Technical Report
No. 13

Stakeholder Analysis: The Women's and Children's Health Project in India

December 1997

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December 1997

Recommended Citation

Kumar, Yogesh, Nabarun Roy Chaudhury, and Navin Vasudev. 1997. *Stakeholder Analysis: The Women's and Children's Health Project in India*. Technical Report No. 13. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.:	HRN-5974-C-00-5024-00
Project No.:	936-5974.13
Submitted to:	USAID/New Delhi
and:	Robert Emrey, COTR Policy and Sector Reform Division Office of Health and Nutrition Center for Population, Health and Nutrition Bureau for Global Programs, Field Support and Research United States Agency for International Development

Abstract

This stakeholder analysis identifies primary groups in selected districts of the Bhopal District of Madhya Pradesh state, India, that have an interest in or will be affected by proposed activities of the Women's and Children's Health (WACH) Project, a USAID-funded community-based health project focusing on reducing neonatal mortality. The analysis determines group reaction to: proposed activities; their possible roles in WACH; and approaches to monitoring the support of key WACH stakeholders. Results of this analysis may provide information on what groups to involve in the design, implementation, and monitoring of WACH; strategies to ensure community participation and direct planning and budgeting; roles for stakeholders to play in WACH to ensure their support of the project; and positive and negative impacts on the stakeholders from the proposed changes in the health system.

The results of the analysis show that, in general, stakeholders agree with the WACH Project objective of improving the quality of women's and children's health. They also support the plan of starting with a pilot project in one district, and later expanding to other districts. There is also general agreement on the state overseeing the effort to involve and train a variety of people and institutions to help fill the gap in providing health-related services, although stakeholders indicate a need to clearly define all collaborators, their roles, responsibility, and areas of accountability. The stakeholders interviewed also believe the government should support flexible funding mechanisms, either through a government institution or a newly created non-governmental organization (NGO) which maintains government, NGO, and private provider representation.

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Foreword

This study was undertaken as part of the Partnerships for Health Reform (PHR) Project's contribution to Phase I of USAID/New Delhi's Women's and Children's Health (WACH) Project. WACH was designed to take place in the state of Madhya Pradesh, with the objective of reducing neonatal mortality through delivery of an essential package of maternal and child health services to be provided at the community level, with funds provided directly to the communities. Although the WACH project did not progress beyond Phase I, due to lack of agreement on implementation arrangements between USAID/New Delhi and the Government of Madhya Pradesh, this study on stakeholder analysis can contribute to related work in India and elsewhere.

The stakeholder analysis was designed to identify the major groups in Bhopal District of Madhya Pradesh that have an interest in, and will be affected by, the proposed activities of the WACH Project, in order to determine their reaction to proposed activities, the roles that each group can play to help ensure its support for project activities, and indicators to monitor the support over time of key stakeholders. This application of stakeholder analysis is one of the first systematic attempts to apply this approach in the design of new forms of health delivery and financing. Although the WACH project did not go forward, the documentation of the approach undertaken by PHR local subcontractor Samarthan, under the direction of PHR consultant Derick Brinkerhoff, may provide guidance to others interested in using stakeholder analysis in the design of new approaches to health care delivery and financing. It is hoped that Samarthan and other partners in India will use this methodology in other health and development work. PHR, in turn, will apply this experience to other activities of this nature in other countries. We hope that the overall result of this chain of experience will benefit the people of India and other parts of the developing world, through improved design of new approaches to the delivery of health services to underserved populations.

Nancy Pielemeier
Partnerships for Health Reform Project

Ackowledgements

This study was implemented by Samarthan Center for Development Support, a regional affiliate of the Society for Participatory Research in Asia (PRIA), in Bhopal, Madhya Pradesh through a subcontract with the United States Agency for International Development-funded Partnerships for Health Reform (PHR) Project.

The Samarthan team is extremely thankful to the community, *panchayats*, government, non-governmental, and private provider representatives of the stakeholder groups for sharing their invaluable views, observations, and opinions candidly and expressing their concern for the project objectives. We are also thankful to Partnerships for Health Reform Project for contracting Society for Participatory Research in Asia and Samarthan to undertake such an important assignment, which is not only a challenging opportunity, but also a pioneering and systematic effort to bring in the voices of all possible stakeholders, especially the community and their directly elected representatives, to influence project planning and implementation.

We are personally grateful to Dr. Derick Brinkerhoff, Organizational Development Specialist for PHR, and Dr. Rajesh Tandon of PRIA, New Delhi, for guiding the process and entrusting the stakeholder analysis team with this project. We are thankful to Ms. Rekha Masilamani and Dr. Rajani Ved of USAID/New Delhi, for their cooperation and encouragement. We also thank Nabarun Roy Chaudhury, development consultant of Samarthan, for taking a lead role and relentlessly planning and conducting interviews, data processing analysis, and report writing, along with team members Navin Vasudev, Leena Kanhere, Sangeeta Ukhade, and Amitabh Singh, who maintained organizational standards of quality and kept our commitments on schedule. My special thanks are also due to Mr. V. Satyamurthy of PRIA, who undertook the overall coordination and support to ensure smooth implementation of the stakeholder analysis.

Acronyms

ANM	Auxiliary Nurse-Midwife
CMO	Community Medical Officers
CRE	Centre for Rural Development
DM	District Magistrate
DMO	District Medical Officer
DREP	Rajeev Gandhi Literacy Mission
HRD	Human Resource Development
ICDS	Integrated Child Development Scheme
IEC	Information, Education, and Communication
JSR	*Jan Swastha Rakshak* (barefoot doctor)
JSS	*Janpad Swastha Samiti* (block health committee)
LHWRF	Lupin Human Welfare & Research
MP	Madhya Pradesh
MPW	Multi-Purpose Worker
NCHSE	National Council of Human Settlement and Environment
NGO	Non-governmental Organization
PAC	Project Advisory Committee
PHR	Partnerships for Health Reform
PRI	*Panchayati raj* Institution
PRIA	Society for Participatory Research in Asia
RMP	Registered Medical Practitioner
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
VSS	*Village Swastha Samiti* (village health committee)
WACH	Women's and Children's Health Project
ZSS	*Zila Swastha Samiti* (district health committee)

Executive Summary

Introduction

This report presents the results of a study conducted in mid-1997 in Madhya Pradesh state to assess and analyze the interests and concerns of a weighted sample of actors in government, communities, non-governmental organizations (NGOs), and the private sector related to the United States Agency for International Development (USAID)/New Delhi's Women's and Children's Health (WACH) Project. The study team used a stakeholder analysis methodology to conduct an intensive series of interviews with nearly 100 actors.

The Women's and Children's Health Project

USAID/New Delhi's WACH Project is intended to improve women's and children's health in seven districts in the Bhopal Division of Madhya Pradesh. The seven-year project focuses on a package of essential health services to be delivered at the local level. WACH will foster linkages and partnerships among community organizations, private sector providers, *panchayats*, and the government health system. The project is designed to be implemented in phases, starting with an 18-month diagnostic and pilot phase in the district of Raisen.

WACH Project Components

The project's major activity components are the following:

- *Community mobilization and action in support of health improvements for women and children. Example of possible activities include integrating health issues into existing groups, helping communities organize for monitoring of Women's and children's health status, supporting community arrangements for transportation of patients to health facilities, and so on.*

- *Health education and media programs to inform and build awareness. For example, these could be linked to ongoing literacy and basic education programs.*

- *Improved access to quality services at the community level. This is where the majority of partnerships are intended to operate. Plans include involving NGOs in working with communities, expanding outreach, training private providers, and increasing the effectiveness of the referral system. Possibilities for state health facilities include helping to create better linkages with communities and local private providers, working with panchayats, or collaborating with jan swastha rakshaks (JSRs) (barefoot doctors). In the private sector, drug houses and local pharmacies could be potential participants for better outreach and services.*

Bridging Activities

The Partnerships for Health Reform Project (PHR), along with several other cooperating agencies from centrally funded USAID projects, undertook a number of analytic activities in support of the diagnostic and bridging phase of WACH. Among these activities is the stakeholder analysis, which seeks to identify and assess the major groups that have an interest in, and will be affected by, the proposed activities of WACH. The study sought to provide analytic input into the design and implementation components and strategies of WACH; including what groups to involve in project activities; sources of support and opposition; options for community participation; and elaboration of appropriate roles for the public, private, and voluntary sectors. PHR contracted with a local organization to conduct the study: Samarthan, an Madhya Pradesh-based NGO that is affiliated with the Society for Participatory Research in Asia (PRIA). Samarthan carried out the study, with technical assistance from PHR and oversight from PRIA.

Stakeholder Analysis

Stakeholder analysis is a tool that assists policy makers and managers to identify whose interests need to be taken into account when making decisions. These can be decisions on designing and initiating a policy or program, on the steps to take to implement a program once designed, and so on. In general, stakeholder analysis focuses on cataloging actors in terms of: (a) their interest in the particular issue at hand, and (b) the amount and nature of resources they can and are motivated to mobilize either in support of, or in opposition to, the issue. The analysis allows policymakers and managers to clarify winners and losers, and develop strategies that can deal with stakeholder expectations, develop appropriate roles for the various actors involved, and build constituency support for change.

The main objectives of the WACH stakeholder analysis were to:

- *identify the major groups and individuals who have a stake in the current maternal and child health service delivery system and the changes that will result from the WACH Project;*
- *determine the impact (positive and negative) of the proposed changes in health service delivery resulting from the project on the various stakeholders in order to anticipate their reactions and reduce opposition among those who perceive themselves to be losers in the new process;*
- *identify potential strategies to increase support for the project among the various stakeholders, including possible new roles for those whose decision-making powers will be diminished;*
- *begin to develop a set of indicators to monitor support for project activities by various stakeholders over time; and*
- *build the capacity of local organizations and individuals to conduct stakeholder analyses for health sector-related activities.*

Information gained from this analysis was intended to be used to facilitate the transition from the design of WACH to start-up and implementation, including key groups to involve in the planning, implementation, and monitoring of project activities; participation strategies to use in planning and

budgeting project activities; and specific roles that various stakeholders can play to ensure their continuing support for the project and to minimize potential opposition to the project.

Methodology

The stakeholder analysis consisted of a series of approximately 90 interviews with people identified by USAID and Samarthan as major stakeholders in the activities and organizational changes that will take place through the WACH Project. These included people at all levels of the health system within Madhya Pradesh and the Bhopal Division, from state and division officials to local community leaders, including members of *panchayats*. At the local (block and below) level, the stakeholder analysis took place in the Raisen District at the same block as did a community diagnosis, situation analysis and other studies carried out by other Cooperating Agencies. At the local level, interviews were done in focus groups; thus the actual number of interviewees totaled more than 90. The list of stakeholders includes:

- *state- and division-level government officials from the departments of health, social welfare, finance, and tribal welfare;*
- *political leaders at the state, division, and block levels;*
- *local community leaders, including members of panchayats;*
- *public sector health providers;*
- *private sector providers, including pharmacies;*
- *media representatives;*
- *NGOs working in the health and social service sectors;*
- *provider associations; and*
- *research groups and universities working in the area.*

The study team, with assistance from PHR, developed an interview protocol and data analysis framework. The interview plan began with the state-level stakeholders at the request of USAID, and an interim report was prepared following these interviews. The interview protocol probed stakeholder perceptions and views concerning:

- *the functions and effectiveness of the existing health system;*
- *the new roles that health sector actors would have given the proposed changes in MCH service delivery that WACH would introduce; and*
- *the institutional capacities of health sector actors to play these new roles effectively .*

Major Findings

Regarding the functions and effectiveness of the existing health system, all stakeholder groups recognized that the government health system is the predominant provider of services, and has an extensive infrastructure and network. Some differences of opinion arose around the effectiveness of the state health delivery system. The majority of stakeholders affirmed that, while the government health system has an extended reach, its ability to provide services is unevenly distributed throughout the system. Critical resource and staff shortages limit actual service delivery despite nominal coverage extending to the community level. Senior officials at the state level tended to have a higher opinion of the government system's capacities. Stakeholders flagged a number of common problems with the existing system: weak outreach to the community level and low quality of service locally, and satisfactory referral procedures.

Regarding new roles for health sector actors in maternal and child health under WACH, stakeholders unanimously acknowledged the desirability and validity of involving NGOs at the community level, particularly for awareness-building and fostering local participation. However, they pointed out that in Raisen and Madhya Pradesh more generally, the number and reach of NGOs operating in the field are limited, especially in the health sector. All stakeholders also recognized a role for private providers, noting that local people already use them to a significant degree, they fill a void in terms of accessibility, and for certain basic services they can be relatively efficient. Health professionals frequently expressed reservations about their lack of technical qualifications, and tended to worry about their propensity to exploit the poor. Panchayats were mentioned as appropriate mechanisms for grassroots monitoring and community sensitization. Points raised by stakeholders about the appropriate role for the public health sector included the views that government: should not have total control of WACH, should provide training and technical support to other implementing partners, should monitor progress, and should increase outreach through mobile health units.

Concerning institutional capacities of health sector actors, the views expressed indicated that government health services are seen as technically of high quality, but lack of resources curtail access to care, particularly for rural women and children, and limit health care providers' ability to use their skills and knowledge effectively. Despite the acknowledgment of the desirability of including NGOs in WACH, there were strong reservations expressed about the weak NGOs' participation, much less playing a central role in implementation. On the subject of private providers' capacity, their lack of technical knowledge and skills was widely cited, although they are often the sole source of care in the more remote areas of the district.

In sum, the stakeholder analysis confirmed that the underlying premises of WACH were based on a relatively broad consensus at all levels on the need for increased attention to primary health care outreach and to women's and children's health requirements in particular. No stakeholder group voiced disapproval of the rationale for WACH, for the improvements in health care delivery that the project envisions, or the participatory approach to linking communities more effectively to the health delivery system. To the extent that stakeholders had differing or opposing views, these related to the allocation of authority for managing and implementing WACH and to the "rightness or wrongness" of having government play the leading and controlling role. In this sense, the stakeholder analysis corroborated what numerous other analyses of Indian public administration in various sectors have found: namely, that the structure of government decision- making remains centralized and hierarchical, and administrative arrangements that seek to decentralize and share decision-making and service delivery authority with partners outside the public sector tend to be resisted.

Epilogue

The interim stakeholder analysis report, and then the full report, served as important input to negotiations between USAID and the government of Madhya Pradesh on WACH. The differing opinions that the stakeholder analysis identified around the organizational structures and procedures to be used to implement WACH proved to be a critical factor in the fate of WACH. Although there appeared to be a relatively broad consensus that NGOs could and should play a role in implementing WACH, a common refrain was heard throughout the interviews, namely that NGO capacity was weak, both in terms of experience with primary health care and of management. What emerged from behind these technical arguments for a fairly circumscribed role for NGOs in the government-NGO-private provider partnership was the unwillingness of government officials to see donor resources transferred to an NGO-driven, as opposed to government-managed, service delivery mechanism.

The government of Madhya Pradesh proposed the creation of a government-organized NGO, with staff seconded from various government health sector agencies, to manage the WACH project. USAID, however, was unwilling to support a pseudo-NGO, and was convinced that the WACH implementation partnership would not have the necessary flexibility and learning capacity if it were dominated by the public health system bureaucracy. The government of Madhya Pradesh was intransigent, insisting that the WACH funds had to pass through a state-controlled mechanism. USAID decided that WACH could not achieve its objectives under these conditions and canceled the project. Had WACH proceeded, the stakeholder analysis would have provided a solid information base from which to begin to negotiate shared understanding and agreement on implementation modalities for project start-up in Raisen District and beyond.

1. Introduction and Methodology

1.1 Background on the Women's and Children's Health (WACH) Project

United States Agency for International Development (USAID) is supporting development efforts in India to reduce poverty, improve standards of living, and attain sustainable development. To improve standards of living for the poor, especially women and children, key areas of intervention are family planning, improved health, and nutrition. Northern states are generally on the lower rungs of development, especially regarding health indicators, and pose the greatest challenges.

Madhya Pradesh ranks lower than the national average regarding maternal mortality, infant mortality, neonatal mortality, and immunization rates. Services provided to pregnant women and newborn children are inadequate due to an array of factors. USAID has, therefore, focused on Madhya Pradesh to implement a Women's and Children's Health (WACH) Project, the goal of which is to significantly reduce no-natal and infant mortality, as well as improve women's and children's health. The WACH Project will be implemented in eight districts of Madhya Pradesh: Bhopal, Raisen, Sehore, Hoshangabad, Chindwara, Betul, Vidisha, and Narishpur.

The specific objectives of WACH are:

- *a reduction in neonatal and infant mortality;*
- *a reduction in mortality of children under five years of age;*
- *a reduction in maternal mortality;*
- *a reduction in the percentage of children under five classified as undernourished; and*
- *a reduction in the percentage of births with intervals of less than 24 months.*

WACH will target girls and women aged 11 to 29 years and children under five years of age. It will develop interventions that correspond to the life cycle of women's health so that specific and cumulative effects of poor health and nutrition at various stages may be attained.[1] The following are the specific groups for intensive support:

- *Adolescents (11–18 years of age) and newly married women,*
- *Newborns under one month of age, and*
- *Infants and children under five years of age.*

1 WACH project document, draft # 6, page 14

The planned activities of WACH will primarily consist of:

- *Mobilizing communities and strengthening of local level institutions to generate demand for health services, and building a support system for social marketing and services at the grassroots level;*

- *Information dissemination and health education to promote better health practices, and to encourage change in attitudes towards maternal and child health in the project area;*

- *Improving access to preventive and referral services involving all actors, e.g., the government health system, non-governmental organizations (NGOs), private providers, etc.;*

- *Improving quality of services by providing training to the staff involved at various levels, e.g., community, referral services, etc. Various research and technical studies will be conducted to improve implementation strategy, inputs, and plans; and*

- *Strengthening institutions efforts will require improving technical and management capacities of the concerned institutions for long-term sustainability of WACH interventions and benefits.*

Based on previous experience in health under various USAID-supported projects, it is understood that standard approaches to implementing projects are not sufficient to attain even the national average performance of infant and maternal mortality indicators. Therefore, several innovative features have been built into the design of the WACH Project to enhance its success in improving MCH service delivery to the poor and under-served populations. These innovative features of WACH are apparent in the following areas.

Public-Private-NGO Partnership

WACH will involve a range of actors and stakeholder groups in its implementation, including private providers, NGOs, state government agencies, and *panchayati raj* institutions (PRIs). The public health delivery system has functioned for a number of decades, consists of a massive number of paramedical staff, and enjoys extensive coverage. Nevertheless, NGOs, although few in number, have demonstrated a potential for implementing intensive community-based MCH programs in a limited geographical area, but with innovative approaches. As for private providers, they are gradually becoming more visible at all levels, from cities and towns to remote villages, as the demand for health services increases beyond what the existing public health delivery system can provide. Moreover, experience has shown that NGOs have been actively involved in managing preventive and referral services in selected villages. Further, many NGOs have taken complete responsibility for managing primary health centers more efficiently (e.g., Self-Employed Women's Association in Gujarat) with sufficient cost recovery from the clients for the services.

An important component of health provision are the traditional and indigenous medical systems (e.g., Ayurved, Unani), which have a strong presence in small towns and villages. These systems need to be productively explored and used to improve access to services by the poor and disadvantaged sections of the population.

The WACH Project, therefore, reflects innovation as it recognizes the roles of a wide section of health providers, from voluntary organizations to private providers.

Phased Design and Implementation

WACH Project designers have also considered experiences of various multilateral and bilateral programs which are being implemented on a large scale. Based on these experiences, it has been assessed that most development programs allocate very little time for the preparatory phase of the project. Investment in the preparatory phase and pilot experimentation have shown significant results in many bilateral projects. Consequently, WACH will undergo four phases. Phase I is primarily an exploratory and diagnostic phase of about 18 months. This phase will primarily be utilized for baseline data, planning of monitoring and evaluation activities, and conducting an institutional survey to develop a concrete strategy for project implementation and institutional capacity-building. A block in the district will also be selected to develop a participatory plan of action which is realistic, holistic, and integrated to generate desired results.

Phase II is also expected to last about 18 months, and will implement WACH in pilot areas. The phase will emphasize setting up an implementing agency, and preparation and pre-testing of a monitoring and evaluation system. Limited activities will be attempted at the district level so that a comprehensive action plan may emerge from the experience.

Phase III will last three years and will develop a more comprehensive plan of action based on pilot experiences in one district. Capacity-building efforts for various implementing and community organizations will be undertaken. A mid-term review will be conducted at the end of this phase, so as to modify the plan and budget accordingly.

Phase IV is a full-scale implementation plan of WACH in all the districts. This phase will last four years. A final evaluation has been planned for mid-2003 to assess the impact of the project.

Experimentation and Learning Focus

The design of the WACH Project reflects a unique emphasis on experimentation and promotes learning opportunities beyond project boundaries. WACH emphasizes involving private providers in promoting health for women and children. It also recognizes that sufficient flexibility must be provided to experiment with innovative approaches to improving the health conditions of women and children, especially those who have not been served by the existing public health delivery system.

Research and institutional capacity-building are key program areas, as opposed to being merely add-ons to the project. Therefore, WACH has strong potential to analyze experiences, experiments, and realities to effectively design interventions and plan strategies. Moreover, the institutional strengthening efforts will ensure greater chances of sustainability of WACH activities.

1.2 Rationale for Stakeholder Analysis

The strategic importance of the key roles played by the stakeholders in the determination of policy, its implementation, and outcome has made stakeholder analysis a vital tool in strategic management. Similar to its use in the corporate sector, it can also be of vital importance for determining the policy and program formulation in the social development sector. Stakeholder analysis encompasses a range of different methodologies for analyzing stakeholder interests, perceptions, importance, and capacity to support or constrain a particular program.

The purpose of stakeholder analysis is to indicate whose interests should be taken into account when making a decision. At the same time, stakeholder analysis should indicate why those interests should be considered. The analysis helps determine when a group or actor's interest must be given specific and serious consideration. The following three points are generally considered: First, if an actor or group is in a position to damage or weaken the authority or political support of the decision-maker or organization, it should be taken into account. Second, if the group's presence and/or support provides a net benefit or strengthens an organization and/or enhances the decision-maker's authority and capacity to secure compliance to decisions, then the group should be given consideration. Third, if a group is capable of influencing the direction or focus of an organization's activities, it needs to be considered as a stakeholder. Generally, stakeholder analysis analyzes the perceptions of groups or actors with a focus on two key elements: (a) the interest they take in a particular issue, and (b) the quantity and types of resources they can mobilize to affect outcomes regarding that issue.

There are two points at which stakeholder analysis is critical. First, when the policy is being formulated, at the point when decisions regarding who will be favored are made, a stakeholder analysis may provide important inputs regarding critical stakeholders and how they can affect policy outcomes. Since policymakers are often not in direct contact or have little to do with critical stakeholders, information supplied by a stakeholder analysis can be strategically important to policymakers to help them avoid erroneous decisions. Second, an analysis of stakeholder expectations and a keen appreciation of the relative importance of different stakeholder groups can be a key input to determine the design of strategies to handle certain groups, key areas to emphasize in the policy, and ways to ensure future support.[2]

Within WACH, this stakeholder analysis will assess support and opposition of various stakeholder groups regarding the proposed design. It will also use their suggestions as inputs for strategic planning.

1.3 Study Methodology

The WACH project stakeholder analysis is an assessment of positive and negative forces which can influence the success of the project. Therefore, stakeholder analysis is based on a qualitative study design that assesses perceptions of various stakeholder groups on the project design. The following steps were undertaken to conduct the study.

1.3.1 Training of Analysis Study Team and Finalization of Study Design

A team was formed by Samarthan to conduct the stakeholder analysis with support and guidance from PRIA. Dr. Derick Brinkerhoff, Organizational Development Specialist for the Partnerships for Health Reform (PHR) Project, visited India from April 22 to May 12, 1997, to:

- *Meet with PRIA/Samarthan and USAID representatives to develop a common understanding on the issues relevant to the stakeholder analysis and to agree to a schedule;*
- *Orient the Samarthan team on stakeholder analysis concepts and methodology;*

[2] Based on *Stakeholder Analysis: A Vital Tool for Strategic Managers,* by Benjamin L. Crosby, USAID's Implementing Policy Change Project, Technical Notes No. 2, March 1992.

- *Identify the categories and levels of stakeholders to be included in the analysis with the study team; and*

- *Develop interview schedules and a detailed study plan.*

Important group representatives were identified at the state, district, block, and village levels. (A list of the stakeholders interviewed at each level is given in annex A.) An appropriate selection of stakeholder representatives was undertaken before initiating the study. Perceptions of state-, district-, and block-level stakeholders were solicited regarding the following:

- *Existing health delivery systems,*

- *Identification of roles that stakeholders could serve under the WACH Project, and*

- *Institutional capacities available to carry out the roles.*

For community-level stakeholders, an attempt was made to obtain opinions regarding the present public health delivery system regarding its quality and accessibility, and the preferred mechanism to build and implement an effective system.

Time schedules and responsibilities were worked out to meet the deadlines set for the completion of the assignment.

