"To assess the performance of Public Health Managers (PHMs) working in the UPHC's under NUHM in cities of Telangana, India."

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By

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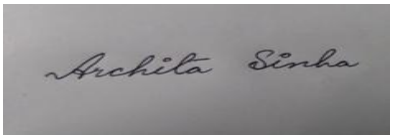
DECLARATION BY STUDENT

I hereby declare that this dissertation titled ““To assess the performance of Public Health Managers (PHMs) working in the UPHC’s under NUHM in cities of Telangana, India.” is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



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Introduction

In India, urbanization has been increasing at an alarming rate. According to the country's 2011 Census, 65.5 million Indians have been living in the urban slums and 13.7 % of the urban population living below the poverty line. This exponential growth of population in urban areas increased the burden on the available resources like shelter, sanitation, clean drinking water, electricity and most important the healthcare needs. Due to lack of planning, proper governance and the existing social inequities the gap between the elite and the poor widened and the urban poor lacked the basic services and became more marginalized.

In the urban areas primary healthcare services are mostly provided by single practitioners running their own clinics and unqualified practitioners. Though there are no external restrictions on the urban poor in seeking health care from the facility of their choice but what limits them from doing so are their financial condition, distance from the facility and their level of awareness. Thus, they lack in terms of receiving quality health care [1]. Thus, the need of separate programme to provide healthcare facilities to the urban poor was felt as their challenges and difficulties were different from the rural setting. The National Urban Health Mission (NUHM) was launched in the year 2013 to effectively address the health concerns of the urban population especially the poor and vulnerable population by facilitating equitable access to quality healthcare through strengthening the existing public health system, partnerships, community-based mechanism and the active involvement of the urban local bodies.

The target groups under NUHM are the poor population of the urban areas living in the listed and unlisted slums. It also focuses on other vulnerable population such as the homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers and other temporary migrants. NUHM aims to supplement resources that would address the social determinants of health like access to clean water, sanitation and housing by strengthening the capacities of the urban local bodies and provide services addressing the primary healthcare needs pertaining to communicable and non-communicable disease of the poor as well as marginalized urban population

The National Urban Health service delivery model made a strong effort to rationalize and strengthen the existing public health care system in the urban areas. Its broad framework encompasses the available manpower and resources to help improve the access of health services. It has a communitised risk pooling mechanism and enhances participation of the community in planning and management of the health care service delivery. The community link volunteers like Accredited Social Health Activist-ASHA/Link Workers-LW from other programs

like Jawaharlal Nehru National Urban Renewal Mission (JnNURM), Integrated Child Development Scheme (ICDS) etc. and establishment of Mahila Arogya Samitis (MAS), Rogi Kalyan Samitis (RKS) ensures participation at the community level. At the same time, it is also ensured that there is effective participation of the Urban Local Bodies (ULBs) and their capacity building along with key stakeholders and special provision for inclusion of the most vulnerable groups amongst the poor as well as development of e-enabled monitoring system. This health service delivery model promotes engagement with the non-governmental sector (profit/not for profit) for expanding reach to the urban poor. NUHM provides a system of convergence of all communicable and non-communicable disease programs through integrated planning at the city level. Public Health laboratories are also strengthened under the NUHM for early detection and management of the disease outbreaks in urban concentrations.

Figure1: Urban Health Care Delivery Model of NUHM

Institutional Framework of the NUHM

- **National Level** – National Programme Management Unit (NPMU) is set up at the central level. It is also responsible to provide technical assistance to the urban health division of the Ministry.
- **State Level** – State Programme Management Unit (SPMU) is set up with a separate Urban Health Cell reporting to the State Mission Director. The staffs are:
    - State Urban Health Program Manager
    - State Urban Health MIS Manager
    - State Urban Health Finance Manager
    - State Urban Health Consultant
- **City Level** – The existing structure of District Health Society/Mission under NRHM can be used or separate City Urban Health Mission/City Urban Health Societies are constituted. For enhancing the Programme Management, City Programme Management Unit (CPM) is established. The staffs of CPM are:
    - Urban Health Data Manager
    - Urban Health Accounts Manager
    - Consultant (Epidemiologist)
- **Community Level** – Mahila Arogya Samitis (MAS) are set up at the community level.

Table 1: Urban Health Care Facilities at the City Level (as per NUHM Framework for Implementation)

Population Served	**Health Facility Worker**
2.5 lakh population (5 lakh for metros)	1 UCHC (30-50 bedded in-patient facility, 100 bedded in Metros for 5 lakh population). It acts as a satellite hospital for 4-5 PHCs.
50,000 population	1 UPHC (OPD facility)
10,000 population with additional 10% for non-metros	1 ANM
1000-2500 population (200-500 household)	Community Health Volunteer (ASHA/LW)
250-500 population (50-100 household)	Mahila Arogya Samiti (MAS)

Urban Primary Health Centre (UPHC):

The Urban Primary Health Centers (UPHCs) under the NUHM are established in the existing public facilities in the urban areas to bring equity in terms of providing quality health care to the

urban poor. UPHC is the first point of service delivery providing primary preventive and curative healthcare services in the urban areas. UPHCs are to be located preferably within or close to a slum within half a kilometer radius. It should ideally cater to a population of 50,000–60,000 including approximately 25,000-30,000 slum population. However, based on local context, states can have one UPHC per 75,000 population in areas with very high density of population or catering to isolated slum clusters with 5000-10,000 population. The UPHCs are required to provide 8 hours of service preferably from 12 noon to 8 pm in the evening.

The key functions of the UPHCs (as per the NUHM Guidelines) are:

- Identify the health needs of the population through vulnerability mapping.
- Provide promotive, preventive and curative services through Out Patient Department (OPD), basic lab diagnostic services, drug/contraceptive dispensing and referral to nearest higher-level facility as per need.
- Provide outreach services through UHNDs for slum and other vulnerable population.
- Deliver RCH services and preventive and promotive aspects of communicable and non-communicable diseases.
- Provide access to drugs and diagnostics care for common NCDs like Diabetes and Hypertension.
- Can have fixed day/specialized OPD services.
- Can have co-located NTEP clinic and have provision of drugs for TB patients.
- Can serve as collection center for the diagnostic tests in partnership with empaneled private diagnostic centers.
- Perform disease surveillance and notification in the catchment area.
- Collaborate with the District Hospitals/ Area Hospitals/ Sub District Hospitals and local Medical Colleges to promote strengthening of the training support and to supplement human resource at the UPHC.

Table 2: Human Resources at the UPHC: Please add source

S. No.	Staff Category	Number
1.	Medical Officer (MO I/C)	1
2.	2nd MO (part time)	1
3.	Staff Nurse	3
4.	Pharmacist	1
5.	Lab Technician	1
6.	Public Health Manager (PHM) or Mobilization Officer	1
7.	Lady Health Visitor (LHV)	1
8.	Auxiliary Nurse Midwife (ANM)	4-5 depending upon the population

9.	Secretarial Staff Including for Account Keeping and MIS	2
10.	Support Staff	1

Need for the Study

Public Health Management can be defined as:

"*The optimal use of resources of the society and its health services towards the improvement of the health improvement of the population*."

