

## REPORT OF COMMON REVIEW MISSION'S VISIT TO STATE Chattisgarh State Report

Period of visit: w.e.f. 15.11.2007 to 20.11.2007

This Common Review was conducted by the Government of India in the State of Chattisgarh with the main Focus of taking stock of the progress made on the implementation of the PIPs during the following years 2005-2007, highlights of key strengths in the health system in the state, along with the identification of key implementation bottlenecks and delineation of corrective measures needed is described in the report.

### Composition of team

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**Process:** The process followed was as per the TOR of the CRM prepared by GOI. State provided the information about the overall impression about NRHM), as communicated earlier, to the visiting team. The State also involved in the selection of three districts for conducting field visits to service delivery facilities and to capture perspectives from key stakeholders. The districts were chosen keeping in view the notification of one backward district, tribal districts and border district as consulted with state authority and Program management team.

The facilities in each district visited during the review mission were as follows:

- i. 3 CHCs
- ii. 5 PHCs
- iii. 6 Sub Centres
- iv. 3 District Hospitals
- v. Village Unit of PRIs

Debriefing with state programme managers was held in the presence of the Secretary Health and input to the draft report including feedback from the field along with major recommendations were shared and consensus achieved. On behalf of the State some assurances were given of the actions to be undertaken for the effective implementation of the activities in the last meeting with state officials presided over by the Secretary Health.

**REPORT OF COMMON REVIEW MISSION'S VISIT**  
**Focus on Mitandin Programme, Chhattisgarh**

**Objective:** To assess the performance of NRHM with emphasis on achievements and challenges of 'Community Processes' and its impact on the successful implementation of various health activities in the state.

**Areas visited**

S.No.	District	CHC/PHC	Subcenter/Village/locality	Hospitals
1	Kanker	1.Charama 2.Hardula	1.Jaiskara 2.Jaipara Pandhari Pani	1. Distt. Hospital, Kanker 2. Distt Hospital Dhamtrj
2	Durg	1.Bhillai-3 2.Ghotia 3.Dondi 4.Chikhla- khasi Kala 5.Balod	1.Katro  2.Kusum Kasa	1. Distt. Civil Hospital, Durg
3	Rajnand Gaon	1.Doongergarh	1.Khaprikalan 2.Indamara	1. Distt. Hospital, Rajnandgaon

NRHM Common Review Mission is an opportunity to understand the success of Mitandin programme in the state while identifying key strengths of the programme and highlighting ongoing challenges for the health system to effectively respond to these challenges in the state.

The concept of the Mitandin as a village based change agent in the field of health is the key to the success of Mitandin programme in Chattisgarh. The primary responsibility of the Mitandin is to be the spokesperson of the village communities' right to health and access to benefits of health Care and health services. Mitandin programme passed through the period of intense environment building in the villages with the help of a cultural programme designed by the Cultural Team comprising of a Pandwani, songs , kalajatha and a short play.

This was followed by selection of Mitandin through a detailed community process. In keeping in view of the deliberations of State Advisory Committee and local specificities the Mitandin was selected by consensus from among the para/village women. In demarcating the para (hamlet) care was taken to see that issues of distance, homogeneity and acceptability of the selected Mitandin were kept in mind. The first step was to organise and empower women in the community as well as Panchayati Raj institutions. This was done by establishing a state- wide Community Health Volunteer (CHV) programme which trained and deployed a CHV in every single hamlet of this state. The CHV is called a Mitandin, (a special kind of friend in local tradition) and is a married woman from the local community, not necessarily formally educated though almost literate.

### Role of Mitanins under NRHM

Her main role is to provide:

- a. Elementary health education.
- b. Facilitate access to health services
- c. First aid help and treatment of minor ailments with the counter drugs
- d. Prompt referral advice where necessary
- e. Facilitate collective disease preventive action by the community
- f. Organise and empower women and women groups.

She is supported at the hamlet level by a women's health committee and by the health (ANMs) and Integrated Child Development Services( ICDS) workers (AWWs).

