Section I

The State Health Resource Centre (SHRC), Chhattisgarh Origin, Role, Review of Achievements

1. Introduction

This section deals with Objectives two and three of the Terms of Reference of the external evaluation namely to ***"Evaluate the SHRC role in strengthening key aspects of the public health system in Chhattisgarh***:

1.1. How far has SHRC been able to achieve its goals and objectives and to carry out the role defined for it as a part of the reform agenda, including the Sector Investment Programme (SIP) milestones?

1.2 Study the SHRC impact as an additional technical capacity for the DHFW, GOC.

1.3 Review partnerships made and managed by SHRC with civil society initiatives in the context of the Mitanin programme and other policy initiatives.

1.4 Review SHRC contribution as an academic group through research activities, publications, and fellowship/internship programmes etc.

1.5 Review significance of the institutional arrangement of SHRC in the public health and health system context of Chhattisgarh.

2. ***Evaluate SHRC as an institution and make recommendations for its future.***

2.1. Review the following aspects and recommend steps to strengthen them further.

a) human resource management and development policies and procedures.
b) institutional structures, mechanisms and social arrangements.
c) governance and accountability systems.
d) financial systems.

2.2. Make overall recommendations for the SHRC" (Ref: Terms of Reference).

2. Methodology

A sub-group of two members of the evaluation team focused on the SHRC component. Methods used included:

- A detailed document review – see Bibliography.
- Interviews and discussions were held individually with key participants from different stakeholders and in groups with some field coordinators.
- Seven districts were visited – Rajnandgaon; Durg; Raigarh; Bastar; Dantewada; Kanker; Dhamtari, seeing health institutions at different levels – district hospitals, CHCs, PHCs, health sub-centres. Discussions were held with health personnel, NGO team members; *prashikshaks* and Mitanins. We were accompanied by field coordinators. (See list for details and annexure for case-studies).
- There was close interaction with the subgroup of the evaluation team studying the Mitanin programme so that perspectives and findings were shared and integrated.
- There were two meetings of the whole evaluation team - in March 2005 in Raipur for planning and in end May 2005 in Bangalore to discuss findings.

3. Profile of Health and Health Care in Chhattisgarh

This brief profile developed from secondary sources is being given in order to contextualize the health interventions that evolved in the new state. Expectations, objectives and achievements from the SHRC, the *Mitanin* programme, and initiatives to strengthen the health system need to be viewed in this context.

3.1. Introduction

The health status of a population reflects the set of prevailing social, economic and political conditions. Health indicators that are used to describe the health status of populations draw particularly on mortality (death) and morbidity (sickness) data as the most gross indications of levels of wholeness and well being. Though they are limited in capturing many important aspects of health and life, particularly the qualitative aspects, they are often the only indicators available. Standardization and comparability across population groups are important features that help in assessing how far a society and its government have progressed in realizing citizens rights to health and health care. These rights and entitlements are enshrined in many national and international documents and agreements. Availability, validity and quality of data depend very much on the efforts and resources invested in developing health information systems. This section utilizes available standard secondary sources of information. It describes the administrative units within which public health services function; the health care services available; and the health status of people in Chhattisgarh with brief comments from a evaluative, recommendatory perspective.

3.2. Administrative Arrangements

The state through its administrative units and systems, including the department of health and family welfare has an important responsibility in initiating and sustaining measures to improve the health status of people and assure access to health care. While individual citizens also have responsibilities, in the context of widespread poverty and deprivation the role of the state administration becomes more important. Following statehood in end 2000 the political and administrative leadership in Chhattisgarh explicitly recognized the difficulties faced by people especially the high levels of ill health and under nutrition, and the challenges inherent in revitalizing the public health sector. The opportunities of new statehood were seized and measures to strengthen the health system were initiated in consultation with donor partners, civil society and NGOs. Several government health functionaries and people have mentioned that the smaller administrative units that resulted from creation of new districts, and the recent state level health and related initiatives have started or accelerated the pace of health sector strengthening. This includes building of infrastructure, roads, administrative mechanisms etc.

Table 1: Administrative Profile of Chhattisgarh

Description		**Comments**
Formation of State	1st November 2000	New opportunities, for health sector development were seized.
Geographical size	9th largest state in the country	Hilly terrain, geographical access difficult, Low population density.
Number of districts	16 increased from 7, in 3 revenue divisions	Infrastructure and personnel needed for new districts. Reduced distance between people and administration
Number of *tehsils*	96	Some states have *tehsil* / block health officers responsible for public health.
Number of blocks	146	Only 114 had CHCs, majority of which were not functional. First referral units technically weak.
Number of *gram panchayats (GP)*	9129	*Gram panchayats* role in governance of health sector to be operationalised through > 9000 dispersed units; requires inter-departmental collaboration; and capacity building of GP members.
Number of villages Number of habitations *(para's)*	19,720 54,000	A mitanin (CHW) was planned for every *para* to reach out to the entire community. This needs flexibility and funding.
Number of Muncipal Organizations Other Municipal bodies	6 69	Health care for urban poor relatively neglected.

3.3. Demographic Profile

While the over all *adivasi* population in the state is 32.46% there is a much higher proportion of *adivasis* in the southern, northern and north eastern districts. Dantewada has 79% *adivasis,* followed by Bastar (67%), Jashpur (65%), Surguja (57%) and Kanker (56%). The languages spoken by these ethnic communities such as *Gondi, Halbi, Bhadri* and others are different from the major languages of the state namely *Hindi* and C*hhattisgarhi*. These factors need careful consideration in health planning. *Health personnel working in these regions should preferably belong to the local community or should learn the language and be sensitized to the cultural patterns of the communities. Training material and health educational/ health promotional material needs to be prepared in the local languages.* This is not yet taking place.

Table 2: Chhattisgarh Demographic Profile (2001 census data)

Indicator	Absolute number	Comments
Total Population Total Males Total Females gender ratio	20.79 million 10.45 million 10.34 million 990 (India 933)	a) Decadal growth rate during 1991-2001 was 18.06% (2000) as against 21.34% in India (2003) b) Gender ratio good, increased from 985 in 1991 census c) Population density low 154 (India 324)
Under 6 year population Males Females 0-6 year gender ratio	3.47 million 1.75 million 1.71 million 975	% of 0-6 age group to total population 16.68% This group needs to be reached by the ICDS and health services.
Literacy levels Number of literates Males Females	 11.2 million (65.18%) 6.7 million (77.86%) 4.5 million (52.40%)	Literacy rate on par with national figures – inter district differences exist, need to introduce indicators of quality of education.

Source: Office of the Registrar General, India, Provisional Population Totals, 2001

Life Expectancy at Birth (LEB) in Chhattisgarh is reportedly better than in the mother state of Madhya Pradesh (MP). In 1991 life expectancy in Chhattisgarh was 61.4 years, while it was 57.3 years for the entire undivided MP. Female life expectancy was higher (62 years) as compared to male LEB (60.9). Urban LEB was much higher (69.6) as compared to rural LEB (60.0) years.

Table 3: Other Demographic Indicators of Chhattisgarh (1991) are:

Indicator	All	Male	Female	Rural	Urban
Mean age at Marriage	25.4	25.5	25.3	25.4	25.3
Total Fertility Rate	4.3			4.3	4.2
Under five Child Mortality	129	134.0	124.0	141.0	79.0

Source: Census of India 1991, Registrar General of India, New Delhi.

3.4. Access to basic amenities as in 1991 when this region was part of Madhya Pradesh

Safe drinking water, sanitation facilities and food are basic determinants of health. Lack of access to them results in a heavy burden of preventable diseases and conditions, which also lower the productivity of the population. The table below reveals a high degree of deprivation. *Greater health gains result from increasing access to basic determinants of health such as food, water and sanitation other than only providing medical care for the diseases and conditions that result from lack of access to the determinants.* It is with this understanding based on principles of public health and human rights that the conceptualization of the health intervention was made through the initial consultations. This requires shifts in resource allocations and power relations, with a longer term vision and perspective. The role of the Department of Health and of Community Health Workers (*Mitanins*) needs to be seen and developed within this context. Impact indicators for the DHFW and GOC after 5 – 10 years of health sector strengthening will need to see the progress made in terms of access to the above basic amenities, as well as provision of primary health care for conditions arising as a result of denial of access. *If the concepts are not adequately discussed, disseminated and communicated widely and regularly, they could easily get misinterpreted and distorted.*

Table 4: Access to Basic Amenities

Basic Amenities	All	Rural	Urban
Access to Electricity	31.8%	25.4%	61.2%
Access to Safe Drinking Water	51.2%	45.1%	79.6%
Access to Toilets	10.3%	3.3%	42.4%
Access to all three	7.6%	1.5%	35.6%
Access to none of the three	36.1%	41.9%	9.6%

Source: Census of India 1991, Registrar General of India, New Delhi (as given in the website of Govt. of Chhattisgarh).

3.5. Poverty

There is a lot of expert debate, discussion and controversy about different poverty lines. Methods generally used measure purchasing capacity necessary for basic

calorie requirements ie covering only food and not shelter, clothing, health and education. Given below are figures from the GOC website citing National Sample Survey Organization data based on the NSS survey of 1993 – 94 (the official poverty line – PL) and another by an expert group (Expert PL).

Table 5: Poverty Levels

	1987-88		1993-94	
	Official PL*	**Expert PL**	**Official PL**	**Expert PL**
All	55.35	45.27	38.91	28.64
Rural	58.47	46.72	38.21	25.74
Urban	35.38	35.99	42.21	42.21

*Poverty line as per Planning Commission
Source: http://chattisgarh.nic.in/development/development.htm.

From the above table as well as from other sources it is apparent that the levels of poverty, deprivation and exclusion in the state are very high. *Studies and experience show that this broader context adversely affects the health status of people, as well as the functioning of health services. Findings of the evaluation need to be seen in relation to this context.*

The Madhya Pradesh government was the first to publish the **State Human Development Index (HDI)** and Gender Related Development Index. Data from the original seven districts which now comprise Chhattisgarh state, along with literacy data were applied to the 16 new districts of GG state by the GOC. *In terms of the HDI in Chhattisgarh, Durg district is the best among the districts followed by Dhamtari, Raipur, Bilaspur and Korba. At the bottom is Kawardha district. Other districts at the bottom are the northern and southern tribal districts of Surguja, Dantewada, Bastar, Raigarh and Koriya.* While the HDI for India is 45, Chhattisgarh is 39.