"*Public Health Management is all about leadership and managing change*." [2]

As the definition of Public Health Management goes, in the year 2001 WHO – University of Durham Meeting Report broadly summed up the roles of Public Health Management as –

- Management and advocacy
- Involvement of people having relevant skills
- Networking to partnerships across organizations and disciplines
- It should be an outcome-based focus
- Public Health Management should be a national agenda for health and health services research.

The report highlighted the fact that in order to make Public Health Management a reality in the countries around the world, a cadre of Public Health Managers and practitioners are required who have received multidisciplinary training. The concept of Public Health Management is an attempt to provide a framework for implementation of the health policies combining knowledge-based decision making with the skills to bring about change and act on knowledge. To be effective, the PHM must possess both public health and managerial skills. As per the WHO report both the developed and less developed countries were struggling to improve the public health system because of the poor performing managers and the public health professionals. As a result of which the health gap between the affluent section and the poor section of the society widened.

In India, the dire need was felt of setting up a primary healthcare system that is able to link the community with the UPHC, UCHCs and higher levels of health system in order to ease the process of health delivery [3]. With this, the position of the Public Health Manager (PHM) was introduced for the first time under the Human Resources framework of the Urban Primary Health Centres (UPHCs) with the launch of NUHM. PHMs are the nodal person responsible for all the non-clinical activities at the UPHC. They are responsible for activities related to health education, multi-sectoral convergence and wellness at the UPHC-HWC and responsible for

providing overall support to the Medical Officer at the UPHC. They act as a link between the UPHC, the community and the higher levels of health service delivery framework. Public Health Managers report to the Medical Officer-in-charge of the UPHC.

The PHM is a professional trained in public health having the knowledge of basic concepts of Epidemiology and Biostatistics, health information system combined with managerial skills. S/he should possess graduate degree in Dental/ Ayush/ Nursing/ Life Sciences/ Social Science with Master's Degree in Public Health/ Community Health/ Preventive and Social Medicine. A relevant experience of 2 years in health program management is essential for the position of a PHM. The key roles and responsibilities of a PHM includes –

- Planning and budgeting for the UPHC
- Management of the human resources in the UPHC, their training and capacity building
- Management of infrastructure, equipment and all support services.
- Quality assurance of all the services being delivered in the UPHC
- Community mobilization, special outreach and referral support
- Convergence and coordination of the national and state health programmes running in the UPHC
- Disease surveillance and epidemic control
- IEC activities and public health education
- Data collection, HMIS reporting and analysis
- Grievance redressal.

When the status of NUHM was studied after its implementation, it was evident that even after the launch of the program, it has not gained enough momentum and the states are not able to utilize the central funds well. This has left the special needs of the urban population unaddressed [4]. It has been found that very little action was taken in the area of ASHA selection and training, formation and capacity building of Mahila Arogya Samitis [5]. Moreover, the states implementing NUHM particularly through the ULBs have been experiencing limitations with regard to fund utilization, coordination, human resources and so on. The most common issues highlighted were-

(1) Non-availability of land for UPHC/UCHC construction,
(2) Lack of linkages between MAS and NUHM and Self-Help Groups under the National Urban Livelihood Mission,
(3) Lack of coordination and periodic meetings between the ULBs, Urban Development and State Health Departments,
(4) Registration and transfer of funds under the NUHM
(5) Formation and registration of Rogi Kalyan Samitis

All these issues stand as hurdles in the goals of strengthening the primary healthcare system under the NUHM [6].

The role of Public Health Managers was envisaged as a link between the UPHC and the community, as a cadre responsible for overall management and functioning of the UPHC so that the health services are delivered equitably to the urban population especially the poor and marginalized population in the urban areas overcoming the challenges. Even after the introduction of Public Health Managers to the UPHCs, the UPHCs still face challenges in ensuring health services to the targeted population. The study has been designed to analyze and understand the gaps or the factors that are hindering in the smooth health service delivery at the primary level,This study puts forward an effort to assess the performance of the Public Health Managers in order to find out if this position has brought about any difference in health care service delivery of a UPHC, analyze the reason behind the existing gaps and challenges and what can be done to increase the effectiveness of the role of a Public Health Manager.

Literature Review

In India, the health service delivery is still lagging behind in terms of ensuring availability of service providers, lack of assured services, medicines and diagnostics and poorly functioning referral linkages. Several studies have highlighted the issues prevailing in the urban areas, ranging from lack of prioritization of urban health by Government, inadequate public health infrastructure, huge variation of infrastructural, environmental and socio-economic conditions of the vulnerable and non-vulnerable slums to even lack of social security mechanism which has led to the inaccessibility of quality healthcare services to the urban poor [7]. According to the 71st round of National Sample Survey report (2013-14), only 28% of rural population and 21% of urban population visited a public healthcare provider. It is even more surprising that the elaborate network of government primary healthcare facilities accounted for only 10% of the OPD services (excluding mother and child services) taken together both rural and urban setting [8]. The NUHM was strategized to fill in these gaps and facilitate equitable access of health facilities to the vulnerable population of the urban areas.

A study on the role of NUHM and UPHCs across India in delivering quality healthcare to the poor and deprived sections of the urban areas has thrown light onto some of the major limitations to NUHM achieving its objective – (a) poor coverage, (b) lower budget allocation and (c) shortage of staffs. It was found that more than 65% of positions are vacant in the Urban Health Centres across India and insufficient financial support is one of the reasons behind it [9]. Other challenges in the implementation of NUHM in the states included the variable timing and the UPHCs located far away from the slums which made the services inaccessible to the target population, it was tough to find space to establish UPHC due to the high density of the population, the women health staffs were reluctant to work in the evening hours in the slum due to security issues etc. The Medical Officers and staffs even held strikes refusing to work on the fixed timings of the facilities [10].

Telangana is one of the exponentially urbanising states of India. Hyderabad district shares the major part of the growth followed by Warangal, Nizamabad and Karimnagar districts which has resulted in the rapidly changing landscape of the state. As per 2011 Census, the urban population constitute of 38.9% of the state's population and this growth in the urban population is much higher than the other states of India [11]. A study conducted in the urban slums of Hyderabad, Telangana on primary immunization coverage gives an image of the healthcare service delivery in UPHCs of Telangana. It was found out that a majority of the mothers were not informed about immunization of their children during their OPD visits which portray a lack of effective communication by the staffs of the Urban Health Centres. Lack of awareness and non-availability of facilities were some of the reasons of delay in vaccination or impartial vaccination of the infants. Thus, the staffs working in the UPHCs along with the community level workers

can help in creating awareness in the community about the health facilities being provided that can improve the health condition in the urban slums [12].