### Selection

Mitanins are selected by the Gram Sabha and the same is endorsed by the Panchayats. There is a specific set of processes for the selection, facilitated by a trained person for the purpose and supported by massive and rigorous social mobilisation activities like Kalajathas and local folk songs.

### Training

The Mitanin is trained (12 days of camp based training conducted over an year of 2 to four days each and about 30 days on the job training) and supported by a fulltime block training team of 20 Block Resource Persons( 1 per about 20 Mitanins) and coordinated by 1 team 3 District Resource Persons (1 Govt official + 2 volunteers) per block. A range of training manuals and support material has been prepared for the training of Mitanins.

Apart from this, a continuing IEC/BCC component is also run through initiatives like a radio serial on the programme, films based on health/programmatic issues. Ten rounds of Mitanin training completed, with adequate provision of Dava-patti, weighing machines, thermometer and provision of available literature in Hindi.

### Programme Management

The programme is run by a state civil society partnership at the state, district and block levels.

At the state level programme management takes two forms:

- a. A state advisory committee.
- b. An innovative institution called the State Health Resource Centre (SHRC) formed as an additional technical capacity of the state health directorate to design and guide the Mitanin programme as well as the entire health sector reform programme of the state. The SHRC has been set up under a memorandum of understanding between the State Government and Action Aid India, a non-government organisation which is as well responsible for coordination of State Coordination Committee.

The most important aspect of the Mitanin programme is that it is integrated with the range of health sector reforms that aim to strengthen the public health

system, rather than work on the demand generation and community health aspects in isolation.

### **Mitanin Training:**

Key Components of Mitanin Training in seven steps spread over 24 months through the availability of supportive structure and State Health Resource Center:

1. Building an understanding of the programme:  
Involvement of a lead NGO along with the health department and supported by district administration build a campaign to convey the Mitanin programme to the villages. As part of this a team of facilitators visit the villages and interact with local communities, NGOs, peoples organisations etc to help the community identify a woman in each hamlet who is willing to be trained and function as the Swasthya Mitanin on a voluntary basis. Special emphasis is made to involving the panchayat and its health committee in this process.
2. Training of Mitanins on Child health:
  - a. Ensure that child health components of the ANM and ICDS programme reach the children ( done in coordination with the health dept and the ICDS programme)
  - b. Identify children ( below five years at risk) by weight for age measurements as well as all children in the first year and counsel and support mothers of such children to prevent infections and optimise feeding practices.

The first round of training helped the Mitanin understand the objectives and organisational strategy of the programme. It also informed her about existing public health care facilities and how to go about educating the community on this.
3. Training of Mitanins on Women's health:
  - a. Help women especially adolescent girls understand the causes and determinants of women's health problems
  - b. Ensure that government programmes to train dais, to provide care in pregnancy are effective and accessible to the public.
  - c. Ensure that there is a capacity to identify common women's health problems and provide relief for them
4. Training of Mitanins to organize community initiatives for the control of Communicable disease in coordination with the health department. Special focus initially on three diseases - malaria, tuberculosis and Hansen's disease- where existing government programmes would be modified to utilise these initiatives and made more effective. A special programme on control of water -borne disease has been undertaken.
5. Training of Mitanins to maintain and use a simple medical kit, supplemented by home and herbal remedies, to provide care for minor illness and first aid.

6. Training of Mitanins to help the local women's health committee maintain a basic village health register that acts as an instrument for programme monitoring and local health planning.
7. Local capacity building and local planning : the women's health committee, the elected panchayat members , the panchayat health sub committee and other interested persons collectively contributes to develop an understanding of health and health care services by participation in the above programmes as well as special training camps organized for this purpose. This capability combined with tools like the data from the village health register and processes like the collaboration with the health department is very much useful in the identification of local health priorities and the drawing up of local health plans.