3.6. Social Development in the Districts

A deep understanding of the context of the process of social development of the entire population of the state would help to shape the contours of a statewide health intervention initiated by the government in partnership with a range of stakeholders and actors. Such a process was infact initiated by the state leadership which catalysed and held together groups and individuals coming from diverse backgrounds. The social realities that they dealt with based on 1998 date are indicated in the table below

Table 6: Gender related Development Index in Districts of Chhattisgarh, 1998

District	EDUCATION				HEALTH				INCOME			GENDER RELATED DEVELOPMENT INDEX
	Literacy Rate		Child Enrolment		Education	Expectancy of Life		Health	Per Capita Income		Income Index	
	Male	Female	Male	Female	Index	Male	Female	Index	Male	Female		
Surguja	30.0%	15.2%	72.2%	43.7%	0.333	63.4	63.8	0.642	6068	2852	0.635	0.536
Koriya	51.8%	24.5%	72.2%	43.7%	0.410	63.4	63.8	0.643	6532	2279	0.605	0.552
Bilaspur	62.4%	28.0%	81.6%	49.1%	0.466	60.1	62.0	0.600	8613	4290	0.733	0.600
Korba	61.5%	28.1%	81.6%	49.1%	0.468	60.1	62.0	0.600	9168	3658	0.714	0.594
Jangir Champa	67.4%	27.6%	81.6%	49.1%	0.469	60.1	62.0	0.600	8567	4409	0.735	0.601
Raigarh	59.1%	26.9%	79.2%	36.9%	0.414	59.9	61.5	0.594	6760	2942	0.648	0.552
Jashpur	51.0%	25.7%	79.2%	36.9%	0.396	59.9	61.5	0.594	6377	3325	0.662	0.551
Rajnandraon	66.0%	31.9%	67.2%	47.6%	0.475	57.0	40.0	0.561	5518	3371	0.650	0.562
Kawardha	45.4%	14.2%	67.2%	47.6%	0.342	57.0	60.4	0.561	5580	3289	0.648	0.517
Durg	74.1%	42.8%	77.9%	58.3%	0.588	62.5	65.0	0.646	9659	4681	0.758	0.664
Raipur	65.5%	31.6%	85.6%	58.5%	0.521	60.4	59.8	0.582	7472	3717	0.696	0.599
Dhamtari	69.9%	36.0%	85.6%	58.5%	0.551	60.4	59.8	0.581	7062	4172	0.707	0.613
Mahasamund	60.2%	25.8%	85.6%	58.5%	0.478	60.4	59.8	0.581	7542	3707	0.695	0.585
Bastar	31.8%	13.5%	44.0%	30.0%	0.248	61.2	62.7	0.614	6523	3483	0.672	0.511
Kanker	53.3%	25.0%	44.0%	30.0%	0.348	61.2	62.7	0.614	6326	3684	0.677	0.547
Dantewara	22.9%	10.1%	44.0%	30.0%	0.214	61.2	62.7	0.614	6406	3614	0.675	0.501

Source: Chhattisgarh – A State is Born, Sanket, Bhopal.

The inter-district variations in literacy rate, particularly women's literacy, and in child enrollment are marked. This would impact particularly on strategies for community awareness regarding health and health programmes. While the use of kalajathas and radio programmes are a strategic option, *the data above would suggest the need for very intensive work in the local languages and idiom that would need to be repeated in various forms over time. Strengths of the local culture and tradition, which are perhaps reflected in the life expectancy and gender ratio, would also need to be respected and reinforced.*

3.7. Health Profile of Chhattisgarh – Recent Trends

The **Infant Mortality Rate (IMR),** which is the annual number of deaths of children below the age of one year per thousand live births, is a sensitive index of levels of child health, maternal health, access to quality health care, as well as standard of living.

Chhattisgarh has not yet achieved the National Health Policy goals for IMR reduction by 2000, though there are indications of some decline. Figures are also much higher than the national average.

Table 7: Infant Mortality Rate (IMR)

IMR	Chhattisgarh		India	
	2000	2003	2000	2003
IMR total	79	76/73*	68	64
IMR rural	95	85	74	69
IMR urban	49	51	44	40

* Different reports cite different figures.
Source: Sample Registration Scheme (SRS) 2003

The IMR is substantially higher in rural compared to urban areas. It is probable that the rates are higher in the hilly tribal districts where the reach of health services and health information systems are much less. The National Health Policy 2002 which for the first time gives IMR by social stratification shows a much higher IMR for scheduled tribes and scheduled castes. While we do not have specific figures for Chhattisgarh, it is important to keep this in mind **as 32.4% of the population are scheduled tribes, 12.2% scheduled castes (SC+ST=46%) and 50% are Other Backward Classes (OBC).** It is also important to keep in mind that in several major states of the country there has been stagnation or worsening of the IMR over the past decade. This has been attributed to the agrarian crisis, jobless growth with widespread unemployment/underemployment due to economic and trade factors; along with contraction or stagnation of the social sector. It remains to be seen whether sectoral interventions with inadequate budgetary support can make a difference. *The DHFW, SHRC and academic institutions should encourage studies and documentation of infant, child and maternal deaths as an integral part of the state's capacity building efforts. This will also help to measure impact of health sector and other macro interventions.*

Under five Mortality Rate

Chhattisgarh has a high under five mortality rate of 122.7 as against the national average of 94.9.

Nutritional Status

Hunger and hidden hunger is high in Chhattisgarh as is evident from available indicators of nutritional status (source NFHS 2).

a) **Anaemia** among women was prevalent in 68.7% of women. WHO standards consider population prevalence rates of anaemia above 10% as a public health emergency. Anaemia prevalence among adolescent girls was 67.5% (mild – 42.1%, moderate 24.5%, and severe 1.9%)

b) BMI (Body Mass Index)
A large proportion of women (48%) have a BMI below 18.5 and 44.9% of adolescent girls fall below this level.

Maternal Mortality Rate (MMR)*

The MMR in Chhattisgarh is reportedly over 400 (Madhya Pradesh 498 in 1997). Figures for MMR in India are contested by different agencies with some reputed groups suggestions that the MMR is much higher. Maternal mortality rates in India range from 29 (Gujarat), 76 (Tamil Nadu), 195 (Kerala and Karnataka) to 451 (Bihar) (Govt. of India, Annual Report 1999- 2000). Anaemia is a leading cause of death (19%) as well as of complications of pregnancy.

The **RCH 2** project implementation plan (PIP) for Chhattisgarh has ambitious and unrealistic goals to -

a) reduce the IMR from 73 to 35 by 2007 / 8.
b) reduce MMR from about 400 to 150 by 2007.
c) increase CPR (Couple Protection Rate) to 65% by 2007.
d) reduce total fertility rate to 2.1 by 2010.
e) achieve a net reproduction rate of 1.0 by 2010.

It is necessary for the state to adopt do-able strategic plans based on a realistic assessment of available human, financial and other resources. If not it would lead to frustration, a low self esteem among health providers and a loss of confidence in the health sector by the community.

The second important factor is the dominance of a demographic focus in the goals, which would influence the functioning of the health system. While the strategies are more broad based, coherence between goals and strategies could be adopted. Response to community need, community involvement in planning and a comprehensive health approach are missing here though they are a part of the conceptual plan in the *mitanin* programme. Divergent policies and approaches may cause conflicts of interests and confusion. *Congruence in health strategies and a move away from vertical approaches as is being attempted by the National Rural Health Mission (NRHM) need to be adopted, with a focus on strengthening primary health care.*

Communicable Diseases

Diarrhoea, malaria and tuberculosis are still major public health problems in Chhattisgarh. Inadequate access to safe water and sanitation lead to high transmission of water borne and water related diseases.

Malaria is endemic in the state and has been described in the region since over a hundred years. A state level workshop on 'Malaria operational research' held in January 2003 discussed the problem and developed recommendations. The Annual Parasite Index in Chhattisgarh was 10.84 in 1997, 19.88 in 2000, 12.89 in 2001 and 10.21 in 2002 with 50, 63.32 and 3 deaths reported through the public health system. The Pf (Plasmaduim falciparum) rate is 69.35%. Malaria cases

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**** MMR – Pregnancy related death of women during pregnancy or within 42 days of delivery / termination) pregnancy per 1,00,000 live births.***

are reported most from Bastar (16%), Jashpur (16%), Dantewada (14%), Ambikapur (12%) and Kanker (11%). However it is well known that there is a lot of under reporting from the health system. The cyclical epidemiological trend of the disease should also be kept in mind. It is reported that there were big shortfalls in supply of insecticides due inadequate budgets and management / logistic problems.

3.8. Profile of Public Sector Health Services

In 2001 Chhattisgarh state had poor health infrastructure, with only 9 District Hospitals, 114 community health centres, and big gaps at the level of PHCs and health subcentres (HSC) in relation to norms. There were large vacancies of doctors and paramedical staff. PHCs in remote tribal areas did not have doctors, and facilities were in a poor condition.

The study report titled "Strengthening Public Health Systems" and the Reproductive and Child Health Programme II (RCH 2) proposal has a detailed situation analysis of the health infrastructure. These reports facilitated by SHRC, with substantial inputs by them, lay the foundation for health sector planning for the state.

Health Sub-centres (HSC)

There are 3818 sanctioned health subcenters covering 54,000 hamlets and 19,720 villages. Of these only **1458 had government buildings,** while the remaining are supposed to be run in panchayat or any other buildings. In 2004 -5, 875 subcentres were sanctioned by government and their location was reportedly decided based on need, using a Geographical Information System. Thus *currently only 25% of subcentres have facilities to conduct deliveries in the centre.*

Primary Health Centres (PHC)

Out of the 748 sectors in Chhattisgarh, only 516 have sanctioned PHCs leaving a gap of 232. However out of the 516 PHCs only 327 have buildings. The quality of existing HSC and PHC buildings and the staff quarters along with availability of electricity, water supply and sanitation facilities also needs to be improved. The siting / location of the health centres is also critical as they have to be accessible to the community. This is not always so leading to non-utilization of services and wastage of resources.

Community Health Centres (CHCs)

There are 116 CHCs out of which only 34 are 30 bedded institutions. The remaining 82 are run in PHCs or other buildings. The state should have at least 146 CHCs (one per block for 146 blocks) or 180 if population norms of one CHC per lakh rural population is used.

It is thus very evident that the primary health care system rests on very weak foundations in terms of physical infrastructure and availability of health personnel. These gaps need to be filled with a sense of urgency.

It is also reported that private practice among public sector health personnel is widespread and that the health sector in general is fairly privatized (Sen, 2005). There are also several ongoing decisions to accelerate the process of privatization, with public subsidy to the private sector (*ibid).* How this impacts on access to medical and health care for the majority poor needs to be studied in greater depth.

Health Personnel

- There are only 3816 ANMs (Multi Purpose Worker – F) out of the sanctioned 4094 covering the 54,000 hamlets, each covering 10-15 hamlets over a 5 – 25 km distance, often with little supervision or encouragement and without transport facilities.
- There are 2905 MPW (Male) out of the 3557 that are sanctioned.
- Among supervisory staff there are 730 Lady Health Visitors (LHV) out of 814 sanctioned.
- There are 355 Laboratory Technicians out of the sanctioned 436, and 125 Block Extension Educators out of the sanctioned 149.