The population growth in urban areas of Khammam district of Telangana, India is higher than state/ national average and has increased by 40-50% in the recent decades. This has led to a growing need of expansion of the health infrastructure. Though the Municipal Corporation has put an effort to expand the health infrastructure, but it could not match up to the needs of the ever-growing urban population of the district. This has forced the urban slums to live in an unhygienic environment leading to increase in vector-borne diseases and an overall poor health scenario of the community. It is evident from the studies done in the district's urban setting that there is a shortage of regular healthcare workers as well as equipment in the facility and this has aggravated the issue [13].

This inaccessibility and unavailability of health services to the urban population especially to the slum population across the states is reflective of the fact that implementation of NUHM has not been robust even years after the launch of this program. Challenges continue to remain in delivery of health services at the primary level though the Public Health Managers were introduced to provide support to the Medical Officer and other staffs at the UPHC along with supportive supervision of the community workers. As the Public Health Managers are entitled to manage the overall service delivery of a UPHC hence, it is important to understand the functioning of a PHM against the roles that were envisaged under the programme. The barrier to the functioning of a PHM needs to be analysed in order to bridge the remaining gaps. Studies have emphasized the need to strengthen the weak managerial capacity at the state, district and municipal levels to ensure the strengthening of the urban health services [14] but research done in this field in India are scanty. There is a wide gap in the literature available for the role of Public Health Manager in health service delivery in the UPHCs and hence, this study attempts to explore the role of a PHM in strengthening the primary healthcare structure in the urban areas.

Aim

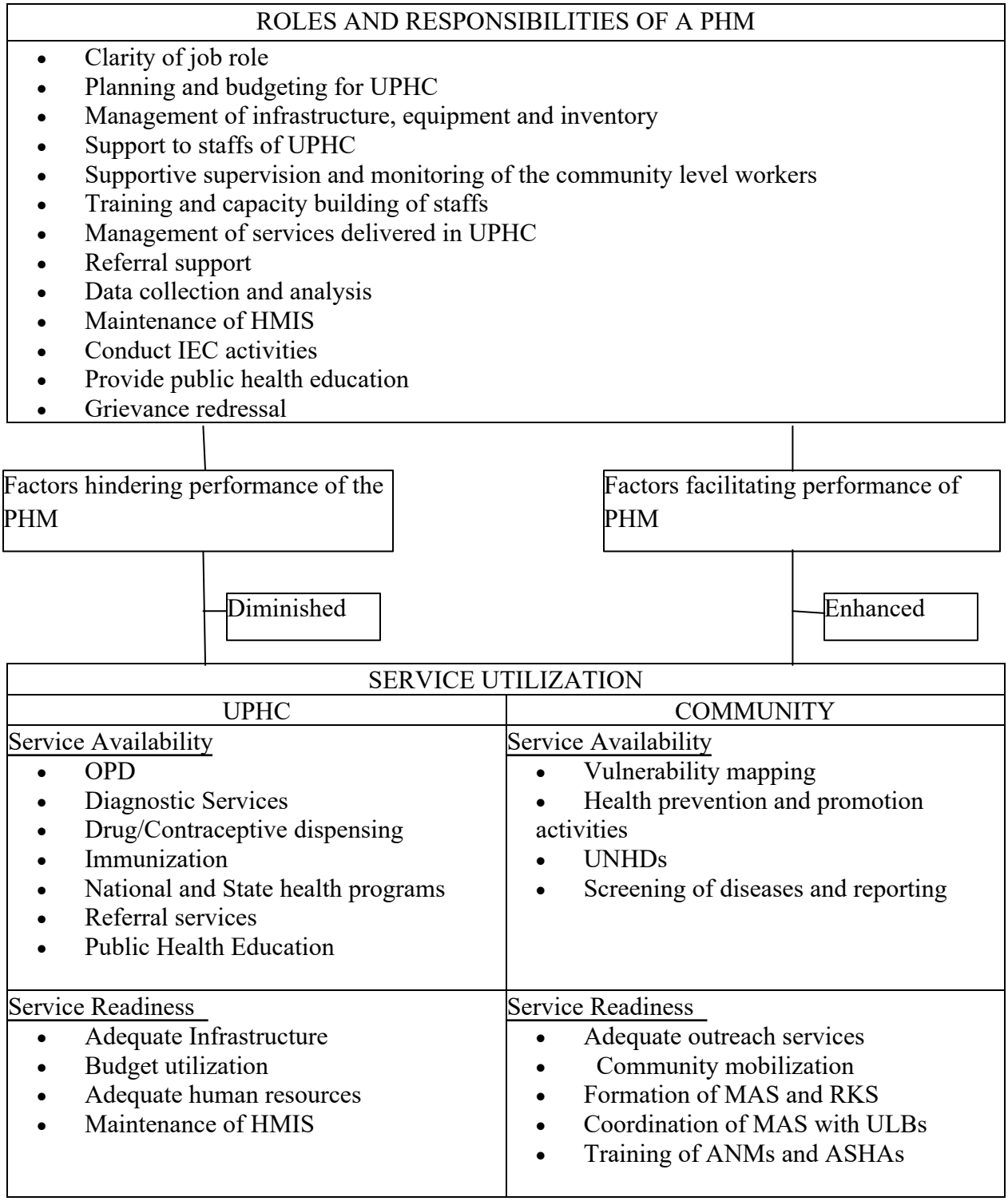
This study aims to assess the performance of the Public Health Managers (PHM) posted in the UPHCs under NUHM in Telangana, India.

Objectives

The objectives of the study are:

1. To assess the tasks performed by the Public Health Managers (PHM) against their perceived roles.
2. To understand how the Public Health Managers are contributing towards improving the utilization of services of the UPHCs.
3. To explore the enablers or barriers that influence or restricts their role.

Conceptual Framework



Methodology

Study Design

The study focuses on perceptions on role and responsibilities of Public Health Managers (PHMs) posted in the Urban Primary Health Centres (UPHCs) under National Urban Health Mission (NUHM). Hence, the research methodology selected was Qualitative in nature. The semi-structured interview tool for interviews helped us map and understand the tasks performed by the Public Health Managers (PHM), their everyday routine experiences, their difficulties, their challenges in planning, implementation and monitoring of health programmes at the community as well as facility level

This study was done as a pilot, which would set the base for a similar study on the PHM cadre across 3-4 states of India.

Sampling Frame/Universe

The universe of the study was selected UPHCs of districts in the state of Telangana.

Study Setting

The study will be conducted in the UPHCs of selected districts of Telangana.

Criterion for Selection of Districts and UPHCs

Stratified sampling method was used to select the districts and then the UPHCs where PHMs are in place from the cities were selected for the study. All the 33 districts were primarily divided into two groups: Aspirational and Non-Aspirational districts. Out of these two groups, districts where PHMs are not in place were excluded. The districts were then selected keeping in view the performance and progress made by the UPHCs in the districts.

Four indicators were considered for this selection:

1. Number of PHM/Community Officer in place
2. OPD conducted per 10,000 slum population in the FY 2019-20
3. Proportion of lab tests performed out of total OPD for the FY 2019-20 and
4. Percentage increase or decrease in ANC registration in 1st trimester of pregnancy from the FY 2018-19 to FY 2019-20.

