
			Expenditure for sweeper Rs 1500 x 2	Rs 18,000	Rs 3,000
			Cost of field visit Rs 500 x 100	Rs 3,00,000	Rs 1,00,000
			Untied fund and contingency Rs 2,00,000/3	Rs 67,000	n.a
			Cost of security person Rs 2500 x 3	Rs 45,000	n.a
			Cost of security person Rs 2000 x 3	n.a	Rs 12,000
			Total	Rs 9,28,000	Rs 4,73,000

An analysis of the programme:

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1. Selection was appropriate and is the single biggest guarantee of good outcomes in terms of attraction and retention of staff to under-serviced areas. The rule about selecting amongst willing and eligible candidates based only a high school marks though they may have passed school many years before is unfortunate. But given the political polarisation at the village level, any process of community selection becomes a bone of contention and even conflict. This was an acceptable way out. The problem is it could exclude minority sections and women who had proven track record of community service- but then the reasons states are also true and the state took the most pragmatic option by their judgement. Even now we note that there are over 500 court cases filed on this recruitment alone, but the government is confident of being able to manage these safely- as its systems are quite robust. It is worth noting and reflecting on the fact that many workforce reforms in India have got mired in

litigation, and one of the criteria of success in this has been their ability to manage it, even if not over come it.

2. Reservation for SC/ST in some HSCs to ensure marginalised communities adequate representation was also an effective and well appreciated measure. The selected students got a stipend and there were no fees, except for registration under WBNC. The entire training was done almost like an inservice training dedicated to the strengthening of a key level of the health sub-centre. Free hostel stay with security for students, and special permission granted for breast feeding mothers and women with infants to bring them along for the training were other special features that show that the government was really thinking through with compassion and commitment the challenge of being able to get the right person working in the right place.

1. The main weakness is in the dearth of teaching staff and the lack of a clear policy at teacher training and faculty development and support. There is also many reports of rural students not having the reuired level of intelligent quotient due to socio economic circumstances etc- which point both to inadequate teacher training and inadequate pedagogy. This notion of excellence and merit in selection as providing rationale for the special powers invested in the medical professions is a dangerous one and the source of much problems. Though nursing as such and ANMs certainly suffer less from such theories, there is a spill over impact on them and it is essential that good pedagogy and sensitisation counters this. There are no dumb students- only dumb systems. The lack of transportation to field visits/rural hospitals/community centres/clinical due to lack of vehicles and driver availability, is also a part of failure to emphasise minimum quality in teaching. Hired vehicles could easily do the job and the system should not hesitate to spend on the ANM.
2. A system of post training follow up and support for at least three years should also be put in place with the nursing schools having a major role in this.

Other weaknesses was placing the student- ANM away from their district for training, resulting in some drop-outs and running counter current to the main trend of this reform. This hopefully is easily corrected.

A more difficult issue is to scientifically work out the work allocation between the two ANMs and actively counter efforts to make a difference in seniority or in skills between the regular and the contractual ANM on anything but the work allocation. Even this work allocation should rotate so that there is no loss of skills and parity is maintained. The first ANM is used to staying away from the headquarters and therefore being remiss on her work. The second has every reason to stay here. If the first now becomes senior, her non working not only becomes justified, but also becomes the aspirational model for the second. That would be a serious set back indeed.

Conclusion:

This case study again brings out how seemingly intractable problems of attraction and retention of workforce in rural and remote areas is relatively easily addressed, given some administrative imagination and competence and some political will. There is much more to be done before this

would show up in terms of improved services, but this case study shows that dramatic improvements in the very short term are possible, if one could only think out of the box.

There has been considerable expert criticism of the ANM as inherently non remediable and based on this a sharp criticism of the second ANM strategy. Much of this criticism is posed as part of an argument to find private sector partnership solutions. Here is a case where private partnerships are used not as an alternative to public provisioning but as a device to make public systems viable. If the administrative imagination and management consultancy skills and good governance to implement such a reform is not available to strengthen public delivery it is unlikely that they would do much better with PPPs. There is a case for PPPs, but the argument certainly cannot be the so-called unremediable nature of public health delivery, and failure to do so is an administrative as well as political failure.

However efforts at replication of this should note that this is not one intervention but a well planned bundle of interventions that made the difference. Thus highlighting the PPP aspect or the local residence criteria of selection alone would miss the point for fragmented interventions in systems development would end up being sub-critical and bringing a bad name to the reform effort. Even now as pointed out in the discussion, the package of interventions is sub-critical - at at least quality of pedagogy and post training supportive supervision needs to be urgently addressed. However clearly this case study is grounds for optimism.