A profile of WACH and introductory notes (annex C) were prepared to initiate interviews with the stakeholders. A field visit was undertaken in the Raisen District to meet with senior government officials, especially those involved in maternal and child health. NGOs were interviewed to test the interview design. This opportunity was also used by the team to receive feedback, especially from PHR's organization development consultant, to improve interviewing skills and design. Guided interview schedules were developed for each group of stakeholders after intensive interaction and analysis among the study team members, with facilitation by Dr. Brinkerhoff (annex B). To generate information from the community members, focus group discussions were planned at two stakeholder levels:

- *Community members, especially mothers and adolescent girls and*

- *PRI members, heads of the households, and mahila mandals (women's groups) and yuvak mandals (youth groups).*

1.3.2 Data Collection, Processing, and Analysis

Considering that about 40 interviews were planned at the state level, prior appointments were fixed with most of the stakeholder representatives, informing them about the broad outline of the WACH project, as well as purpose of the study. Similarly, about 40 interviews were planned for the district and block levels. About 10 focus group discussions were planned to interact with the community-level groups.

Interviews were conducted by a team of two persons so that responsibilities of facilitation and note-taking could be shared and information systematically recorded. Notes were formatted for easy data processing and analysis. The team also exchanged notes to better understand the information

provided by the stakeholders representative and to minimize personal biases. Data generated from the interviews were transcribed, creating tables relevant for analysis of the issues. Information gathered at the community level was converted into field notes. Qualitative data emerging from the focus group discussions were structured around the issues relevant for the stakeholder analysis. A structured format for stakeholder analysis for the state, district, and block levels is presented in annex E.

2. Overview of WACH Stakeholders in Madhya Pradesh

Actors who have a direct or indirect link with the health delivery system (and especially with MCH) are considered by WACH to be stakeholders, and are categorized into eight major groups:

I **Political leaders** who are not only people's representatives, but also decide state government policies;

II **Bureaucracy**, i.e., senior government officials who directly influence the policies of the government and determining group for the delivery of services;

III **Non-governmental Organizations** who are either directly working in the area of health or willing to be involved in this sector;

IV **Private providers** who are actually providing maternal and child health services, but who are not recognized as part of the state health delivery system;

V **Media and others**, including academic or research institutes, who are not direct stakeholders as such, but as far as their social commitment and status as a fourth estate is concerned, can influence and mobilize a cross-section of people and government;

VI **Government health institutions** who are directly involved in the health delivery system and influential in determining operational policies;

VII **Panchayati Rai Institutions (PRIs)** who presently supervise the health delivery system on the district and block levels, and are also responsible for implementing development activities at the community level; and

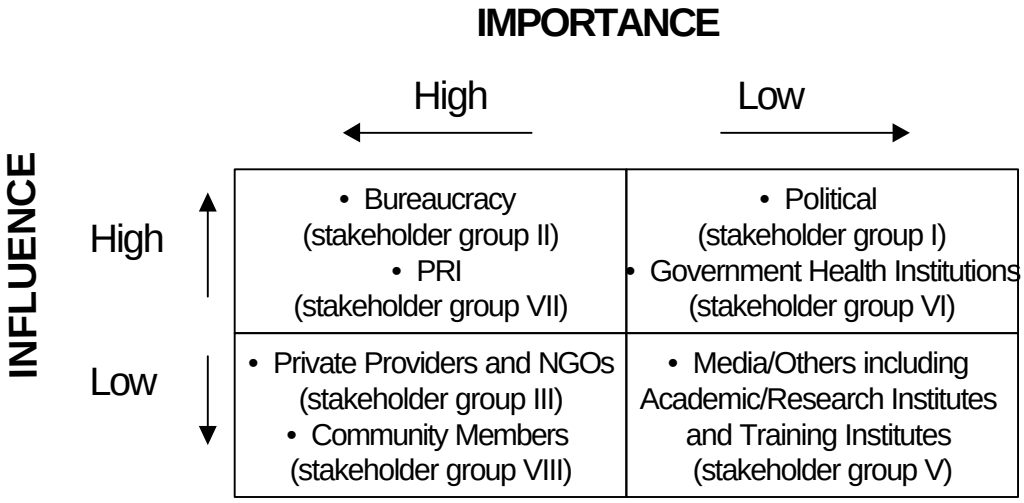
VIII **Community members**, the most important stakeholders, who are directly affected, but, at present, are only on the receiving end of the service delivery system.

These stakeholders have varying influence. Their positions in the Importance/Influence Matrix are illustrated in table 2-1 (see next page).

In this matrix, political stakeholders, bureaucracy, NGOs, private providers, and media/others have been studied at the state level, while at the district, block, and village levels, political stakeholders, PRI members, bureaucracy/government functionaries, NGOs, and private providers have been considered for stakeholder analysis. The community as stakeholders will be analyzed only at the village level.

Table 2.1

Importance/Influence Matrix for Stakeholders



The **political stakeholders** at the state level, and the most important and influential Ministers related to health, women and child development, rural development, PRIs, finance, and human resource development have been selected for the analysis. At the district level, the *zila PRI* president, who is also the ex-officio president of the district-level health committee (*zila swastha samiti),* and women members of the *zila PRI* will be taken into consideration for the stakeholder analysis. Similarly, at the block level, the *janpad* (block) PRI president, secretary, and members, and, at the village level, the *gram* (village) *panchayat*, *Sarpanch* (panchayat president) and panchayat members will be considered for the analysis.

Within the **bureaucracy**, the important stakeholders considered for state-level analysis are the Chief Secretary, Principal Secretaries, and Secretaries of Health, Women and Child Development, PRI, Public Health, and Finance. Besides these, the Commissioner, Deputy Secretaries, and Director of Public Health, and Women and Child Development are also considered for the stakeholder analysis. For the district-level analysis, the District Magistrate, District Medical Officers and other District level officials (e.g., the Integrated Child Development Scheme [ICDS], rural development) are considered. At the block level, the Block Development Officers (BDOs), Block Medical Officers (BMOs), and other officials have been considered for interviews. Stakeholders of this group at the village level consist of government schoolteachers, Anganwari workers, government health workers, and others.

For the category, **NGOs and other stakeholders**, some of the large, important NGOs in Madhya Pradesh have been considered for state-level analysis. Similarly, small NGOs operating at the district level will be included in the stakeholder analysis at the district level. At the block and village levels, small registered and unregistered groups/associations, cooperatives, youth groups, and women's groups have been included. Representatives from the media, academic/research institutions, and training institutes have also been included in this group for stakeholder analysis at the state level.

Chief medical officers and doctors of the hospitals at the state level have been considered for the **government health institutions**. This group also includes the government training institutes for health programs and medical colleges. Similarly, the departmental heads of district hospitals have

been considered for the district level. Medical officers, doctors, and health workers of the primary health centers and subcenters will be considered for the block and village-level analyses.

Regarding **private providers**, the president, secretaries of the private doctors' associations, private nursing home managers, and managers of private health service delivery agencies have been included for the state-level analysis. At the district level, doctors of private hospitals, nursing homes, private clinics, and drug houses have been considered. Similarly, at the block and village levels, the local private doctors (both registered and unregistered), registered medical practitioners (RMPs), *vaidhs* (traditional healers), "quacks," and *dais* (traditional midwives) will be considered for the analysis.

The study has considered **community members** as an important stakeholder, and their representatives have been divided into the following subcategories:

- *Heads of households,*
- *Youth groups,*
- *Mothers and married women,*
- *Adolescent girls, and*
- *Panchayat representatives.*

Focus group discussions have been conducted with each subgroup separately, making a homogeneous group of representatives. The presentation of community-level analysis has been structured in the following subgroups of stakeholder representatives:

Subgroup I:	Household heads/youth groups/community members
Subgroup II:	Women/adolescent girls
Subgroup III:	Panchayat members/Sarpanch (Panchyat President)
Subgroup IV:	Government functionaries (auxiliary nurse-midwives [ANM], teachers)
Subgroup V:	Private providers (Dais, RMPs, quacks, private doctors)

For the block-level interview, four blocks have been covered—Sanchi, Obaidullagunj, Silwani, and Bari. For the village-level study, data has been generated from nine villages of the Sanchi, Obaidullagunj, Silwani, and Bari blocks of Raisen District. Block Silwani was particularly selected to get community members views on the health service delivery provided by Rural Development Service Society, a local NGO in that block. The list of villages included in the stakeholder analysis is given in annex D.

Details of the stakeholder categories selected and the number of interviewees for each stakeholder group are given in table 2-2. A list of stakeholders interviewed is shown in annex A.

Table 2-2
Categories of Stakeholders

State Level	Inter-viewees	District & Block Levels (3 blocks)	Inter-viewees	Village Level* (2-3 villages per block covered)	Interviewees	Total
POLITICAL STAKEHOLDERS: CM, Ministers: Health, Finance, PRI, Rural Development	6	Members of the Legislative Assembly, Members of Parliament	7	PRI Head & Members	3 (including 1 focus group discussion)	16 (including 1 focus group discussion)
GOVERNMENT/BUREAUCRACY: Chief Secretary, Departments: Health, PRI, Finance, Rural Development, PHED, Mother & Child Program	10	District magistrate, community medical officers, development officials, BDOs, etc., other government officials	9	Teachers and Anganwadi Workers	1 focus group discussion	20 (including 1 focus group discussions)
NGOs/OTHER STAKEHOLDERS: NGOs/Media/Academic and Training Institutes	12	Small NGOs and unregistered groups/associations, cooperatives	5	NGOs, Women's groups	1 focus group discussion	18 (including 1 focus group discussion)
GOVERNMENT HEALTH INSTITUTIONS: State health services, medical college	3	District hospital, primary health centers, subcenters	6	Referral Centers/Subcenters	3	12
PRIVATE PROVIDERS: Private health services, doctor associations	3	Private hospitals/nursing homes, private health practitioners (registered & unregistered), drug houses	7	Traditional birth attendants, traditional healers, quacks	3	13
SPECIAL INTERVIEW/DISCUSSION: with the Ex-Chief Secretary of the Government of Madhya Pradesh, and Regional Representative of UNICEF	2			Mothers/adolescent girls focus group discussion, heads of households	6 focus group discussions, 3 focus group discussions	9 focus group discussions
Total	36		34		20 (including 14 focus group discussions)	90 (including 14 focus group discussions)

Grand Total: 90 interviews. In the focus group discussions, 10 to 15 members will be interviewed together.
*For the block level analysis, four blocks have been covered, and for the community-level analysis, nine villages have been covered.

3. Findings of State-level Stakeholder Analysis

3.1 Perceptions of State-Level Stakeholders on the Existing Health Delivery System

Stakeholder representatives have been asked for their perceptions on the existing health services being provided by the government, NGOs, and private practitioners. In many cases, their perceptions were varied and overlapping and identified in the following broad categories: government (ministers and bureaucrats), technocrats of the health delivery system, NGOs involved in or having the potential to undertake health programs, and private practitioners operating at the state level and representing associations of private practitioners.

3.1.1 Government Health Delivery System

The political stakeholder group is of the opinion that the gradual linkage of rural health services with PRI institutions is a positive step, and the state health machinery has adequate infrastructure and human resources to provide large-scale coverage. State outreach services, however, have been poor, especially in remote areas. The existing level of health infrastructure cannot meet the growing demand, and bureaucratic procedures are seen as hurdles for attaining efficiency. The attitude and commitment of the staff also reflect a wide gap between principle and practice.

Stakeholders of the bureaucracy group feel that the government health system is efficient and well established to provide coverage and outreach. In their opinion, the services of government doctors are high quality, often better than in other sectors. The major constraint expressed by this group is low funds for maintaining delivery of services, especially below the district level (primary health centers and sub-centers). Referral services are inadequate compared to the growing demand. Moreover, the system has not been effective in awareness raising and community participation due to a lack of commitment and proper attitude. Concern was also raised regarding the quality of human resources directly working at the grassroots level, as most grassroots-level workers possess little skill and capacity to undertake the required activities. According to this group, training undertaken by government agencies is not effective because it is concentrated at the middle-management level, rather than strengthening the capacities of grassroots-level workers.

Representatives of NGOs recognize the large infrastructure base and network of para-medical government staff, but felt that their reach to the villages, especially remote areas, is minimal. In their view, government functionaries are unable to promote health-seeking behavior and attitudinal change for preventive health at the community level, and have a weak commitment towards their role in health service delivery.

Representatives of media stakeholders reported that there is no alternative to the existing government system in the rural areas. This system is constrained by bureaucratic procedures and ineffective management and coordination, which result in an inefficient and ineffective system. In

addition, the referral linkages and services are weak, which has had the effect of promoting nursing homes in small towns.

Table 3-1
Perceptions of State-Level Stakeholder Groups Regarding the Public Health Delivery System

Stakeholder Category	Favorable	Unfavorable
A. Political	▲Delegation of responsibility to *panchayati raj* institutions is exemplary and shows positive results. ▲Proper infrastructure, machinery, manpower	▲State infrastructure and its reach are insufficient to provide health for all. ▲Bureaucratic procedures of planning and implementation are major bottlenecks to efficiency. ▲Cannot meet the generated demand for service delivery ▲State health system lacks proper attitude and commitment to serve the people.
B. Bureaucracy	▲Government-run system of health service delivery is efficient and well established for coverage and reach. ▲High-quality professional doctors are working with the government.	▲Lack of funds for maintaining delivery of services at the community level; primary health centers and subcenters cannot perform as first referral centers ▲Government system is unable to create effective demand for health services, community participation, and awareness raising. ▲The quality of training for grassroots-level workers under the government system is weak.
C. NGOs	▲Government has good infrastructure base and health delivery system.	▲Reach to the remote villages is minimal due to poor communication and attitudinal problems of the health workers. ▲Unable to encourage health-seeking behavior among the community and attitudinal change for preventive health ▲State health services reflect high coverage but lack efficiency, resulting in high preference for private practitioners.
D. Media/ Others (Academic, research, and training institutions)	▲Well-defined line and staff functions for health delivery ▲Government services are visibly available in the rural areas.	▲ Bureaucratic procedures lack proper management and coordinators; poor infrastructure and resources result in inefficiency and ineffectiveness. ▲State health delivery system is a failure with weak referral linkages.
E. Government Health Institutions	▲The state health delivery system in the rural areas is working effectively. ▲MCH and ICDS programs are doing better than the other programs.	▲Problem of effective delivery only in remote areas; mobile health delivery system needs to be linked. ▲Primary health centers and hospitals are unable to deliver services to the community due to resource constraints and minimal allocations for medicines, infrastructure, and diagnostic facilities.
F. Private Providers	▲Rural areas are still covered mainly through government Health delivery system, which has an extensive network of services. ▲Government MCH and ICDS programs are running successfully in rural areas.	▲Poor doctor-patient ratio and insufficient infrastructure ▲Quality of services under the government programs is not up to standard.

Representatives of the government health institutions consider their functioning efficient, and the Mother and Child Care Program and ICDS more effective than any other programs. It is accepted by and large that their services are weak in remote areas. The basic difficulty expressed by the health service delivery system is a paucity of funds, especially for medicine, infrastructure, and diagnostic facilities.

Private providers, an important group in the health sector, believe that the existing capacities of the public health delivery system are inadequate, both in terms of infrastructure and the doctor/patient ratio. Therefore, most of the time the unmet demand is fulfilled by the private providers. Because the quality of services at the public referral centers does not meet norms, people prefer to get services from private providers in the villages and nearby cities.

In sum, the overall perceptions of the various stakeholder groups regarding the government health system are as follows:

- *The state health delivery system is well established and reflects a network of large paramedical staff and well-developed infrastructure up to the block level.*
- *High-quality, professional doctors work under the public health delivery system, reflecting a high potential for quality services.*
- *There are inadequate resources available in the public health delivery system, especially for direct activities, medicines, supplies, etc.*
- *The public health delivery system is unable to meet the existing demand, and will not be able to create awareness and enhance people's participation.*
- *Because the quality of services, especially referral services, is not satisfactory, people prefer private providers.*

3.1.2 Non-governmental Organizations

According to the political stakeholder group, the efforts of NGOs are valuable because many of the small NGOs are working closely at the grassroots level and have a clear understanding of the realities "on the ground." The general perception of the political group, however, is that Madhya Pradesh does not have committed and credible NGOs and that the NGOS that do exist have capacities too weak to be involved in a health program. Most NGOs are concentrating only on awareness raising and preventive health rather than on curative health (referral services).

Table 3-2
Perceptions of State-Level Stakeholders Regarding NGOs in Health Service Delivery

Stakeholder Category	Favorable	Unfavorable
A.Political	▲The work of NGOs in this sector is highly appreciated. ▲Coordination with government functionaries is good. ▲Most NGOs are committed to their work. ▲Small NGOs working at grassroots levels have a true understanding of realities on the ground.	▲Lack of devoted NGOs in Madhya Pradesh. Most NGOs lack institutional capacities to undertake health delivery system activities. ▲NGO operations in the health sector are poor. ▲NGOs are partly involved in raising awareness about health and hygiene.
B. Bureaucracy	▲Several NGOs have the potential and institutional capacities; but are not presently actively involved in this sector. ▲A large number of the total ICDS centers have been entrusted to NGOs and they are working effectively. ▲State government projects are being implemented by NGOs. ▲No problems are faced in monitoring and coordinating with the NGOs from the government side. ▲NGOs are active in the field of raising awareness and creating demands for health services.	▲Institutional capacities of the NGOs are not strong enough to pursue any health delivery programs. ▲NGOs promotion of health awareness is not satisfactory. ▲Number of NGOs working in this sector is very minimal. ▲Lack of experience, professional competence, and technical knowledge in health service delivery, particularly in maternal and child health. ▲Very limited role in health delivery, and area coverage is very limited. ▲Mostly urban-based, minimal intervention in rural areas. Unwillingness to work in rural/remote areas ▲Amount spent per capita in health delivery is very high.
C. NGOs	▲There are few but good NGOs in the health sector, including MCH and family planning. ▲Primary health care and family welfare are other areas where NGOs are also working or want to work.	▲Few NGOs have capacities to provide health-related services, especially the smaller ones working at the block\village levels. ▲NGOs working in health delivery are not effective. ▲NGOs working in this sector need not only technical but also management skills. ▲Poor human resource base of the existing NGOs in Madhya Pradesh results in poor capabilities, especially in the health sector. ▲Most NGOs are driven by funds and projects rather than by commitment and strategic focus. ▲Target-oriented approach ▲The health intervention strategy of many NGOs is only for publicity's sake. ▲Health is not a priority sector for NGOs in Madhya Pradesh. Historically, no emphasis on the health service delivery, only on advocacy and health education. ▲A number of NGOs undertaking health education activities are just an extension of government activities and lack in critical information, commitment, and vision.
D. Media/ Others (Academic, research, and training institutions)	▲Working mainly in the field of awareness raising, organizing health camps, etc.	▲NGOs in Madhya Pradesh have not demonstrated any capacities to provide health services. ▲NGOs in health sector are virtually non-existent and those working in this sector are doing it superficially for their image-building and publicity. ▲Small NGOs do not have the capacities to deliver health services.

Table 3-2
Perceptions of State-Level Stakeholders Regarding NGOs in Health Service Delivery

Stakeholder Category	Favorable	Unfavorable
E. Government Health Institutions	▲Working meaningfully in the field of awareness raising and motivation.	▲Madhya Pradesh has very few NGOs in the health sector, especially in the area of health service delivery. ▲Most NGOs are project/grant-based, and thus lack sustainability as well as a broad base. ▲The linkages between the government delivery system and NGOs are not cohesive and coordinated.
F. Private Providers	▲ NGOs organize awareness-raising activities in health education as well as grassroots-level training as part of their health programs.	▲There are few good NGOs in Madhya Pradesh, and moreover, health is not on their agenda. ▲NGOs are not able to provide the full package of health services, e.g., immunization, nutrition, maternal and child health care, family planning. ▲NGOs are doing very little regarding the health service delivery, especially in rural areas.

The bureaucracy stakeholder group feels that although NGOs have demonstrated their potential to work in government development projects, they have not been actively involved. NGOs do not have professional competence and experience in health management. Inadequate numbers, coupled with weak capacities and their concentration in urban centers, result in poor, ineffective, and inefficient performance.

The NGO stakeholder group feels that there are a few good NGOs working in the area of health, although very few have capacities to provide health-related services due to limited human resources. Because NGOs are fund-driven, they become target-oriented and limit their role only to awareness-generation and health education.

The media stakeholder group reveals that NGOs have not demonstrated good results and their involvement in the health sector is negligible. According to this group, most NGOs are working primarily at a superficial level for image-building and publicity.

Representatives from government health institutions have also expressed the view that NGOs' involvement in the health sector is negligible. They agree that most NGOs are working at a superficial level, and their involvement is restricted to providing health education and motivating people to generate demand for health services. Added to this is the NGOs' dependence on project grants, which lead to weak sustainability and a weak community base. The relationship between NGOs and the government is also felt to be one of confrontation and criticism.

The private providers group also expressed that NGOs are involved only in health education and broad awareness, and do not have health high on their agenda.

In sum,the following are key observations of the stakeholder groups regarding NGOs:

- *NGOs have demonstrated good examples of implementing development programs.*

- *There are a few good NGOs in the state capable of assuming responsibility for health service delivery.*

- *A few NGOs are working on health issues and could provide good coverage under the project.*

- *The capacity of NGOs to implement health programs is low. Small NGOs in particular have extremely weak technical and management capacities.*

3.1.3 Private Providers

Representatives of the political stakeholder group felt that private providers serve the community in emergency situations, as they are accessible around the clock. Many have good infrastructure, especially in the case of large practices at the state and district levels. Their quality treatment is also rated better than that of the public health delivery system. The fact that people pay for their services reflects the confidence that community have in private providers as compared to the government services.

It is also believed, however, that private providers comprise a poor human resource base and exhibittechnical incompetence. Their basic motivation of profit maximization contradicts the concept of serving the poor and, at times, can be exploitative.

The bureaucracy stakeholder group realizes that a substantial proportion of people below the district level are served by private providers. Private providers services are better than those provided by the public health delivery system. It is felt that local doctors practicing indigenous medicine need to be actively involved in the health delivery system. They do not have a perceived role in preventive health, and in addition, they are concentrated in urban centers and do not leave offices from which they can provide free services. Private providers do not have adequate referral services and, at times, patients are referred to unqualified, incompetent health practitioners.

NGO representatives believe that a substantial proportion of the rural community is served by local, unrecognized health practitioners, especially traditional healers. Registered medical practitioners are providing services in remote and inaccessible areas, but they charge for their services. This view is contradicted by a few NGO representatives, who state that medical practitioners' reach is limited to urban centers and accessible areas. Overall, NGO representatives believe that the private providers are inefficient, weak, and profit-oriented.

Table 3-3
Perceptions of State-Level Stakeholders Regarding Private Providers Health Service Delivery

Stakeholder Category	Favorable	Unfavorable
A. Political	▲They have good infrastructure and resource base (especially the large set-ups). ▲They are useful in serving the community in emergency situations. ▲Provide better treatment than their government counterparts, especially at the block and village levels (in comparison to the primary health centers and sub-centers) ▲Less time is spent by community members on travel and transport, as private providers are easily accessible and reside in close proximity. ▲Occasionally provide service on credit, especially at the block and village levels	▲Poor human resource base and technical competence at the district/block levels ▲Their profit maximization tendency at times becomes exploitative and even damaging to patients. It acts also as a deterrent to the welfare concept.
B. Bureaucracy	▲A substantial proportion of people is served by the private providers, especially at the district level. ▲Both facilities and treatment provided by the private providers are better than their government counterparts (at every level).	▲Private providers practicing traditional Indian medicine systems are yet to be actively involved in the service delivery system. ▲They have no/limited role in the preventive aspects of health services. ▲Private practitioners are mostly urban based. Almost all clinics and nursing homes are in the urban areas. ▲An inadequate referral system; patients are sometimes referred to under-qualified or incompetent persons. ▲Private providers have a poor human resource base and lack technical capabilities/expertise.
C. NGOs	▲A substantial proportion of rural communities is served by private providers and local faith healers or non-registered practitioners. ▲Local RMPs and other non-registered practitioners are offering services to remote and inaccessible areas, though at a cost.	▲The health services provided by the private providers are inefficient and weak, especially in the rural areas. ▲The bigger private providers are busy with their own practice and profit-making and do not contribute much to health services in general, especially in poor, rural communities. ▲Private providers are serving in areas which are accessible or are in close proximity to the urban centers, but not in remote or disadvantaged areas. ▲Referral services are weak with poor linkages.
D. Media/Others	▲Private providers are more efficient in terms of services and treatment.	▲Private providers are exploitative in nature. ▲Questionable quality of services provided by private providers who do not have formal medical training. ▲Privatization of medical services is non-existent in rural areas due to economic disadvantages.
E. Government health institutions		▲Private providers are less interested in the field of social marketing, especially of family planning products. ▲Private providers below the district level are mainly non-technical persons who do more harm than good to the community. ▲Linkages between private providers and the government system are non-existent.
F. Private providers	▲Private providers are helpful and operate within the reach of the community, providing them with basic services and emergency care. ▲They also provide services at many places and help the government with their immunization programs, health education, and other awareness-raising activities.	▲Private practitioners are available only up to the *tehsil*/block level, but not below that because of the lack of economic viability, as well as infrastructural and communication problems.