All the districts were scored according to the above-mentioned indicators. The higher the value of these indicators for the districts, the score is higher and lower score is allotted for lower value

of indicators for the districts. Then the individual scores of each district are added up to get a cumulative score for each district and the districts are ranked according to these scores. The district with highest score was ranked the highest and considered as the best performing district and the district with lowest score was ranked lowest and was considered as poor performing for both aspirational and non-aspirational districts.

Based on the scoring, the two districts selected for the study were:

1. Aspirational Districts: Bhadradri Kothagudem
2. Non-Aspirational Districts: Karimnagar

Study population/Respondents

The study population consisted of the Public Health Managers (PHM) and the Medical Officer In-Charge (MO/IC) working in the UPHCs of the selected districts.

Data Collection Method

Semi-structured interview tool was used to collect primary data. Interviews were conducted with the help of interview guidelines. The interview guideline was prepared according to objectives, literature review and discussion with professionals. The primary data collection was conducted using telephonic in-depth interviews among the aforesaid stakeholders at their place of work. The in-depth interviews were conducted telephonically keeping in view the current COVID Pandemic. Interviews were taken in English and Hindi language preferred by the participants. After receiving the informed consent from all the respondents, the responses were recorded with the help of a mobile recorder for the study purpose.

Work Plan of the study

This study conducted in three different phases:

Phase 1: Secondary review

The first step in this study was a detailed background analysis from the available literature including programme guidelines of National Urban Health Mission (NUHM) and its framework document, Government orders, State Programme Implementation Plan and record of Proceedings, various studies and published reports. Based on this background analysis, the study tools were prepared.

Phase 2: Data collection

In-depth interviews were conducted with individual respondents and the interviews were recorded. Interview recorded with each individual was transcripted, followed by cleaning of collected data in order to extract the necessary information. Prior to initiation of the data collection informed consent was taken verbally from each and every respondent before interviewing them.

Phase 3: Data Analysis and Report preparation
Content analysis was done with the information gathered and findings generated for the study. Then, the report was prepared compiling all the findings generated from this study.

Data Analysis

The primary data collected through telephonic in-depth interviews were analysed using the technique of thematic analysis. The audio recorded interviews were further transcribed and translated. The data thus generated was codified and themes were identified. These themes were further categorised into sub themes. Analysis was done using content analysis methodology in MS Excel. While quoting the respondent responses, disclosure of participant's name or identity was avoided for ensuring confidentiality.

Study period

The study was conducted for a duration of 3 months and 16 days starting from 22nd March, 2021 till 8th July, 2021.

Data completion

A total of 8 in-depth interviews were conducted which included 4 interviews with Public Health Managers and 4 interviews with Medical Officer in-charge supervising them from four selected UPHCs from two selected districts.

Limitation of the study

1. All the interviews were conducted telephonically due to current COVID situation, hence the information shared in the interviews by the respondents was not validated in the field. E.g., roles and responsibilities described by the PHM.
2. The interviews were conducted when the respondents were in the UPHCs, there may be a possibility where the respondents may have not shared accurate information.

3. Certain districts that were initially sampled for interview were later on dropped due to language barrier. The respondents identified in those districts were unfamiliar with either Hindi or English languages, which were preferentially used to conduct interviews under this study.

Study Findings

Section A: Background

According to the census of India (2011), Telangana has a total population of 35.19 million spread across 33 districts. In June 2, 2014, Telangana was separated from the north western part of Andhra Pradesh and became the newly formed 28th state of India. Telangana is the 11th-largest state with a geographical area of 112,077 square kilometres and 12th most populated state in India. The largest district of Telangana is Bhadradri Kothagudem and the smallest district is Hyderabad.

NUHM in Telangana

The NUHM framework of Telangana comprises of three levels –

1. **Primary level –** It includes the Urban Primary Health Centres (UPHCs) and the Community health workers.
2. **Secondary level –** It includes the Area Hospitals, Community Health Centres (CHC) and Mother and Child Healthcare Centre (MCH).
3. **Tertiary level –** It comprises of the District Hospitals, Teaching and Speciality Hospitals.

Primary Healthcare System of Telangana

In order to strengthen the primary healthcare system of the state, besides the UPHCs there are some flagship programs introduced in the state run by the Telangana Government:

Basti Dawakhana

The aim of setting up these facilities in the urban areas mostly in the slums of Telangana is to provide the population with the essential primary healthcare services reducing the Out-of-Pocket-Expenditure (OOPE) on treatment. Each Basti Dawakhana caters to a population of 5000-10000. The staff includes an allopathic (MBBS) doctor, a staff nurse, and one maintenance worker. These facilities function from 10 am to 4 pm at most of the places. The services offered are- consultation with doctor, immunization services, antenatal and postnatal care, sample collection for laboratory investigations, drug dispensing, counselling and contraception services,

screening services for anemia, and noncommunicable disease (NCD) such as high blood pressure, blood sugar, cancer, and health promotion activities. The Basti Dawakhanas have a referral linkage with nearby urban primary health centre (UPHC).

Specialist Evening Clinic

To make the specialist services available to the urban poor, these Specialist Evening Clinics have established in some of the existing UPHCs. These operate between 4:30 to 8:30 pm in the evening 42 such clinics were functional in Telangana as per Telangana Health Medical and Family Welfare Annual Report, 2018-19.

Health and Wellness Centers (HWCs)

SCs and PHCs are being strengthened as Health and Wellness Centers to provide comprehensive healthcare including non-communicable diseases, maternal and child health services. They also provide free essential drugs and diagnostic services.

Telangana Diagnostic Services

There is a provision of free diagnostic service in every public health facility under Telangana Diagnostic Services since April 2018.

Section B: Results

1. Public Health Managers (PHMs) in the Health Care System of Telangana

The section deals with the analysis of data that was collected during the course of the study. The data is an account of the perspectives and experiences of the Public Health Managers and the stakeholders related to public health managers. The responses received from the respondents have been categorized into broad themes which help to understand the roles and responsibilities of the PHMs, the institutional mechanisms and human resource management practices and the barriers/enablers that are faced by the PHMs while performing their roles in the UPHCs.

Institutional Arrangements – Past and Present

> The UPHCs in Telangana were run by NGOs since early 2000s, the individuals who are posted in the UPHCs as Public Health Managers were absorbed by the NGOs as Community Organizers, whose main role was to act as a link between the community and the health facility. Community mobilization and health education were envisaged as the key roles of the Community Organizer. In 2016, across Telangana the UPHCs were taken over by the Government and the Community Organizers along with other staff were absorbed under National Urban Health Mission.

"Before 2016, the Urban Health Center was run by the NGO, in 2016 it was taken under NHM."- PHM, UPHC

"Before 2016, we had a contract with the NGO, it was outsourcing by the government. After 2016, everyone was taken under NUHM contract directly without interviews." – PHM, UPHC

Most of the PHMs had not received a contract letter post transition to NUHM, some of them even had the confusion about their designation after the transition had occurred.