### **Mitanin Programme and Strategic Contribution to Health Sector Reforms**

The Mitanin Programme is no doubt generating a greater demand for health services in the state, but this is expected to be met with an improved supply of services by the existing public health system. The concern is that the programme would raise expectations, which for the government may be difficult to fulfill. Recognizing this problem the Mitanin programme is planned in parallel with a number of measures to strengthen the health system. The Mitanin programme is funded by the Sector Investment Programme and the MoU signed between the government of Chhattisgarh and the Government of India specifies that each quarterly installment is received only when certain objectives are attained- and the objectives state not only Mitanin objectives but also measures to make the public health system more functional. This is a commitment proposed and made by the state government, which recognizes this linkage of strategic strengthening of health system.

On one hand, the health centers are able to do little for many emergencies that local community faces while on the other, community is unaware of the existence or importance of the services that the health facilities are providing. Partly also because currently there is a larger scope for community participation and involvement for initiating decentralized planning & implementation of health programmes under NRHM.

Mitanin Programme largely contributes to increase utilisation of public health services in the state by;

- a. Increasing public awareness & knowledge of health facilities are available and also needed at the local level;
- b. Facilitating local dialogue with health care providers to ensure better delivery of health services;
- c. Promoting community initiatives in health care programmes and by organizing community engagement to facilitate and participate in the delivery of health services.
- d. Contributing to the benefits of advocacy to secure health services and health rights through promoting linkages with PRI bodies in the district from the gram-sabha for effectiveness in decentralized planning and implementation

The ongoing Mitanin programme sees better effectiveness of existing services as essential to build public opinion for the provision of comprehensive primary health care- the health for all slogan and organization of Village Health & Nutrition Day etc.

### **Issues on strengthening health systems through Mitanin Programme:**

#### **Drug Kit and Drug Distribution systems:**

Highest level of political commitment is shown in the state, under the 'Mitanin Mukhiya Mantri Dava-petti Yojana', the Drug-Kit is supplied to the Mitanins. However distributing the drugs for re-filling the Drug-kit - is a special problem. As the ongoing drug distribution system should be responsive to changes in utilization patterns. The current system is to dispatch a fixed quantity of drugs to the peripheral facility irrespective of the pattern of usage.

#### **Blood Smear Examination**

Mitanins make and send blood smear slides in fever cases. But reports never ever come back as feedback to them. Though is a strategy in place to crack this problem as part of the village health plan - but as yet this has not taken off and it stays where it is. This issue was noticed and discussed during our interaction with the Mitanin groups in the village Indamara as well as shared with SPM unit.

#### **Mitanin Referrals**

Mitanins refer cases to hospitals with referral slips and often accompany them. However often they are treated rudely and even where the doctor sees the patient properly he may make appoint of dismissing the referral slip as of no consequence. But there are certain PHCs or CHCs which were willingly and with dignity responding to referrals, which then maximized referrals to these centers. The team visited the Mitanin Help Desk in the Durg Dist. Hospital facilities is worth mentioning.

#### **Mitanins and Immunisation**

Mitanins of hamlets where even half the children had not been immunized were to report this separately and the system is expected to take it up and hold a health and immunization camp in this village. A list of such hamlets was compiled with the help of Mitanins. Some chief medical officers interacted with during visit clarified that they have acted on this list when it was presented to them. This mechanism contributed to address the problems of immunisation and its coverage as was expected to have risen after the involvement of district authority.

Mitanin programme invested in training ANMs and AWWs on the Mitanin programme and sought their help as trainers. No doubt these helped the capacity of Mitanins, but there is still considerable room to improve cooperation. The coming-up of Janini Suraksha Yojana and the imunisation day incentive has made no change to this general pattern of lack of cooperation from the health department functionaries. The issue of timely availability of compensation is critical and need immediate attention. There are similar problems in almost all aspects of coordination between health department and the Mitanin

programmes; where Mitanins efforts are expected to be complemented by health department's responses at large as was felt by the team during their interaction with officials from the PHC, CHC and Districts covered under this visit.