The media stakeholders consider private providers to be exploitative in nature and the quality of the services they, very poor. Private providers are non-existent in the rural areas, and good doctors do not want to settle in the rural areas due to poor opportunities to make money.

The government health institution stakeholder group feels that private health practitioners are mostly quacks and non-technical persons who are more harmful to the community than they are beneficial. Private providers are less interested in the field of social marketing, and they have no linkages with the government health delivery system.

The private provider stakeholder group considers their greatest strength to be their availability in emergencies. Sometimes, they may work with the government in immunization, awareness-building, and health education activities. However, they recognize that most of the private practitioners are present only at the Tehsil or block level,due to economic, infrastructural, and communication problems.

The major perceptions on private providers can be summarized as follows:

- *A substantial proportion of demand for health services is met by private providers. Their services are available in emergencies.*
- *Although they charge for their services, they are able to attract large numbers of patients.*
- *The quality of human resources and technical knowledge of this group is quite low, especially at the block and village levels, and their referral systems are strong only in big towns and cities.*
- *Their motive of maximizing profits works against the interests of the poor, and they have no linkages for preventive health and awareness-raising activities.*
- *Traditional healers and indigenous medical systems have not been adequately utilized to strengthen the health delivery system.*

3.2 Proposed Roles in Health for Possible Actors under the WACH Project

All strakeholder groups realize that within the bounds of their capacities, all key actors, including the government, NGOs, Panchayats, and private providers have a role to play in the WACH Project. Table 3-4 summarizies the various roles proposed across stakeholder groups for each key actor.

Table 3-4
Roles Perceived by State-Level Stakeholders for Possible Actors in the Health Delivery System under the WACH Project

Government	▲Become involved in health delivery in collaboration with NGOs and private health practitioners ▲Define roles and areas of work for the government, NGOs, and private practitioners ▲Promote use of alternative Indian medical practices within the existing health delivery system ▲Supply of inputs, i.e., medicine, nutritional foods, etc., in a standardized manner, up to the lowest unit of service delivery
NGOs	▲Become involved in health delivery system for direct implementation ▲Define roles and areas to minimize duplication of efforts and conflict ▲Awareness-raising and sensitization of the community involving informal groups (i.e., youth groups) at the grassroots level ▲Function as support to the existing health delivery system ▲Become involved in planning, action research, and documentation activities ▲Assess program performance and social auditing
Private Providers	▲Become involved in implementation health service delivery ▲Support capacity-building and training of grassroots-level organizations and private providers on MCH and family welfare issues ▲Support awareness raising and health education at the community level and undertake social marketing for family welfare program
Panchayati raj Instutions	▲Play a key role in implementation of WACH at the community level ▲Conduct awareness raising and health education activities and support to traditional health practitioners and traditional birth attendants ▲Function as an implementing agency for the government health program ▲Help generate demand for better quality health services by strengthening *gram sabha* and panchayats

3.2.1 Government

The table reveals that government or public health delivery system has been considered an important institution. However, the government system should form more linkages with other actors, however, especially NGOs and private providers. Government collaboration with PRIs is strong, possibly because panchayats have a legitimate right to be involved in health programs.

The government has an important role in defining parameters of work that can be done by the various actors to minimize overlap and maximize coverage. The government should also promote traditional and alternative medicine systems (other than allopathic) to link a large population with health services. The government has a large, well-established system to distribute medicines, nutritional food items, etc., across the state and should continue to support this system.

3.2.2 Non-governmental Organizations

Stakeholder representatives raised the possibility of NGOs becoming involved in direct implementation. Many of them feel that their involvement should not be limited to the role of awareness raising and community mobilization, rather, they could also be actively involved in curative services. By and large, stakeholders feel that NGOs have limited technical and managerial capacities, and their numbers are inadequate for wider coverage. All stakeholders felt that NGOs will

work best by linking up with informal community-level groups, e.g., *yuvak mandals* and *mahila mandals* (youth and women's groups).

A new role envisioned for NGOs may be to support project planning, action research, and documentation of activities. The NGOs can critically assess project performance and social auditing.

3.2.3 Private Providers

Stakeholder groups envision a constructive role for private providers: to fulfill the unmet demand for preventive health. Large private institutions with good infrastructure and a high level of competence among staff also can be engaged to undertake curative services.

Local private health providers, registered medical practitioners, healers, and quacks can be utilized to raise awareness, provide basic preventive support and guidance to women during pregnancy, as well as to promote immunizations for newborns and encourage family planning and better nutrition.

3.2.4 Panchayati Raj Institutions

Panchayats are seen as critical links in the health delivery system at the community level. Despite weak capacities to implement health programs and the questionable quality of local self-governance, stakeholders unanimously recoginze the potential of PRIs in providing preventive and back-up support.

PRIs can play a key role in awareness raising and sensitizing the community on key health issues. They can support, monitor, and utilize traditional practitioners and work with trained traditional birth attendants to ensure their effective services at the community level.

PRIs can also be effective in demand-generation by creating pressure on the government health delivery system to provide better services to the people.

3.3 Institutional Capacities for WACH Implementation

The stakeholder groups gave their perceptions of the capacities of the various actors to take part in implementing the WACH Project. These perceptions are summarized below.

3.3.1 Government Health Delivery System

The groups consider that the government has a well-developed network of health service delivery up to the village level; therefore, coverage through the government system is high. Questions have been raised about the health delivery system in terms of efficiency, optimal utilization, and preparedness of the system to meet the growing demand.

The government system is perceived to be weak in promoting health education and community participation, due to the very centralized nature of the system. The perception is that the government

needs to improve its attitude and commitment towards community involvement and health education before it can effectively take up this role.

Workers responsible for providing preventive services to mothers and children find it difficult to reach to the community on a regular basis, as infrastructure, such as, accessible roads and transportation to the villages, is inadequate.

Referral services are available only at the district level and below. Primary health centers and sub-centers are unable to function as first centers of referral. The referral centers of the government are poorly equipped and the doctor/patient ratio is very low.

The government has a large network for conducting training of the paramedical staff; however, it cannot promote participatory learning, which is important for sensitization and motivation of the staff. There is a weak follow-up to training, and therefore, the impact of government-led training is not visible.

The overall approach of the government is top-down, which inhibits a participatory process involving the community members. It was also felt that the government has a well-established monitoring system that generates an enormous amount of information which is compiled at various levels.

Table 3-5
Capacities of Government Health Delivery System as Perceived by State-Level Stakeholders

Areas	Perceived Capacities
1. Coverage	▸ Well-developed system; linkages to district, block, and village levels
2. Community Participation/ Health Education	▴ Staff at block and grassroots levels lack attitudes and commitment to community participation and health education
3. Preventive Services	▴ Weak services, due to transportation and access problems, and inadequate facilities for multi-purpose workers
4. Referral Services	▴ Qualified doctors available through the block level for effective referral services ▴ Existing referral centers are inadequate, poorly equipped, and underutilized
5. Training/Research for Quality of Services	▴ Training capacities lack quality ▴ Training programs do not promote participatory learning process for sensitization and motivation; weak follow-up to trainings
6. Planning/Monitoring/ Evaluation	▴ Centralized planning approach with excessive control and weak community participation
7. Internal Capacities	▴ Large, inefficient system that promotes control and red tape
8. Coordination and Coverage of Programs	▴ ICDs system, which promotes health, works efficiently ▴ Efficient health services wherever PRI works effectively

The government system can promote integration and aid linkage between programs, such as ICDS and safe motherhood and child survival programs. The government is also collaborating increasingly with PRIs, with the supportive political will in favor of PRIs.

The overall capacity of the government is seen as inefficient, and the existing top-down culture promotes an excessive "red tape."

3.3.2 Non-Governmental Organizations

The groups acknowledged the poor coverage of NGOs in health delivery. There are very few NGOs working in the rural areas, or working on health issues in general. With little evidence of the NGOs managing health activities, the few which are working in this sector are restricted to community mobilization, health education, and organizing communities at the local level. The NGOs have the potential to offer preventive services if they are properly oriented. Moreover, they can support the governmnent system of preventive services already existing at the grassroots level.

NGOs have limited experience, professional competence, and infrastructure to provide referral services effectively. But they feel that they have capacities to provide referral services, if proper financial support, infrastructure, and back-up are ensured.

To improve the quality of services, NGOs are preceived to be an important resource to train the local paramedical staff of the government (e.g., TBAs, ICDS workers, RMPs). NGOs are also seen as good partners for collaboration as demonstrated by the many successful examples of NGO-government parnterships (e.g., ICDS and Rajin Gandhi Watershed Mission) and NGO-NGO (e.g., ACTIONAID and CARE/India).

Table 3-6
Capacities of NGOs Perceived by State-Level Stakeholders

Roles	Perceived Capacities
1. Coverage	▲Poor coverage for health delivery and weak institutional capacities
2. Community Participation; Health Education;and IEC	▲Creating and improving health awareness and community mobilization are strenghts of NGOs.
3. Preventive Services	▲Potential to provide preventive services
4. Referral Services	▲Limited experience and professional competence to manage MCH program
5. Training/Research for Quality of Services	▲Can be successfully involved in training local medical practitioners, e.g., traditional birth attendants, ICDS workers, RMPs
6. Internal Capacities	▲Smaller NGOs lack technical as well as managerial expertise; weak credibility and accountability
7. Planning, Monitoring, and Evaluation	▲Useful in performance assessment and social auditing of the programs
8. Coordination and Partnership and Convergence of Programs	▸Good examples of NGO–NGO and NGO–government partnership exist in Madhya Pradesh

3.3.3 Panchayati Raj Institutions

PRIs are seen as important grassroots institutions that can enhance coverage of WACH because of their presence in smaller and remote villages. Due to their weak management of development programs, however, stakeholders expressed reservations about involving PRIs directly in the implementation process. PRIs can be supportive to the existing government health delivery system or to NGOs that can implement WACH activities. PRIs will create demand for health services, so their participation in health awareness and in WACH is recommended. Representatives believe that PRIs can institutionalize services of barefoot doctors and trained traditional birth attendants and build a strong local system for preventive services. However, stakeholders have reservations about their capabilities. Panchayats can also be involved as links to referral centers, and can transport difficult cases, in a timely manner, to the centers.

Groups did not consider PRIs in any role in training and research activities, as their capacities are limited. Stakeholders feel they can contribute to WACH planning, monitoring, and evaluation. A second group of stakeholders disagreed, however, stating that PRIs are more or less political units, and political dynamics would affect the performance of the program. They suggested that community representatives should only plan, monitor, and evaluate.

PRIs are seen as strong links for the convergence of programs, and are perceived to have a holistic understanding of their village development. Because most government programs are implemented through them, they can be instrumental in integrating various development efforts at the grassroots level.

Table 3-7
Capacities of PRIs Perceived by State-Level Stakeholders

Areas	Perceived Capacities
1. Coverage	▲Potential to enhance coverage due to large presence and well developed system up to the district level
2. Community Participation; Health Education;and IEC	▲Prime responsibility in creating demand for health services
3. Preventive Services	▲Perceptions on health issues is poor; health is not a priority under the government-driven programs delegated to PRI
4. Referral Services	▲Build strong linkages to referral centers for transportation of difficult delivery cases
5. Training/Research for Quality of Services	▲No role
6. Internal Capacities	▲Quality of governance is low and management capacities for implementing development projects are weak
7. Planning, Monitoring, and Evaluation	▲Should be actively involved in planning, monitoring, and evaluation; should be involved in implementation, but not monitoring
8. Coordination and Coverage of Programs	▲Strong role can be played, since PRIs have overall responsibility for development

3.3.4 Private Providers

Private providers can be instrumental in improving coverage of preventive services, as they treat case of diarrhea and common cold among children. Women also visit these doctors in case of complications during pregnancy.

The role of private providers as sources of referral is perceived to be limited, as their infrastructural support is weak and competence to handle complicated cases is low, especially those functioning below the district level. Well-trained and experienced private providers can play a role in training lower-level providers and paramedical staff working at the village level. Their role, however, is limited in training and research, and will not include training, monitoring, evaluation, or promoting convergence of WACH. The overall perception of private providers is that they are a highly enterprising group working in remote areas, with limited technical knowledge and infrastructure.

Table 3-8
Capacities of Private Providers Perceived by State-Level Stakeholders

Areas	Perceived Capacities
1. Coverage	▲Wide coverage by the private providers at the grassroots level, especially in emergency support
2. Community Participation; Health Education;and IEC	▲Guided by profit maximization; needs social orientation
3. Preventive Services	▲Providing basic services in cases of illness, especially diarrhea and common cold among children; guides and refers pregnant women in case of complications
4. Referral Services	▲Below the district level exists weak infrastructure and level of competence; may refer cases to referral centers after providing initial treatment
5. Training/Research for Quality of Services	▲Weak competencies for training and research; some at the district level and above may function as resources
6. Internal Capacities	▲Enterprising, yet limited technical knowledge and infrastructure; highly profit-oriented rather than welfare-oriented
7. Planning, Monitoring, Evaluation	▲No role
8. Coordination and Coverage of Programs	▸No role

4. Findings of Block- and District-Level Stakeholder Analysis

4.1 Perception of District- and Block-Level Stakeholders on Existing Health Delivery System

Similar to the state-level analysis, stakeholder representatives at the district and block levels were asked to state their perceptions about the existing public health delivery system and the services provided by private providers and NGOs. In Raisen District in particular, there is relatively weak involvement of NGOs in health service delivery. Apart from the missionary hospital in Sultanpur (Asha Sadan) and another in Silwani, NGOs are only partially involved in some form of health awareness raising.

The perceptions of the stakeholder groups were varied, frequently overlapping, and even contradictory. Efforts have been made, however, to categorize the perceptions around the following broad categories:

- *PRI members of the zila (district) and janpad (block), including women members,*
- *the bureaucracy, including government functionaries at the district and block levels,*
- *doctors, medical officers, and health workers of government health institutions (e.g., hospitals, primary health centers),*
- *NGOs and small registered/unregistered groups who are either involved in health service delivery or working in other sectors, and*
- *private practitioners, including doctors, registered medical practitioners, quacks, local birth attendants, and local medical practitioners.*

4.1.1 Government Health Delivery System

Political stakeholder groups (including PRI members) felt that, while the public health delivery system has a large network in states with different levels of health workers, there is an inadequate number of doctors (especially women doctors) in rural centers. Moreover, PRIs' unavailability, coupled with a lack of basic medical infrastructure, has led to a very poor state of service delivery. The poorest members of society have no alternative but to use public health services.

Populations living in remote areas are solely dependent on government health workers, e.g., multi-purpose workers (MPWs), auxiliary nurse midwives (ANMs), and barefoot doctors (JSRs). The majority of ANMs, MPWs, and JSRs often have a bad attitude and lack commitment to their jobs. Poor back-up support from the government has further exacerbated the situation. Many PRI members pointed out that maternal and child health is an area that is the most neglected in the public

health delivery, and most government programs fail to reach the target populations because of ineffective information dissemination systems. PRI members agreed that, because of a lack of coordination and proper linkages between district and block health committees (ZSS and JSS), the PRIs are not yet effective in managing the public health delivery system at the district level. It is also evident that there are misconceptions and a lack of understanding regarding the PRIs' role in the public health delivery system.

Representatives of the bureaucracy and government believed that the existing service delivery system network is effective in providing primary and preventive health care. A number of initiatives and programs have been undertaken by the government to improve the public health delivery system. This group of political stakeholders also perceived that, even with a well-developed system, the fact that the district level has very little infrastructure to support the staff and the rural centers has resulted in poor reach and coverage. The group cited low levels of commitment among staff and doctors as a concern. They expressed their inability to encourage participation in the WACH Project. Lack of coordination and poor incentives were some of the other deterrents reported by this stakeholder group. It was also pointed out that the present public health delivery system does not put enough effort into promoting alternative medical practices (e.g., Ayurved).

The NGOs (including registered/unregistered groups) felt that in health delivery, the public health delivery system caters to most of the people with its vast network and qualified personnel. They also thought that maternal and child health care issues have not been addressed satisfactorily, and that these issues are especially neglected in the remote and inaccessible areas. This is represented by the poor services at the government hospitals and health centers where, in most cases, there are no gynecologists or pediatricians. Even in the area of general medicine, there are very few women doctors and assistants. Moreover, a gender-sensitive approach is not practiced in treatment or patient care.

Stakeholder representatives and government health institutions stated that the good public health delivery system network has helped them achieve satisfactory coverage and results, especially in primary health care and immunization. They agreed, however, that most of the public health delivery centers, especially those in the rural areas, have inadequate personnel and infrastructure resources. The bureaucratic process and lack of incentives have led to reduced levels motivation among doctors as well as among grassroots-level health workers. The coverage area of the rural health workers is vast, but their activities are not supported by transportation and infrastructure. The monitoring aspect of the health delivery system is also very ineffective.

Private providers thought that the public health delivery system has a vast network of qualified personnel that is unavailable to private providers. They added, however, that government services do not reach remote areas due to lack of motivated staff and infrastructure. Maternal and child health is a much-neglected area in the public health delivery system, due to lack of female doctors and health workers. Very little has been done by the government regarding awareness-raising and health education within the community.

Following are the key observations of the groups on the public health delivery system.

- *The public health delivery system has a vast network up to the village level, which enables them to achieve wide coverage in primary health care and immunization activities.*

- *The quality of professional staff is good, but they are inadequate in number to cover existing demand. The system also lacks proper back-up support, infrastructure, medical facilities, and incentives.*

- *The grassroots-level workers of the public health delivery system are not very effective because of their heavy workload and weak support.*

- *Maternal and child health is a much-neglected area in public health delivery, which is mainly due to a lack of women doctors and trained health workers, especially in the rural areas.*

- *Poor information dissemination and the tendency to overlook awareness-raising and health education are concerns within the system.*

- *The government has done little to promote alternative medical practices in the present health delivery system.*

Table 4-1
Perceptions of Block- and District-Level Stakeholder Groups Regarding the Public Health Delivery System

Stakeholder Category	Favorable	Unfavorable
Political (including PRI members)	▲Government has a huge network of public health delivery systems ▲The presence of MPWs in the villages is an important mechanism for reaching out to the villages ▲The poorest segments of the community is mostly served by the government system because these community members cannot pay for private services.	▲Rural centers have inadequate number of doctors in general and lack women doctors. There is a lack of basic medical and infrastructure in the primary health centers and sub-centers (e.g., medicines, X-ray, clinical and diagnostic facilities, etc.) ▲Women's health, especially care for pregnant women, is one of the most neglected areas in health service delivery. ▲Because of a lack of coordination and proper links between the district and block health committees, the PRI system is ineffective in delivering health services. ▲The reach of the public health delivery system is limited to accessible areas. In remote and inaccessible areas, there are no proper health facilities. People who live in these areas depend on JSRs, whose visits are infrequent in general and nonexistent during monsoons. ▲JSRs are not effective because no back-up support is provided to them. ▲Most of the government health programs do not reach the poor because of poor information dissemination and unwillingness among government staffs to help the people.

Table 4-1
Perceptions of Block- and District-Level Stakeholder Groups Regarding the Public Health Delivery System

Stakeholder Category	Favorable	Unfavorable
Bureaucracy (government officials)	▲The government has taken initiatives to improve the public health delivery systems, e.g., immunization drives, *Matri Prasuti* scheme for pregnant mothers, training of dais, etc. ▲The government has a good network up to the village level for public health delivery. The first-referral unit centers, primary health centers, and immunization program are some of the strong points of the public health delivery system.	▲Maternal and child health is the most neglected area in health service delivery. ▲The existing public health delivery system has many limitations, e.g., staff members are extremely overloaded, lack of vehicle support, and have limited resources. ▲Most officials do not want to stay in a small district, and this has serious repercussions, especially in the health program. ▲Public health delivery health staff members are unmotivated and uninterested in performing their duties, and their commitment levels are low. ▲There are information and communication gaps between different government departments and implementing agencies working in the area of health. ▲Health issues have been neglected in the Raisen district because of its poor health infrastructure, support systems, and referral services ▲Government health services neglect alternative systems, especially that of Ayurved, as minimal funds have been allocated to these sectors. ▲The JSR scheme has not been successful.
NGOs and Registered/ Unregistered groups	▲In the health service delivery sector, the public health delivery system serves most of the poor. ▲The government has a vast network of staff and qualified human resources.	▲Maternal and child health has not been addressed satisfactorily and is neglected, especially in remote areas. ▲Government hospitals and health centers are providing poor services, especially in maternal and child health.
Government Health Institutions	▲The first-referral unit centers, primary health care, and immunization programs are strengths of the public health delivery system. ▲The government has a good network up to the village level for public health delivery system, with ANMs, MPWs, and JSRs. ▲Very good immunization and antenatal care coverage exists.	▲Poorly trained personnel are employed in most of the public health delivery institutions. Most rural centers lack inadequate numbers of well-trained staff, medicines, and infrastructure (e.g., in most government hospitals, operations are not performed because there is no anesthesiologist). ▲There is a lack of incentives for staff working at the grassroots level. ▲Maternal and child health has been a neglected area of service, especially in remote areas. ▲MPWs are usually overloaded with data generation and reporting work; they find it difficult to cover the vast geographical area; and there is lack of clarity about their roles. ▲Doctors and other health workers are not satisfied with the bureaucratic procedures of the government. They have no logistic and infrastructural support to work in the rural areas. Salaries are low, and there are no incentives, ▲The monitoring aspect of the public health delivery system is very poor,
Private Providers	▲The government has taken a number of initiatives like total immunization drives, training of dais, etc., to improve the public health delivery system. ▲The government has a vast network and qualified personnel, which is unavailable to private providers.	▲Government services do not reach most of the remote areas of this district. Most of the centers do not have the required staff or infrastructure. ▲Very little has been done regarding awareness-raising and health education within the community. ▲The lack of female doctors, especially gynecologists, in government hospitals and primary health centers (there is only one female gynecologist in the whole district) indicates the neglected status of maternal and child health.

4.1.2 Non-governmental Organizations

Representatives from the political/PRIs stakeholder group felt that NGOs are committed to their work and are working effectively in the field of awareness-raising, education, and preventive health services. Because there are only a few examples of NGOs working in health, and these NGOs have limited capacities and coverage, stakeholders could not provide a comprehensive analysis of NGOs.

Bureaucracy and government officials agreed that NGOs have a much better understanding of the field situation and are closer to the community than other groups working in the health sector. NGOs' strength lies in community mobilization and participation. Similar to the views of political groups, the bureaucracy and government group felt that their number and coverage is restricted in this district. NGOs in this district lack linkages with the government and donor agencies to use necessary funds to assume activities on health-related services.

Representatives of the NGO stakeholder group reported that they are already supporting public health delivery systems, especially in the field of awareness-raising, by organizing health camps and organizing the community around various issues. Some NGOs that provide health services in the district believed that, although their coverage and reach is limited, they provide quality services to the community with little or no cost. NGOs are much closer to the community, better understand community members' needs and feelings, and are much more committed. Due to lack of funds, however, NGOs cannot manage health programs on a large scale.

Representatives of the government health institutions believed that, although the role of NGOs has been very restricted in this district regarding health service delivery, they have played a supporting role in awareness-generation. Since NGOs are closer to the people, have better understanding of the grassroots issues, and show commitment, they have the capability of planning and implementing the project more realistically.

Private providers have little perception of NGOs involvement in the area, but pointed out that there are limited efforts being undertaken by some NGOs and voluntary agencies.

The overall perception of the groups was that:

- *There are few NGOs and voluntary groups with limited capacities and coverage working in the area of health in the Raisen District.*
- *NGOs in the district lack a good network and resources to pursue health programs.*
- *Voluntary associations and NGOs have a much better understanding of the area and people and their needs, and the community has faith in their work.*
- *NGOs have been playing a supportive role in health, especially in awareness-raising, health education, and preventive health care.*
- *Although limited health services are presently being offered by the NGOs, their quality of services and commitment is very good.*

Table 4-2
Perceptions of Block- and District-Level Stakeholder Groups Regarding NGOs in the Health Delivery System

Stakeholder Category	Favorable	Unfavorable
Political (including PRIs members)	▲NGOs are committed to their work. ▲Voluntary associations/NGOs are working effectively in awareness-raising, health education, and preventive heath care.	▲NGOs have not been very effective in providing health services in this district. There are only few examples of their involvement in health service delivery in this area. ▲There are limited NGOs or voluntary groups working in health service delivery with limited capacity and coverage.
Bureaucracy (government officials)	▲NGOs generally have a much better understanding of the field situation and are closer to the community. ▲NGOs have strength in community mobilization and participatory development.	▲NGOs lack linkages which restrict their activities to a small area. ▲NGOs do not have the necessary funds and resources to assume activities in health service delivery. ▲NGOs depend on government and other donor agency grants for funds, so their activities can be donor-driven. A restricted and weak resource base makes their interventions short- lived and unsustainable.
NGOs and Registered/ Unregistered Groups	▲NGOs are playing a supportive role in public health delivery system, especially in the field of awareness generation, organizing health camps, and educating the community. ▲Health services, especially related to maternal and child health, are delivered at little or no cost. ▲NGO workers are committed and serve the community with a missionary zeal. ▲The community has faith and trust in NGOs, and NGOs enjoy a personal rapport with the community. This results in better community interaction and participation.	▲NGOs do not have the necessary funds and resources to assume activities on health service delivery. ▲There are limited number of NGOs and voluntary groups working in health, with limited capacity and coverage.
Government Health Institutions	▲Although restricted to small areas, NGOs play a role in generating health awareness on a large scale. ▲Close association of NGOs with the field and people gives them a better understanding so they can plan and implement activities realistically. ▲NGOs have good intentions and are far more committed than private providers.	▲The coverage and reach of NGOs in the Raisen District is restricted.
Private Providers	▲Some efforts have been made where NGOs have assumed various activities related to health services.	▲There are a limited number of NGOs and voluntary groups working in the area of health, with limited capacity and coverage.