"I received no letter post transition; it was verbally told by the Medical Officer that you are not Community Organizer anymore but you are PHM but the work remains the same." – PHM, NUHM

Absorption into the system and Motivation

Vacancy

The respondents highlighted that the vacancies were highlighted by the NGOs in the first place and it happened in the early 2000s. The vacancies were advertised in the newspapers and in some cases stuck on the walls of the existing health centers and some private hospitals.

"It was in the newspapers and also, they had pasted it on the walls of the rented building of the UHC which the NGO was already running the facility. My friends told me that such a vacancy has been advertised while they were circulating the information."- PHM, UPHC

The vacancy advertisement had not clearly mentioned the roles and responsibilities of the position, and it had only mentioned that there was a requirement of the social worker in most of the cases

"In the advertisement they had only mentioned about the requirement of a social worker and in the interview, they mentioned that the positions name is Community Organizer. They did not mention about the roles and responsibilities in the advertisement, but mentioned some of the roles and responsibilities during the interviews." – PHM, UPHC

Appointment & Induction Training

The respondents stressed that there were no induction trainings that happened at the time of joining the NGOs, and they were verbally instructed by the coordinator in the NGO about the roles and responsibilities of the Community Organizer.

"In the appointment letter which I received upon selection also did not have any roles and responsibility mentioned in it, it only said that you have been selected as a Community Organizer. All the work of the community organizer was told orally." – PHM, UPHC

After the transition happened in 2016, few trainings have been conducted by the state for orienting the staff about NUHM. Some of the trainings have also been conducted at the district level. Most of them felt that the refresher trainings must be conducted and some additional skills also must be included in such trainings like computer skills.

"Before 2016, there was no training that had happened, after the transition in 2016 a training was conducted at the state level in Hyderabad. All the staff in the UPHC had gone for the training like the MO, the ANM etc." – PHM UPHC

"The training that I received in 2016 was good, it covered all aspects of UPHC. But I feel if refresher trainings are planned which may reorient us towards our roles and responsibilities as PHM then it would be better. As the time has progressed, multiple new program reports have come up, certain new programs have also been introduced, data for all these programs have to be shared on a regular basis, if we receive a basic training in computer skills then we may be able to work in a better way." – PHM UPHC

Motivation

Of the respondents who were serving as PHMs in the UPHCs, some of them had completed graduation in sociology, botany, zoology or commerce. They were engaged either in social work or with some private hospital as a supporting staff prior to joining the NGO. Most of them joined the NGO as they considered it as a better opportunity, however few joined the UPHC as they had interest in the medical field and wanted to serve the community.

"I joined as Community Organizer as I had interest in the medical field and also, I wanted to do Public Service." – PHM, UPHC

2. Roles and Responsibilities of the Public Health Managers

The following section describes key findings on role and responsibilities of Public Health Managers working in the Urban Primary Health Centre (UPHC):

Broad role and responsibility:

Majority of the PHM's broad role and responsibility include field level coordination with ANMs and ASHAs for outreach activity and monitoring and supportive supervision. In addition to this, field level coordination with local leaders in conducting health promotional and IEC activities and community mobilization in accessing the available health services at the UPHC. Other field level responsibilities include organizing and facilitating medical camps for NCD screening and treatment, vaccination and family planning services. Some of the PHM's also reported role in school health programme and mental health programme. Almost all PHMs reported engaging in identifying the COVID positive cases, tracking of patient's status with the illness, facilitating in isolation and quarantine activities. At the facility level most PHMs reported assisting the medical officer in public dealing, grievance redressal, referral procedures, identifying the resources needed in delivering the health services at the UPHCs and monitoring the functioning of UPHC along with other national and state health initiatives.

> *"My work is to coordinate with the local leader, and with the ASHA's and ANM's regarding the health camps and other outreach activities.I also coordinate and plan community visits"*-PHM, UPHC

> *"I ensure coordination of all programmes, ANM supervision for field services, report to programme supervisors such as Leprosy nodal person, NCD nodal person, Community mobilization."*-PHM, UPHC

> *"I conduct health education for the pregnant ladies, NCD camps, Outreach camps, Covid testing and tracking of patients, School Health camps. My major work is around health education."*-PHM, UPHC

> *"PHM is completely responsible for all the field activities. He will be monitoring all the UIP sessions, all the national programmes we have like tuberculosis and vector borne disease, leprosy. He will be monitoring each and every national programme at the field level and we have five ANMs. He will be monitoring all the ANMs work and he will be report to me regarding the activities undertaken for all the programmes in the evening .I randomly visit subcenters and monitor them."* -MOIC, UPHC

> *"PHM is mostly engaged with the outreach related activities.For facility we have other staff I am here, then staff nurse, pharmacist so we are taking care of the facility and that is sufficient. We generally ask PHM to manage the field level implementation of national programmes, organizing medical camps, supervising ASHAs andANMs."*-MOIC, UPHC

A. Role and responsibilities specific to planning

Planning process:

Most of the PHMs reported role in community level planning process that ranges from preparation of monthly action plans that include plan for monthly health camps for immunization, NCD, MCH services to date wise allocation of camps to the areas depending on the burden of the diseases. The selection of areas is largely done as per Medical Officer's instructions. The action plans also include the supervision and monitoring plan. For the facility level planning process includes gap identification and communication specifically with regards to KAYAKALP and NQAS programmes to facility and district level supervisors. However, most respondents mentioned they have limited role in the facility level planning process.

> *"For example, currently we are planning for the NCD camps so we had planned for each sub-center we taken the line list of diabetes and hypertension patients. Before the day of camp I will be communicating whole village, ASHA and ANM to bring all the susceptible people to camp for screening and check-up and provide medicine as per the need and refer to the higher center as well. PHM help in organizing the camp and necessary resources."*-PHM, UPHC

> *"Under MCH programme first I identify the number of sub-centers then identify the number of beneficiaries such as number of pregnant women that will be requiring ANC and PNC services based on population coverage and on the basis of that I prepare action plan for MCH for my facility."*-PHM, UPHC

> **"***We make two action plans one for field and one for facility and then we get it signed by MO"*-PHM, UPHC

> *"He does pulse polio, national leprosy day, everything, all action plan is made by him [PHM] and handles all the monthly report, and I sign the action plans. All the monthly reporting is being maintained by xxx [PHM] and then I sign them and it goes to DMHO."*-MOIC, UPHC

> *"Prepare action plan for seasonal disease, planning of health camps, immunization, family planning, NCD."* -PHM, UPHC

> *"Other example for KAYAKALP, first I discuss with ANM, ASHA and staff nurse about the KAYAKALP and identify the gaps as per the guideline and then discuss with Medical Officer then I record the identifying gaps in the register and then fulfil the identified gaps. MO also communicate this with DO madam at district."*-PHM, UPHC

> *"PHM is mostly engaged with the outreach related activity for facility we have other staff and I am here, then staff nurse, pharmacist so we are*

taking care of the planning for the facility and that sufficient also. We generally ask PHM to manage the field level implementation of national programmes, organizing medical camps, supervising ASHAs, ANMs."- MOIC, UPHC

Planning for Budgetary Activities:

Most of the respondents reported that the budget related planning activities done by accountant under the supervision of medical officer. The financial decision and allocation done by the hospital development society that comprise of representatives from facility and district health officials, municipal corporation, local leader and MAS representative. The society meets on a monthly basis. PHMs mentioned their contribution only around identifying the resources that are required for the UPHCs under budget planning.