The short falls in health personnel are well known in many parts of the country. The state however under took a study in 2003 to look more closely at issues of workforce management and human resource development. They also embarked on reforming the health sector through a set of mutually agreed milestones. Progress in this regard will be discussed elsewhere.

Some indications of the reach of the services are given by data available regarding coverage of reproductive and child health care.

Table 8: Coverage of RCH services

RCH Service Provision	Coverage
Antenatal care registration	97%
Antenatal care checkup	12.8%
Safe delivery	42.03%
Institutional delivery	21%
Postpartum Care	20%
Total immunization	57.58%
Couple Protection Rate	39.9%
Percentage of women who had the first child in the 15-19 age group	73.8% Median age 18.1 years

Source: NFHS, SRS 2002

The coverage of basic mother and child health care by the system is very sub-optimal. The quality of care is also said to be inadequate.

District Hospitals

There were 9 district hospitals, many of which were poorly equipped and in need of repair. The state government is building new district hospitals for the new districts. In Dantewada for instance the new hospital has been well sited and built and is being utilized by people. Older district hospitals are being renovated and strengthened.

Medical Colleges

There are two government run medical colleges in the state in Raipur and Bilaspur. Public private partnerships are underway in both these institutions.

Overall observations

The Govt. of Chhattisgarh initiated a consultative process soon after state formation to strengthen the health system. Financial support was negotiated through donor partners such as a DANIDA supported Rupees15 crore Chhattisgarh Basic Health Services Improvement Programme, and Rupees 16 crore Sector Investment Programme supported by the European Commission through the Govt. of India. The global fund for malaria, TB and HIV/AIDS RCH I; UNICEF and EAG (Empowered Action Group) funds were also made available through the Govt. of India. The injection of funds was used for construction of new buildings and repairs to District Hospitals, CHCs and PHCs; purchase of equipment; training; production of material and the *mitanin* programme. Some of the changes are visible. The programmes and initiatives have continued despite political and bureaucratic changes. Findings of the evaluation team as of April 2005 are given and discussed in the respective sections, *keeping in mind that three years is a relatively short period in a statewide effort to strengthen the health system.*

3.9. Conclusion

The health situation that the political and administrative leadership faced was of a population of around 20.7 million suffering from the diseases of poverty, with high levels of under-nutrition or hunger, anaemia, water borne diseases and communicable diseases. There were also several gaps in the health system and its functioning. It is a cause of concern for citizens and professionals that such a situation prevails fifty eight years after Independence, at a time when there is so much access to knowledge and resources. The magnitude and scale of suffering due to preventable ill-health is large, pointing to gross inequities in health in the country and the state.

It was therefore timely and appropriate that the GOC initiated steps to strengthen the health system and involve communities through the mitanin programme and panchayats. How serious they were would be indicated by budgetary allocations, expenditure patterns, and fund flow systems; by methods adopted or not adopted for workforce management; by selection of strategies and the quality of implementation and its supervision and monitoring in the field.

4. Origins of the Health Initiative in a new State

The formation of the new State of Chhattisgarh in November 2000 provided a unique opportunity to strengthen measures to improve health and health care. The context for health sector initiatives, as outlined earlier was challenging. Social stratification and deprivation of some social groups were centuries old; geographical terrain and access were problematic; literacy rates particularly of women were low, in some districts touching 12%; health indicators (barring gender ratios) were at the lower end of the national range; hunger levels, were unacceptably high. Health sector resources including trained health personnel of all categories were inadequate in numbers, working in weak health institutions without adequate equipment or drugs. There was a maldistribution and mismatch of personnel and infrastructure with areas of greatest need left underserved. Low motivation, private practice by publically paid health personnel during office hours and corruption in the health sector were not unknown here, as in many other parts of the country and the world.

To dream dreams for better health and health care, especially for the poor and to work towards actualizing them, in this context of impoverishment required vision, courage and support from several sectors and actors. The state initiated processes to work towards this goal, backing it up with support. The mother state of Madhya Pradesh had already experimented with a *Jan Swasthya Rakshak* scheme and a *Swasthya Jeevan Guarantee Yojana* from the mid 1990s. Thus health was to an extent on the public and political agenda though in a muted way. The Peoples Health Movement (*Jan Swasthya Abhiyan* - JSA) was developing at the national level throughout 2000 with a large *Jan Swasthiya Sabha* in Kolkatta in December 2000, during which a Peoples Health Charter was adopted. This process of social mobilization for health had built on 2-3 decades of earlier work. Though the movement was weak in the State, there were individuals groups, and smaller social movements within Chhattisgarh who contributed to and supported the call for 'Health for All, Now!' and worked on determinants of health based on an understanding that health and universal access to health care is a basic human right.

5. Evolving Institutional Mechanisms and Roles

The political and administrative leadership in the state drawing on their earlier experience with health programmes and the literacy campaign seized the opportunity of new statehood and decided to initiate steps towards the community basing of health services, along with restructuring and reforming the health system. Whether the implications and requirements for this ambitious goal were fully realized is not clear. But important and significant first steps were made. The *Rajiv Jeevan Rekha* programme was launched on Ist November 2001, with the *Indira Swasthya Mitanin Programme* being developed by the Department of Health and Family Welfare as an important component. The core idea was to have a *mitanin* (trained community health worker) for every one of the 54,000 *majra tola's/para's* (hamlets) in the state. There was political commitment and pressure

from the highest level, with the Chief Minister taking personal interest in its launch and progress.

The new state had a single health secretary unlike 3-4 in the mother state. Being a medical professional from the region with experience of health and literacy programmes was an asset[1]. The value of NGOs and civil society was recognized and a consultative process which was fairly unusual was initiated and sustained through frequent discussions both formal and informal for over a year starting in 2001.

The dialectical discussions of this group placed equity concerns, participatory approaches, flexibility, and the need for poverty and gender analysis on the agenda. This grouping was later formalized into the State Advisory Committee by a Government Order. Documentation of this early process was meticulous, outlining the thinking and planning processes that took place.

In the early phase the main focus of attention seemed to be on developing a community health worker (*Mitanin*) scheme. The approach adopted during the early phase is best understood in their own words,

"*Operational mechanisms need to be worked out for NGO involvement in the programme and addressing equity concerns" (Minutes, November 24th, 2001*). Critical issues of scale and phasing of the programme were discussed. "*The scheme is entirely demand driven, the phasing of the interventions and the scale that it would assume would entirely depend on the number of mitanins who come forward for the training, nominated by the communities that they hail from.* ***No targets have been set for the collector for identification of mitanins bearing in mind the spirit of the programme"(ibid). "****Health will need to be understood by the mitanins as a social phenomenon" (ibid).*

The following important steps were identified for the *Mitanin* Scheme:

1. "*Community mobilization and campaigning on the scheme.*
2. *Selection of mitanins.*
3. *Listing of duties of the Mitanin.*
4. *Ongoing refresher trainings for the Mitanin.*
5. *Community financing mechanisms for the Mitanin.*
6. *Monitoring and evaluation of individual Mitanins.*
7. *Redressal mechanisms for the community.*
8. *Community support systems*
9. *Interface with formal public health functionaries (PHC doctor, ANM)*
10. *Interface with other Government functionaries (Anganwadi Karyakarta's, Teachers etc)*
11. *Role of panchayats / village health communities" (ibid).*

[1] He was an IAS officer, with a post graduation in Surgery with experience in health programmes in Madhya Pradesh, and a publication on approaches to improving health care in India.

Thus the state started leveraging a change process in the health sector through a dialogue with health and social activists, NGOs, donor partners and some DHFW staff. These groupings become a think tank which provided a conceptual framework to the evolving initiatives. The discussions based on study, documentation and learning from the rich experience and diverse perspectives of a mixed group threw up new approaches to a state run community health worker programme, built on to the earlier MP-JSR and 1978 national community health volunteer scheme. How much these approaches were internalized and implemented will be seen later. However it is important to flag the issues raised, as well as the process factors, as the learning from the Chhattisgarh experience will influence other states and the National Rural Health Mission.

By this time the small group had gelled. Action Aid – India and its regional unit head quartered in Raipur became an important institutional partner which played a catalytic role facilitating the process, helping develop a non-threatening interface between government, NGOs and donors through which process the overall perspective for the health initiative evolved. The European Commission Technical Assistance (ECTA) which was involved in supporting sector wide approaches (SWAP) in health sector reform in several states participated in key meetings. An important workshop in Raipur on **"Moving Towards Community Based Health Services** (January 16th – 18th 2002), raised the key issue of the **urgent need to strengthen the public health system, along with training community health workers**. The consensus of the group was that community health workers were not to be seen as a quick fix to improve health or as a low cost alternative to the health system. Participants, particularly the NGOs and professionals felt that "*the mitanin programme was unlikely to succeed unless wide ranging structural reforms were undertaken by the GOC to change the existing laws, policies, programmes and institutions of the state health delivery system "* (Ref. Patnaik B, Beginning of the Mitanin Programme, undated) Infact the *mitanin* was seen as a change agent who was to increase community awareness about health and available health services, to generate a demand and increase the social accountability of health and related services. All partners including the state and donors took the outcome of this meeting very seriously. ***Fifteen important issues were raised which became the milestones for operationalisation of the health sector reform process.*** The issues included: "*developing community based services; delegation and decentralization; strengthening health intelligence, surveillance, and epidemiology and planning; control of epidemics; addressing health problems of poor people; capacity building; rational drug use policy; improving internal systems of Dept. of Public Health; workforce management and transfer policy; drug distribution and logistics; uniform treatment clinical protocols; management information system; developing decentralized laboratory services; mainstreaming Indian systems of medicine especially tribal medicines into the state health system and drug resistance in malaria*." The timeframe for achievement of these far reaching changes was short, and expectations in the given context seem ambitious. While important issues were raised, the ability or capacity to operationalise these at a state or even district/block level were relatively limited in the entire health sector – public, voluntary and private. Prioritization of the 15 complex issues; with step by step planning; identifying or recruiting experienced, competent persons responsible for each

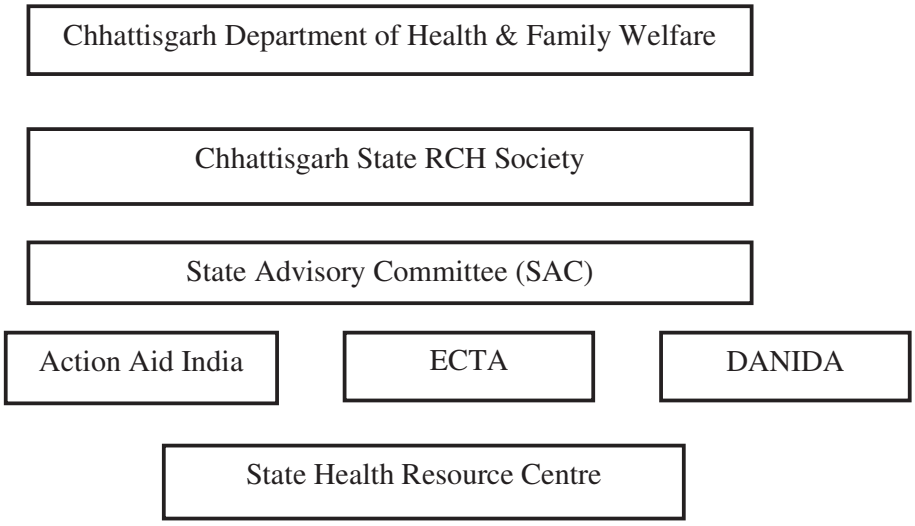
component; using a management instrument such as the Logical Framework Analysis; could not be done fully in the given circumstances. However, it must be recognized that this was a decisive and defining moment, a window of opportunity to initiate measures to strengthen the health system and link it with a strong base in the community. An important and good beginning has been made.