4.1.3 Private Providers

The political group was of the opinion that private providers are serving the major proportion of the community because of their wide coverage and reach. Private providers are easily accessible and address most of the emergency cases. A majority of the representatives felt that most private providers do not have technical expertise and skills, and thus offer poor quality of services. Since most of the private providers intend to make profits, they have a tendency to exploit people at times.

The representatives of the bureaucracy believed that, because of easy availability and accessibility, a majority of the people in rural and inaccessible areas prefer the private providers for basic health services. The group also felt that because of a lack of technical experience and training,

the quality of services provided by most providers is poor and that private providers do more harm than good.

NGO representatives felt that, although the private providers are important because they provide basic health services in rural and inaccessible areas, they have poorly trained personnel with low levels of expertise, and the quality of services they provide is ineffective. Some also felt that most private providers are exploitative by nature.

Representatives of government health institutions believed that more than 70 percent of the general health problems in the rural areas are being treated by private providers. Although most providers do not have proper qualification and lack clinical knowledge, the community has faith in their treatment. Some representatives felt that, because of the poor quality services and lack of technical expertise, providers can harm patients by complicating the cases.

Private providers felt that they have considerable reach and that the cost of services provided by the village-level private practitioners is quite minimal and affordable. They also admitted that the cost of consultation for established and experienced private doctors is quite high and, in most cases, community members do not have the ability to pay for their services. Representatives of private providers felt that they have limited resources and lack the training that would improve the quality of their services.

The general perception of private providers can be summarized as follows:

- *A majority of the rural community is being served by the private providers, generally for basic medical services and particularly at times of emergency.*
- *Most private providers lack proper technical knowledge and experience, but a majority of the community members have faith in their services.*
- *The quality of services offered is very poor and often harms the patient. Complicated cases are then referred to the government hospital or to private nursing homes.*
- *Despite the fact that most private providers are perceived as profit-motivated and exploitative, they are still able to attract a major proportion of the community for health services.*

Table 4-3
Perceptions of Block- and District-Level Stakeholder Groups Regarding Private Providers in the Health Delivery System

Stakeholder Category	Favorable	Unfavorable
Political (including PRI members)	▲Traditional medical practitioners, traditional trained birth attendants, and quacks generally tackle emergency cases, frequently administering basic medication and referring them to private or government hospitals. ▲The major portion of the community is being served by private providers because most live or practice in or close to villages. ▲Private providers are easily approachable and, in many cases, provide services affordable by the community.	▲Because private providers are profit-oriented , they have a tendency to exploit the community at times. ▲Private providers are of limited use in health, since most lack technical expertise and training. ▲Private doctors are limited in number and only a small proportion of the community can afford their high-priced services. ▲Traditional healers and traditional trained birth attendants are experienced, but lack technical training and scientific understanding.

Table 4-3
Perceptions of Block- and District-Level Stakeholder Groups Regarding Private Providers in the Health Delivery System

Stakeholder Category	Favorable	Unfavorable
Bureaucracy (government officials)	▲Private providers are widely available. ▲Private providers are important for providing basic health services to rural and inaccessible areas.	▲They lack capacities and proper training and sometimes do more harm than good. ▲Most private providers do not have proper infrastructure to deliver the basic health care services.
NGOs and Registered/ Unregistered Groups	▲Private providers provide most of the health services in rural and inaccessible areas.	▲Because of lack of technical experience and training, the quality of services provided by most private providers is poor and ineffective. ▲Private providers with the objective of making profits have weak social commitment.
Government Health Institutions	▲More than 70 percent of general health problems in the rural areas are being treated by private providers. ▲The community has faith in private providers.	▲Private providers work only for profit. ▲Most private doctors do not have proper qualification and lack technical knowledge, experience, and training. ▲The quality of the services offered by private providers is very poor and often does more harm to the patients by complicating the case.
Private Providers	▲Private providers are widely available. ▲The cost of services provided by village-level private practitioners is generally minimal and affordable. ▲Private providers have more reach because they are large in number and coverage.	▲Private providers have limited resources and lack experience and proper training. ▲The cost of consultation of the established and experienced private doctors is quite high. In most cases, the community does not have the capacity to pay for their services.

4.2 Proposed Roles in Health for Possible Actors under the WACH Project

Stakeholder representatives for the various groups at district and block levels have proposed roles for key actors, i.e., government, NGOs, and private providers, under the WACH program. Due to the importance accorded to the PRIs, the groups also suggested roles for the PRIs. Some of the roles suggested overlap and include certain limitations related to institutional capacities. A summary of the roles suggested by the representatives is presented in Table 4-4.

The perceived roles proposed by the stakeholder groups emphasize a major position for the government under WACH. It is generally felt that the government should be more involved in the management aspect, such as identifying different partners and providing guidance, training, and technical and financial support. It has also been emphasized that, while the government should have its own monitoring system, monitoring should also be done by other agencies. The government should emphasize preventive and curative health services and promote alternative and traditional medical practices. They should also promote mobile units for better coverage and reach. Support is also needed for dissemination of information and accountability of the program up to the community level.

Table 4-4
Roles Proposed by Block- and District-Level Stakeholders for Possible Actors in Health Service Delivery under the WACH Project

Actors	Perceived Roles
Government	▲Provide training and technical support to other partners, including government, NGOs, and private providers (e.g., local RMPs, quacks, local persons in basic health services). ▲Provide both preventive and curative health services with special focus on maternal and child health, antenatal care, postnatal care, and immunization. ▲Take overall responsibility for monitoring the project and the activities of private providers and other NGO partners. ▲Government should not have total control of WACH and an independent agency should monitor and check the government public health delivery system. ▲Manage the program, identify the partners, provide guidance and advice, help in capacity-building and fund them to implement the program at different levels. ▲Give major emphasis to information dissemination and transparency of the different programs at the community level. ▲Open Ayurved centers at the village level and promote use of traditional herbs and medicines. ▲Promote mobile units to reach inaccessible areas.
NGOs	▲Get involved in awareness-raising and health education, especially on family planning. ▲Provide training and support to the other partners, including government, grassroots-level workers, small groups at the community level, and private providers (e.g., RMPs, quacks) in community participation, education, and motivation. ▲Organize and mobilize the community; improve participation in the program through formation of groups at the grassroots level. ▲Monitor health activities, especially at the grassroots level. ▲Reserve and promote traditional medical practices.
Private Providers	▲Have no involvement in WACH, or take on clearly defined roles to prevent them from focusing only on making profits. ▲Collaborate with the government in activities in health at the grassroots level, especially in preventive health and referral services. ▲Undertake training so services, which much of the community depends on, can be more useful. ▲Undertake awareness-raising and basic education programs on preventive aspects of health at the community level, as well as social marketing on contraceptives. ▲Get involved in training of community-level health workers and practitioners. ▲Get involved in providing some basic medical facilities to serve the community under WACH (since private providers already cater to some of the curative aspects of a health delivery service).
PRIs	▲Take responsibility for monitoring the program implemented by the different partners at the grassroots level. ▲Conduct awareness raising, sensitization, health education, and information dissemination programs. There is a need to sensitize and orient them, however ▲Act as an information base at the village level, collecting information on health programs and disseminating it to the community.

The stakeholders have expressed that the major role of NGOs in WACH should be to incorporate a community participation component with the service delivery system and promote awareness raising and health education. They could also provide training and capacity-building of grassroots-level health workers of all the partners, particularly in community participation, institution development, and health education. They could also monitor activities, especially at the grassroots level.

While there have been some reservations expressed by a number of representatives regarding the direct involvement of private providers, everyone agrees that they need to be involved in WACH. Private providers can offer preventive health care and referral services, including awareness-raising and social marketing of family planning products. It was

emphasized that there is a need to build capacities and define roles of providers in WACH before their actual involvement.

Regarding PRIs, their major roles could include awareness-raising and mobilization of the community, and acting as a resource for information dissemination at the community level. A number of representatives also encouraged their involvement in project management, i.e., identification of resource persons, monitoring the implementation process at the grassroots level, etc.

4.3 Institutional Capacities for WACH Project Implementation

The suggestions of stakeholders regarding institutional capacities have been categorized into four major areas: (I) promoting community participation; (ii) health education and capacity-building; (iii) delivering preventive and referral services; and (iv) planning, monitoring, and evaluation of the program. The proposal for each actor is represented here.

4.3.1 Government Health Delivery System

The groups perceive that the government health delivery system, with its different levels of health workers, especially that of MPWs at the grassroots level, enable the system to reach the community and cover a vast geographical area.

Table 4-5
Capacities of Government Health Delivery System Perceived by Block- and District-Level Stakeholders

Coverage	▲Presence of MPWs at the grassroots level enables the public health delivery system to reach the community, cover a vast geographic area, and provide preventive and referral services.
Community Participation/Health Education/Training	▲The government does not provide consistent back-up support in its training programs. ▲Government capacity regarding awareness-raising and health education needs to be systematized and enhanced. ▲The government, with its technical and experienced personnel, can provide training and undertake research.
Preventive/Referral Services	▲The referral system should be run by the government, as they have the resources and experience to do so. ▲The public health delivery system have the advantage of an already established system which provides both curative and preventive services.
Planning/Monitoring/ Evaluation	▲The government can play a role in bringing policy level changes in health service delivery. ▲The government has a proper system and manpower for monitoring and training activities. ▲The government should be responsible and accountable for technical support and resource management (e.g., drug supply).

The government already has an established system that is delivering both curative and preventive health services. Referral and other services related to maternal and child health should also be run by the government becasue it has the resources and experienced personnel to do so. In monitoring and planning, the government role should be to bring policy level changes in the state to promote WACH objectives. It also has the system and personnel for monitoring the program at various levels. Responsibility for technical support and resource management should be with the government for reasons of accountability.

4.3.2 Non-governmental Organizations

As stated earlier, since there are very few NGOs working in this district, apart from the missionary hospitals (Silwani and Sultanpur), they have undertaken few health-related activities. Thus, the stakeholder groups could not shed much light on the question of NGO institutional capacities. The summary of their responses below indicates that NGOs have a good reach to the community.

Table 4-6
Capacities of NGOs Perceived by Block- and District-Level Stakeholders

	NGOs
Coverage	▲Reaching out to the community is a major strength of NGOs. They can expand coverage of the program.
Community Participation/Health Education/Training	▲Voluntary organizations can raise awareness and provide training. They can make people aware about reproductive health, i.e., maternal and child health, antenatal care, prenatal care, by conducting health camps, awareness drives, participatory communication, etc. ▲NGOs are strong in community mobilization and promoting peoples participation because of their outreach and links with the community. They can be involved in forming grassroots groups at the community level. ▲NGOs can play a major role in awareness-raising, as well as training the grassroots-level health workers and private providers.
Preventive/Referral Services	▲Because of their grassroots-level work and links with the government and other NGOs, NGOs can help in promoting preventive health care and refer cases to these institutions.
Planning/Monitoring/ Evaluation	▲Because of their independent, autonomous funding, NGOs can integrate this program with their existing ones. ▲As autonomous institutions, NGOs can monitor WACH activities independently. ▲NGOs can monitor and supervise the working of private providers under this program and under government health programs.

Representatives also feel that voluntary organizations can mobilize the community and promote participation through institution-building at the grassroots level. Because NGOs have a better understanding of the area, community, and its needs, they could play a major role in awareness-raising as well as in training the grassroots-level health workers and private providers. The representatives also stated that NGOs who are working at the grassroots level and also have links with government and other groups could help in promoting preventive health care as well as referral services. The NGOs have an advantage because of their autonomous status and flexibility. Some stakeholders feel that NGOs could be involved in monitoring and evaluation as an autonomous body.

4.3.3 *Panchayati Raj* Institutions

The involvement of PRIs has been encouraged by a majority of the stakeholders, as panchayats have a better understanding of the community and its problems. It has been emphasized that panchayats can help in identifying the needs of the community and can ensure participation in the program. Their experience in organizing people, identifying local resource persons, and information dissemination has been noted by a majority of the groups.

PRI members can be involved in some of the direct implementation of WACH activities, especially in the field of preventive health and referral services at the village level. A number of stakeholders (especially from the government and bureaucracy) believe that the PRIs could not play

an effective role in health service delivery because of their lack of experience in managing health care, as well as their frequent and strong political nexus and vested interests. Motivated PRIs, however, can play a major role in planning, monitoring, and evaluation of the program. The district panchayat, which recently received supervisory control of the rural health delivery system, can play a very important role, especially in monitoring and supporting health service at the community level through the district, block, and village health committees.

Table 4-7
***Panchayati Raj* Institutions' Health Delivery Capacities**

Coverage	▲Because of their understanding of the village and their problems, PRIs can help in identifying the needs of the community, ensure participation in the program, and ensure a greater reach of the Health Delivery System
Community Participation/Health Education/Training	▲The role of PRIs can be significant, as they are village-level institutions dealing directly with the people, and have an important say at the community level. They can help in organizing people, identifying resource persons, and in awareness-raising and education by organizing programs, camps, etc.
Preventive/Referral Services	▲PRI members should be given responsibility. Funds should come to them directly to undertake preventive health and links for referral services at the village/town levels.
Planning/Monitoring/ Evaluation	▲PRIs, if motivated, can play a very important role in supervising the Health Delivery System. ▲PRIs cannot play an effective role, as they don't have experience in dealing with health-related activities. Some PRI members, with their political nexus, may have vested interests.

4.3.4 Private Providers

The overall view of stakeholders regarding the institutional capacities of the private providers shows that there is a need for collaboration. This would increase the reach of the program, because private providers play a very important role in rural health care and enjoy the faith and trust of the community.

Table 4-8
Private Providers' Health Delivery Capacities

	Private Providers
Coverage	▲Their services are widely available, and they have a wider geographic coverage and reach at the community level.
Community Participation/ Health Education/ Training	▲There is a need to collaborate with private providers as the community has faith in them. They can be involved in promoting health education and raising awareness. ▲Qualified private providers can play a role in training (including technical inputs) to the implementing partners, especially the NGOs and private providers working at the community level. ▲Private providers are widely available, but they need to be trained before being involved in the program. Only qualified private providers should be involved in WACH.
Preventive/Referral Services	▲Private providers can be motivated to provide quality services. This can set a model for the government to enhance quality of services. ▲The involvement of private providers in preventive and curative health care is questionable. This is because a majority of them are inexperienced and are not qualified. ▲They can provide curative services (basic medical help) at the village level. ▲Private providers can play an important role in referral services, as, in most cases, they are being consulted at the initial stage. Their involvement in this program is essential.
Planning/Monitoring/ Evaluation	▲The private providers do not have the capacity to monitor program activities, as a majority of them are corrupt and underqualified.

It has been emphasized by the groups that, since the majority of the private providers lack proper experience and training on health aspects, they should be oriented and trained before their get involved. Private providers can be involved in promoting education and raising awareness because of their close links with the community. As far as training is concerned, it has been suggested that some qualified private doctors and traditional practitioners can provide training to the implementing partners at the grassroots level. Although the involvement of private providers in preventive health care is questioned by a majority of the stakeholders, a number of them believe that the private providers can play an important role in referral services becasue, in most cases, community members are consulting them in the initial stage of illness. With proper training and orientation, private providers can have the capacity to provide curative services and basic medical help at the village level. Their involvement in planning, monitoring, and evaluation has been ruled out by the groups because most believe that the majority of private providers are corrupt and are not qualified to assume these responsibilities.

5. Findings of Community-level Stakeholder Analysis

Community-level data has been divided into five subgroups of stakeholders:

- *Subgroup 1: Heads of households, youth groups, and community members*
- *Subgroup 2: Women and adolescent girls*
- *Subgroup 3: Panchayat members and sarpanch (panchayat president)*
- *Subgroup 4: Government functionaries*
- *Subgroup 5: Private providers*

There were two key issues discussed at the community, which reflect the principal objectives of WACH design: (a) access to services, and (b) quality of services, primarily in relation to maternal and child health. The views of community-level stakeholders involve supporting institutions or actors, i.e., government health system, private providers, NGOs, and PRIs. The perceptions of the community-level stakeholders are presented in the following text.

5.1 Perceptions of Community-level Stakeholders on the Existing Health Delivery System

5.1.1 Perceptions Concerning Access to Health Services

Government Health Delivery System

The basic institutions that provide or facilitate access to health services in rural areas are government district hospitals, primary health centers and sub-centers, and private providers, which include quacks, RMPs, traditional healers, compounders of primary health center, and qualified MBBS[3]/BMS[4] doctors. In certain areas, NGOs are also involved in health programs. PRIs do not provide health services directly, but function as an important vehicle for strengthening community-based health system.

[3] Bachelor of Medicine and Bachelor of Surgery
[4] Bachelor of Ayurvedic Medicine and Surgery

Community subgroup 1 (i.e., heads of household, etc.) and subgroup 2 (i.e., women and adolescent girls) stated that the primary health center is 5 to 15 kilometers away from the village and, most of the time, trained doctors are not available. They depend on the MPWs for immunization and other basic health services, which are primarily government-dominated inputs. Women in particular felt that MPWs find it difficult to visit to the villages due to poor roads. They also feel that gynecologists are inadequately staffed to address the specific concerns of women, so they have to travel to the larger towns for adequate care.

Figure 5-1
Information Dissemination

The Case of Ghot Village, Block Bari, Raisen District

"Some of us were given injections and medicines when we were pregnant, but we were never told what these were," say the women in this village during a discussion. Most of the community members are unaware of health issues, especially those pertaining to women's health. Moreover, health is not a priority in this village.

"It is electricity and water that we require. Everybody falls ill once a while. It is God's wish," said one of the male members of the village community. Very little information-sharing takes place in this village. According to the sarpanch of Parthalai panchayat, of which Ghot is part, "While the ANM does visit the village, she hardly has time to sit with the women and share information on health. The little information that we get on immunization, etc., is through the family planning camps that are organized once a while."

During discussions with the community, it was also learned that minimal information-sharing takes place among the community members on health-related issues. Sexual health is not discussed and usually considered taboo. Treatment usually means going to the local traditional healer. It was interesting to note that young girls receive information on menstruation from their sisters-in-law or a married sister, rather than their mothers.

The PRI and government functionary subgroups reported that the performance of MPWs and government health workers is unsatisfactory because their visits are irregular. Doctors are not available at primary health centers and sub-primary health centers, and they often encourage patients to come to their residence for treatment. Government functionaries specified problems of the public health delivery system, such as each primary health center has to cover a large number of villages because there are no mobile units and the community primarily depends on the MPWs. Private providers feel that government health services are out of the reach of the people because they must travel long distances to reach government hospitals. Moreover, they may have to wait for a day to get treatment, due to inefficiency of the hospitals and attitude problems of the doctors.

Private Providers

Regarding private providers, the following perceptions are expressed by subgroups at the community level. Subgroups 1 and 2 feel that private providers are easily available and approachable. The community depends on traditional, untrained dais for normal deliveries, and for complicated cases, they consult private doctors or private nursing homes, or use the private services of trained MPWs. Subgroup 3 (PRI members) feel that about 90 percent of the community seeks treatment from private doctors. In cases of complicated disease, they visit the private hospitals or nursing homes at Bhopal, which are closer to Raisen district. Very few deliveries take place in private

nursing homes. Government functionaries feel that private providers serve the community at their doorsteps, and the community does not have any option but to consult them, as they are easily available. Private providers (Subgroup 5) felt that they cater to people of low economic status, as the community normally opts for private providers and has faith in them. Women and adolescent girls (i.e., Subgroup 2) find private doctors more exploitative as they have to borrow money to pay for their fees. Women have strong faith in traditional healers and believe in spiritual treatment. Women noted that all the deliveries are undertaken by traditional birth attendants, who charge 50 to 100 rupees[5] per delivery.

Figure 5-2
Transportation of Patients in an Emergency: A Case Study

A Case of Two Forest Villages in Block Obaidulagunj, Raisen District

About 40 kilometers from the district headquarters lies the dense forests of the Ratapani Sanctuary. There are about 25 forest villages inside this sanctuary, mostly inhabited by tribal communities. Nilgarh and Dhundhwani are two such forest villages, situated eight to ten kilometers from the main roadway. Three to four small rivulets need to be crossed before reaching these villages. Each village has a population of 500 to 600, and all belong to the Ghond tribe.

While appraising the health scenario in the two villages, it was learned that the village community has to travel nearly 20 kilometers to reach the town. There is no other place they can go to receive services. Says one of the community members, "We live a life of struggle. For any requirement, we have to undertake a day-long journey before we can reach the market, and we are still not sure whether we will receive the service. It becomes worse when somebody falls ill. Recently, my brother-in-law took ill. He could not walk, so he had to be sent on a bullock cart. It took the whole day, and by the time he reached the hospital in the town, it was too late."

In the case of Kanta Bai, a pregnant mother, she needed care during the rainy season and communication was totally cut off. She had to be carried to Asha Sadan, a hospital run by missionaries, on a stretcher made of bamboo reeds.

In Dundhwani, the community gets together to share the cost of travel when any person of their village gets sick and has to be taken to a doctor. "Anybody could fall ill and the whole community should be responsible for their well-being," they stated.

Panchayati Raj Institutions

Perceptions of the stakeholder subgroups were that PRIs could function as a vehicle for promoting health services at the village level. The community and household heads (subgroup 1), feel that there exists a communication gap among the three tiers of PRIs. The schemes of the government, (i.e., financial support for pregnant women provided by the government under the Matri Prasoti scheme), is not used by women because of lack of knowledge and difficulties with procedures. Subgroup 2 (women and adolescent girls) feel that health-related information does not reach the Panchayat level. MPWs expressed that they should be under the supervision of the Panchayats so that their accessibility to the community will improve. Women members were not aware of subcommittees on health formed by PRIs at the community level.

[5] At the time this study was conducted, the exchange rate of Indian rupees (Rs.) was approximately Rs. 35 per US $.

Panchayat members feel that they are not involved with any health delivery activities at the village level. Involvement of PRIs in health is based on the PRIs leadership and individual interest. The primary job of the panchayats is to identify candidates for JSRs and dais from their panchayats. Poor coordination exits between the health committee at the block, district, and village levels. Private providers feel that PRIs have limited or no involvement in health delivery services, and should only nominate JSR candidates.

Table 5-1
Perception of Community-Level Stakeholders on Access to Health Services Provided by the Existing Health Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
Household Heads/Youth Groups/ Community Members	The villagers depend heavily on the MPWs for their immunization and basic health services, especially in remote areas. No proper health facility is available at the village level. The nearest primary health center is 5–15 km away from the village. Hospitals and clinics are very far away.	Private providers are widely available. Local, untrained dai is available, who helps in normal delivery cases.	At times, there exits communication gaps between the janpad (block) and panchayat levels because of inaccessibility and distances. Pregnant mothers do not receive money under the government Matri Prasuti scheme. Some said that because of procedural difficulties, they did not apply.	For women's reproductive health and maternal and child health, they prefer to go the Asha Bhawan missionary hospital in Sultanpur (38 km. from Raisen). Most are not aware of any health services that are provided by the NGOs. The Rural Development Service Society staff of Silwani Hospital visit the villages regularly. They also run informal schools in some villages, and provide a health awareness drive and health education camps.
Women/ Adolescent Girls	Trained doctors are not accessible, since in most cases they are either not present in the primary health centers or sub-centers or are available only for a few hours. Mobility of the MPW is hindered because of poor roads. They reach Vidisha or Bhopal by tractor. Women doctors are preferred for gynecological problems. Since they are not readily available (one female doctor is posted in Bari primary health center and one private female doctor practicing in Raisen), they have to go to Vidisha or Barelily (30 km., 35 km. from the block) for treatment.	They consult private providers, as they are available nearby, accessible, and easily approachable. Due to unavailability of trained dais and government doctors, they prefer to go to private nursing homes (in most cases, government ANMs) and pay 250 to 300 rupees per delivery.	Information regarding health does not reach the panchayat level. Recommendations passed recently have put MPW under control of panchayats and resulted in considerations for incorporating more health-related issues and improving accessibility of services. They are not aware of any health committee in the village or janpad.	They prefer to go to missionary hospitals because of the female doctors/nurses. Most are not aware of any health services that are being provided by the NGOs. The hospital at Silwani provides better services since not only the doctors and sisters are available (even at night), but they are also sympathetic to their problems and treated them with care. Women doctors are also available to take care of the women's health problems.