"No Madam, there are Accountant /Data Entry Operator who look after budget in discussion with Medical Officer".-PHM, UPHC

"Yes, I try to make the budget estimates and after the activity is completed, I collect the bills and I enter it into PFMS to process the payments. Sometimes we have to take loan from the Medical Officers to complete tasks that need to be priority basis. In these situations, both the Medical Officers and the PHMs contribute money and get the necessary things done which are required to run the UPHC. The HDS committee gets 1.5 lakhs per year. For any activity that needs to be done under the UPHC, a meeting has to be convened with the HDS committee who gives approval for making the expenditures." -PHM, UPHC

"*UPHC gets the Hospital Development Committee, for every hospital development committee, corporate chairman is there, and there is a budget officer, MAS member is also there. Every month meeting is organized and every required issue is raised and discussed in front of committee and also how much budget is for UPHC is also decided and budgeting is done accordingly. Hospital Development Committee meetings are done twice a month and if something important comes up we organize extra meetings in a month"*-PHM, UPHC

"Generally, we have accountant who looks after the budget part. PHM only has to submit the bill to the accountant who further checks the bill and reports it to DMHO."-MOIC, UPHC

B. Role and responsibilities specific to implementation

Tendering of Civil works:

Most of respondents reported that no major civil work happened in the recent years and tender process for the civil works done from district level. However minor repair and maintenance such as painting of the facility building were the responsibilities of PHM under the supervision of facility in-charge by engaging local labors.

> *"Civil work has no tender process because this is a rented building if some part need repairing, we get it done ourselves and if some work was done, we adjust with rent only."*-PHM, UPHC

> *"Last year in 2020, portions of the UPHC were painted and the repairs were done for the washroom fitments and blockages. We also made a separate shed for covid testing for the people. The deputy DMHO is the nodal officer so the tendering process was done by his office, my work was limited to monitoring of the civil works."*-PHC, UPHC

> ***"****All of the work is done through district office, I have no role in this matter."*-PHM, UPHC

> *"I don't look after, medical officer does."*-PHM, UPHC

Bio-Medical Waste Management, Cleanliness and Hygiene at the UPHC:

All the respondent mentioned they were involved in ensuring the collection of bio-medical waste by the agency. However, bio-medical waste management practice within facility is the responsibility of Staff Nurse. All the respondents agreed that they are responsible for ensuring the adherence with cleanliness and hygiene maintenance as per the guideline and monitor on a daily basis.

> *"Dumping yard is 4 kms away from city. They take away, and my work is just to make sure he comes every day and if they do not come, I enquire the reason and report to medical officer."* - PHM, UPHC

> *"Yes, Biomedical waste resource person comes in 1-2 days in a week, they do not come regularly to take the waste, my role is not much in waste management, the staff nurse takes care of the segregation of waste as per the guideline."* -PHM, UPHC

> *"Sweeper looks after. I make sure cleanliness of the facility. I have prepared a checklist and provided to sweeper. He cleans twice per shift."* -PHM, UPHC

> *"The sweeper is responsible for maintaining cleanliness in the UPHC facility, before covid the facility was being cleaned once a day, but since*

covid pandemic started, the facility is being cleaned twice daily." -PHM, UPHC

Equipment, Inventory and Stock maintenance:

None of the respondent indicated presence of annual maintenance contracts for the equipment/ machines nor the existence of quality system for calibration of equipment. In most facilities' equipment/machines repair done by local mechanics arranged by PHM while in few cases arranged by DMHO.

All the respondent mentioned that inventory and stock management are the responsibilities of Pharmacist and the places where pharmacist post was vacant managed by Staff Nurse. However, PHMs mentioned they often support Pharmacists/Staff Nurse in the maintenance of stock registers.

"Local technician does come here and I have his number so I call him whenever needed." -PHM, UPHC

"He comes from DMHO office whenever there is issue. xxxxji came 7 months ago, because freezer regulator was not working." -PHM, UPHC

"There are no maintenance contracts in the district, we (me and the medical officer) have to get the repairs done for the machines and bear the costs from our pockets." -PHM, UPHC

"Inventory and stock management look after by the staff nurse only. In case if staff nurse on leave and busy with other work, then only I look after and manage these." -PHM, UPHC

"The staff nurse and the pharmacist look after the stock and the inventory registers. I often look after the registers. In absence of the pharmacist, the staff nurse looks after the stock register and indenting of drug demand, I have to send a compiled report of all the logistics to DMHO office" - PHM, UPHC.

"The validation is done by the staff nurse for all the logistics, I only do the supervision of such activities." -PHM, UPHC

Mahila Aarogya Samiti (MAS) formation, meetings and committees:

Most of the respondents mentioned that they formed and organize Mahila Aarogya Samiti (MAS) monthly meeting. The number of MAS groups formed by each PHM ranges from 12 to 15. MAS comprises of group of community people, in which community member are encouraged by the PHM to discuss, learn and engage in community level health issues and mobilizing the community in decision making that enable them to act to

address local health problems. In addition, PHMs also uses this platform for health promotion and community awareness activities.

> *"I know about MAS, Mahila Arogya samiti is made by group of 15 to 20 women of community. They identify any problem in ANC, PNC, NCD, Fluorosis, Tb within community and we conduct awareness campaign in the meeting also. MAS has 1016 people and one center has 215 groups. I organize once a month meeting with MAS."* -PHM, UPHC

> *"We have forty-five. MAS group. In each group there are ten members. Every group has one health resource person and one community Resource Person. They coordinate all the health programmes in village. They help me in IEC activity and educating the community about the health services available to the community, they also help in organizing health camps and other health surveys. My main role is to coordinate with MAS group member, facility health staff, field staff such as ASHA and ANM and facilitate the MAS activity. We conduct monthly MAS meeting-sector, area and village wise."* -PHM, UPHC

> *"There are 7 wards in the UPHC and there are a total of 18 MAS committees. The meetings are conducted once every month usually, but since COVID has happened these meetings are not that frequently held, but whenever there is a meeting, I make sure that I attend the meetings."* -PHM, UPHC

> *"Yes Sir, I am aware and I support in formation of MAS committees in the catchment area. My role is mainly to support the committee formed by the Municipal Corporation; they play a major role in formation of MAS committee. A resource person is present in the committee who works with me in the field facilitating the formation of MAS."* -PHM, UPHC

C. Role and responsibilities specific to monitoring and supervision

Monitoring and supervision:

All PHMs reported responsibility of field level monitoring and supportive supervision to the ASHAs, ANMs and MAS members in implementation of programmes such as routine immunization, ANC, PNC services, NCD services, elderly care. They plan and schedule these visits for supportive supervision and report the observations to the medical officer in-charge and district programme nodal, and the officer in-charge of facility also visited in a pre-designed reporting format and or checklist. Number of field visits for PHMs ranges from 3 days to 30 days in a month. Few respondents also mentioned the online monitoring of few outreach services such as ANC, KCR kit distribution, NCD, vaccination and COVID testing.