While discussions, conceptualization and strategic planning was underway, there was a genuine need, as well as a strong political compulsion to get the programme off the ground with a greater sense of urgency. Thus work on the implementation aspects was initiated. For the *mitanin* programme it was decided to identify community based facilitators (*preraks)*, one or two for 10 -15 villages to enable the selection process by the community through the *gram sabhas*. The process of developing Hindi manuals for the facilitators and the *mitanins* was initiated early in 2002, by involving NGOs and individuals with experience of community based health work.

The group now felt the need for an additional body to provide technical and organizational support to this emerging initiative. Action Aid India was entrusted with the task of operationalising this component.

The formation of SHRC as a distinct entity emerged from the earlier loose formation which also got formalized as the state Advisory Committee (SAC). The state health secretariat through a pro-active process developed a new institutional innovation, the SHRC, out of a working network between the public sector, civil society and donors.

Key players at the state level were



The State Health Resource Centre (SHRC) was established as a product of a Memorandum of Understanding dated Ist March 2002 between the Reproductive and Child Health (RCH) Society, Govt. of Chhattisgarh and Action Aid - India (AA-I). The two parties agreed to facilitate *"the formulation, implementation and*

monitoring of reforms process in the health sector" in Chhattisgarh. This was an imperceptible but significant shift from health sector strengthening envisaged in the February 2002 meeting to health sector reform which had a different history and meaning, which may not have been grasped by all partners.

The MOU was to "***make structural changes in state policy and practice, to make health services more accessible to people*** *who need them the most including very poor and marginalized groups, tribal people inhabiting remote hamlets, women and other people at risk****, mainly by strengthening community health , primary and district level health delivery systems; health surveillance, epidemic control and comprehensive reforms in policies, laws, programmes and institutions for realizing the vision of "Health for All".***

The SHRC was to be staffed by persons with vision and perspectives, combined with competence, organizational and technical skills, with an ability to work with governments, NGOs, civil society and communities. Interestingly recruitment processes included "head hunting" (the process of searching for a very specific sort of person through a number of formal and informal means – ref. -SHRC HR policies and procedures).

The SHRC had one staff member, as programme coordinator of the *Mitanin* programme from March to September 2002 who continued subsequently. At the end of September the Director, who was earlier involved in a couple of meetings and some discussions in the previous six months, joined SHRC. The first two months were spent by the new director in understanding the programme, visiting all the districts and beginning the recruitment process to staff and develop the SHRC.

In a relatively short period of time, by March 2005, that is in two and a half years, the SHRC has grown to a 33 member team and has initiated a significant amount of work related to the reform agenda as described in the MOU. During this period the SHRC adopted a "blistering pace" of work, operationalising many aspects of their mandate and driving the agenda that had evolved collectively. Though this has been critiqued by some, there was undoubtedly a need to take the Mitanin programme to a larger statewide scale. There are important lessons from this experience, especially as the ASHA initiative is being implemented in much larger states.

It was decided to pilot test the *Mitanin* programme at a block level by working through partner NGOs. Negotiations were held with some of the larger, more established NGOs in the state to join this process and the mitanin training programme was started in 14 blocks from May 2002. It was understood that further development of this initiative would take place one year later, based on the learning of this phase. Separate memorandums of understanding were signed between the RCH Society, Action Aid India (AAI) and different NGOs. These were signed by the Director of Health Services and RCH Society for the GOC, the Regional Manager of AAI and the Director of the respective NGO. Without waiting for completion a year, the up scaling of the *Mitanin* programme started around November 2002, working through the District RCH Societies and through a variety of mechanisms and partnerships that evolved at block level. Some depended on

ANMs for training, others in collaboration with local NGOs where they had a presence. Nodal officers, who ranged from medical officers, public health nurses etc, played a role, along with field coordinators and other SHRC staff to establish those arrangements, which used existing institutional bases and linked with civil society and others, demonstrating flexibility and creativity. There were differences of opinion in the SAC about the up scaling, and some saw this as a breach of trust.

While SAC was a 'high powered' advisory think-tank that had conceived of the idea, the SHRC became the executive arm. The potential for differences of opinion leading to some polarization of views and approaches became real and there was a distancing between the two bodies over time[*]. The SHRC became the dominant player, establishing close linkages with government and health department officials at state and national level over time.

The SHRC later registered as a Society, with a governing body. This shift of institutional arrangements reduced the role of the State Advisory Committee and some of the earlier partners, including civil society groups in Chhattisgarh. Methods of handling dissent; negotiating with several stakeholders at different levels; responding to varied reality sound bytes from the field; and handling shifting power relations are part of the complex tasks of the SHRC. How different groups that are involved handle these relationships influences the health initiative. *Given the important role the SHRC is playing, and the way it has positioned itself, it is important for the governance mechanisms to function well.*

6. Review of Achievements[2]

The SHRC was expected to facilitate the reform agenda of the State of Chhattisgarh (health sector reform was funded by the European Commission as part of its nation wide Sector Investment Programme). In this context, the following observations are made:

- Chhattisgarh is a newly established state and the health department is not fully functional. Large vacancies among Director and Deputy Director levels exist. Chhattisgarh does not yet have a State Institute of Health and Family Welfare (SIHFW), which in other states is expected to provide the Department with technical inputs and coordinate the ongoing training and continuing education of health personnel. Currently the function of the SIHFW is performed by the SHRC which acts and is acknowledged (by senior technocrats in the Department) as a think tank, and by the Danida Support Unit which manages training related functions. The SIFHW, Chhattisgarh is expected to be functional later this year 2005.

[*] This was articulated clearly through discussions with several respondents, as well as in print (ref. Binayak Sen, Myth of the Mitanin, June-July 2005, MFC Bulletin)

[2] This part of the report relates to both objectives two and three of the TOR.

- The SHRC was established in March 2002. However it became fully functional around July 2002. Given the relatively short period of functioning- July 2002 to March 2005, **the SHRC has accomplished a significant amount of work related to the reform agenda as described in the MOU.**

- Several of SHRC's initiatives have informed national and state programmes- the *Mitanin* programme is reflected in the ASHA component of the National Rural Health Mission, several human resource and rationalization of service components are in the RCH II plans of other states. Several of the GOC and SHRC initiatives have served as models for the newly created states of Jharkhand and Uttaranchal.

- The SHRC has been engaged in four major programmatic areas:
  1. The *Mitanin* programme,
  2. Health Sector Policy Reform,
  3. Response to ongoing ad hoc requests from the department for data, reports, presentations and generally functioning as a think tank,
  4. Function as an arm of the Department in designing, negotiating new projects with GOI and external donors.

- **The SHRC with its limited staff has been able to contribute significantly to policy and programmatic reforms with in a relatively short time**. However acceptance and sustainability of these reforms remains questionable. Unless they are pursued and commitments from bureaucratic and political powers are obtained, the likelihood of continuation remains limited. Health sector reform is a long haul process that takes place over an extended time frame. Implementation takes place in an environment of vested interests, constantly changing profile of actors, and is infused with politics, where technical analysis and policy prescriptions are first starting steps. In Chhattisgarh like in several of the Empowered Action Group (EAG) states, several challenges to health sector reform exist. Thus SHRC achievements need to be seen in a larger context of lack of decentralization, low capacity, low morale, and limited support for reform process at various levels of the hierarchy.

- **The flagship programme of the SHRC is the *Mitanin* Programme.** It is this that has given them visibility and the other achievements- in terms of policy support, technical assistance to the Department really pale in comparison to this politically high profile programme. It is to the credit of the SHRC that they have been able to ensure commitment and ownership through political and bureaucratic changes. SHRC has weathered these changes, partly because of its efficacy in enabling a programme of this scale and the recognition from political and bureaucratic leadership that this task could not have been handled within the government establishment. Several lacunae exist, many of them remediable, nonetheless the SHRC is to be commended on the scope and scale of the programme which deserves continued and sustained support. From a community perspective however

the *Mitanin* programme needs a lot of strengthening. A detailed analysis with recommendations are given in the second section of the report.

- The sector reforms package was intended to ensure that health systems performed efficiently and equitably to be able to meet the expectation generated by the community based *Mitanin* programme. However in a newly created state which literally had to begin establishment of a range of systems, deal with manpower issues, and ensure effective management, the absorption of reforms by poorly motivated staff is bound to be slow paced.

- Also it cannot be expected that SHRC developed policies can transform organizational or political processes that affect actual implementation. The workforce study, for example, is a masterpiece of explicit analysis of the situation, clear policy directives and clear statements of intended outcomes. Nevertheless this could not by itself affect significant change.

- An important "missed opportunity" to trigger and sustain health sector reform has been due to lacunae in the *Mitanin* programme. The *Mitanin* component offered SHRC and the GOC the opportunity to transform the system because the demands generated by the community (based on the *Mitanin's* work) should have enabled greater responsiveness by the system and thus both policy makers and direct implementers at the district and local level in health and health related sectors (Public Distribution System, *anganwadis,* etc) would have been forced to act. However because the *Mitanin* programme was greatly accelerated, compromising selection, training quality and supervisory support, the micro processes that lead to intensive community engagement have not yet occurred.