Table 5-1
Perception of Community-Level Stakeholders on Access to Health Services Provided by the Existing Health Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
PRI Members/ Sarpanch	Services delivered by the MPWs and government health workers are unsatisfactory, as their visits are irregular and, in most cases, not available for emergencies. Unavailability of doctors and medicine at the primary health centers and sub-centers. Even ANMs are not present regularly. Even when doctors and compounders are available at the sub-centers, they are available only at fixed hours. In most cases, they ask the patients to come to their residence for a check-up.	About 90 percent of community members go to private doctors or nursing homes for general treatment either nearby or at block headquarters. In complicated cases, if they can afford it, they consult private doctors or nursing homes in Bhopal. A few of them visit the private maternity homes for delivery and gynecological problems.	The PRIs do not have any interest or involvement with any health delivery activities at the village level. There are communication and coordination gaps between the village Swasth Samiti and the block-level Swasth Samiti.	At times, they go to the missionary hospital for treatment (but mostly for treatment of the women members of the family or women's gynecological problems).
Government Functionaries (ANMs, Teachers)	Government public health delivery system does not reach a number of remote villages and communities depend either on the mercy of private providers (mainly quacks) or on health workers and MPWs, whose sincerity and commitment are often questionable. There is no mobile health unit in these areas to reach the people. Information dissemination from the government is very poor. There are no efforts from the government to organize health camps or awareness-raising activities. The community- level workers are burdened with work, since they must cover at least 10 villages and do a lot of reporting. It is possible to cover only 20-25 households in a day.	The reach of the private providers exceeds the government health delivery system. They provide health services at the doorstep of the community. The people do not have any options but to consult private providers, since they are all that is available nearby and easily approachable.	PRIs have nothing to do with health service delivery. Apart from identifying people for JSR and Dais for training, their involvement in health delivery is very minimal.	There are few hospitals or health centers run by NGOs in these areas, so their accessibility and coverage are limited. Very few people are aware of any health services being provided by the NGOs or charitable institutions. Even if they know, they are skeptical about them, the men especially feel that the missionaries have religious motives.
Private Providers (Dais, RMPs, Quacks, Private Doctors)	Because of unavailability of government services in many areas, the community must opt for private treatment. Community members have to spend the whole day if they have to visit the government hospitals at Raisen, Vidisha, or Bhopal. Many times, they cannot get treatment on the same day.	People from nearby areas, especially from low economic status, generally opt for private providers. People have faith in private providers, as they are only available at the village level.	PRIs do not have any interest or involvement with health delivery activities at the village level.	Very few people are aware of any health services provided by the NGOs or charitable institutions.

Non-governmental Organizations

Experiences of the community in receiving health services from the NGOs are few. Silwani block, where RDSS provides health services in neighboring villages and runs a hospital, is a preferred option over the other delivery mechanisms. Subgroups 1 and 2 preferred NGOs because female doctors are available. The NGOs are providing more comprehensive support in health awareness drive, managing informal schools, etc. Services are better in RDSS as, even at night, doctors or sisters are available and the staff is sympathetic and caring.

Subgroup 3 (PRI members) feels that the missionary hospital is preferred by the women. The government functionaries mentioned that there are few such hospitals, and therefore coverage and accessibility of such hospitals is low. Regarding missionary hospitals, there exists the perception that some religious interests may prevail. Subgroup 5 (i.e., private providers), as well as other subgroup representatives, feel that services of NGOs and charitable institutions are scanty and less known in the community.

5.1.2 Perceptions Concerning Quality of Government and Private Sector Health Services

Quality of services has been assessed from the point of view of the users of the services as well as key stakeholder subgroup representatives. Their perceptions on health delivery service alternatives are presented in the following text.

The government public health delivery system, especially at sub-primary health center and primary health center levels, provides very limited services and does not have adequate infrastructure to provide referral services even up to the district level. Subgroup 1 (e.g., heads of household) mentioned that relative preference for government services is low because they provide only consultation or prescriptions rather than medicine. Private providers normally give medicine. For complicated cases, the community prefers to consult government hospitals since private providers have limited resources (i.e., medicine and equipment) and limited professional skills or capacities. At the village level, some MPWs provide drugs to schoolteachers, who help to get services, contraceptives, etc., distributed at the household level. There is poor quality of services in relation to the dissemination of information by the government health workers. The community learns more about many preventive aspects through health camps organized in their villages periodically.

Subgroup 2 of women and girls thought that primary health center services are unsatisfactory, as poor quality services from the compounders is available for limited daily hours and doctor visits restricted to two or three times each week. There are no emergency services. Women have less faith in MPWs and Anganwadi workers, and the services from them are poor. The block or district hospitals are not equipped for curative or emergency services, and are not economical options as compared to private providers. Immunization services are erratic and largely depend on the motivation level of the MPW, who usually visits once a week. The immunization concentration is primarily in polio vaccination. Patients

prefer the government hospitals because they are low cost, but feel they do not get sufficient care in such hospitals.

Figure 5-3
Status of Antenatal Care and Immunization in Ghot Village, Block Bari, Raisen District

Ghot is a small, isolated village with only a muddy track linking it to the main road. During the monsoons, this track fills with water, making it impossible for the people of this village to reach the main road. Dhanvanti Devi is a resident of this village.

"We have to suffer a lot because there is no roadway," she complains. About 28 years old and looking very frail, Dhanwanti Devi has two girls, aged one and three. She confides that she had suffered two miscarriages earlier. "After the miscarriage, I gave birth to a baby boy who was deformed. He died after six months."

When asked where she went for her delivery, Dhanwanti stated, " In the earlier case, I had gone to a private doctor in Bari Town, and in the present two cases, the delivery was done here by the local *dai* present."

When asked whether she had received any vaccination during her pregnancy and or took any medicines to improve her health, Dhanwanti Devi seemed confused, saying, "Well, during my last pregnancy, I think the doctor had given me an injection but I do not know why. I did not take any medicines at all. Why should I? God will help me."

There are five cases of deformity among children in this village. A number of pregnant mothers reported that they had not received any vaccinations or been provided any medicine.

The stakeholder subgroup of panchayat members reflected on the quality of services. Government health workers do not undertake preventive and diagnostic measures, (e.g., chlorination of wells), and the primary health centers do not have facilities to test blood for malaria, parasites, etc. In complicated cases, they prefer to take the patients to the district hospitals of Raisen or Vidisa or to Bhopal; however, the behavior of doctors is unsympathetic, and if they are referred to private pathology labs, treatment becomes very expensive.

The services of MPW for immunization of children is far better, due to special attention by the government to WACH. Care for pregnant women, however, is very poor. The government functionaries subgroup revealed that the poor quality of services is basically the result of the unavailability of doctors, poor infrastructure, and a low supply of medicine. Service quality is also affected by weak capacity-building efforts and lack of performance incentives. Bureaucratic and procedural bottlenecks also affect morale and ultimately affect quality of services.

Figure 5-4
Expenditures on Health

Experiences of Chapna Village, Block Sanchi, Raisen District

Bindeshwar, a resident of this village, works as a laborer in Sanchi Town. He is illiterate and has four children— three boys and two girls. "My children are very small. I need to spend a lot of money on their treatment when they fall ill." It was revealed that none of the children have been immunized. Bindeshwar says that he spends around Rs 500 -Rs 700 each year for medicines to treat various family health problems. "But recently I had to spend Rs 1000 on my wife, who was very ill."

Discussions with community members revealed that they usually buy medicines from the local private doctor. Further, most community members stated that they did not spend money when the ailment seemed minor. “We depend on household cures for small health problems." When asked what they expected from the health worker who visited their village periodically, some of them stated, "The health worker is a good person, often taking a lot of pains to make house to house visits. He does not, however, give us any medicines. We are forced to go to the private doctor, who charges us a lot, more than what the medicines actually cost. We would rather pay the health worker if he provided us treatment on a regular basis."

Subgroup 5 (private providers) considered competency, infrastructure, and resources of the government health delivery system of higher quality than those of the private providers. Therefore, in the case of critical or chronic problems, patients visit government hospitals at Raisen, Vidisa, and Bhopal. Primary health centers are ill-equipped with medicines, especially injectables and drips, which are psychologically preferred by the community. The quality of maternal and child health and other preventive services are dependent on the individual motivation levels of the MPWs.

Preference for private doctors is primarily due to their behavior and ability to provide medicine. In case of reproductive problems, patients prefer to take herbal medicines provided by local religious healers. Panchayat members feel that private providers are key actors and traditionally recognized in health, especially local healers. Government functionaries (Subgroup 4) questioned the legal license of the private providers to practice. Moreover, private providers do not have professional competence and infrastructure to play any important role in health. Private providers accepted that they have low competencies and poor medical infrastructure, as they cannot afford to invest in infrastructure development. Complicated cases are normally referred to government primary health centers, district hospitals, or private nursing homes in nearby towns. Gradually, the faith of the community in traditional medicine is weakening, especially Ayurved and Unani, and the practice of traditional healers.

Table 5-2
Perception of Community-Level Stakeholders on Quality of Health Services Provided by the Existing Health Service Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
Household Heads/Youth Groups/Community members	Government hospitals have very limited services and lack basic infrastructure at both block and district levels. Services offered by the primary health center could not satisfy the need of the people, even for primary health care, and they are usually referred to the district level. They also do not prefer the treatment, since government doctors provide only consultation and no medicine. For any other services apart from consultation, money has to be paid to the staff. In complicated cases, they go to the government hospital, as private providers have limited resources and capacities. Drugs are sometimes given to the primary schoolteachers by the MPWs, while the contraceptives and other medicines are distributed to the households.	They prefer to go to private providers, who are more accessible. They have faith in their consultation and their medicines. They use private provider services because behavior is good, although private treatment is very costly. For complicated cases, they prefer to consult private nursing homes. The community goes to the local ojha (traditional healers) in case of specific problems (mostly sexual), otherwise they use their traditional medicines. All deliveries in the villages are undertaken by the local dai. They have faith in her and do not know whether she is trained or not.	Panchayat has limited resources for health activity and are least concerned with health issues. Though health committees do not function well, they have recently started monitoring the services given by MPWs. During emergencies, panchayat members and the community helps transport patients and contributes money. PRIs try to mobilize resources from govt. for health-related activities and also influences the local Member of the Legislative Assembly to assist with health-related issues.	Health camps are being arranged by Bharat Petroleum, who also distributes medicine. The hospital at Silwani (run by RDSS) is one of their best options, since they not only provide proper services but also charge very little for their services. If the patient cannot afford the cost, the services are free.

Table 5-2
Perception of Community-Level Stakeholders on Quality of Health Services Provided by the Existing Health Service Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
Women/ Adolescent Girls	The quality of services in terms of consultation and medicines in the primary health center is unsatisfactory. At sub-primary health center, doctors come three times a week, whereas compounder comes daily for two hours. Function of the sub-center is not good. There is no facility available in emergencies. Women do not have faith in MPWs, who seldom visit the villages and either do not distribute enough medicine and contraceptives or do not distribute them at all. The primary health center at Dewanganj block provides very limited service, so most cases are referred to Bhopal, which is costly. There is no difference between the government functionary and private providers, since they often have to consult them at their residences. The services of MPW related to maternal and child health are erratic in the villages. Government hospitals are preferred by the women, but they are taken care of. They cannot afford to pay much, thus have to depend on the government hospital. Contraceptives and family planning goods are delivered to the sarpanch's house, not individually, and no instructions regarding their use is	For complicated problems, they go to private hospitals in Bhopal. The private doctors in most cases are highly exploitative and patients must borrow from the local money lenders to pay for services. Women have faith in traditional healers and believe in spiritual strength or *shakti*, which keeps evil spirits out. Thus, in many cases, they prefer the traditional healers. Almost 100% of the deliveries are done by local dais who are untrained and charge 50 to 100 rupees per delivery. The locals have immense faith in her. They have faith in private doctors, who give information and treat patients with care, unlike government doctors. Private doctors provide medicine with the prescription. Getting a check-up and medicine at one place is preferred, although it may be more expensive. In the case of reproductive and sexual diseases, traditional herbs are often provided by the local vaidh or traditional ojha.	As funds are not available for health service-related issues, PRI are unconcerned about it and it is not discussed in panchayat or gram sabha meetings. No specific actions were taken by the PRIs regarding health service delivery, but since the sarpanch is active, the MPW visits the village. In case of emergencies, the panchayat helps arrange trans-portation as well as money for treatment.	The nurses and doctors of the missionary hospitals treat patients with care, are sensitive to their problems, and visit some of the villages and check the health status of the women and children. Apart from camps for general health and eye check-ups, there is no involvement of NGOs in the health service sector. NGOs (*Sansthas*) are playing a better role in health service delivery since they are not only providing consultations and medicines, but also providing health education and awareness. NGOs and their staff are not business-minded and treat the patient with care, often without any remuneration.

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Table 5-2
Perception of Community-Level Stakeholders on Quality of Health Services Provided by the Existing Health Service Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
PRI Members/ Sarpanch	Preventive and diagnostic measures (e.g., chlorination of well, blood tests) have not been properly undertaken by government health workers. In most primary health centers and sub-centers, proper diagnostic infrastructures are not available, and even if the tests are done, the results are not known. Very few people visit the government health centers. They visit govt. hospitals at Bhopal, Vidisha, and Raisen only in the case of critical or chronic problems. In many govt health centers or hospitals, after primary treatment, they refer cases to private doctors or nursing homes. Poor people have no options and must spend much money on treatment. The govt. doctors are unsympathetic and often behave badly towards the patients. Mothers and children are dependent upon the immunization and vaccinations given by MPWs. Vaccination of children is satisfactory, but ANC vaccination of the mothers is not properly administered by MPWs.	The private providers are the main actors in the health service delivery. The people have faith in them as they not only provide consultation but medicine as well, for a fee. The dais in most areas are traditionally carrying out this profession, and a majority of them are not trained. The people are less interested in using the traditional healers and vaidhs for their general ailments. Only in case of sexual diseases and related problems will they visit them, because of social pressure and secrecy. A majority of the private providers in the villages are quacks, are not competent to give proper treatment, and do more harm than good to the people. People usually prefer traditional healers or ojhas for removing spells or spirits, which are medical disorders such as epilepsy, tetanus, or infertility.	At times, the sarpanch, with its own initiatives, is used to influence the MPW and JSR to visit the villages. The Matri Prasuti Parijojona provides Rs. 300 for pregnant women. But it successful only where the sarpanch has personally taken initiatives. In other places, either the money has been misappropriated, or the community is not aware of the program. Very little can be done by the PRIs, since there re no resources for initiatives in health services. There is very little information and guidance from the district health committee (ZSS) regarding this issue. There are no resources allotted for undertaking (village) health-related services in the gram panchayat. Sometimes the gram panchayat helps the government or other initiatives to organize health camps, awareness drives, etc., but it is infrequent.	There is very little NGOs intervention in health service delivery, except for camps for general health and eye check-ups.

Table 5-2
Perception of Community-Level Stakeholders on Quality of Health Services Provided by the Existing Health Service Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
Government Functionaries (ANMs), Teachers	Government system lacks doctors and proper infrastructure. The provision of medicines and diagnostic equipment is inadequate and supplied irregularly. The quality of services suffers due to lack of knowledge, information base, and incentives. A number of services are being offered by primary health centers. Of them, postnatal care and immunization are the best services presently being offered. A lot of bureaucratic and procedural bottlenecks exist in the present system. These lead to low morale/motivation for the government health workers which affects directly on the quality of services.	Most private providers do not have license to practice medicine, are operating illegally, and exploit the people. Private providers lack not only professional competence, but equipment and other medical infrastructure as well.	At times, the PRIs members help transport patients to the nearest health centers, hospitals, or private doctors. The PRIs are supposed to have a village Swasth Samiti, but in most cases, these are non-existent. The panchayats are also supposed to supervise the visits and working of the ANMs. In few panchayats where the sarpanch is active, some initiatives have been taken.	Hospitals run by missions and other charitable institutions are better than the government health centers since they provide better services, proper care, and they have some medical facilities as well.

Table 5-2
Perception of Community-Level Stakeholders on Quality of Health Services Provided by the Existing Health Service Delivery System

Stakeholder Subgroup	Government Health System	Private Providers	PRIs	NGOs
Private Providers (Dais, RMPs, Quacks, Private Doctors)	The government doctors are technically competent and have better infrastructure and resource base, which the private providers do not. In most primary health centers and sub-centers, proper diagnostic infrastructures are not available, and medicines are either inadequate or unavailable. Most available medicines are not preferred by the community, who want injections, drips, or tonics. For immunization, ANC/PNC, the community depends on their local primary health centers, the MPWs, and other health workers. If the doctor at the primary health centers, MPWs, and ANMs are good, they receive proper care.	The private providers, especially those operating at the grassroots level, lack competence, medical infrastructure, and equipment. The traditional healers and medical practitioners initially treat all kinds of diseases, but complicated cases are referred to the government primary health centers/hospitals or to private doctors/nursing homes at Raisen, Vidisha, or Bhopal. People are less interested and have little faith in traditional medicinal practices, thus, the Ayurved, unani, etc., practices are becoming obsolete. People generally consult local, private medical practitioners for general health problems and minor ailments.	At times, panchayat members help in transporting the patients to the nearest health centers, hospitals, or private doctors.	The women prefer to go to hospitals or centers because there are female nurses and doctors, whom they prefer for their gynecological problems and treatment of their children.

5.2 Preferred Mechanisms to Strengthen the Health Delivery System

The community stakeholder groups have identified various mechanisms to strengthen the health delivery system, which are presented in the following text.

5.2.1 The Government Health System

The groups feel that community involvement is important in the management of health services, and the community would be willing to share the cost of maintaining the hospital and services. With self-generated funds, the sub-centers can be managed by the community representatives.

Table 5-3
Preferred Mechanisms of Community-Level Stakeholders to Strengthen the Government Health Delivery System

Stakeholder Subgroup	Government Health Delivery
Household Heads/ Youth Groups/ Community Members	▲The government should build hospitals and health centers at the village or cluster levels Administration of the hospital or center should be handed over to the community. Health centers or hospitals should be linked with block hospitals, and necessary facilities should be created. People are willing to contribute money for the maintenance of the hospital. ▲General training on health issues and personal hygiene at the village level for adolescent girls should be provided by female resource persons, teachers, MPWs, or Anganwadi worker. ▲Training and orientation should be assigned to male and female MPWs. ▲With self-generated funds, sub-centers can be managed by local people.
Women/Adolescent Girls	▲There should be a hospital for a cluster (within 2 km). ▲Late-night facilities should be available for emergency cases in the government health centers. ▲The government should build hospitals or health centers at the village or cluster levels. Administration of the hospitals or centers should be handed over to the community. The centers or hospitals should be linked with block hospitals, and necessary facilities should be provided. People are willing to contribute money for hospital maintenance.
PRI Members/ Sarpanch	▲The government should build hospitals or primary health center at the village or cluster levels. Administration should be handed over to the community. The health centers or hospitals should be linked with block hospitals with adequate facilities. People are willing to contribute money for hospital maintenance. ▲There can be a village or cluster-level subcenter in each panchayat. One male and one female RMP or health worker from that same panchayat can be appointed. It is important that they should be local and stay in that village only. The monthly honorarium may be paid by the gram panchayat, and medicines, medical equipment, etc., should be supplied by the government. ▲If a monthly honorarium must be given by the government, it should be paid directly to the concerned people through postal money orders. ▲There should be regular feedback from the govt. regarding health education and details of different health programs. A village-level information center can be created in each panchayat.
Government Functionaries (ANMs, Teachers)	▲Government hospitals or primary health centers should be properly equipped and a woman doctor should be stationed in each primary health centers or sub-center. ▲The government should promote preventive health and education, organize health camps and awareness drives more often, and disseminate information at village panchayat levels.

Table 5-3
Preferred Mechanisms of Community-Level Stakeholders to Strengthen the Government Health Delivery System

Stakeholder Subgroup	Government Health Delivery
Private Providers (Dais, RMPs, Quacks, Private Doctors)	▲Effort should be made by the government to collaborate with private providers to increase the coverage and reach of the present health delivery system. ▲Most private providers lack technical knowledge and other medical or health-related information. If the government wants them to be integrated with health programs, they should provide proper training and follow-up. ▲The government should provide some medical and diagnostic equipment. ▲It is difficult to provide services and maintain medical equipment at the village level. There is a need to provide cheaper medical testing facilities and other support to private providers.

The women and adolescent girls subgroup want health services that are in close proximity, i.e., within two kilometers, of each village. More importantly, there should be a mechanism for late-night services, especially for pregnant women. The PRI-level subgroup suggested that there should be a village or cluster-level subcenter, where one male and one female RMP or health worker from the same panchayat may be appointed and an honorarium paid by the government. If panchayat is not provided resources, the honorarium of the health worker should be paid by the government directly through money orders, rather than provided through the government health delivery system. The government functionaries suggested that a woman doctor be appointed at the primary health center and sub-primary health center levels. Health education should be promoted and awareness drives initiated at the PRIs level. Private providers want a collaborative mechanism with the government to bring themselves into the mainstream of health services. There should be mechanisms for capacity-building of private providers. Some equipment and infrastructure should also be provided to them to improve their quality of services.

5.2.2 Private Providers

Subgroup 1 (e.g., household heads) of community-level stakeholders strongly suggested that the government doctors should be banned due from private practice of the so that they can be available at government health centers. The traditional health system should also be monitored. Women feel that the operations of private providers should be monitored by the government or panchayats. The stakeholder group of PRI members feels that traditional birth attendants must be given proper orientation in a long-term support strategy rather than providing ad hoc training support once in their lifetimes. Subgroup 4, government functionaries, wants to explore mechanisms to bring private providers in as collaborative actors for maternal and child health and enhance coverage of services. Private providers consider local birth attendants as key links in improving health services at the community level. Emphasis has to be directed towards building incentive-based rather than honorarium-based systems.

Table 5-4
Preferred Mechanisms of Community-Level Stakeholders to Strengthen Private Providers

Stakeholder Subgroup	Private Providers
Household Heads/ Youth Groups/ Community Members	▲ Practice of government doctors in private nursing home should be stopped. ▲ Traditional health practices should be monitored.
Women/Adolescent Girls	▲ The service and operations of the private providers should be monitored either by the government or panchayat.
PRI Members/ Sarpanch	▲ Local dai and JSRs must be given proper orientation and training. Long-term support should be provided, rather than the present ad hoc type of training.
Government Functionaries (ANMs, Teachers)	▲ Effort should be made by the government to collaborate with the private providers and increase coverage.
Private Providers (Dai, RMPs, Quacks, Private Doctors)	▲ Local dai must be given proper orientation, training, and follow-up, and they should receive incentives from the government.

5.2.3 *Panchayati Raj* Institutions

Various mechanisms have been suggested to more effectively involve PRIs in health. Subgroup 1 (e.g., household heads) suggests that a cluster-level health committee with five panchayats should be formed. This committee can have direct link with the block-level health delivery system. At each panchayat level, an information center should be created, which would provide basic preventive services, e.g., oral rehydration therapy and family planning. The MPW should be accountable to the cluster-level committee. Local representatives, one male and one female, should be identified and trained to provide basic health services. The health workers may be identified from outside the village, but they must stay at the village, and provision for their houses will be the responsibility of the villagers. A local doctor who lives in close proximity to the village needs to be identified and should be linked with panchayat or the proposed committee to provide emergency services.

Subgroup 2 (women and adolescent girls) expressed the need for the health worker to be trained and stationed at the village level. The women would also like to form a health committee at the village level, which would not be governed by the PRIs. Emphasis should be placed on health education. Panchayat members need to be trained in health issues.

PRI members (Subgroup 3) feel that the constraint of financial resources needs to be addressed and special funds should be provided to the panchayats for the construction of health centers in the villages. PRIs should receive funds directly from district health committees. Panchayats also expressed that potential for generating resources at the village level exists, but clear guidelines need to be issued from the government or Zila Panchayats. Panchayats also expressed their preference to link with ZSS rather than with the district administration. Panchayat members need to be trained on several issues of health management and preventive aspects of health, and this training should be considered a priority.

Government workers (Subgroup 4) say that responsibility for the existing health delivery system at the village level should be assigned to a committee of community representatives. Private providers want some mechanism that the panchayat local providers and traditional practitioners can use to administer their services in an institutional manner.