"I do all the monitoring along with programme managers and provide the support in case ASHAs or ANMs face any problems on ground, if they need any help and support, I provide them as much as possible." - PHM, UPHC

"House to House visits, during these visits I also monitor if the ASHA/ANM has touched upon this house. Online monitoring is done for KCR kits, NCD, COVID etc. There are separate portals for online reporting and monitoring for many different interventions like KCR kits, COVID, NCD, OPD. There are separate applications too which are used for reporting and monitoring purposes like ASHA diseases profile and also recently COWIN app for monitoring covid testing has also been introduced, which I have to facilitate the entry. There are specific formats which are received from the DMHO office which I have to share with the DMHO office every month. There are specific protocols in place which state that I have to monitor the vaccination sites every Wednesday and Saturday, recently covid testing and vaccinations also have been added." - PHM, UPHC

"We do field visits every day to monitor the ASHAs and ANMs for their field activities in the field like NCD screening, and also MCH activities have been added to the activities that I need to monitor every month. I also monitor the elderly care services which are offered every Thursday." - PHM, UPHC

"I provide supportive supervision in all the outreach activities related to all programmes, and also look after the activities at the UPHC. Similarly, while monitoring the immunization activities, I interact with the PRIs and ensure the activities are done properly." - PHM, UPHC

Data Collection, Collation and Corrections:

For HMIS, beneficiaries level data collected by ANMs while facility level data collected by the Staff Nurse, Pharmacist, Lab technician from their respective department. These data then filled by the DEO while PHM ensure the data completeness, accuracy on day-to-day basis.

"ANM and ASHA and other staff collect data and DEO enters the data and I check completeness and prepare reports."- PHM, UPHC

"The data source are the ANMs, who collect the coverage data weekly in fixed formats. I often collate the data and use it to prepare the reports, the medical officer supports me in this. The programs that we have data

collected on a regular basis are immunization programs, NCD programs, COVID Testing and Immunization, KCR Kits, OPD data. IDSP data is also collated from the OPD data, we share the s, p and l forms weekly from the UPHC, the s forms are sent by the ANMs, the p forms are sent by the pharmacist and the l form is sent by the lab technician. I also have the responsibility to cross check the data reports submitted by the ANMs to avoid inaccuracies, in case there are inaccuracies it is corrected with the help of the MO."- PHM, UPHC

3. Perceived Barriers

Issues arising due to staff shortage:

The respondents highlighted that most of the UPHCs have high vacancies and the reason is delayed recruitment. Due to shortage of staff, they have to handle the multiple work. The most common amongst all is the shortage of Medical Officer, ANM, Lab technician and Pharmacist. Due to which PHM is over-loaded with the other work, due to which their time for the other activities hampers.

"In the UPHCs high number of vacancies and delayed recruitments, and there are UPHCs in the district and only 2 Data entry operator cum Accountant. They are working in rotational basis and handling all the UPHCs. That creates difficulty in handling all the work and I am assisting the ANM in the data entering."- PHM, UPHC

"Since, there are many vacant posts in the facility, so, I have to do handle my work also and complete the additional work. Due to which I am unable to finish my assigned work in time."- PHM, UPHC

Other issues – salary, contract management etc.

Most of the PHM have raised the concern of dissatisfaction for the salary and other allowance. In 2016, the formal letter was issued mentioning the Community organizer given the charge of Public Health Manager. But they haven't received any written communication on contract letter. Due to which the officials do not consider them the authorized person. This creates the dissatisfaction among them and lack of clarity on their roles and responsibilities.

"The basic salary of a supervisory cadre like us is in the range of xxxx, and on the other side the similar cadre in the PHC gets a basic salary twice more than me, and apart from the basic salary they get another perk."- PHM, UPHC

"We haven't received any written contract letter from the officials, and due to which many a times we are not considered as the main authorized person, this creates a dissatisfaction among me."- PHM, UPHC

4. Perceived Enablers:

A. Support from the Supervisors and other PHC staff.

PHMs perceived high degrees of satisfaction with the degree of coordination, mutual trust and cooperation between them, the medical officer, ASHA and ANM that enable them to perform their tasks.

"Yes, our medical officer provides me with all kinds of support, in case of any problem programme nodal also support me on my outreach activity."-PHM, UPHC

"The medical officer provides me with all the required staff. Medical officers themselves visit the camps and provide the treatment, they also provide necessary drugs and consumables required for camps." -PHM, UPHC

Conclusion

The Public Health Managers are an integral component of the Urban Public Health System and they were envisaged to play a multitude of roles to ensure proper functioning of the Urban Primary Health Centers. They were assigned administrative roles at the UPHC as well as assert monitoring and supportive supervision roles in the community. For the UPHCs in Telangana they act as a bridge, linking the community and the UPHC. Most of the PHMs were performing the tasks that were assigned in the TOR, but from the study it was found that the PHMs played a limited role in the decision-making process at the UPHCs due to their non-technical backgrounds. Moreover, they showed limited understanding the importance of data reports in the UPHCs, most of the data was monitored by the concerned Medical Officers.

In the context of the UPHCs in Telangana the PHMs were effectively engaged in field level planning, implementation and monitoring of programmes such as Routine Immunization (RI), MCH outreach services, organizing medical camps, IEC activities by engaging multi-sectoral convergence and wellness platforms. However, their roles pertaining to technical roles, critical decision making, management tasks and functions were partially or completely delegated to other staff in the UPHCs.

The PHMs in the UPHCs of Telangana, have been associated with their concerned UPHCs for duration of 8-20 years. Most of the PHMs reported factors like low salaries as a major demotivating factor and considered that absence of formal contracts was a major reason that led to non-recognition of their contribution towards functioning of the UPHCs. In order to ensure that the UPHCs effectively cater to the needs of the urban population in Telangana, steps must be taken to address the pressing issues like lacking capacities of the current PHMs in the UPHCs, low salaries and poor contract management of the PHMs as well as facilitate recruitments to rationalize the work load on the PHMs.