- **Human Resource Development (HRD) and Training Policy**: Over the last two and a half years, SHRC has worked on a human resource development policy for the Directorate of Health Services, and provided inputs to the training strategy, design, development of training material, and training of trainers for a range of providers including *dais,* multipurpose workers (health assistants), and medical officers. The formal training/HRD policy was developed by SHRC and sent to the Dept. of Health and Family Welfare (DHRW) on 25th October 2004 and approved on 11th December 2004. The training policy has clear cut goals and objectives which if implemented will help improving access to quality health care. It outlines in detail the number of existing and proposed public sector training institutions to meet the training needs in the state. There has been a detailing of the content of training as well as requirements regarding the training of trainers. The proposed State Institute for Health and Family Welfare (SIHFW) has been given a key role in providing the vision, direction and over-all guidance to the operationalization of the training policy.

- The goals of the training policy mention the need for '*requisite skills required for full capacity, utilization and effectiveness of health services*'. It is also necessary however for participants to develop an adequate

knowledge base, good interpersonal skills / attitudes and an understanding of the social realities (including social stratification) within which they need to function The actual training, follow up and supervision was managed by the Danida Support Unit and the Directorate. Both acknowledge the high quality input provided by SHRC to the training component. Most of the medical officers in the field were for the most part, appreciative of the standard treatment guidelines. In conjunction with the Essential Drug List (EDL), many perceived the training to be useful in their daily work.

- **Workforce Development Study**- Health Sector Reforms- SHRC worked with national consultants to conduct a detailed study of rationalization of services, workforce management, and human resource development in the public health sector. The recommendations of the study were shared with all stakeholders on the GOC and civil society and the discussions and consensus resulted in policy formulation on-

- Human resource development, especially in-service training and multiskilling of all cadres,
- Policy on cadre restructuring and promotions,
- Policy on service conditions of health workforce
- Contribution to drug policies

- Of these policies the component on human resource development is being implemented. (For multiskilling, please see section on EQUIP). Part of the Drug Policy has been accepted and implemented, but its future remains tenuous given the power of the drug lobby and the munificence of the carrots dangled before the political and senior decision makers.

- The other two policy recommendations on cadre restructuring promotions and service conditions have not yet been implemented although they constitute important components of the reform process. Action on this critical component will be one of the measures to build up the morale of the health personnel and develop a high quality cadre. Currently, besides the large number of vacancies, a large number of even senior officials are only "in-charge" or holding temporary charge of their positions. Interest is therefore low adversely affecting work. Supportive supervision of staff in the periphery is also affected and needs to improve.

- **The Enhancing Quality of Primary Health Care (EQUIP) programme** is based on the recommendations of the Workforce Management study on rationalization of services using a block level approach. The original intention of EQUIP was to use a participatory process to enable Block Medical Officers (BMOs) to assess gaps in infrastructure, human resources, and equipment. Based on this individual assessment, the Directorate would provide funding to ensure that each of the facilities received sufficient resources to close the gaps and ensure coordination between skills, equipment and physical infrastructure. Although envisaged for primary health care, the goals of EQUIP at block level were narrowed down to provision of Emergency Obstetric Services and round the clock institutional delivery.

- EQUIP was initiated in 2003 in 32 blocks (out of the total of 146 blocks) with the purpose of ensuring that each of the 16 districts would have two institutions at block level (CHC- Community Health Centres) to offer comprehensive care for obstetric emergencies. Planning involved the Block Medical Officers, oriented to conduct needs assessment and develop specific plans. SHRC facilitated the multiskilling training process, conducted in three teaching medical institutions. A good relationship has been built by SHRC with the three institutions, ensuring a good quality training with provision of teaching material. Teaching staff suggest a longer duration training programme so that participants get enough experience and confidence to conduct the surgical or anesthetic procedures on their own. Review of the records shows that, to date, 27 of 32 First Referral Units have the physical infrastructure; all of them have an anesthetist and obstetrician (trained through the four month multiskilling process). Available data indicates however that only 19 Caesarian sections have been conducted so far. The team visited a few CHCs. Findings from some CHCs are tabled below.

Table 9 – Implementation of EQUIP in some CHCs

Name of CHC	FRU- Physical Status	MO trained in Anesthesia	MO trained in Obstetrics	Obstetric load	Comments
Dondergaon	Equipment in place, Theatre repaired -No blood storage facility	BMO is a trained anesthetist	Lady MO just completed four month multiskilling course	Sixty deliveries per annum, no MTP services (04-05)	However the medical officer trained obstetrician is unsure of ability to actually handle obstetric emergencies, concerned about lack of indemnity and issue of what cover to expect in case of problems, and has not independently handled any CS during her training.
Balot	Equipment delivered one year ago-Boyle's apparatus has one cylinder missing -No blood storage facility	MO trained in short course anaesthesia- in place since October 2004	Two gynecologists- in CHC for several years	About 75 deliveries /annum, (04-05), 38 referred to district, 10 MTP per year	Interpersonal problems between gynaecologists and the anesthetist, thus they do not want to work together jointly, averse to taking risks, easier to refer to Durg district hospital
Dharamjayagadh	Equipment delivered, theater fixed, no leakages, AC installed, -no blood storage	Anesthetist returned from training early April 2005	Gynaecologist in place, but not sent for training, MO trained in short course obstetrics, but refuses to conduct deliveries	69 deliveries /annum, 24 MTP	Boyle's apparatus, can't be used- complained several times over past year to CMO, no response

- Discussions with doctors who have undergone the training and visits to the other CHCs (see list) revealed that for a variety of reasons (lack of equipment, inadequacies in operation theatres, staff mismatch) a large majority could not

put their new knowledge and skills into practice. However all of them appreciated the quality of the training, the materials given and follow-up during the course.

- Thus it appears that meeting the gaps alone is insufficient in ensuring improved obstetric care. Another factor that is at play here is perhaps the relatively high number of deliveries being conducted by ANMs and LHVs in the periphery. Delivery loads were higher in the PHCs and SHCs visited. They were being conducted by the multipurpose worker (female) in the center/or in women's own homes. This is an encouraging sign that more women are accessing "skilled attendants". However, the ability of the First Referral Unit (FRU) to perform is at the heart of resolving the maternal mortality issue. There are also many parts of the state where PHCs and SHCs lack buildings, staff and supplies, where deliveries cannot be conducted.

- SHRC staff are closely involved with the design, and supervision of the multiskilling training. Detailed progress reports on each of the medical officers trained are prepared and they are followed up rigorously during the training period. SHRC staff monitor the inputs and outcomes at the EQUIP blocks, and have evolved systematic processes to do so, but beyond bringing lacunae to the attention of the Directorate officials there is little direct action. Few field visits have been made until now in connection with EQUIP monitoring. Some transfers have been stayed to ensure that the team is not disturbed. Much more work with active follow-up in the field is required to make this functional and to expand to the remaining blocks within a realistic time frame.

- **Primary medical care needs of communities:** The response by the DHFW, SHRC and the DANIDA – support unit to the above need, by enhancing knowledge and skills through provision of training and supplies to auxiliary nurse midwives (ANMs), multipurpose workers (MPWs) and trained birth attendants (TBAs), is a rational and good approach. This approach strengthens existing health assistants who already have a basic knowledge and are a part of the health system. However despite these good efforts the gap in access to primary medical care still exists at community level, and needs to be addressed by the state as a priority. As mentioned in Section II the Mitanins could play a role in this, but after longer and better hands – on training, assessments and with systems in place that ensure supportive supervision and supplies. This approach may need to be implemented in a phased manner, in places where experienced trainers are available. The financial and operational aspects need careful consideration, including integration with the primary health care and referral system.

- **Documentation and writing** are one of SHRC's core activities. This is another area of impressive progress. Both in quality and magnitude of subjects, SHRC has contributed to the literature and has pioneered several publications. The Essential Drug List, Drug Formulary, Standard Treatment Guidelines have reached the peripheral health facilities in Chhattisgarh and have been appropriated for use by Jharkhand. The SHRC publications (listed in the

bibliography) both in English and Hindi are of good quality technically and in terms of presentation. The number of publications is large, for the short time in which they were produced. While SHRC's publications have acceptance within senior policy makers in the state and elsewhere, there is however little to suggest that other officials of the Directorate and medical officers at district and below appreciate or indeed are aware of these documents.

- The SHRC has accepted a number of **young professionals** from different parts of the country into their midst **to do their fellowship / internship and to work on dissertations**. The mentorship has been motivating and good. The team has provided a learning environment with a lot of openness and time for discussion.

- The **overall academic approach** used within the SHRC team enabling their professional personal and team growth; and through workshops for government and other staff; and the research work initiated through internal evaluations and studies has established a sound base for further development of the concerned health personnel, which can potentially positively impact on the health interventions. SHRC so far has been a learning organization, generating a tremendous amount of energy. A research based academic approach has generally not been used by the DHFW. This is a very welcome and useful introduction into the state health services by the SHRC.

- However there is a danger of the SHRC leadership and team taking on too much, with possible burnout, and loss of quality.

- SHRC has certainly provided **additional technical support** to the Dept. of Health and Family Welfare, GOC. However one has to consider whether a dependency has been created on it or whether there has also been a growth in technical and operational capacity within the department. It can be very convenient for the DHFW to have competent and willing workers on whom responsibilities can be offloaded. But this will not strengthen the department, though it could potentially undermine and even fragment it. It could also set a precedence to rely on sources outside the department; on consultants who may not have long term interests in the state. Alienation of health department staff may occur, resulting in a further reduction of their involvement. Capacity building in public health, wihin the Department is still a major gap.

- One area of concern is the **rapidity of scaling up processes**. This is clear in the *Mitanin* programme. In the EQUIP programme too, the state plans to expand the process to an additional 50 blocks, beginning April 05. SHRC has been unable to halt this rapid expansion. There is little evidence that there is effort in doing so

- A second area of concern is the **limited involvement of civil society partners in the process of sector reform.** Over the past few months, discussions and document reviews show that increasingly the dialogue is between the government and SHRC. This is in a sense negates the idea of the MOU, and invalidates the role of the State Advisory Committee (SAC). The SAC

expected to be a sounding board for the SHRC, has not met for several months and some of its members appear removed from and critical of SHRC functioning. It is likely that the caution constantly advocated by SAC members on too rapid up - scaling, on inclusion of organizations of integrity, to steer clear of political interests, actually impeded the SHRC from gaining legitimacy in the politico-bureaucratic arena. SHRC perceived that the exercise of such caution would reduce their image of efficiency with the system in Chhattisgarh and at national levels. SHRC somehow failed to achieve a balance between these two constituencies.

- **Several partnerships have been developed with NGOs/civil society for the Mitanin programme** at different levels (state, district and block level). Several of them are working well for instance in Manendragarh, Raigarh,Ambikapur, Bastar, Dantewada and Dhamtari. This involvement has helped the programme to perform better; the NGOs to enhance their capacity and increase the scope of their work; and the community to get greater space for participation as well as to get better services. Some partnerships with NGOs / civil society have not worked that well. One hears that the capacity of NGOs are varied. It is reported that new NGOs have emerged as the programme grew in importance and visibility, some with diverse interests and capacities. Partnerships need to be managed and fostered keeping community interest as priority. This is a new experience for block level staff of the DHFW. The over-extended SHRC team have played a pro-active role in this regard.