Table 5-5
Preferred Mechanisms of Community-Level Stakeholders to Strengthen PRIs

Stakeholder Subgroup	PRIs
Household heads/Youth groups/ Community members	▲One cluster-level committee of five panchayats should be formed, with members from each panchayat forming health, education, and social welfare committees, and should be managed by community representatives. ▲Committee members should have a direct link with the block-level health service delivery system. ▲Information on health education and various government health programs should be given to this committee. ▲At each panchayat level, one center should be opened for information dissemination and distribution of medicines. ▲The committee can take up responsibility for preventive health care and MPWs should work under their supervision. ▲Health service delivery should be done through these committees and the community should pay for the services. ▲Local persons, preferably a male and a female, should be identified, trained on basic health services, and placed at the village level. ▲The present education committee can be given the responsibility to look into the health aspect as well. ▲There is a need of a local doctor at the village level who can provide services in case of emergency and daily need. The health worker may be an outsider, but he/she should stay in the village only. Villagers can provide him/her with a house.
Women /Adolescent Girls	▲There can be a village health committee, which may be under the Gram Panchayat. ▲There can be a committee at the village level (not within the Panchayat) who can be entrusted to assign health-related activities in the village. They can appoint one male and one female from the village (or in that panchayat) who will be given a house in the village and would be stationed there. The government could provide basic training and supply the required medicines. A part of the cost (e.g., an honorarium) can be borne by the community. ▲Panchayat, along with its village health committee ((VSS) can take up health education and awareness-related activities. A center at the village level can display and disseminate all health-related information and programs of the government. ▲The panchayat members (especially VSS members) need some orientation on health-related issues and require management and administration-related training.
PRI Members/Sarpanch	▲Some resources should be given to the VSS to undertake health-related initiatives and for emergencies. ▲The panchyats can also seek funds from the BDO or from district health committee (VSS) to construct village- level health centers, undertake some initiatives on preventive health care, and as a first referral unit. ▲The panchayat can mobilize funds from the community for health services but they need guidance from the government or ZSS. ▲JSS should formulate a participatory plan, along with the VSS, to strengthen the present health delivery system. ▲VSS should coordinate with the ZSS for health services, rather than with the district administration. ▲The panchayat members (especially the VSS) must be properly trained by the government on several issues of health, including technical and managerial skills.
Government Functionaries (ANMs, Teachers)	▲The community should form a committee at the local level and committed people should be given the responsibility for administering some health delivery and monitoring the existing health delivery system.
Private Providers (Dais, RMPs, Quacks, Private. Doctors)	▲The panchayat should provide some basic facilities at the village level for some local level private providers and traditional medical practitioners and help in health awareness-raising.

5.2.4 Non-governmental Organizations

Subgroup 1 feels that capable NGOs should be equipped with infrastructure and medical equipment to provide wider coverage and effective services. The women's subgroup felt that the government should provide a woman doctor and some infrastructure support to the NGOs to expand coverage, especially maternal and child health, to a larger area. Panchayats also consider involvement of NGOs at all three levels, (i.e., district, block, and village).

Table 5-6
Preferred Mechanisms of the Community-Level Stakeholders to Strengthen NGOs

Stakeholder Subgroup	NGOs
Household heads/Youth groups/ Community members	▲ Capable and well-oriented NGOs should be provided with infrastructure and equipment so that they could more effectively assume health delivery and also increase their coverage.
Women/ Adolescent Girls	▲ Government should provide women doctors to the NGOs and other medical institutions so that they would be able to treat more women and mothers in a larger area.
PRI Members/ Sarpanch	▲ NGOs should be involved in health delivery at the district, block, and especially the village levels.
Government Functionaries (ANMs, Teachers)	▲ There is a need for the government to integrate and strengthen the small efforts of NGOs and local unorganized groups. Some could be properly trained and given some responsibility for providing referral and preventive health services at the village level.
Private Providers (Dai, RMPs, Quacks, Private Doctors)	▲ There should be an integrated effort from the government to involve private partners as well as NGOs in the health service.

Subgroup 4, government functionaries, feels that NGOs and well-meaning, unorganized groups should be properly trained and given responsibility for referral and preventive aspects of maternal and child health at the village level. Subgroup 5, private providers, suggests that NGOs and private providers in health should be integrated into the government heath delivery system.

6. Synthesis of Stakeholder Perceptions and Conflicts

If we analyze the perceptions of the stakeholder groups at different levels, i.e., state, block, and district, a number of contradictions can be observed regarding the government health delivery system. While the political group at the state level claims that the state health machinery has adequate infrastructure and human resources for large-scale coverage, the same group at the district and block levels complained about the inadequacy in the number of doctors (especially woman doctors) at rural centers. They also believe that there is a significant lack of basic medical facilities and infrastructural support to cover large geographical areas. The community-level peoples' representatives, i.e., PRI members, also subscribed to this opinion.

The political group at the state level are of the opinion that gradual linkages of rural health services with PRIs is a positive step, and the existing level of health infrastructure cannot meet the growing demand. Bureaucratic procedures are seen as hurdles to attaining efficiency. The attitude and commitment of the staff reflect a wide gap between what is principle and what is practice. Political groups at the district and block levels (including PRI members) suggested that, because of a lack of coordination and proper linkages between the district committees and block health committees, the PRIs are not yet effective in managing the public health delivery system at the district level. It is also evident that there are misconceptions and a lack of understanding regarding the PRIs' role in the public health system.

A major contradiction can be observed regarding the efficiency of the government health system. The bureaucracy at the state and district levels feels that the government health delivery system is efficient, well-established to provide coverage and reach, and that services rendered are of high quality. They further feel that the existing public health delivery system and networks effectively deliver primary and preventive health care. Representatives at the block and community levels, however, feel otherwise. These representatives complained about a shortage in proper infrastructure and staff, an overburdened workload, and insufficient incentives. Doctors and other health workers are not satisfied with the bureaucratic procedures of the government and complained about lack of infrastructure and other logistic support in the rural areas. They feel that some of the well-publicized schemes, like Matri Prasuti and JSR, are not at all successful in the rural areas. These observations support most views expressed by other stakeholder groups, including NGOs, private providers, and community-level representatives. They have also expressed their inability to encourage people's participation in WACH. Lack of coordination and poor incentives are some of the other deterrent factors pointed out by this group. It has also been noted that the present health delivery system has put limited effort into promoting alternative medical practices. According to this group, the training undertaken by government agencies is not effective, because it is concentrated at the middle management level rather than strengthening the capacities of grassroots-level workers.

Representatives from the private providers at the state level believe that the existing capacity of the government system is inadequate both in terms of infrastructure and doctor-patient ratio. Therefore, unmet demand is frequently fulfilled by the private providers. They stated that the quality of services at the public referral centers is not up to standards, and people prefer to get services from the private providers in the village or nearby cities. Interestingly, some representatives at the district, block, and community levels

expressed that the government system has a vast network and qualified manpower, which is not available with the private providers. Moreover, they added that government services do not reach the remote areas due to a lack of motivated staff and good infrastructure.

NGOs stakeholders at the state level recognize that the large infrastructural base and government network of paramedical staff, but felt that their reach to the villages, especially remote areas, is minimal. In their view, the government functionaries are unable to promote health-seeking behavior and attitudinal change for preventive health at the community level, and have weak commitment towards their role in health service delivery. NGO representatives at the district and block levels feel that in health delivery, the public health delivery system caters to most people with its vast network and qualified manpower, but maternal and child health has not been addressed satisfactorily and is neglected in remote or inaccessible areas. This is reflected in the poor services at government hospitals and health centers where, in most cases, there are no gynecologists or pediatricians. Even in general medicine, there are very few women doctors and assistants. Moreover, a gender-sensitive approach is seldom practiced in treatment and patient care.

Regarding NGOs in health service delivery, the major difference in perception lies between the state and district or block-level groups, since the district has very little NGO involvement in health service delivery. According to the political group at the state level, efforts of NGOs are valuable, as many of the small NGOs are working closely at the grassroots level and have a clear understanding of realities. The general perception of the group, however, is that Madhya Pradesh does not have committed and credible NGOs and their capacities are quite weak to be involved in a health program. Most NGOs are concentrating only on awareness-raising and preventive health rather than curative health (i.e., referral services). Their counterparts at the district or block levels feel that the NGOs are committed to their work, and are working effectively in the field of awareness-raising, education, and preventive health services. The stakeholders group at this level have little input because there are only few examples of NGOs involvement in the health service delivery in this district, and they have limited capacities and coverage.

The bureaucracy feels that, although NGOs have demonstrated their potential to work in government-aided development projects, they have not been actively involved in the health sector. They feel that NGOs do not have professional competence and experience in health management. Their inadequate numbers, coupled with weak capacities and concentration in urban centers, reflects poor, ineffective, and inefficient performance. Conversely, the bureaucracy and government officials at the district and block levels agree that NGOs have a much better understanding of the field situation and are closer to the community. NGO strength lies in community mobilization and participation. Similar to the views of political groups, bureaucracy and government also think that the number of NGOs and their coverage is restricted in this district, and that NGOs lack linkages with the government and donor agencies to utilize necessary funds to assume activities in health-related services.

The NGO group feels that there are a few good NGOs working in the area of health, but that few NGOs have capacities to provide health-related services due to weak human resources development. NGOs are fund-driven, and therefore become target-oriented and limit their role to awareness-raising and health education. Representatives of NGO groups at the district, block, and community levels, however, expressed that they are already supporting public health delivery systems, especially in the field of awareness-raising, by organizing health camps, etc., and organizing the community around various issues. Some NGOs that provide health services in the district are also of the opinion that, although their coverage and reach is limited, they provide quality services at little or no cost. NGOs are close to the community and understand their needs and feelings. The people working with the NGOs are much more committed. Due to lack of funds and resources, however, NGOs are unable to assume health programs on a large scale.

Stakeholders from government health institutions at the state level thought that NGOs involvement in the health sector is negligible. They added that most NGOs are working at a superficial level for image-building and publicity. In their opinion, NGO involvement is restricted to providing health education and motivating people to generate demand for health services. Added to this is the problem of high dependence of NGOs on project grants, which leads to weak sustainability and community base. The relationship between NGOs and the government is also assumed to be one of confrontation and criticism rather than mutual appreciation. Representatives of the government health institutions at the district and block levels note that, although the role of NGOs has been very restricted in this district regarding health, they have played an important role in supporting awareness-raising. Since NGOs are closer to the people, have a better understanding of the grassroots issues, and reflect commitment, they have the capability of planning and implementing the project more realistically.

Private providers at the state level expressed the opinion that NGOs are only involved in health education, do not have health as their agenda, and play a limited role in raising awareness. Private providers at the district, block, and community levels have little perception of NGOs involvement, but they have pointed out that there are limited efforts being undertaken by NGOs and voluntary agencies in the area of health. Regarding involvement of private providers in health delivery system, the principal difference lies between the state and the district or block-level stakeholders and their perceptions of capacities and quality of services.

While the political group at the state level and at the district, block, and community levels do not have much differences about the private providers, a number of representatives at the state level expressed that private providers serve the community in emergency situations, as they are accessible around the clock. Many of them have good infrastructure, especially in the case of large set-ups at the state and district levels. Their treatment is also rated better than that of the public health delivery system services. Their services are paid, which reflects confidence of the community in private providers as compared to the government. But it is also realized by the representatives, especially at the district and block levels, that private providers reflect poor human resources development and technical competence. Their basic motivation of profit maximization contradicts the concept of serving the poor, and, at times, can be exploitative.

The representatives of the bureaucracy at all levels are of the opinion that a majority of the people in rural and inaccessible areas are going to private providers for basic health services because of their easy availability and accessibility. The representatives at the state level feel that the services of the private providers are better than those of the government health system. It is felt that local doctors practicing indigenous medicine system need to be actively involved in health service delivery. Their role is not perceived in preventive health, as they are mainly concentrated in urban centers, and do not administer free services.

In contrast to these beliefs, representatives at the district and block levels felt that, because of a lack of technical experience and training, the quality of services provided by most private providers is poor and does more harm than good to the community. They also thought that private providers do not possess any basic medical infrastructure to deliver proper health care services. The NGO representatives at the state level feel that a substantial proportion of the rural community is served by local, unrecognized health practitioners, such as traditional healers. Private providers are providing services in remote and inaccessible areas, although they charge for their services. The NGO stakeholders at the district and block levels believe that, although the private providers are important for providing basic health services in the rural and inaccessible areas, they are known for poor manpower, expertise, and quality of services. Some also feel that most of the private providers are exploitative by nature.

Representatives of the government at the state level feel that private health practitioners are mostly quacks and non-technical persons who can be harmful to the community. Private providers are less interested in the field of social marketing, and their linkages with the government health delivery system are non-existent.

In contrast to their counterparts at the state level, representatives at the district and block levels expressed the fact that more than 70 percent of the general health problems in the rural areas are treated by private providers. Although most of them do not have proper qualifications and lack clinical knowledge, the community has faith in their treatment. Some felt that because of poor quality services and lack of technical expertise, private providers may harm the patient by complicating the case.

Private provider stakeholders at the state level considers their availability during times of emergency as a strength. They occasionally join the government in its immunization, awareness-building, and health education programs. But most private practitioners are available only up to the block level, due to economic, infrastructure, and communication problems. The private providers at the district, block, and community levels feel that they have considerable outreach, and the cost of services provided by the village-level private practitioners is generally quite minimal. They have also admitted that the cost of consultation for established and experienced private doctors is quite high and, in most cases, the community is unable to pay for their services. The representatives of private providers feel that they have limited resources and lack the training which might improve their quality of services.

7. Perception of Government Health Policies

Regarding the government policy on health, different stakeholder groups have provided critical responses. The response from the political group acknowledges a number of favorable policies undertaken by the Madhya Pradesh government, which include policies to prevent private practices of government doctors, decisions to shift surplus doctors from the urban areas to the rural areas, and a mandatory ruling that junior doctors have to serve the rural areas for at least 3 to 5 years. Regarding infrastructure development, the government decided to open a sub-center in every village by the year 2000. During the current financial year, 500 crores[6] has been allocated for improving the primary health care in the state. Medical education has been also given priority and resources to improve the present resource base have been allocated. As far as decentralization of power is concerned, the government has delegated the recruitment of doctors at the primary health center/sub-center levels to the PRIs. The media has responded that the government policy of promoting privatization in some areas of the health delivery system will help improve the efficiency and quality of services.

Representatives of the government have added that integration of health care training with the Integrated Rural Development Program has resulted in community training in preventive and community health under Training for Rural Youth for Self-Employment, Development of Women and Children in Rural Areas, and other schemes. The government is initiating comprehensive training of the JSRs (barefoot doctors) at the gram sabha level, conducting a six-month training program. This will help build a community-based preventive health care system and increase the reach of the government to remote areas to enhance access to services.

Political stakeholders maintain that no special budgetary allocation emphasis is presently being given to maternal and child health. There is no effective policy in existence to integrate and coordinate different departments in an effort to develop a maternal and child health program. It has been also been pointed out that many government policies that facilitate or promote family programs are not practical and do not consider the diversified culture and system of the rural community.

Regarding decentralization of policy, the government has still not delegated enough responsibility, in terms of executive power and resources, to the PRIs to make them effective. It has been pointed out that, at present, no priority and specific allocation has been made for maternal and child health in the village panchayat budget. The representatives have pointed out that the problem of overlapping of services or legality of practices by the different medical practitioners (e.g., allopathic, homeopathic) needs to be sorted out by the government. It has been expressed that there is no effective policy from the Madhya Pradesh government to empower the NGOs or to integrate their views into the policy formulation and program implementation processes. Some representatives of medical stakeholder groups have criticized the government for its target-based approach and coverage, which is not sensitive enough to the community needs. They have also emphasized the need for incorporating the perceptions of the people and institutions involved directly with the community and health delivery system for more realistic and effective planning. The same has been expressed by some representatives of the private providers group. Some at the

[6] 1 crore = Rs. 10,000.00

government health institutions have emphasized the need for delegating more administrative and executive power to the PRIs to make them more effective.

The following proposed policies have been suggested by the different stakeholder groups at the *state level* to support the effective implementation of the WACH Project.

The government should have policies to strengthen the human resource base and its technical skills in maternal and child health as follows:

- *The government should take up specific policies to promote NGO participation, especially those smaller NGOs who are working at the grassroots level. The legal proceedings and bureaucracy should be minimized to facilitate their active participation.*

- *The project should be integrated or linked with other bilateral and multilateral programs, such as the World Bank-aided program that strengthens ICDS centers.*

- *Women need to be included not only as a special target group, but also in all aspects of program implementation.*

- *Government should take particular interest to promote traditional and other Indian systems of medicine.*

- *If WACH is to be implemented through NGOs and private providers, they should be given complete autonomy as far as formulation of implementation policies is concerned. The state should act as an advisor rather than a controlling authority.*

- *There is a ban on the health workers and practitioners who do not have a medical license to administer scheduled drugs. But, in the case of the WACH project, some of the service delivery and preventive health care are to be assumed by local health workers and practitioners who do not have a medical license, including administration of tetanus vaccine and other scheduled drugs. This dichotomy needs to be addressed in the future health policies.*

- *Government policies should give more emphasis to empowering and training the existing mechanisms, including PRIs, before delegating responsibilities to them.*

- *Collaboration among the government health delivery system at the gram sabha level rather at the zila (block) parishad level needs to be clearly worked out.*

- *The government should constitute a separate unit of the state's system to check up, monitor, collect feedback, and provide back-up support to health delivery services.*

Stakeholders at the *district and block levels* have suggested the following policies for the effective implementation of WACH:

- *The rural health delivery staff and schemes related to health are under the control of the block panchayat, which lacks the capacity to handle them. They should either be trained or the responsibility should be revert back to the district administrations.*

- *The government should ban private practice of government doctors and under-qualified medical practitioners (e.g., quacks, ojhas[traditional healers]).*

- *At present, the health system is too centralized. There needs to be a shift towards collaboration with other partners (e.g., NGOs, private providers) who are also involved in health. The government should follow the Gujarat model of health service delivery by establishing a partnership between government and NGOs or private providers to strengthen the existing system.*

- *The government should have a clear policy regarding RMPs and quacks. At present, it is very unclear. They should be properly trained and provided with back-up support.*

- *There is a need for a clear policy about the involvement of private providers.*

- *Government doctors should be allowed to charge patients some fees.*

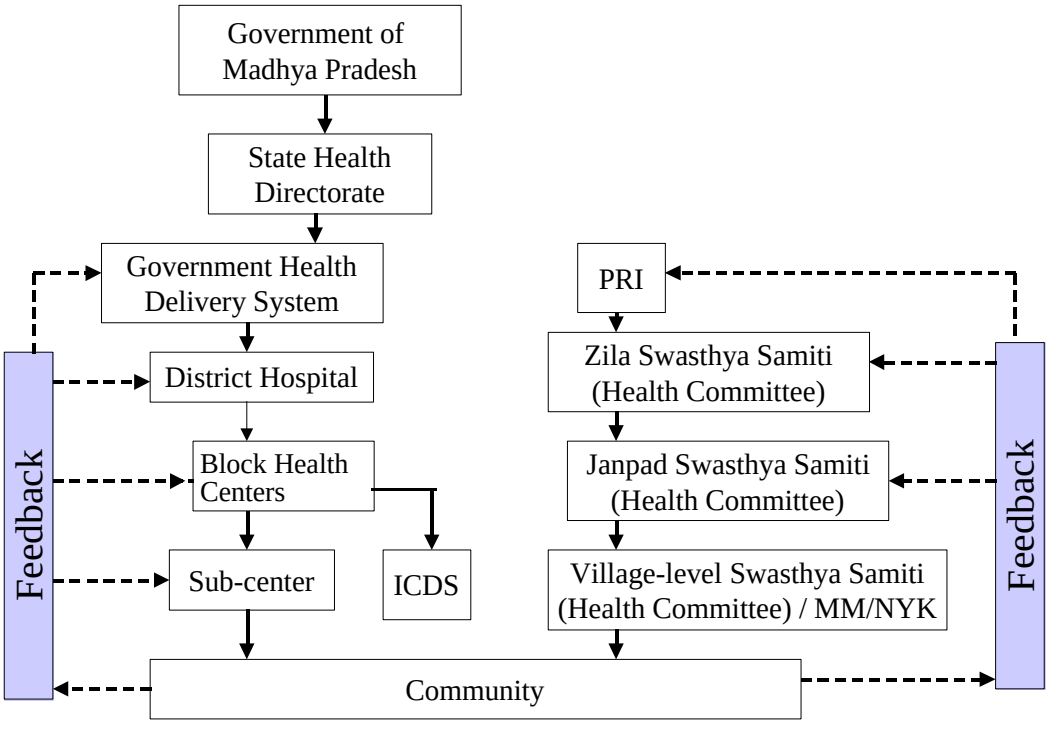
- *There should be a provision to monitor governmental activities.*

8. Preferences for WACH Implementation Mechanisms

An overall view of the different mechanisms for implementation expressed by the stakeholder groups can be represented as three alternative models, with varying degrees of collaboration with the different partners.

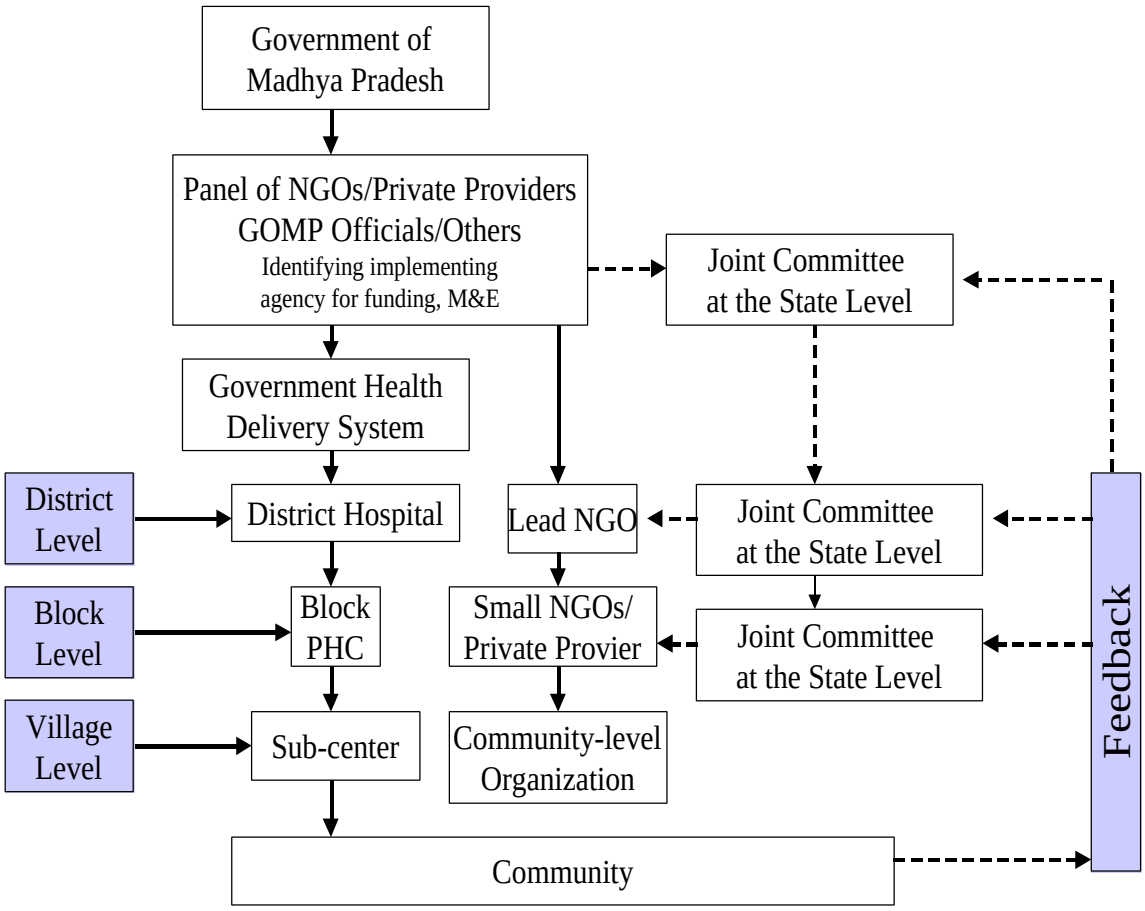
- *The first model can be called the **Government–Government/PRI** partnership model, in which the project would be implemented through the existing government health system along with the PRIs, i.e., through PRIs units and health committees (Swasthaya Samitis) at the district, block, and village levels. An empowered committee can be formed by the government, and concerned departments can be involved at the state level to facilitate the processes. The curative aspect of the health system will be implemented by the government system through the district hospital, block primary health centers, village-level sub-centers, and ICDS centers. The PRIs, along with their district, block, and village health committees (ZSS, JSS and VSS) and the mahila mandals and the Nehru Yuvak Kendra (NYK) would be responsible for implementing the preventive and referral aspects of health, including awareness-raising, health education, and community participation activities. The public health delivery system will supervise, monitor, and fund the whole program. At the grassroots level, supervision and monitoring can be also done by PRIs.*

Figure 8-1
MODEL I. Government–Government/PRI



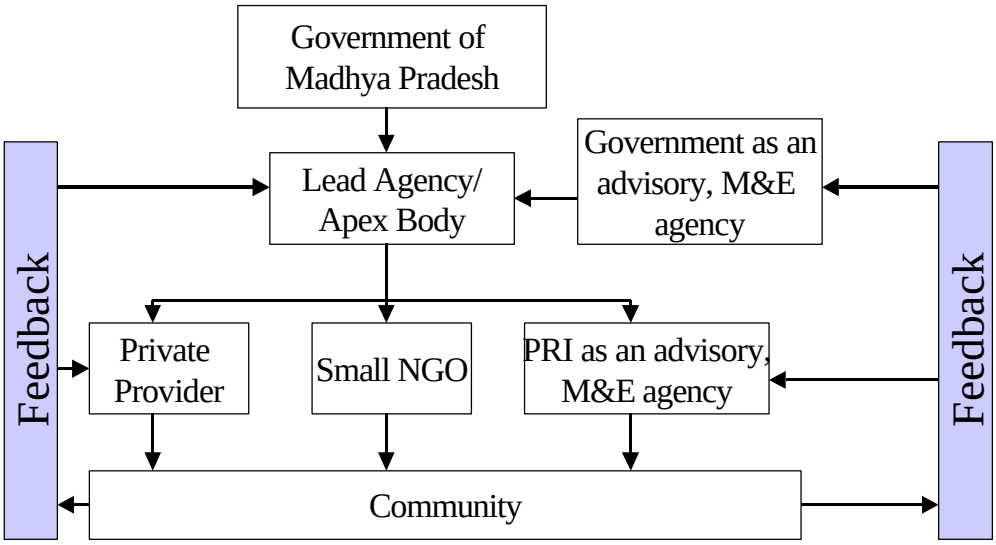
- *The second model is the **Government–NGOs/Private Providers** partnership model, in which the program would be implemented jointly by the existing government health delivery system, as well as through the NGOs and private providers. Several variations of this model have been also suggested, including formation of a joint Project Advisory Committee (PAC)/apex body at the state, district, and block levels with representatives from concerned government departments, NGOs, and other partners (e.g., private providers). This joint PAC would implement WACH activities through the existing government system as well as NGOs and private providers. Another variation would be to implement the project simultaneously by the health directorate through the existing government health system and lead NGOs/apex NGOs consortium at the state level. This NGOs would implement the programs through smaller NGO groups and private providers at the district level and below. Regarding delivery of services, the government would be mainly responsible for the curative aspect of health, while NGOs and private providers would be responsible for preventive and referral services as well as training, research, community participation, and health education, along with the government.*

Figure 8-2
MODEL II. Government–NGO/Private Providers



- *The third model is the **NGO–NGO/Private Providers** model, in which the responsibility of the project implementation will be entrusted to a lead NGO at the state level. The government system should only be in the advisory capacity. The lead NGO would be implementing the program through smaller NGOs and private providers at various levels (i.e., district, block, and village) in coordination with the existing government health delivery system. The responsibility of the total health delivery system will be entrusted to the NGO, who will be delegating the various activities and responsibility of health service delivery to its different implementing partners.*

Figure 8-3
MODEL III. NGO–NGO/Private Providers



Regarding funding mechanisms, two major alternatives have been suggested by the different stakeholder groups. The first alternative is that funding to the different implementing agencies should be routed through government only. To facilitate the processes, there can be a special committee at the state level, who would have the responsibility for fund disbursement, monitoring, and evaluation. A variation of this model suggests that instead of a government-empowered committee, a joint PAC may handle this issue. The second mechanism suggests that funds from the state government may bypass the present government system and could be given directly to the implementing agencies. A variation of this model suggests that funds can also be given to an NGOs/apex body at the state level, which would be responsible for the disbursement of funds to implementing partners. Details and variations of the three models and two funding mechanisms are given in the second document of the WACH stakeholder analysis.