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Annexure

Eligibility and Qualifications of a PHM as mentioned in the Terms of Reference (TOR) in NUHM Implementation Framework:

- Master's degree in Public Health/Social Work/ equivalent master level degree in Health Planning and Health Education.
- At least 3 years of experience in management/coordination of the community health programmes or community mobilization related field activities in development sector.
- Minimum 1 year experience in health sector, preferably in Public Health.
- They should have familiarity with working in urban community health workers programme, with government and NGO health projects or involvement of ULBs in Health projects.
- Sensitivity to and knowledge and experience of working on health systems and coordination with Government and NGOs.
- They should have experience in monitoring/training of Frontline workers at the state/district level.
- They should have familiarity with MS Word, Excel, Power Point etc.
- They should have excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Key Roles and Responsibilities of PHM as mentioned in the Terms of Reference (TOR) in NUHM Implementation Framework:

At the Community Level

- The PHM has to undertake supervision and monitoring of outreach teams and subsidiary facilities.
- Ensuring health prevention and promotion activities including screening/wellness activities to be undertaken by outreach teams and at subsidiary facilities.
- Under the guidance of the Medical Officer PHM would undertake the process of vulnerability mapping and assess the vulnerable population in the geographic area of the UPHC/HWC at the household level and slum/ward level.
- Ensure adherence to outreach functions for frontline workers (ASHA and ANM) in the catchment area of the UPHC-HWC.
- PHM has to facilitate the formation of MAS and monthly meeting of MAS, enable fund utilization and submission of quarterly reports.
- PHM has to facilitate Community mobilization and ensure coordination of MAS with other community-based platforms like Self Help Groups, and work closely with the Urban Local Bodies to address social determinants of health in the community.

- S/he has to provide support to the ASHAs to improve their functionality including facilitating household visits, ensuring timely refurbishment of the kits and enabling refresher training.
- S/he has to provide supportive supervision to ASHAs through cluster formation of ASHAs and monitoring visits in the catchment areas of the UPHC/HWC.
- The PHM facilitates wellness activities and campaigns for the community for health promotion with *Swachh Bharat Abhiyan*; lifestyle modifications including yoga and physical activities, against gender violence; reducing indoor and outdoor air pollution and adherence to HWC calendar.

At the Facility Level (UPHC)

- The PHM is required to supervise Public Health functions at UPHC outreach teams and subsidiary facilities.
- S/he has to facilitate accreditation of the UPHC/HWC and supporting quality assurance in Infection Control and Biomedical Waste Management.
- Facilitating selection of new ASHAs and expediting their training is another responsibility.
- S/he has to enable Grievance Redressal system for frontline workforce, including feedback and redressal.
- The PHM has to collate monthly performance report of the ASHA and ANM from respective geographic areas, to prepare a monthly analysis.
- The PHM has to support the outreach teams and subsidiary facilities in maintaining records and reports of service delivery, and submit a monthly performance report for the UPHC-HWC to the Medical Officer in-charge.
- Support monitoring and report mechanisms for the routine and special outreach.
- Support in generating integrated reporting between HMIS and IDSP and other portals to serve as early warning and also to support better integrated planning.

At the Higher Level (District and Sub-district level)

- S/he should have active engagement in facilitating convergence across levels of care (Primary and secondary) for effective coverage and delivery of services.
- S/he should accompany Medical Officer-in-charge at monthly/quarterly meetings in district and sub-district level.
- Liaison with IDSP and specific disease control programme personnel to ensure effective epidemiological surveillance, analysis and alert generation is another responsibility of the PHM.
- S/he should have active engagement with the Urban Local Bodies/ Deendayal Antyodaya Yojana- National Urban Livelihoods Mission (DAY-NULM)/Nutrition/Drinking water and sanitation/AMRUT/Swachh Bharat Mission/other agencies in urban areas for facilitating access to entitlements of the population.
- The PHM should coordinate with NGOs working in urban areas to facilitate access to social services.

Abstract

To assess the performance of Public Health Managers (PHMs) working in the UPHC's under NUHM in cities of Telangana, India.

Background:

Urbanization in India has been increasing at an alarming rate, with increasing urbanization there is also an increase in the population living in the urban areas (65.5 million-2011), of which 13.7% were living below poverty line. The National Urban Health Mission aims to strengthen the existing public health care systems in the urban areas of the country and effectively address the healthcare needs of the urban population especially those belonging to the poor and marginalized groups. Availability of human resources for health are integral to provision of health services in any setting, but they must also be adequately skilled.

The Public Health Managers (PHMs) in the Urban Primary Health Centres (UPHC) were envisaged as a cadre that would enable the UPHC to effectively provide clinical and outreach services to the community utilizing their technical and managerial capacities. However, even with introduction of PHM cadre the UPHCs still face challenges in providing quality health services to the urban population, hence, it is important to understand the functioning of a PHM against the roles that were envisaged under NUHM and need to explore what factors act as enablers/barriers that influence or restrict them in performing their role.

Objectives:

1. To assess the tasks performed by the Public Health Managers (PHM) against their perceived roles.
2. To understand how the Public Health Managers are contributing towards improving the utilization of services of the UPHCs.
3. To explore the enablers or barriers that influence or restricts their role.

Methodology:

Study Design: Qualitative Study involving Semi-Structured Interviews with Public Health Managers and Medical Officers at UPHCs in Telangana.

Study Setting: Urban Primary Health Centres of two districts of Telangana.

Criterion for selecting Districts:

A. Districts were ranked based on four indicators:

1. Number of PHM/Community Officer in place
2. OPD conducted per 10,000 slum population in the FY 2019-20
3. Proportion of lab tests performed out of total OPD for the FY 2019-20 and
4. Percentage increase or decrease in ANC registration in 1st trimester of pregnancy from the FY 2018-19 to FY 2019-20.

B. Based on the scores achieved by the districts for the above indicators, the districts were categorized from low to high and further grouped into aspirational and non-aspirational districts. Two low scoring districts were selected, considering one district from the two groups.

Study Sample:

A total of 8 in-depth interviews were conducted which included 4 interviews with Public Health Managers and 4 interviews with Medical Officer in-charge supervising them.

Results:

While understanding the role of Public Health Managers three themes that emerged were their roles under Planning, Implementation and Monitoring activities at the UPHCs. It emerged from these themes that the most of the PHMs performed a multitude of activities however these were largely pertaining to outreach activities, activities that needed to be performed at the UPHCs seemed to be delegated completely or partially to other staff. While exploring the barriers that the PHMs faced in performing their roles and responsibilities, themes that emerged were staff shortage, issues with contract management and salary. On the other hand, while exploring enablers, support from the supervisor and other staff at the UPHCs emerged as the only thematic area.

Conclusion:

Most of the PHMs were performing the tasks that were assigned in the standard terms of reference, but from the study it was found that the PHMs played a limited role in the decision-making process at the UPHCs due to their non-technical backgrounds. Their roles pertaining to technical roles, critical decision making, management tasks and functions were partially or completely delegated to other staff in the UPHCs. Most of the PHMs reported factors like low salaries as a major demotivating factor and considered that absence of formal contracts was a major reason that led to non-recognition of their contribution towards functioning of the UPHCs. These findings were uniform across both the aspirational and non-aspirational districts.

In order to ensure that the UPHCs effectively cater to the needs of the urban population in Telangana, steps must be taken to address the pressing issues like lacking capacities of the current PHMs in the UPHCs, low salaries and poor contract management of the PHMs as well as facilitate recruitments to rationalize the work load on the PHMs.

Key Words: National Urban Health Mission, Public Health Manager, Role and Responsibilities, Enablers and Barriers