- A **community perspective** that emerges from the *Mitanin* evaluation and from several civil society members indicates that despite a lot of efforts there is still an ***implementation*** gap. The public health system is still not seen as performing adequately, making access to health care difficult. The *Mitanins* are in place, but need more capacity building, supplies and support from the health system.

- **Buy in and Ownership**: The Directorate appreciates SHRC's role and support. However, since SHRC as an entity does not belong within the system, it is not incumbent on the Directorate or bureaucrats to accept SHRC's recommendations. This applies to the harder to swallow areas of health sector reform.

- **Quality of implementation, supervision and functioning of the public health system**: How much can SHRC actually influence this? The challenge is to draw the line between supporting the department and actually undertaking the department's work. While implementation and follow-up in the field is strictly not the role of the SHRC, the intent, goal and role of the SHRC in strengthening key aspects of the public health system get limited if major improvements do not take place in the functioning of the health system. Experience of field visits for the SHRC evaluation and feedback from the Mitanin evaluation suggest that there is still a long way to go in strengthening the public health system. This is an indicative and not a definitive statement. Though the time period from launch of the initiative in 2002 was short to achieve significant change, the momentum of strengthening the health system needs to be much stronger. In

some institutions visited it was evident that infrastructure and staffing had improved and there was a fair degree of utilization of services. But we were possibly taken to the better institutions. Even so, there were health centres that appeared non-functional. The SHRC also had to develop its own team during this period and shoulder too many responsibilities. There was however a greater focus on the *Mitanin* programme than on health sector strengthening. *A greater balance may need to be achieved in future, with adequate number of staff and resources allocated from SHRC for the latter component.*
The DHFW too needs to take greater, if not the prime responsibility for health sector strengthening.

- **Institutional Arrangements**- The establishment of the SHRC through an MOU between an NGO donor agency (Action Aid India) and the Government of Chhattisgarh is a unique arrangement and really has no precedence in any other state in the health sector. Action Aid India staff were closely associated with SHRC and involved in key decision making processes during the first two – three years. There is some evidence of discomfort of late with the shift of SHRC closer to the system and their perception that compromises are being made in the micro processes of reform - such as community engagement, fostering activism, expanding the scope too quickly, and "choosing a route of political negotiation rather than staying with bureaucratic processes". However the support in the early period was critical in getting SHRC functional and a combination of leadership within the SHRC, AAI, and the GOC set in pace the entire agenda and ensured buy in from all stakeholders.

- It appears that SHRC will need to make a choice between continuing to stay within the system's sphere of influence and ensure that they are part of larger macro processes and in the forefront of policy at state, regional and national levels, or be content with a technical support and capacity building role. SHRC's future choice is closely linked to the direction the *Mitanin* programme takes.

- **Support from GOI:** The Govt. of India has recognized the health initiatives in Chhattisgarh and have involved state government and SHRC representatives actively in deliberations concerning EAG states; the National Rural Health Mission; the RCH II planning process etc. The GOI has backed the support from various donor agencies and programmes. The SHRC has been instrumental to a large extent in taking the Chhattisgarh experience to the national level and participating actively in the health planning process at the national level.

- **Sustainability:** As mentioned elsewhere the different health interventions have been sustained over changes in government and changes of key government personnel. There seems to be recognition by many at central and state levels that health sector issues cannot be further neglected. However there are a variety of competing interests that intersect, including those interested in strengthening processes of privatization and commercialization of the health sector; to others for strengthening the public health system; increasing the role

of AYUSH etc. *It is important for the SHRC and a wider core group to keep their focus and be proactive in taking measures and monitoring the strengthening of the public (government) health system. This was one of their key mandates.* The temptation to get involved in a variety of initiatives at state, national and other levels may divert their attention and energies. And sooner or later the window of opportunity to leverage change may close.

- **Donor support:** SHRC has been part of the negotiation team along with GOC officials in negotiating with donors such as the ECTA of the European Commission, DANIDA, RCH and others. The SHRC team have provided timely and professional help with preparation of project proposals and reports besides participating in discussions. Their technical assistance has been valued by GOC. The participation and support of Action Aid India has been invaluable not just as a donor, but as a partner in equitable development.

Institutional aspects of SHRC

- **Human Resources in SHRC:** In terms of expertise, skill, and capacity, the SHRC team is comprised of individuals with a composite of skills that enables it to play the role it does. Currently it has a small team with a reasonable skill mix. However there is need for more people with expertise and experience in community health, public health, including health worker training[3]. At the Raipur office the SHRC is headed by the Director with three programme coordinators. While each of the Programme Coordinator (PC) has a specific job description, they are aware of the entire programme, although not in depth. The PC in charge of the *Mitanin* programme is almost a deputy to the Director and has far more in depth understanding of the *Mitanin* and health sector reform agenda issues.

- All the staff of the SHRC display a high level of organizational and professional commitment, a substantial majority is also very enthusiastic, motivated and competent, in a learning mode, and dedicated to the vision of the organization. These traits are reinforced by the leadership of the Director who leads by example.

- Overall there is an environment of openness within the SHRC team which has contributed to the early and rapid growth phase. However communication is mutually strained at an institutional level with some groups as indicated earlier.

- There are an inadequate number of experienced staff who can work on health sector reform/strengthening.

- The structure is bottom heavy with almost all field staff focused on the *Mitanin* programme. Their participation in the health sector strengthening process, apart

[3] It is not easy to find such people, willing to relocate in Chhattisgarh.

from monitoring referrals and satisfied users is limited. There are 25 field coordinators, of whom ten are female; seven belong to SC/ST and six to OBC.

- However all the staff are stretched for time and are constantly working under time constraints and do feel pressured. For the programme coordinators, the task of dealing with the system is not stress free, although the Director is the key contact point. Day to day implementation requires constant interaction with several officials in the department and at the district levels and they are not always cooperative. The SHRC staff has two sets of tasks- one to attend to their day to day responsibilities and second to respond to ad hoc requests. Together the two constitute a substantial work load. It is perhaps only a matter of time before the burn out begins to show.

- There are no intermediate structures between Raipur and the district, particularly for monitoring the health sector reform agenda. The field coordinators are hugely overworked. Each covers five blocks and given the topography spends most of their time in the field traversing vast distances.

- SHRC has well established systems for work review through regional and state level staff meetings. At Raipur staff meet on an ad hoc, but at all times staff appear to have a broad understanding of current status. Morale is high and the work culture is conducive to good performance.

- The **financial systems** within SHRC are well established and function well. There has been an under utilization of budgeted and available funds. Printed annual reports of the SHRC could give the audited statement of accounts.

- **Fund flow delays** are common and this is reflected down to the block levels. This has been a major constraint as will be seen in the *Mitanin* evaluation. There are delays in payments to field staff (BRPs/*Prashikshaks)* and in drug supplies. These delays can seriously hamper the initiatives.

- SHRC has developed its own **institutional policies and procedures** and sometimes adopted Action Aid policies. It has an HR Policy and Procedures Manual, Accounting Manuals, and an Operations Manual which are open to staff. The HR policy is sensitive to women's needs and supportive of additional capacity building for those who opt to continue their education further

7. Overall Recommendations for the SHRC

- With greater autonomy of SHRC as it institutionalizes more and more the **governance systems** through the governing body etc needs to be stronger, with members giving it more quality time and efforts to ensure social accountability. There is need for brainstorming about SHRC's longer term role in relation to its mandate, and its linkages and positioning vis a vis the DHFW and other bodies such as the State Advisory Committee, the State Institute of Health and Family Welfare (SIHFW), the State RCH Society etc. The goal as mandated is to

strengthen the public health system. The timeframe and boundaries of SHRC functioning could also be discussed.

- Undoubtedly the success of **the *Mitanin* programme** with a focus on increased community awareness and empowerment will drive the health sector reform / strengthening process. Recommendations regarding the *Mitanin* programme are given in the second section of the report. The role of the SHRC is as technical support group in giving direction; providing content; developing educational material for different levels; training of trainers, facilitating ongoing assessments and evaluations. SHRC could further develop these areas, and be a group to make sure that community processes are strong and the programme works at the field level.

- Finally however **policy implementation remains firmly within the arena of the health department at all levels**. SHRC should find policy champions, constantly engage in constituency building, (strategies- bargaining, negotiating, marketing, and building strategic alliances). Enable civil society partnership and participation- over a period of time this pushes for transparency and accountability, set up monitoring and evaluation systems that include public sector functioning, civil society action and community perspectives.

- Acceptance of sector reforms and strengthening the public health system is contingent on a host of politico-bureaucratic and other motivations over which the SHRC can really have no control. However if one envisages this as the first phase of familiarizing the system and the second phase of ensuring that at least the technical components get ingrained into the system- key among them being the EQUIP programme to strengthen primary health care, the referral linkages between the *Mitanin* and the system (strengthening the *Mitanin* is key to create pressure on the system), and implementation of the Drug Policy and the Workforce study recommendations.

- **Training Policy:** SHRC could have a stronger nodal group of 2 – 3 experienced community health trainers to facilitate the further implementation of the training policy in close collaboration with the DHFW, SIHFW and the DANIDA support unit. Focus could be on:
- A variety of interactive, participatory, learner centered teaching learning methodologies could be used to help participants develop the necessary knowledge, skills and attitudes. Use of relevant role-plays, simulation games, exposure visits etc could be evolved.

- It is very necessary to have a focus on primary health care and the new public health as a common theme for all levels of training. This requires conceptual clarity as well as good communication.

    - The financial requirements of the training programmes that are being proposed need to be outlined in greater detail on a annual and longer term basis. Reviews of training programmes also need to be built into the planning. Mechanisms to follow-up trainees in the field, to provide

supportive supervision, and to ensure that the new skills are being applied in the field is most critical. Earlier training reviews at the national level have shown that despite large expenditures on training the outcomes and impact was poor.

- Doctors trained in Obstetrics and Anesthesia under the EQUIP programme in Chhattisgarh have not been able to practice their skills at the time of this evaluation in April 2005 for a variety of infrastructural and management reasons and also due to lack of confidence by some to undertake the surgeries / procedures independently. Newly acquired skills get lost fairly soon if they are not practiced, leading to frustration among the professionals. Follow-up is required to ensure operationalisation at field level, with mechanisms set up to get feedback from doctors and health personnel so that necessary action can be taken. The newly trained doctors could work in their district hospitals for a few days a week, to get the necessary hands-on experience with help.