**Only those activities which are directly linked to the achievements of Mitanin Programme are discussed;**

a) TBA (Traditional Birth Attendant) training programmes:

Provision of a trained birth attendant for every hamlet is an effort that parallels the Mitanin programme. At the end of the first month after the first round of training of Mitanins, village level group discussion must identify those in need of training and send the information to the block center. In parallel a new dai training syllabus has been readied by the CBHSP working with State Health Resource Center and a strategy of training has been evolved so as to improve both quality and pace of the training programmes.

b) Co-ordination with MPWs:

This is one of the key steps as much of the services outreach that the programme aims to improve are the services delivered through the MPWs. The following steps are envisaged:

1. Regularly organization of block level meeting of MPWs with Mitanin trainers.
2. An in-service training programme of MPWs on the Mitanin Programme and community basing of health programmes. A guidebook for this purpose has been prepared by SHRC. The aim is for all the MPWs to undergo this training.
3. Panchayat level meetings with all Mitanins and with MPWs so that a calendar of visits for the MPW is worked out. Mitanins would help by informing people and bringing those in need of services at the time of visit and MPWs would keep to their schedule. This calendar is discussed and finalized preferably in presence of panchayat leadership. Panchayat Swasth Diary is seen in the Villages visited during our interaction with Sarpanches of these villages.
4. The Mitanin maintaining a village health register where she is able to track which service each family has got. This helps to identify gaps within the service provision area of both the MPW and anganwadi delivered services to reduce overlapping and to initiate convergence.
5. Block level leadership is important to mediate and negotiate between both streams (Mitanin and MPW) giving them equal respect and encouragement so that the gap is narrowed. The Health sector staff sees this as an opportunity to learn that complaints of shortfalls and gaps in the provision of health services when brought out by Mitanins and not as a problem in majority of the sub-centers visited.
6. The skills of the MPW to act as a referral to the Mitanins and to respond better to the perceived health needs of the community are being upgraded through a number of measures. An expanded list of drugs has been made available for them. Along with this is the introduction of a

- special 'Hindi Standard Treatment Guidelines' and a training programme where they learn to expand their primary level curative care skills is very much observed in the field visits.
7. Improved disease control programmes through designing for community based disease control approaches:
    - In service training inputs for MPWs and health supervisors on community health services based on a guidebook prepared have been widely available.
    - Strengthening referral services:  
This is taken care from Mitadin level up to CHC level with feedback mechanisms to Mitadin for identified categories of health problems.
  6. Strengthening Health information and disease surveillance systems:  
Linking data inputs from the community (through the Mitadin programme) with health information management systems and disease surveillance operated by the health department could benefit the community and assist health sector functioning. Care needs to be taken that this does not increase the workload of the Mitadin. This linkage is yet to be established for bringing out effectiveness in the process of HMIS.
  7. Streamlining drug procurement and distribution mechanisms:  
This is essential to ensure that drugs are regularly supplied to Mitadin and that its use is monitored. This is observed to be a critical area needs immediate attention for re-feeding of drug-kit.
  8. Local Health Planning:  
Preparation of a block level health plan integrating the panchayat level plan with the district health system and with inbuilt feedbacks from disease surveillance and health management and information systems should enable effective decentralization and planning of health services. This is in the process of initiation through Panchayat Health Committees and involvement of PRIs in health care activities like ensuring functioning of sub-center in some critical areas visited during our visit to Khaprikalan village and was revealed to us by the Sarpanch of this village, who is providing his personal house for the functioning of sub-center activities.
  9. Strengthening panchayat role and accountability of public health system:  
In the process of undertaking implementation of community health through community involvement and the involvement of their elected representatives in the local government within the PRI get a much better understanding of health services with response to the rights of local community. This is taken care through the implementation of Panchayat Swasth Scheme in the state. Mitadin programme expected to build capabilities of involvement of PRIs by;

- i. Sensitizing member from PRIs and involving them in health issues
- ii. Increasing their knowledge of existing health care and related services
- iii. Promote their participation in organization of health related events
- iv. Help them to represent health related issues to authorities
- v. Encouraging panchayat level priority identification and planning for health using benefits of Panchayat Swasthya Scheme and Panchayat Swasth Diary.