8.1 Views of State-level Stakeholders on Possible Implementation Mechanisms

If we analyze the responses of various groups, it can be observed that, among political stakeholders, the majority have been in the favor of the Government–NGOs partnership (Model II), while a few favored the Government–Government/PRI partnership (Model I), or NGO–NGO/Private Providers partnership (Model

III). The representatives of the bureaucratic group also strongly favored Model II. A number of them favored Model I, while only one representative supported Model III.

NGOs have strongly supported Model III, with NGOs as lead agency. A few have supported Model II, but no NGOs representatives have supported Model I. A majority of media/other stakeholder groups support Model II, while a few of them also suggested Model I for effective implementation. None of the media representatives have favored the lead NGO model, Model III.

Government health institutions have strongly supported Model I, and only one representative favored Model II. They have all expressed strong reservations regarding the idea of Model III, a NGO-NGO/Private Provider model of implementation, noting the poor accountability of the NGOs and private providers. The private providers have strongly suggested Model III. One stakeholder suggested Model II. Like the representatives of the NGOs, this group expressed reservations regarding the idea of implementing the program through the government and PRIs system (Model I).

Thus, the overall suggestion from the different groups at the state level shows that a majority of representatives are in favor of the Government–NGOs partnership (Model II) because of its flexibility and innovation, as well as possibilities of different collaborative mechanisms among the partners. A joint effort also can be useful in proper program monitoring, evaluation, and implementation. But most have suggested that the government and NGOs collaboration should be more at the state and district levels, whereas regarding the field-level implementation, they should operate parallel to each other and as autonomous units. Almost all groups have strongly recommended this model, especially the bureaucrats, political and media/other groups. Regarding the other two models, i.e., Government–Government/PRI and NGO–NGO/Private Providers, the first was suggested by the bureaucracy, government, and media, but the NGOs and private providers expressed strong reservations. The NGO–NGO/Private Providers (Model III), however, was recommended by the NGOs and private provider groups.

Regarding funding mechanisms, the first mechanism of funding, i.e., government through a special committee, has been suggested by most groups because of its flexibility and higher accountability, while the other model of direct funding or funding through an apex body/lead NGOs was supported by fewer respondents mainly because of minimal accountability and problems in monitoring.

The following table shows the choices of different models made by the representatives of the various stakeholder groups.

Table 8-1
Stakeholder Group Preferences for Partnership Models

Stakeholder Level	Stakeholder Group	Model I Government-Government/ PRIs/NGOs partnership (# of responses)	Model II Government-NGOs/ PRIs/Private Providers partnership (# of responses)	Model III NGO-NGO/ PRIs/Private Providers partnership (# of responses)
STATE	Political (including PRIs)	1	4	1
	Bureaucracy	3	6	1

Table 8-1
Stakeholder Group Preferences for Partnership Models

Stakeholder Level	Stakeholder Group	Model I Government-Government/ PRIs/NGOs partnership (# of responses)	Model II Government-NGOs/ PRIs/Private Providers partnership (# of responses)	Model III NGO-NGO/ PRIs/Private Providers partnership (# of responses)
	NGOs	0	2	4
	Media/Others	2	4	0
	Government Health Institutions	2	1	0
	Private Providers	0	1	2
Overall State Total		**8**	**18**	**8**
DISTRICT and BLOCK	Political (including PRIs)	4	3	0
	Bureaucracy	5	4	0
	NGOs	1	3	1
	Government. Health Institutions	3	3	0
	Private providers	1	6	0
Overall District and Block Total		**14**	**19**	**1**
TOTAL		**22**	**37**	**9**

8.2 Views of District- and Block-level Stakeholders on Possible Implementation Mechanisms

At the district and block levels, the political stakeholder representatives suggested both the model of Government–Government/PRIs (Model I) as well as the Government–NGO/Private Providers partnership (Model II) for implementation of WACH. The representatives emphasized that, while the responsibility of implementation should be in the hands of government only, the supervision of the health delivery system would be through one PRI. The role of NGOs and private providers should be limited to awareness-raising, community participation, and providing preventive services at the community level. Similar mechanisms of implementation are suggested by the bureaucracy and government institutions. Some government health institutions emphasized that the district hospital could be the coordinating center for all the activities to be implemented at the district level, could also provide training support on technical issues, and undertake monitoring of the activities.

A number of the NGOs and private providers emphasized the need for a clearer definition of the roles of all the project partners, while suggesting a collaborative model of government, NGOs, PRIs, and private providers for implementation of WACH (Model II). They also emphasized the need for a joint committee both at the state and district levels to coordinate, manage, and monitor the program. Regarding training, the role of the government health department as well as qualified private providers for technical support has been emphasized. It is also suggested that PRIs, private medical practitioners, and NGOs should be especially involved in the training of the grassroots-level workers.

It is suggested that funding should be administered through the existing system, and the funding department should be responsible for monitoring. Some have suggested that Panchayat and other implementing partners should be given some funds directly from the state government to assume health initiatives.

The responses of the stakeholder groups suggest that, like the state-level groups, a majority are in favor of the Government–NGOs partnership model (Model II), with strong PRI involvement. They feel that the possibilities of collaboration, flexibility, and innovation involving this mechanism will help towards better program implementation at the community level. NGOs and private providers strongly recommend this model. Interestingly, unlike the representatives of the political bureaucracy, the group at the state level and their respective representatives at the district and block levels do not recommend Model II. This may be due to very little involvement of NGOs in health in this district. District and block-level government officials (the bureaucracy, along with government institutions and a majority of the PRIs) suggested Model I, with limited involvement of NGOs. In contrast to the state-level perception, we have only one representative from the NGOs group who has emphasized Model III for WACH implementation. All other representatives from other groups ruled out this model of implementation, especially at the district level.

8.3 Major Advantages and Limitations of the Proposed Models

The major advantages and disadvantages of the three models, emerging from discussions with the stakeholders, are the following:

8.3.1 Model I: Government–Government/*Panchayati Raj* Institutions

Advantages

Due to the well-established paramedical staff and infrastructure for referral services, access to services can be enhanced with available funds from WACH.

- *In the state, PRIs have been provided with greater responsibility for monitoring the public health delivery system; thus, PRIs can find a meaningful role under WACH as it will provide them a chance to demonstrate their capacities.*

- *Since a number of important ministers in the state government are supporting the PRIs, and the bureaucratic lobby is equally strong in this state, Model I is perhaps the best option, as it is suitable for both of the most influential groups, and would ensure their support.*

- *Since PRIs would be a major player in the implementation process, some concerns and interests of the community would be also fulfilled through their involvement, such as social monitoring and decentralization of power at the grassroots level.*

Disadvantages

The existing government health delivery system is perceived as inefficient, as maximum resources (i.e., proportion of funds) are channeled towards meeting salaries and expenses of the staff. Therefore, no significant improvement in enhancing access to services or quality of services can be achieved by investing energy and resources in this system.

- *PRIs have yet to gain credibility, as their quality of governance is still doubtful. Moreover, whether existing controls of the government will allow them to function independently as effective units is questioned.*

- *Because PRIs are politically biased in this state, with strong components of caste and class influencing the decisions, there is more likelihood that they will have strong conflicts with the different political leaders (i.e., ministers), as well as their bureaucratic counterparts.*

- *Since the present model does not assume any role of NGOs and private providers, it will not be able to integrate these important stakeholders within the implementation system. Moreover, it will broaden present conflicts between stakeholder groups.*

8.3.2 Model II: Government–NGOs/Private Providers

Advantages

It is perceived to strike a good balance of accountability and flexibility, so the government can utilize its existing experience and system to enhance accountability. NGOs can experiment with innovative designs, as envisioned under WACH.

- *NGOs presence is limited in the project districts, so combining the public health delivery system with NGOs initiatives will fill the gaps. NGOs can be promoted meaningfully to strengthen and prepare them to take up health-related programs in the long term.*

- *A good mix between the three important stakeholder groups will lead to more synergy and integration, thus benefitting the most important stakeholders, i.e., community members in the long term.*

- *Since private providers are one of the important players in the health delivery system, a more flexible approach will give them extra space for operating, and the government, with its expertise and manpower, can add more value to their accessibility and quality of services.*

- *A healthy, competitive atmosphere can be created between all three major actors in the health delivery system by eliminating conflict and contradiction, thus strengthening the presently much-constrained demand side of the health delivery system.*

Disadvantages

The stereotypical functioning and procedural rigidities will be transferred to the fund management and project administration structure created within the government. This will deter good NGOs from being associated with WACH. Similarly, private providers will find it difficult to meaningfully collaborate in a government-led project.

- *The government's overpowering systems and procedures have the potential threat of converting an innovative project into a government-type project, ultimately affecting the basic spirit of WACH.*

- *There is always a potential risk of confrontation and contradiction between the three major players in the health delivery system. The bureaucratic and political lobby are much stronger and might try to overwhelm the other partners (which are weak in this state), thus putting the program in jeopardy.*

- *Strong groups with vested interests might emerge within these combined operating partners, and might try to create rifts and conflicts between these three unequal partners.*

8.3.3 Model III: NGO–NGO/Private Providers

Advantages

Considering the enormous investments, the existing public health delivery system will continue through planned government funds and WACH resources can have greater value addition, promoting NGOs and private providers initiatives. A good lead agency can effectively substitute for the accountability role of the government.

- *Private providers have taken an important role in meeting the growing demand for health services. The model will constructively utilize the potential of private providers to promote WACH objectives. Private providers will more easily relate with NGOs than with the government.*

- *Community-based groups of voluntary organizations as well as PRIs will be helpful in creating community-based systems of maternal and child health.*

Disadvantages

The model heavily depends on the performance of the lead NGO. It is difficult to find an ideal NGOs to play this role in MP.

- *The model isolates the public health delivery system as well as the other initiatives of the government.*

Therefore, the possibilities of converging programs for improving the quality of services related to WACH will be restricted.

- *Since the present model does not provide any lead role for the government and PRIs, it will not be able to integrate these important stakeholders within the implementation system. Moreover, it will broaden the present conflicts between these groups.*

- *Strong groups with vested interests might emerge within these operating partners, and, since the bureaucratic and political lobbies are much stronger in this state, they might try to impose their will on these unequal stakeholder groups and jeopardize the program.*

9. An Assessment of WACH Stakeholders: The Balance Sheet

9.1 State Level

The following analysis explains the overall views expressed by stakeholder groups on issues related to the proposed strategy of the WACH Project.

Regarding technical objectives/activities under WACH, strong support has been expressed by all state-level stakeholder groups and none have shown any concern or opposition. As can be seen from the following table, political stakeholders as well as bureaucracy, NGOs, and private providers have expressed moderate to strong support for technical objectives, while the media and government have expressed mixed reactions.

Table 9-1
Level of Support of Different Stakeholder Groups at the State Level for the Technical Objectives and Activities of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL	Strong Moderate Limited Weak Neutral	4 2		The majority of stakeholders show strong support, while a number of them remain neutral.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	6 3 1		Almost all of them have moderate to strong support in this aspect.
C) NGOs	Strong Moderate Limited Weak Neutral	5 1		Almost all of them have moderate to strong support in this aspect.
D) MEDIA/OTHERS (Including academic and research institutions)	Strong Moderate Limited Weak Neutral	 2 2 2		No clear trend can be analyzed. This group expressed mixed feelings, varying from neutral to moderate support.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	2 1 2		Though they have expressed mixed feelings, overall there is moderate to strong support.
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	3		Very strong support has been expressed.

Table 9-1
Level of Support of Different Stakeholder Groups at the State Level for the Technical Objectives and Activities of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
G) OVERALL	Strong Moderate Limited Weak Neutral	20 7 2 5		Overall, strong support has been expressed by all stakeholders in this group. None have shown any concern or opposition to this issue, but a number have taken a neutral stand.
OVERALL TOTAL		34		

To determine the proposed implementation mechanism, a clear demarcation can be traced between the views of the government institutions and the bureaucracy, NGOs, and private providers. While the bureaucracy has expressed limited to moderate support to the overall implementation mechanism, very strong support has been expressed by NGOs and private providers. Representatives of the government have mentioned some reservations towards the proposed implementation strategy. Political, media, and other stakeholders expressed a varying degree of support for the proposed implementation mechanism, while only a few of them have articulated some reservations. Observations for each stakeholder group are presented in the following table.

Table 9-2
Level of Support of Different Stakeholder Groups at the State Level for the Implementation Mechanisms of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL	Strong Moderate Limited Weak Neutral	1 2 2 1		Unclear, mixed feelings have been expressed, which show a range of support from weak to strong.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	1 3 4 1	1	Shows weak support on the implementation strategy. Some opposition to the idea is also expressed.
C) NGOs	Strong Moderate Limited Weak Neutral	3 3		Very strong, positive support has been expressed by this stakeholder group.
D) MEDIA/OTHERS (Including academic and research institutions)	Strong Moderate Limited Weak Neutral	2 2 1	1	Mixed feelings expressed but, overall, moderately strong support, with some opposition.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	 1	1 1	Strongly opposed to the proposed implementation mechanism. Limited or no support has been extended.

Table 9-2
Level of Support of Different Stakeholder Groups at the State Level for the Implementation Mechanisms of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	3		Very strong support has been expressed regarding the implementation process
G) OVERALL	Strong Moderate Limited Weak Neutral	10 10 7 1 2	1 3	Clear demarcation can be seen between the views of the bureaucracy and government institutions, and the NGO and private providers. While the former expressed very strong opposition to the overall implementation mechanism, very strong support has been expressed by NGO and private providers. Political and media stakeholders did not express any clear inclination, although a number showed limited to moderate support.
OVERALL TOTAL		30	4	

An overall assessment shows that strong support for NGOs' role in implementation has been reflected by the political, NGOs, private providers, and government institutions. There is strong opposition expressed by some stakeholders from the bureaucracy and "media/other" group on NGO capacities, weak presence, and accountability. Detailed analysis of the stakeholder groups shows that private providers and NGOs, as well as the government, strongly support the role of NGOs in the WACH implementation process, while mixed reactions have been expressed by the bureaucracy, political, and media stakeholder groups. A detailed analysis of all groups is represented in the following table.

Table 9-3
Level of Support of Different Stakeholder Groups at the State Level for the Involvement of NGOs under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL	Strong Moderate Limited Weak Neutral	3 2 2		Expressed mixed feelings about NGO participation. The overall expression shows that they have more or less supported their participation.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 5 1	1	Very mixed feelings. An overall assessment shows that, although they have expressed moderate support for NGO participation, they have also opposed it.

Table 9-3
Level of Support of Different Stakeholder Groups at the State Level for the Involvement of NGOs under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
C) NGOs	Strong Moderate Limited Weak Neutral	4 1	1	While there is obvious strong support shown by the category, some opposition and only limited support has also been expressed.
D) MEDIA/OTHERS (including academic and research institutions)	Strong Moderate Limited Weak Neutral	4	2	Contradictory views expressed by this group. There is a strong support for their inclusion, while there is substantial opposition expressed as well.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	2		Strong support expressed by this group regarding NGOs inclusion in the implementation process.
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	3		Very strong support has been expressed.
G) OVERALL	Strong Moderate Limited Weak Neutral	19 7 2 1 1	3 1	An overall assessment shows that strong support for NGO's role in implementation has ben expressed by political, NGOs, private providers, and government institutions, but there is also some strong opposition from media/other and bureaucracy
OVERALL TOTAL		30	4	

Regarding the proposed participation of private providers in WACH, an assessment shows that mixed feelings have been expressed by the different groups of state-level stakeholders. While very strong contradictory views have been expressed both for and against by the bureaucracy and media, very weak support has been expressed by the political, NGOs, and government health institutions. The only strong support has been expressed by the private providers themselves. Detailed observations for each stakeholder group is presented in the following table.

Table 9-4
Level of Support of Different Stakeholder Groups at the State Level for the Involvement of Private Providers under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL	Strong Moderate Limited Weak Neutral	1 3 1	1	Mixed feelings, but the overall expression is that they have very little to limited support for including the private providers.

Table 9-4
Level of Support of Different Stakeholder Groups at the State Level for the Involvement of Private Providers under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 2 1	3 1	Contradictory views and very sharp reaction regarding the proposed role of the private providers, i.e., some are strongly supportive, balanced by an almost equal opposition.
C) NGOs	Strong Moderate Limited Weak Neutral	1 1 3	1	The NGOs have expressed limited support regarding the role of private providers.
D) MEDIA/OTHERS (including academic and research institution)	Strong Moderate Limited Weak Neutral	2 1	2 1	Contradictory views and very sharp reaction regarding the proposed role of the private providers, i.e., some are strongly. supportive, balanced by al almost equal opposition.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	1 1	1	No clear picture emerges. Moderate to limited support with a strong opposition.
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	3		Very strong support.
G) OVERALL	Strong Moderate Limited Weak Neutral	10 5 8 1	6 2 2	A variety of mixed feelings has been expressed by the stakeholders regarding the inclusion of the private providers in WACH. While very strong contradictory views exist, both for and against them, by the bureaucracy and media/others, very limited weak support has been expressed by political, NGO, and government health institutions. The only strong support has been expressed by the private providers themselves.
OVERALL TOTAL		24	10	

Regarding the proposed shift in roles for the public sector as a result of WACH implementation, strong support has been expressed by the NGOs, private providers, political stakeholders, and media. An equally strong opposition has been expressed by the government. The bureaucracy showed a somewhat conflicting view, both in support and opposition to the shift in the role of the government. A number preferred to remain neutral. Following is a detailed analysis:

Table 9-5
Level of Support of Different Stakeholders at the State Level for the Shift in Roles for the Public Sector under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL	Strong Moderate Limited Weak Neutral	3 1 1	1	Mixed opinions expressed. Overall analysis shows that strong support exists in support of the shift, with some opposition.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	 5 1	3 1	Strong conflict expressed. While there is moderate support, there is strong opposition expressed by equally strong members.
C) NGOs	Strong Moderate Limited Weak Neutral	5	 1	A strong support has been expressed for the shift.
D) MEDIA/OTHERS (including academic and research (institution)	Strong Moderate Limited Weak Neutral	2 1 2 1		A mixed picture has been presented; all are supportive, with support ranging from limited to strong.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral		2 1	Very strong opposition expressed.
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	2 1		Very strong support has been expressed.
G) OVERALL	Strong Moderate Limited Weak Neutral	12 7 6 3	6 3	Strong support has been expressed by the NGOs, private providers, political stakeholders, and media, whereas equally strong opposition has been indicated by the government. Bureaucracy has expressed a somewhat conflicting view, both in support as well as opposition. A number also remain neutral on this issue.
OVERALL TOTAL		28	9	

Regarding the proposed role of PRIs in WACH, an overall assessment shows that the majority of the state-level stakeholders have expressed limited support. While the political stakeholders expressed strong views both for and against them, the bureaucracy and NGOs have expressed strong support. The media, private providers, and government have shown limited support to the idea of including the PRIs in WACH activities. A number of stakeholders preferred to remain neutral on this issue. Detailed observations for each stakeholder group are presented in the following table:

Table 9-6
Level of Support of Different Stakeholder Groups at the State Level for the Involvement of PRIs under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A)POLITICAL	Strong Moderate Limited Weak Neutral	3 1	 2	Contradictory views expressed strong support for PRIs' inclusion in WACH, as well as opposition.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 2 4 1		Overall support has been expressed, although it mostly ranges from limited to moderately high.
C) NGOs	Strong Moderate Limited Weak Neutral	2 1 2 1		Overall support has been expressed, although it ranges from limited to moderately high.
D) MEDIA/OTHERS (including academic and research institutions)	Strong Moderate Limited Weak Neutral	1 1 2 1	1	Limited support has been expressed, and limited opposition.
E) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	 1 1	1	Limited support has been expressed, and limited opposition.
F) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	 1 1	1	Limited support has been expressed, and limited opposition.
G) OVERALL	Strong Moderate Limited Weak Neutral	9 6 11 3	3 2	Overall, the majority of stakeholder groups expressed limited support regarding the proposed role of the PRIs. While political stakeholders expressed contradictory strong views both for and against them, a number of stakeholders remained neutral.
OVERALL TOTAL		29	5	

9.2 Block and District Levels

The analysis of perceptions on issues of the WACH implementation strategy was also carried out at the district and block levels, with a different category of stakeholders. The following analysis summarizes the findings regarding the degree of support, concern, and opposition to the overall WACH strategy.

Regarding the proposed technical objectives under WACH, strong support has been expressed by all representatives. The political group especially supported the idea of incorporating maternal and child health, followed by antenatal care and postnatal care. While strong positive support has been expressed by the

bureaucracy, NGOs, and government health institutions, moderate to strong support has been expressed by the representatives of the private providers group. The stakeholders feel that, along with maternal and child health, overall community health should be also taken into account in any program design.

Table 9-7
Level of Support of Block- and District-Level Stakeholders for the Technical Objectives and Activities of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRIs)	Strong Moderate Limited Weak Neutral	7		All are strongly supportive, especially for maternal and child health, followed by antenatal care and postnatal care.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	7 2		The bureaucracy strongly supports the technical objectives.
C) NGOs	Strong Moderate Limited Weak Neutral	4 1		Strong support has been expressed.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	5 1		Strong, positive support has been expressed.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	4 3		Moderately strong support has been expressed.
F) OVERALL	Strong Moderate Limited Weak Neutral	27 7		Overall, the support towards the technical objectives is quite strong, and no representative has shown any concern or opposition to this issue.
OVERALL TOTAL		34		

An overall analysis of the perception of the different stakeholder groups on the proposed implementation mechanisms shows that most representatives have expressed moderate to strong support. Political and government stakeholders have expressed fairly moderate support to the implementing mechanism, stating that referral services should remain with the government system, without any involvement of private providers. A number of representatives of the bureaucracy have also expressed their moderate to limited support regarding the proposed involvement of PRIs and private providers in direct implementation. The NGOs have supported the implementing mechanism fairly strongly, and appreciate its flexible, innovative, and collaborative mechanism. Private providers, however, have expressed their limited support, since they are skeptical towards the proposed collaborative implementation mechanism and feel that the present government system would create problems in their proposed involvement in supporting the health delivery system. Thus, a mutual mistrust and strong differences of opinion regarding each other's role in health exist between government

functionaries and private providers. Representatives of both groups have expressed limited support for a collaborative implementation mechanism, for the WACH program.