- An integrated approach to training in keeping with the approach of the National Rural Health Mission will need to be evolved, as against the previous programme and donor driven fragmented approach, be it RCH, RNTCP, HIV-AIDS or Malaria training programmes.

- **Linkages with the SIHFW:** The role of SHRC and its relationship to the State Institute of Health and Family Welfare (SIHFW) will also need to be clarified to avoid duplication and confusion.

    - The SIHFW is a long term institutional mechanism to conduct higher level training programmes at state level for a variety of health personnel which should function as an autonomous institution. It could also possibly undertake operational and action research or facilitate this through other academic institutions in the state. The necessary infrastructure will need to be built up and maintained in keeping with its role.

    - Linkages with District Training Centres and Anganwadi Worker Training Centres and possibly with a University could enable the SIHFW to grow into the nodal public sector training and human resource development centre for the state.

    - Careful staff selection as teaching faculty of the SIHFW will need to be done in keeping with its envisaged role. Post training follow-up and reviews to solve performance related problems in the field will require to be planned.

- **Publication of training material** will need to be continued and newsletters can be considered, with inbuilt feedback mechanisms for responses by departmental staff and other participating groups.

- This is a good moment for **SHRC to re-define its targets and goals**, making them more realistic. This could be done in a collective manner with the different stakeholders.

- **Financial requirements for different components** have been outlined in various reports, using this base and adding components that may be left out a higher financial planning process for the DHFW needs to be undertaken for the next 10 years with potential sources of funding from state, central and other sources.

- **Health promotion** could be given a separate budget. Money from tobacco taxation could be considered a source. A health promotion unit could also be developed.

- As part of **human resource development,** young DHFW staff could be sent for post-graduate studies in a range of disciplines under the broad umbrella of public health. A pool of clinical specialists (anesthesia, psychiatry etc) also needs to be built up, along with allied health professionals (public health nurses, counselors, health promoters etc).

- **District training teams** for both arms – health sector strengthening and trainers for the Mitanin Programme could be developed.

- **Career pathways and incentives for heath department staff** could be built up.

- Creative use of **mass communication methods and folk media** could be continued with adequate financial and organizational support as an ongoing mechanism for health awareness among the community.

- **Report cards on health institutions** by the local public done at judicious intervals would provide public feedback to the institutions.

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ANNEXURE 'I'

DISTRICTS AND INSTITUTIONS VISITED FOR SHRC EVALUATION

I. RAJNANDGAON DISTRICT

a) Rajnandgaon District Hospital
   i) Dr. Moti Ramani, Civil Surgeon
b) Dondergaon CHC
   i) Dr.Devdas, BMO
   ii) Dr. Manisha Kesar
   iii) Mrs. Pushpa Veera, BEE, also DRP
c) Kappa PHC
   i) Dr. Pradeep Kundu, MO/IC
d) Kujji Sub Centre
   i) Mrs. Kiran Yadav, ANM

II. DURG DISTRICT

a) Balot CHC
   i) Dr. Claudius, MO/IC
   ii) Dr. Padmavathi
   iii) Dr. Gore
b) Sankra PHC
   (PHC shut – no staff available)

III. RAIGARH DISTRICT

a) Dharamjayagadh, CHC
   i) Dr. Bhagat
b) Seesringa PHC
   i) Mrs. Malathi Ratiya
c) Gersa Sub Centre
   i) Mrs. Suhani Ikka, ANM
d) Gersa Village
   i) Mitanin Discussion

IV. BASTAR DISTRICT

a) Nodal officer –Ms. Shalini Raj, District Public Health Nurse
b) Field Coordinator – Mr. Ram Jaj Gond
c) District Resource Person (DRP) - Ku. Mamta Sikdar
d) Maharani District Hospital, Jagdalpur
e) Bakaawan CHC/FRU
f) Chiyoor Subcentre
g) Makdi CHC /FRU, Dr.S.Soni
h) Shampur PHC

V. DANTEWADA DISTRICT

a) Mr. Om Prakash Burman, Field Coordinator
b) Dantewada District Hospital
   i) Dr. Chetan Dahariya from Geedam CHC, also block nodal officer
   ii) Dr. Alka Soni
c) Pratibha Vanvasi Chetna Ashram (Partner NGO)
   i) Sri Himanshu Kumar and Smt. Veena and team
   ii) Ms. Bhuwaneshwari, DRP
   iii) Ms. Ambati Yadav – Prashikshak
   iv) Ms. Sangeeta Bagha – Prashikshak
d) Bhairamgarh CHC
e) Tamnan PHC
f) Durparas Sub-Centre

VI. KANKER DISTRICT

a) Kanker District Hospital

VII. Dhamtari District

a) Shri. K. R. Bhosale, DRP
b) Dr. Thakur, Medical Officer (TB and Leprosy)
c) Dr. Shandilya, CMHO
d) Dr. A. D. Purena
e) Dr. Y. K. Singh
f) Ms. Satyavati Gajendra, BRP
g) Shri. J. Kalihari, DRP
h) S.R. Tandon, Trainer

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ANNEXURE 'II'

LIST OF PERSONS MET FOR SHRC EVALUATION

1. Mr. B. L. Agarwal, IAS, Secretary Health & Family Welfare, Govt. of Chhattisgarh (GoC)
2. Mr. Sunil Kujur, IAS, Secretary, Women & Child Development, GoC.
3. Dr. A. K. Sen, Director Health & Family Welfare Services, GoC.
4. Dr. Atre, Joint Director, GoC.
5. Dr. Pramod Singh, Joint Director, RCH, GoC.
6. Dr.Subhash Pandey, Deputy Director, RCH, GoC.
7. Dr. Madangopal, Danida Support Unit, Raipur.
8. Mr. Harsh Mander, Chairperson, SHRC Society, Delhi (previously Director, Action Aid –India when the process started).
9. Prof. Babu Mathew, Director, Action Aid, India, Delhi.
10. Mr. J.P. Mishra, European Commission Technical Assistance (ECTA), Delhi.
11. Mr. A. B. Singh, Externally Assisted Projects, Ministry of Health and Family Welfare, GoI, New Delhi.
12. Dr. T. Sundararaman, Director, SHRC.
13. Mr. Biraj Patnaik, Regional Manager – Action Aid India, Raipur Offie.
14. Dr. Binayak Sen, PUCL and National Alliance of Peoples Movements, Raipur, Member, State Advisory Committee (SAC).
15. Dr. Yogesh Jain, Jan Swasthya Sahyog, Member Governing Body, SHRC.
16. Mr. D. N. Sharma, Member Governing Body, SHRC.
17. Mr. Lakhan Singh, Member Governing Body, SHRC.
18. Mr. V. R. Raman, Program Coordinator, SHRC.
19. Dr. Premanjali Deepti Singh, Program Coordinator, SHRC.
20. Dr. Kamlesh Jain, Program coordinator, SHRC.
21. Mr. Komal Devangan, Accounts Officer, SHRC.
22. A number of field coordinators of SHRC in two group sessions and individually.
23. Mr. Jayant Bagh and Ms. Pratibha, Research team; SHRC.
24. Some NGO partners -
    - Mr. Himanshu Kumar, Pratibha Vanvasi Chetna Ashram.
    - Mr. Iqbal and Mrs. Kalavathy, Adivasi Harijan Kalyan Samiti,
    - Sameer and Sulakshana from Manendragarh district (very briefly)
25. Two groups of doctors from CHCs in different districts undergoing 4 month training in Anaesthesia and Obstetrics at Raipur Medical College and Sector IX Hospital.
26. Group meeting organized in June 205 by SHRC with NGOs from different parts of the state. (/this was for discussion on he draft report).

ANNEXURE 'III'

NARRATIVE REPORT REGARDING MITANIN TRAINING PROGRAMME IN DANTEWADA AND BASTAR DISTRICT*

(by Dr. Thelma Narayan)

Visit to Dantervada district, 1st April 2005

I. **Meeting with** 40 mitanins, 7 prashikshaks, 2 DRPs, the field coordinator and NGO leader from Pratibha Vanvasi Chetna Ashram at Kutru Village,Dantevada block. We met for about 2 hours under a large tree.

Background: Kutru is 110 km from the district headquarters at Dantewada . Dantewada is one of the largest blocks in Dantewada district about 150 km across. People are mainly adivasis, speaking *gondi* and *halbi.* It is predominantly a forested area with widely dispersed villages, within which *paras (*hamlets) are spread 2 -3 km apart. It is largely a forest based subsistence economy. Bullock carts are not yet used in this region. People transport goods tied to bamboo sticks which are carried on the shoulder while they walk long distances to the weekly market. Some including the prashikshaks cycle. Buses ply on the main roads only. Seriously ill patients have to be carried. Levels of education and literacy particularly of women is low. This is an area reportedly with a strong presence of naxalites, who incidentally extended support to the mitanin programme after a study of the manuals and a discussion with the field coordinator.

Six blocks of Dantewada district mentioned below were covered under Phase I of the mitanin programme. In five blocks the programme worked in partnership with NGOs (mentioned below), through the district RCH society.

a) Pratibha Vanvasi Chetna Ashram covers 2 blocks (Dantewada and Bhairamgarh). This NGO under the leadership of Sir Himanshu Kumar has been in Dantewada since 13 years. They work in watershed development, rural sanitation, education of children, and health is inspired by Gandhian philosophy and by Sri Vinobha Bhave.

b) Prajya Seva Ashram covers Kuakonda block.

c) Adivasi Harijan Kalyan Samiti covers Chindgarh block.

d) Ramkrishna Sadar Seva Ashram covers Katekalyu block.

e) Geedam Block programme is run directly by the Govt. Block Medical Officer (BMO).

In the second phase five blocks was covered, namely Bijapur, Sukma, Usur, Konta, Bhogatpatnam.

Observations from the meeting

There were differences in the knowledge and social skills in the group which was a mix of mitanins and their trainers. The DRPs and prashikshaks though younger were more educated (some were doing their post graduation through correspondence courses). In this case they were identified by and work through the NGO and their payments are ensured even if there are delays in fund flows from the district level. They traveled to work on cycles. Mitanin training programmes are conducted in the NGO training centre. They have leadership abilities, self confidence, social mobilization and group skills. Their knowledge and skills in health work could be deepened. The 40 mitanins were all women in the age range of 20 – 45 years. They were mainly the daughter- in -laws of the village. In these remote areas it is an achievement and effort for women to come out of their homes for a social purpose. They seem to enjoy this. Some who were longer in the programme were more empowered and confident to speak. They narrated experiences in an authentic manner. Two examples of collective action taken by the mitanin groups, mentioned below were confirmed by the others.

a) The village primary school teacher was a heavy consumer of alcohol and often came late or not at all; slept in class and did not do much teaching. The mitanins discussed this in their meetings and

decided to take action. They complained to the concerned authorities and after the issue was looked into the teacher was changed. They are happy with the new teacher who is diligent.

b) The ANM was not doing her work properly. After discussions with her and recognizing the difficulties that she faced, the mitanins began assisting her by collecting children for immunization and bringing mothers for antenatal care etc. They are now satisfied with her work.