In addition to the Mitanin programme some of the other measures being taken by the SHRC to strengthen the public health system in the state include:

- The adoption of an Essential Drug List, State Drug Formulary and Recommendations for Comprehensive State Drug Policy.
- Standard Treatment Protocol and delineation of levels of care and training on the same.
- Training of primary health sector staff-- especially of Medical Officers & ANMs - both on STPs and on local planning on health. Building up of training infrastructure also is in place.
- A study has been undertaken by SHRC to make recommendations on workforce management, on rationalization of services, on human power development and on decentralization of health sector planning and management.
- Based on all the above inputs a plan is being drawn up to take up a number of Mitanin blocks for intensive motivational, planning and organizational inputs so as to actually be able to demonstrate an improvement of primary health care.

This programme, Enhancing Quality in Primary Health, is very much reflected in the delivery of Primary Health Care in the state.

#### **Critical challenges for Mitanin programme:**

- In the current structure of the programme, increasing demands are made on Mitanin to be accountable to the ANM for health programme achievements, whereas her original mandate was different as she was accountable to the community. This largely creates confusion about accountability structures.
- Since the ANM, a paid worker, has an easy way out of non performance, and the Mitanin is expected to fulfil her targets, do ante natal check ups and referrals. This process is making her role into an unpaid assistant for the ANM which violates all norms of voluntary action as per the guidelines under NRHM.
- Many of the failings of the health care delivery system are by passed by using the Mitanin as a whipping woman. The entire push for institutional

delivery is misplaced. Chhattisgarh has only 10 % capability for inst delivery; had the facilities and staff been there, women would themselves have come forward to avail them, currently the entire blame game is laid at the door of the Mitantin who is graded by the district programme coordinators based on the number of cases she sends for institutional deliveries. This is also an issue of gender injustice.

- The mitantin is also constantly undervalued by the professional health care staff, their referrals torn up, etc. in majority of cases. BMO under Hardula PHC was complaining about Mitantins as they are not aware of any training given to Mitantins.
- Re-filling of Drug-Kits: The absence of dawa peti re-fills after the first issue was probably the most serious threat the programme is facing subsequently and this caused considerable loss of morale and confidence among the Mitantins. Many of the Mitantins had taken on the structures of exploitation in their villages and this failure on the part of programme administration gave them renewed vigour to attack the Mitantins as articulate women and as health workers. Some of the villages visited still suffers from this difficulties.
- Issue relating to incentives payment is also a major concern though the level of incentive currently reaching is enough to keep the system going. Problems mostly relate to delayed payment, non payment, and reduced amount of payment to the beneficiaries of Mitantin scheme. Clear strategies though in place for facilitation of strengthening the payment process but this issue needs immediate attention of concerned health functionaries.
- A health and Nutrition day under the rubric of 'Immunization Day' is organized regularly with the coordinated involvement of Mitantin, ANM and AWWs. The challenge is to sustain this community process so that they do not become operate as one level of functionaries of government in the state.
- The Mitantin's contribution to curative role is only a supplement to her other functions. The focus of Swasthya Mitantin work is on preventing disease and promoting health. The Swasthya Mitantin focus is on improving public health care services and not substituting for it. There is a danger that the Swasthya Mitantins will also fall into the prevailing culture of unnecessary drugs use and injections for earning a living. Training the Swasthya Mitantin to safeguard the community against harmful and useless medical care would also help in this regard.
- All districts visited is having a Mitantin Help desk to help Mitantin with Patient in reaching the specialist and initial counseling support is highly effective and well conceived by the senior management of the Dist. Hospitals visited in the Durg district.
- Orientation regarding Mitantin's effort in achieving benefits of general health services especially in the areas of community mobilization is yet to be understood to many among the health functionaries.
- Issue of recognition of Mitantin effort among the government health system and sustainability of community processes for effectively contributing to the challenges of health systems development in the state is critical.

### Relevant Observations from the field:

- ❖ Utilization of Untied fund is critical with the absence of input for record keeping and accounting system - a general observation in almost all the facilities visited.
- ❖ The issue of provision of second ANM under NRHM was discussed though not approved as discussed during our visit. According to ANM visited under sub-center, Jaisakara, she has to pay electricity bill for Rs.300/ per month for the sub-center where she is staying. Lack of coordination between ANM and Sarpanch was discussed in village Jaisakara making it difficult to contribute to the supportive facilitation of NRHM.
- ❖ Drugs and storage facilities are largely mismanaged. This account for the poor understanding and implementation of IPHS standard for 24X7 PHCs, FRUs and diagnostic facilities for quality care for delivery of health services in demand. Under Jeevan Deep Samiti Scheme, the equipment and furnishing of peripheral health facilities is yet to be taken care.
- ❖ Community Processes contributed to the increase in institutional delivery, but absence of minimum standard of facilities as per IPHS standards, lack of Toilet for women, unclean Operation Theater, vacancy of staff nurse and physicians critically contributing to poor quality of care. Innovations of Public-Private partnership are yet to be streamlined except DURG Dist Hospital. This is one of the best available facilities in the state as per IPHS standard, as visited by the team.
- ❖ Utilization of RKS through Jeevan Deep Samiti is implemented at all level under NRHM. It was felt seriously by the team that there is lack of appropriate monitoring and record keeping systems in place which account for ineffectiveness in utilization of benefits of Jeevan Deep Samiti in the state. Similarly, health department staff members need to be sensitized in this regard, the role of DPMU is essentially critical in this aspect. This contributes to large amount of fund being unutilized.
- ❖ Effective involvement of PRIs and Community Processes in the state is observed by the team. Especially our interaction with PRI leaders revealed that the draft guideline on Village Health and Sanitation Committee is to be operationalised within the scope of Village Health Committee as headed by PRI bodies under the rubric of 'Panchayat Swasthya Scheme'. The team also observed the Panchayat Health Diary is available to all the Sarpanches for their easy understanding of health priorities and maintenance of diary of events in their locality. Adequate sensitization of PRI bodies on health issues is suggested along with interdepartmental coordination for larger benefits of village panchayats under NRHM.
- ❖ The state has yet to prepare the District Health Action Plans based on inputs from the Block health action plans and Village level action plan. This process is in the progress at present through SHRC support involving health departments. Involvement of other linking department is essential to initiate intersectoral convergence involving

multiple stakeholders from concerned programmes /departments from various vertical programmes in the state.

- ❖ The state has the tradition of involvement of NGOs in public health programmes. The role of SHRC in the state as a facilitator for capacity building and assessing multiple stakeholders' capacity is worth mentioning. State level ASHA Mentoring Group is formulated to take up the assessment of effectiveness in the 'Community Monitoring' under NRHM. Periodic stakeholder consultation is envisaged under the present role of SHRC for the effective engagement of NGOs in the state especially in the areas of IEC/BCC strategies under NRHM.
- ❖ Assessment of Programme Management structure is in place at the state as well as at the district level. The state has established SPMU at the capital and DPMU throughout the state. Continuity and retention of PMU personnel is critical to the success of contribution of DPMU to the implementation of NRHM. The coordination between SPMU and DPMU is facilitating the programme management in the state. But the strategic cooperation between SHRC team district facilitators and DPMU is critical in building bridges that are essential in narrowing down existing challenges of governance of NRHM in the state. This in brief can contribute to;
  - Larger understanding of field situations by the DPMU team as well as SPMU
  - Optimizing the benefits of various vertical programmes through convergence from the field
  - Exchange of information and strategies that are essential to reduce overlapping of capacity building measures at the field level for HMIS, Systems strengthening, Monitoring and initiating supportive mechanism & strategic supervision for mid-course corrective measures.
  - Monitoring and coordination of Capacity Building activities starting from village, block and district level of operations
  - Involvement and support from the government health functionaries in the capacity building for ASHA, VHSC and PRIs
  - Effective contribution to the operational issues in HMIS at the village, block and district level of operations
- ❖ Capacity building of DPMU and SPMU is critically essential for the effective coordination of implementation of NRHM in the state. Formation of Health Monitoring and Planning Committees at all levels of operations is worth mentioning starting from PHC, CHC to District and State. Review of district, block and PHC level MIS reports, integrated MIES formats and use of IT in tracking of reporting and documentation revealed that there is inadequacy in the hands on training input to these functionaries in this aspect of managing HMIS involving field level functionaries. Sensitization of stakeholders for the use of MIES format is critical. Establishing and operationalisation of feedback mechanism for mid course corrective measures are recommended by the team. Data disaggregating by gender and critically vulnerable group is suggested to be included in the integrated MIES formats.