On independently talking to an ANM in the nearby Kutru PHC she also said that the mitanins are very helpful.

The mitanins present had undergone different rounds of training and varied greatly in their knowledge of health issues eg. ORS, Malaria presumptive treatment, recognition of TB etc. A few had understood the concepts to an extent and appeared to have a little experience of actually handling cases. A larger number knew a little bit but did not seem to put it into practice. Others had very little recall. They had not received the drug kits and this could be one of the reasons. They were more enthusiastic and experienced in using local herbal remedies. They all warmed up and participated in singing health and mitanin songs in different languages. They complained that the local PHC doctors asked people to come to his house in the evening and charged them for services that were to be free. They felt his treatment was not good. This was based on their own personal experience. At the end a few raised the issue of need for an honorarium.

On visiting the PHC which was visible very close by we were accosted by armed men with revolvers in civilian clothes who said they were from the CRPF. They questioned us in some detail about who we were, what the meeting was about who organized and ran the meeting etc. They had apparently been keeping an eye on us throughout to check if we were naxals. We hear that there are more CRPF units than PHCs in the area.

II. Meeting with seven mitanins in Medse village, Geedam block, Dantewada district Ist April 2005

We met the group in a small remote village hamlet when it was already dark. They were older, more confident and knowledgeable about pregnancy, TB, diarrhoea. The Geedam block mitanin programme is run by the BMO. Three of them had undergone a ten day dai training programme after becoming mitanins and had conducted 4 -5 deliveries each. They refer patients and often accompany them to Geedam CHC which reportedly functions well. This was confirmed by the field coordinator. They know and use a variety of herbal remedies which they described. One was elected as a member of the Gram panchayat and another was a GP Sarpanch. They had a good set of songs and participated in singing very tunefully. They reportedly have weekly mitanin meetings and less frequent Mahila Swasthya Samiti (MSS) meetings. In the SHRC field coordinator's experience where the MSS are strong the mitanins work is better. While mitanins initially experienced a little resistance from their husbands, this had changed over time to active support; we saw some of the husbands waiting to take their wives back on their cycles.

III. Met two mitanins at Dantewada district hospital

The NGO, Pratibha Vanvasi Chetana Asheram has taken the initiative to have two mitanins to base in the new district hospital inaugurated in January 2005 at Dantewada as a 'help desk'. They talk to patients who come from distant villages and help them with registration, direction to the concerned department/doctor etc.

IV. Action by Prashikshaks

A rapid nutritional assessment survey measuring weight for age of under five children was carried out in November 2004 by the Prashikshaks supported by the field coordinator. Out of a total sample of 10,852 children the findings were as follows:

Normal : 3675
Grade I : 3281
Grade II : 2467
Grade III : 934
Grade IV : 495

This report was handed over and discussed with the District Collector for follow up action as 25% of Bhairamgarh block does not have anganwadis.

B

Field Visit in Bastar district 3rd April 2004 –Dr.TN

The district nodal officer for Bastar district is a graduate (B.Sc) Public Health Nurse, having joined the MP Govt. Health Service in 1977. She is the only nodal officer who is a nurse, the others being doctors, sub collectors, ICDS officers etc. She had a fairly good knowledge about the scheme, but did not know the CHC and subcentre visited. She has good communication and training skills as witnessed. Nodal officers are part of the support structure for the mitanin programme at district level. They help to coordinate, take responsibility for fund flows and occasionally trouble shoot. She said that meetings of all district nodal officers at state level were held earlier, but not since the past year. Partnerships have been developed with the following four NGOs in Bastar district for the mitanin programme: (i) Participatory Action for Rural Development Society (PARDS), (II) Institution for Management of Participatory Action for Community Development, (IMPACT) (iii) Social Education and Basic Awareness (SEBA), (IV) TRIVE – A society for the development of tribal and rural people, with a focus on women and education.

I. **Visited Bakaawan Community Health Centre (FRU) in Jagdalpur district 30 km** away from the Bastar district headquarters at Jagdalpur. Met the DRP Ku.Mamta Sikdar who was a very bright, lively and confident young person who had earlier work experience with the NGO Participatory Action for Rural development Society (PARDS). Met 20 prashikshaks from different villages some as far as 70 km away. In the remote areas there were male prashikshaks (3 in this group). They had a very good set of songs in the local adivasi language. They also spoke Hindi well. They had a good knowledge of common medical problems, TB, malaria and the expected functioning of the PHCs and CHC. They were very enthusiastic and spontaneous. Many were graduates. It is reported that deaths due to gastro enteritis have been minimized in the past year. Malaria slides are taken and sent to the health centres. Getting results from the health centre is often delayed. Bastar is a thickly forested adivasi area endemic for falciparum malaria. Prashikshaks do not have experience of working in health eg in being able to diagnose common ailments, in managing patients with dehydration, using herbal remedies etc. Hence their training on these issues is theoretical. Their knowledge regarding health and disease is just a few steps ahead of the mitanins. They are also not conversant about pedagogical methods for teaching in health.

II. Brief interaction with 40 mitanins at Primary Health Centre Village

These mitanins were gathered for the second round of training in the second phase blocks. They had completed only 3 days of training in the first round. A senior health assistant from the government PHC and prashikshaks were conducting the session. The male dresser from the PHC who was present was obviously drunk. It was a one day training. Women come by bus and arrive around 10.30 – 11 am. The actual hours of training are very short. This group was much quieter, very shy and did not know much. They however all sang together very well. Some of them raised the issue of smaller payment during the second round as compared to the first round. The lunch for all was organized at the Anganwadi Workers house. Here too the complaint was that the amount given was less than the previous time. Adequate reasons had not been communicated to the participants and local organizers.

The **overall impression** is there is an evident gradation in levels of self-confidence, social skills and health knowledge if one compares mitanins from Phase I and II. There are the beginnings of empowerment of women at individual and group level. There is reportedly a relatively low drop-out / turnover rate among mitanins (reportedly around 5%) according to the field coordinator. However some are not actually functional in the field. There are long gaps between training rounds. For instance in Bastar district the training rounds for mitanins were as follows:

I Phase

Ist round – April 2003
2nd round - May 2003
3rd round – November 2003
4th round – July, August 2004
5th round – November 2004
6th round planned in May 2005
ie only five rounds of training (12- 15 Days) were completed so far.

IId Phase

Ist round – July / August 2004
2nd round – March / April 2005

From July 2004 work has been slow. When there is no training, the momentum of the programme reduces, and subsequently contact and work in the field declines.

Attrition of knowledge and poor recall would occur especially when what is taught is not put into practice. The dropouts among prashikshaks is said to be higher at about 10%. We were unable to get data about dropout rates.

Issues concerning mitanin programme arising from discussions in the field.

1. **Fund flows:**
   - The mitanin programme was initially planned and budgeted for 18 months. Because of some savings they were able to continue though at a slow pace till March 2005. Conceptually and in practice health worker programmes need to have a long term perspective of 5 – 7 years and ideally 10 years. Even 3 years is too short to achieve results. Provision of insufficient funds is a sure way of disabling a programme. When such large state wise programmes are initiated through public policies the planning, budgeting and fund flow monitoring need to be done with a great sense of responsibility.

   - Monitoring of fund flows and taking prompt corrective action has been lacking. Cash flow problems have been a major bottleneck in the implementation of the programmes. The field coordinators are paid by cheque from SHRC. DRPs (Rs. 2,500 paid per month plus some transport costs), BRPs / Prashikshaks (paid Rs. 1000/- per month) are paid in cash by the Nodal officer and DRPs respectively. BRPs pay the mitanin training costs. Bastar district has been put in a special category and receives adequate funds. There has reportedly been no problem in disbursements of funds from SHRC. However there are delays at the level of the district RCH society and below. The full amount is also often not paid.

   - Uncertainty about continuation of the programme causes anxiety and could lead to lack of interest and loss of faith.

   - When community health worker programmes are not followed up and supported in the field most of the gains get lost resulting in a huge wastage of effort, time and money. Government policy makers, planners and donors would surely consider the public health ethics dimensions of their decisions. Accountability to the thousands of health workers, trainers and the community must be given the highest priority.

2. **Kalajatha's** on health issues were prepared and conducted in Phase I Blocks (66), through preparatory workshops and sessions with local artistes from Chhattisgarh. They involved a large number (about 3000) of young people from colleges etc participating in street plays in different villages to create community awareness about health issues and about the mitanin programme. A book of health and mitanin related songs has been published. The evaluation team has heard a large number of the songs sung by field coordinators, mitanins and prashikshaks. We have seen photographs of the kalajathas. This was a very important medium of communication and dialogue on social issues underlying health and should continue to be supported financially and organizationally. To save on costs Kalajathas were reduced in Phase II. Some were conducted through the IEC programme of DANIDA. There has been less outreach to communities in Phase II and efforts are reportedly less effective. Recall of messages from a single educational / kalajatha session is small. For a good impact health education sessions are sometimes repeated twelve times.

3. There is a major **language problem** in training and community involvement. SHRC staff, field coordinators and DHFW staff are not conversant with all languages such as gondi, halbi, bhadri and oriya which are spoken in just one block Bakaawan in Bastar district for instance. The major languages in the state are Hindi and Chattisgarh. Prashikshaks who are all educated usually know the local languages and dialects as well as Hindi. They are a bridge for communicating with mitanins and the people. DHFW staff have found prashikshaks and to a smaller extent mitanins very helpful in overcoming the language divide between the health system and the people.

4. The 14 part **radio programme** aired on All India Radio every week at prime time is in Hindi and Chhattisgarhi. More than one round of transmission has been completed. It has received good feedback. Other language versions are being developed. The radio programme has been one of the medium of communication used to reach out statewide. A listener feedback review can be done and a larger range of health issues can be regularly covered.

5. More recently a **video programme** has been produced about the mitanin programme. Some of it was shot in Bastar district. This will perhaps be used for advocacy purposes. It seems to be promotional in nature highlighting understandably only the positive aspects.

6. **Communication efforts to involve communities.** The SHRC team has been very proactive and creative in its use of songs; street plays, kalajatha programmes radio programmes and publications in Hindi produced in a fairly short period of time. The quality of productions has been good. The efforts though commendable have not been able to reach out to the entire community. Feedback from gramvasi's show that many people (60-70%) do not know about the programme at all or very minimally. Community processes and efforts towards increasing community awareness and involvement need to be strengthened and sustained.