- ❖ SHRC involvement in effective contribution to Mitnin programme, Swasth Panchayat initiatives, preparation of draft guidelines for VHSC, Jeevan Deep Hospital Reforms Scheme, Facility Assessment, evaluation and hospital development planning with the completion of 4 district hospital planning so far is worth mentioning. Additionally involvement in the capacity building initiatives for district health planning is under progress. Research support in the areas of Intra-panchayat and interpanchayat variations in health status is an ongoing activity contributing to effectiveness of the Panchayat Swasth Scheme in the state. Behaviour change communication intervention needs at community level is also an undergoing activity with the support of SHRC in the state.
- ❖ Mainstreaming of AYUSH initiative is largely seen in the following areas with the contributions and active involvement of SHRC;
  - Mitnin training design on home based herbal remedies
  - Support in development/modification of Ayurved Gram Concept which is operational in all the blocks in the state
  - AUSHDEEP Samiti Planning is in the progress
  - A separate AYUSH cell is coming up in the state for the provision of research and development in SHRC
- ❖ Convergence Initiatives in the state is largely supported by SHRC team in coordination with SPM in the following areas of operations;
  - Coordination with WCD in capacity building of AWWs workers involving Mitnins under forthcoming 'Kuposhan Mukti Abhiyan'
  - Mitnin diversities Programme in 20 blocks focusing on food and social security
  - Coordination with UNICEF on IMNCI involving Mitnins, Swasth Panchayat, School Health and Joint BCC activities of AWWs and Mitnins
  - Swasth Panchayat effectiveness by integration of intra-panchayat status and planning on health determinants
  - Effective coordination with WCD, PHED, P&RD, TWD and SWD
- ❖ Pending Issues of 'Governance of NRHM' with the Mission in the State
  - Approval of New PIP for 2007-2008 for which fund has already been allotted
  - Renewal of SHRC MOU
  - Approval of draft Village Health Sanitation Committee Guidelines
  - Approval of proposal of delegation of Financial Power with special reference to sanctioning, approving and signing authority
  - Approval for formation of New Programme Management Committee
  - E-transfer through notification server

## **ACTIONABLE RECCOMENDATIONS:**

- ❖ Issues of “Governance of NRHM” are critical and need immediate attention of the state authority to address.
- ❖ Capacity Building of SPMU and DPMU along with State functionaries on Implementation Framework and Financial Management of NRHM
- ❖ Advocacy on NRHM Strategic Milestones with the effective engagement of multiple stakeholder from Government, NGOs and Private Sector involving intersectoral coordination within various programme managers of health department
- ❖ Capacity building on HMIS involving SPMU, DPMU and Concerned functionaries for effective monitoring, reporting and documentation
- ❖ Continuity of Mission Director in the state for providing strategic direction to SPMU and effective implementation of NRHM. At least 2-3 years of tenure is recommended for the position of Mission Director.
- ❖ Capacity building of state functionaries along with SPMUs on ‘Advocacy on intersectoral coordination under NRHM’ is suggested for maximising convergence of services at the implementation level.
- ❖ Capacity building of district management team including District Facilitators need to be addressed in bridging the gaps between District Facilitators and District PMUs for effective coordination of programme management operations. This will surely facilitate the field visit and field level techno-managerial input to the programme management in the state.
- ❖ Approval of pending commitments along with draft guidelines on VHSC will ensure effective linkage between Mitandin and PRI bodies. This will contribute to sustain the ongoing effort on Community Processes in the state.
- ❖ Strategic planning on ‘Sustainability of NRHM involving multiple stakeholders’ is critical to assess the effectiveness of NRHM at this stage of programme implementation in the state.