Table 9-8
Level of Support of Block- and District-Level Stakeholders for the Implementation Mechanisms of the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRIs)	Strong Moderate Limited Weak Neutral	2 3 2		The political stakeholders expressed fairly moderate support, stating that referral services should remain with the government, supported by private providers.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 4 1 1		Strong to moderate support; limited support has also been expressed. One of the representatives remained neutral on this issue.
C) NGOs	Strong Moderate Limited Weak Neutral	3 2		The NGOs supported the implementation mechanism fairly strongly and appreciate its flexible innovative and collaborative mechanism.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	1 4 1		Moderate support, and concern about involving private providers.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	2 5		The responses towards the implementing mechanism have been moderately strong.
F) OVERALL	Strong Moderate Limited Weak Neutral	11 18 4 1		Overall, stakeholders have expressed a moderately strong support towards the implementing mechanism. Some representatives expressed limited support, because of the mutual mistrust and differences between the government functionaries and private providers. Only one representative maintains a neutral position.
OVERALL TOTAL		34		

An assessment on the role of NGOs in the implementation of WACH reflects that a majority of the representatives have expressed strong support. While some representatives of the political, bureaucracy, and government have expressed limited support regarding their involvement, a few have expressed reservations against them. A majority of these representatives feel that the involvement of NGOs should be limited to awareness-raising and community participation, because of their limited experience in health and weak institutional capacities. This may primarily be due their minimal involvement of NGOs in the Raisen District. In contrast to these views, the representatives of the NGOs expressed moderately strong support regarding the proposed involvement of NGOs, not only in community participation, health education, and awareness-raising, but also in preventive health and referrals.

Table 9-9
Level of Support of Block- and District-Level Stakeholders for the Involvement of NGOs under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRIs)	Strong Moderate Limited Weak Neutral	4 2 1		While a majority of the representatives expressed strong support for NGO involvement, a number have also expressed neutral or limited support, stating that the involvement of the NGOs should be limited to awareness-raising and community participation only.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 3 2	1	Most officials support involvement of NGOs. Some of them have also shown limited support for their proposed involvement, and one opposed their involvement strongly, expressing their poor accountability and lack of experience in the health sector.
C) NGOs	Strong Moderate Limited Weak Neutral	5		Very strong, positive support has been expressed at the block and district levels. NGOs favored for their involvement in community participation, awareness-raising, and health service.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	2 1 2	1	While some officials expressed strong to moderate support, a number of them have expressed their reservations; some support limited NGO involvement. One representative feels that they should not be involved at all in the implementation process.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	3 3 1		While a majority of the representatives express strong to moderate support, one of them expressed his reservation regarding involvement of NGOs, stating their existing limited involvement in health services in this district.
F) OVERALL	Strong Moderate Limited Weak Neutral	17 7 7 1	2	Most representatives support the involvement of NGOs in WACH. While some expressed limited support because of minimal involvement of NGOs in the district, two representatives opposed their involvement, noting their limited institutional capacities and accountability.
OVERALL TOTAL		32	2	

Regarding the proposed role of private providers in the program, while a majority of the representatives have encouraged their involvement, along with the government and NGOs, a number of representatives from the PRIs, bureaucracy, and government have expressed their limited support. A few have expressed their strong reservations regarding the proposed role of the private providers, stating that they have weak capacities, poor accountability, and are exploitative in nature. The representatives of the NGO groups have

emphasized that private providers should be involved in a limited capacity and trained properly before their involvement. Stakeholders from the private providers group, while supporting the proposed implementation mechanism, also wanted their role to be made specific regarding their nature of involvement in WACH.

Table 9-10
Level of Support of Block- and District-Level Stakeholders for the Involvement of Private Providers under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRI)	Strong Moderate Limited Weak Neutral	1 1 2 1 1	1	No clear picture emerges from the views of the representatives of this group. Most expressed their limited to weak support, or even opposed their involvement because of their poor capacities and exploitative nature.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	3 3 1	2	While a majority of the representatives emphasized their involvement, some of them have also expressed limited support or opposition due to poor accountability and their limited/poor services in health.
C) NGOs	Strong Moderate Limited Weak Neutral	2 3		Some strongly support the involvement of private providers. A majority also expressed limited support and emphasized that they should be involved in limited roles and trained properly before their involvement.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	2 2	1 1	A contradictory view has been expressed. While some of them emphasized strong support for their involvement, others expressed only limited support or opposed their involvement.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	4 3		The private providers encouraged their strong involvement in the project implementation, but wanted their role specified.
F) OVERALL	Strong Moderate Limited Weak Neutral	12 7 8 1 1	4 1	While the representatives have expressed a positive response to involvement of private providers, a number of the representatives from the bureaucracy and government health institution groups also expressed their limited to weak support regarding their involvement. A number of them have also expressed their opposition, due to their weak capacities, exploitative nature, and poor accountability.
OVERALL TOTAL		29	5	

As far as the proposed shift in roles for the public sector under this program, moderately strong support has been expressed by a majority of representatives. While a majority of the political, government health institution, and private providers welcomed the decentralization process and the proposed role shift of the public sector, the bureaucracy expressed their moderate support regarding the proposed shift. Some have shown strong opposition and feel that the shift should only be in the fields of awareness-raising, health education, and community participation, and not in the direct delivery of health services. NGO representatives, however, have expressed their full support. They feel that the proposed shift of the government into the advisory capacity would help improve the quality and reach of the health delivery system, especially in terms of preventive and referral services, which should be delivered by other partners.

Table 9-11
Level of Support of Block- and District-Level Stakeholders for the Shift in Roles for the Public Sector under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRIs)	Strong Moderate Limited Weak Neutral	3 2 1 1		Moderately strong support has been expressed by the representatives of this group. While a majority welcomed the decentralization process and proposed shift in role of the government, some have also shown either limited support or neutrality.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	 4 1 1	3	While the bureaucracy expressed its moderate support, a number expressed their strong opposition towards the proposed shift, and it should be limited to awareness-raising and health education and not in the implementation of the health delivery system.
C) NGOs	Strong Moderate Limited Weak Neutral	5		Full support has been expressed by NGO representatives, who feel that the proposed shift of the government to become more like an advisor than a direct implementor would improve the quality and reach of the health delivery system.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	1 1 2 2		While very few have strongly supported this proposed shift, most of the representatives feel that the shift should only be in the fields of health education, community participation, and preventive health. Two representatives expressed neutrality.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	5 1 1		Fairly strong support has been expressed by this group who believe that the implementation of the system should be done primarily by the government and private providers can help only in preventive and referral services.
F) OVERALL	Strong Moderate Limited Weak Neutral	14 8 5 4	3	Moderately strong support to a shift in roles for public sector is evident. While some representatives expressed their limited support, a number of them also expressed neutrality or even opposition to the proposed shift (mainly those from the bureaucracy), stating that the shift should be only in the fields of health education, awareness-raising, and community participation and not in direct delivery of health services.
OVERALL TOTAL		31	3	

Regarding the proposed role of panchayati raj institutions in WACH activities, moderate to strong support has been expressed by majority of the PRIs, NGOs, and private providers. A few representatives and the bureaucracy and government health institutions expressed either limited support of or strong reservations against the proposed inclusion of the PRIs in the implementation process. They feel that the PRIs have not matured enough to take up implementation of health delivery directly because of their limited experience in the various health programs and lack of transparency. They also feel that, due to poor linkages between the block and district as well as vested political interests, the role of PRIs should be limited to community participation and health education activities and monitoring and not include direct health service delivery.

Table 9-12
Level of Support of Block- and District-Level Stakeholders for the Involvement of PRIs under the WACH Project

Stakeholder Category	Degree	Support (# of responses)	Opposition (# of responses)	Observations/Remarks
A) POLITICAL (Including PRIs)	Strong Moderate Limited Weak Neutral	4 1 2		Fairly strong support has been expressed by the stakeholder representatives of this group. Some representatives also expressed limited support of their proposed inclusion in the direct implementation, since they feel the PRIs have not matured enough to take up direct implementation of health.
B) BUREAUCRACY	Strong Moderate Limited Weak Neutral	2 1 2 1	3	No clear perception has emerged from the representatives of this group. A number have expressed limited support or even opposed the idea of the PRIs' involvement because of their inexperience and lack of transparency and accountability. They also feel that, due to poor linkages between the block and district and vested political interests, PRIs should be limited to community participation, health education, and monitoring, not be direct health service delivery.
C) NGOs	Strong Moderate Limited Weak Neutral	3 1 1		Fairly moderate support has been expressed by the group. A majority of them emphasized the importance of PRIs in awareness-raising and supervision of the program at the community level.
D) GOVERNMENT HEALTH INSTITUTIONS	Strong Moderate Limited Weak Neutral	1 2	1 2	Representatives of this group opposed the idea of the PRIs' inclusion. A few expressed limited to moderate support. They feel that their involvement should be limited to community participation, health education, and awareness raising only.
E) PRIVATE PROVIDERS	Strong Moderate Limited Weak Neutral	1 5 1		Moderate to strong support has been expressed by the representatives of this group regarding PRIs' involvement. They feel that PRIs should be involved in supervising and monitoring at the community level.
F) OVERALL	Strong Moderate Limited Weak Neutral	10 9 8 1	4 2	Overall, a very strong support has been expressed by the PRIs, NGOs, and private providers regarding the involvement of the PRIs in program implementation. A few representatives of the bureaucracy and government health institutions oppose their involvement in the direct health delivery because of their limited experience, lack of transparency, vested interests, and political nexus. A majority of them feel that they should be involved more in community participation, health education, supervising, and monitoring at the grassroots level.
OVERALL TOTAL		28	6	

10. Implications Emerging from the Balance Sheet

The stakeholder analysis for the WACH Project should be reviewed using the Importance/Influence Matrix from Section 2, so as to assess attitudes of a range of stakeholder groups. It is important to understand the groups' stakes in WACH in relation to the larger interests of the project.

The matrix clearly shows that the bureaucracy and the PRIs have considerable influence and importance in the present socio-political environment of the state. The community, however, which is a primary stakeholder, has much importance, but minimal influence. People's elected representatives (i.e., political) have considerable influence on projects like WACH, but have a low impact on decision-making process.

The WACH design has many innovative propositions. The project considers a collaborative relationship of voluntary organizations, private providers, and the government health delivery system. Nevertheless, it proposes that the government should promote rather than provide services, and therefore should generate greater flexibility, power, and resources to voluntary agencies and private providers for implementation of WACH and fulfillment of its objectives. Interests expressed by the stakeholder groups are based on their experiences, socio-political conditions, and respective group interests.

Analysis of the balance sheet clearly reveals that the stakeholder groups agree on technical objectives of the project, as the existing health status of the state is below the national average. Serious contradictions emerge in opting for more collaborative implementing mechanisms. The bureaucracy and government have expressed weak support, especially towards the involvement of voluntary agencies and private providers in the health delivery system. Such involvement is viewed as a threat to the existing mechanisms of health delivery and would involve a greater sharing of resources with the other competitive institutions. Overdomination of the government infrastructure, network, and well-established systems also creates limitations among many stakeholder representatives who want to look beyond the existing mechanisms and experiment with new ones. In large and powerful systems, redefinition of roles and collaboration with other agents does not happen easily. Therefore, we find that the bureaucrats and government do not support equal partnership with NGOs and private providers.

Stakleholder groups are beginning to realize that the existing government health delivery system can cater to a selected segment of the population at the grassroots level. Weaknesses of the system are being expressed in terms of coverage, timely response to community needs, and access to services for poor and disadvantaged sections. Therefore, political representatives, communities, and NGO strongly favor the implementation mechanism of WACH and greater involvement of NGO and private providers. Some stakeholder groups that are neutral to the health delivery system, particularly the media and academic institutions, have acknowledged that health services required at the community level are simpler and less technical. A good network of locally trained staff is needed to promote the objectives of WACH; therefore, voluntary organizations and private providers should be actively involved in project implementation. There is a need to develop a cadre of trained health workers at the community level to deal with preventive maternal and child health. Participation of NGOs in large-scale programs is discouraged because they have weak capacities and their responses are based more on perceptions and limited experiences rather than on realities.

Panchayati Raj Institutions in Madhya Pradesh have been actively involved in managing many development programs related to health and education. Under a recent initiative to transfer power to local-level democratic institution, PRIs have decision-making power for the health structures created by the government at the district level and below. There are pleasant and unpleasant experiences associated with PRIs. Changes in the political structure, including the Panchayati Raj Amendment, have created conditions for state assembly and Parliamentary representatives, as well as the bureaucracy, to share their power with local-level democratic institutions. Similarly, NGOs are finding themselves in a difficult position to redefine their roles, as panchayats are being empowered to plan and run their own development projects. Therefore, the responses of the stakeholder groups on the issue of involvement of PRIs in WACH Project implementation are mixed. Strong opposition is perceived from the bureaucracy and government health institutions, which are gradually losing their control and power in favor of the local self-governance institutions. Involvement of PRIs is questioned because of its weak capacities in planning, implementation, and monitoring of development programs.

Since the bureaucracy controls the allocation of resources available to the WACH Project participants, it is quite strong. The fact that the bureaucracy receives bilateral/multilateral project funds and controls the initial allocation of these funds strengthens their ability to influence WACH mechanisms, objectives, and interests. The PRIs have considerable of political resources at the local level and can provide financial as well as human resources for greater successes of WACH, using their recently attained power. The people's representatives, i.e., political stakeholder group, can mobilize resources to influence the bureaucracy regarding policy decision-making; however, in the history of development projects, people's representatives have never mobilized their support to influence the operational policies of large-scale development projects. Therefore, their resources may not be adequate to influence the interests of WACH.

NGO and private provider resources are insufficient to influence the operational effectiveness of WACH. The NGOs as federations are weak in the state, which can influence WACH to tilt the balance in favor of voluntary efforts. NGOs' resources are insufficient to design and implement the WACH Project, and NGOs' influence too weak to influence the role that the government plays in WACH. The media can critically and objectively analyze the implications of WACH and create a strong people's consensus regarding the interests of WACH at the state and local levels. The media have distanced itself from serious development issues, and would not be able to utilize its resources to influence policies related to WACH. Given good direction and support, however, the media can be an important stakeholder group to provide information about WACH from a critical angle and influence policy decision-making at the state level.

The stakeholder analysis shows that the bureaucracy and government would mobilize their resources to ensure control over WACH funds, and over policies resulting from NGO and private provider collaboration. Therefore, implementation of WACH design without creating mechanisms for broad-based consultation, and without encouraging representation of important stakeholder groups in the decision-making process, would fail to address the spirit of collaboration with NGOs and private providers and fail to achieve the goals of the project.

Table 10-13
Summary Balance Sheet of Support of Stakeholders at the State, District, and Block Levels for Proposed WACH Project Strategies

Issues of WACH Implementation	State-Level Response				District/Block-Level Response				Overall Observations			
	Degree*	Support	Opposition	**Remarks**	Degree*	Support	Opposition	Remarks	Degree*	Support	Opposition	Remarks
Technical Objectives	S M L W N T	20 7 2 5 34		Overall, strong support has been expressed by all the stakeholders in this group and none have shown any opposition to this issue. A number of stakeholders have also taken a neutral stand.	S M L W N T	27 7 34		Overall, the support towards the technical objectives is quite strong, and none have expressed opposition to this issue.	S M L W N T	47 14 5 66		Both the state and district level stakeholder representatives have expressed a strong support towards the technical objectives of WACH. None have shown any concern or opposition regarding this issue emphasizing that women and children's health is one of the major concerns in this state.
Implementation Mechanisms	S M L W N T	10 10 7 1 2 30	1 3 4	Clear demarcation can be seen between the views of the government/bureaucracy, government institutions, and NGOs and private providers. While the former have expressed very strong opposition to the overall implementation mechanism with little or no support, very strong support has been expressed by the NGOs and private providers. The political, media, and other stakeholders did not express any clear inclination, though a number have expressed limited to moderate support.	S M L W N T	11 18 4 1 34		Overall, the stakeholders have expressed moderate to strong support towards the implementing mechanism. Some stakeholders have expressed limited support to the proposed implementation mechanism. This is due to the mutual distrust and differences between the government functionaries and private providers. Only one representative maintains neutrality regarding this issue.	S M L W N T	21 28 11 1 3 64	1 3 4	There is a difference between the state-level representatives' views and the district or block level representatives' views regarding incorporation of NGOs, private providers and PRIs in the direct implementation process (especially by the bureaucracy and government health institution representatives at the state level). An overall assessment of all the stakeholders' responses shows that there is a moderately strong support for the proposed WACH implementing mechanism.

Table 10-13
Summary Balance Sheet of Support of Stakeholders at the State, District, and Block Levels for Proposed WACH Project Strategies

Issues of WACH Implementation	State-Level Response				District/Block-Level Response				Overall Observations			
	Degree*	Support	Opposition	**Remarks**	Degree*	Support	Opposition	Remarks	Degree*	Support	Opposition	Remarks
Emphasis on NGOs involvement	S M L W N T	19 7 2 1 1 30	3 1 4	An overall assessment shows strong support for NGOs' roles has been expressed by the political, NGOs private providers, and government institutions. There are also some strong oppositions expressed by media/other groups, including bureaucracy.	S M L W N T	17 7 7 1 32	2 2	Most representatives support the involvement of NGOs in WACH. Some expressed limited support because of poor/limited involvement of NGOs in health in the district. Two representatives opposed their involvement, voting their limited institutional capacities and accountability.	S M L W N T	36 14 9 1 2 62	5 1 6	An overall assessment shows that there is a strong support for involvement in this program. A few of the representatives, especially from the bureaucracy and media, also expressed some reservations against NGOs' involvement because of their limited experience in health service delivery and their poor image of institutional capacities and accountability.
Emphasis on Private Providers involvement	S M L W N T	10 5 8 1 24	6 2 2 10	An overall assessment shows that a variety of mixed feelings have been expressed by the stakeholders regarding the inclusion of the private providers in WACH. While very strong contradictory views have been expressed both for and against them by the bureaucracy and media/others, very limited and weak support has been expressed by the political, NGOs, and government health institutions. The only strong support is from the private providers themselves.	S M L W N T	12 7 8 1 1 29	4 1 5	While most representatives have expressed support for the proposed involvement of private providers, a number of representatives from the bureaucracy and government group have also expressed their limited to weak support regarding their involvement. A number expressed their opposition to their proposed involvement in the project, due to weak capacities, exploitative nature, and poor accountability.	S M L W N T	22 12 16 2 1 53	10 3 2 15	While the state-level stakeholders show a strong contradictory view both for and against their proposed involvement in this program, there is a more positive support from the district and block level stakeholder groups. The majority of the stakeholder who opposed their inclusion are mainly from the political bureaucracy, media, and government health institution groups. They expressed their reservations due to the poor technical skills, exploitative nature, and poor accountability of the private providers in the field of health service delivery.

Table 10-13
Summary Balance Sheet of Support of Stakeholders at the State, District, and Block Levels for Proposed WACH Project Strategies

Issues of WACH Implementation	State-Level Response				District/Block-Level Response				Overall Observations			
	Degree*	Support	Opposition	**Remarks**	Degree*	Support	Opposition	Remarks	Degree*	Support	Opposition	Remarks
Shift in the role of the government	S M L W N T	12 7 6 3 28	6 3 9	Strong support has been expressed from the NGOs, private providers, and political stakeholders, and media; whereas equally strong opposition has been demonstrated by the government health institutions. The bureaucracy has expressed conflicting views both in support and opposition to the shift in the role of the government in WACH. A number are neutral.	S M L W N T	14 8 5 4 31	3 3	Moderately strong support has been demonstrated for a shift in roles in the public sector. Some representatives expressed limited support and a number of them, mainly from the bureaucracy, expressed neutrality or even opposition to the proposed shift. They stated that the proposed shift should be only in the field of education, awareness generation, and community participation, not in direct delivery of health services.	S M L W N T	26 15 11 7 59	6 3 9	A strong reservation has been expressed by the representatives from the bureaucracy from both the state and district level. The overall responses from the other groups have strongly supported the proposed shift in role of the government in this program. The bureaucracy and some of the representatives of the government health institution (state level) maintained that the proposed shift should be only in the field of health education/community participation and not in other areas of health service delivery.
PRIs' involvement	S M L W N T	9 6 11 3 29	3 2 5	An overall assessment shows that the majority of the stakeholder groups have expressed limited support for the proposed role of the PRIs in WACH activities/implementation. While the political stakeholders expressed strong views both for and against them, a number of the stakeholders preferred to remain neutral on this issue.	S M L W N T	10 9 8 1 28	4 2 6	Overall, very strong support has been expressed by the PRIs, NGOs, and private provider representatives for the involvement of the PRIs. A few representatives of the bureaucracy, and especially some in the government health institutions, opposed their involvement in the direct health delivery because they feel that PRIs have limited experience, lack transparency, and have vested interests and political nexus. A majority feel that they should be involved more in community participation and education, and supervising and monitoring at the grassroots level.	S M L W N T	19 15 19 1 3 57	7 4 11	While a moderate to limited support has been expressed by the SH representatives of the different groups, especially from the state level, a majority of them have also felt an importance of their involvement, especially down the district/ block level. The stakeholders from the bureaucracy and government health institutions opposed the PRIs' indirect involvement because of their limited experience in health, as well as for their lack of transparency, vested interest, and political nexus.

*Degree: S-Strong; M-Moderate; L-Limited; W-Weak; N-Neutral; T-Total.

11. Conclusions and Recommendations

11.1 Positive and Negative Forces for WACH

11.1.1 Positive Forces

Various positives forces support WACH objectives and design. All stakeholder groups agree that such a project is extremely important for Madhya Pradesh, considering the low performance rates of the state on maternal and child health. Most stakeholder representatives accept the design of the project and technical inputs. The approach of initiating activities in one district and gradually replicating the approach in other districts has been highly praised.

Stakeholders have recognized the growing role of private providers in health, and, therefore, most support their involvement. Stakeholders other than the NGOs acknowledge the efforts of NGOs in community mobilization and health delivery; have accepted the presence of the government health delivery system and its reach into all possible villages; and recognize the high quality of professional doctors available in the government system. The system is considered to be inexpensive and available in all areas of the state. The role of PRIs in managing health service delivery at the community level has been widely accepted. PRIs can monitor health services as well as build capacities to manage and run community-based preventive health for women and children.

11.1.2 Negative Forces

The government public health delivery system has been labeled as inefficient. Its large size, expenditures in salaries, overhead expense, and unmotivated staff are key weaknesses of the system. Most stakeholders still rely on the state to provide basic health services, and therefore are unable to see the positive role of NGOs and private providers. The NGOs are few and have a limited coverage area. They have, however, been working in remote and neglected areas where the public health delivery system does not reach. It remains to be seen whether NGOs could replace the public health delivery system. Concerns have also been expressed relating to capacities of NGOs in accountability, transparency, and expertise.

Private providers are viewed as profit-making entrepreneurs, contradicting the basic value of service to the poor and marginalized sections of the society so as to improve the quality of life of the people. Their low expertise and skills in providing referral services is unanimously acknowledged. Similarly, PRIs are charged with being corrupt, political, and inefficient. The quality of governance at all the tiers of PRIs is questioned. The community-level stakeholders suggest the development of subcommittees at the village and cluster levels to help remedy this problem.

Overall, the stakeholders see both positive and negative forces for each actor’s efforts to build a collaborative mechanism for WACH. The community, which is the most important stakeholder, considers the most appropriate design to be one that offers them a range of actors, working together for the improvement of women’s and children’s health.

11.2 Prospects for Moving Forward with the WACH Project

The Stakeholders Analysis at the state, district, and village levels, with a cross-section of stakeholders, reflects a positive environment to initiate project activities. The following are the key trends that encourage moving forward with WACH.

11.2.1 The Objectives of WACH

Stakeholders express a general consensus on the overall objectives of WACH, which intends to improve the status of women by improving their quality of life. The project's approach to building interventions during the life cycle of women's health, i.e., from birth to adolescence, married life, and motherhood, is likely to bring about improvement in the status of women. With the grim record of the state in maternal and infant mortality, the interventions are being anticipated with great interest by all stakeholder groups. The groups also realized that WACH objectives are consistent with the overall national or state objectives, which open up possibilities of integration and value-adds being appended to the ongoing effort.

11.2.2 The Design of WACH

Stakeholders appreciate the efforts of USAID in investing resources and energy in project design as well as conducting studies and using their inputs for effective project planning. The concept of a pilot project in a single district and later implementing the approach in the remaining districts is widely accepted. A general consensus emerged that more innovative designs are required, rather than adding the project to the ongoing intervention strategy.

11.2.3 Government–NGO–Private Providers Partnership

With certain reservations from selective representatives, there is a growing demystification of centralized knowledge about health, especially about maternal and child health care. The need was expressed to determine various levels of health care knowledge, which can be provided by trained human resources at the village, block, and district levels. There is a need to involve schools, colleges, private hospitals, cooperatives, clubs, or any form of institution that can help fill the gaps in providing health-related services. The stakeholders favor the state taking an oversight role and promoting more actors, based on their strengths, to fulfill the objectives of WACH and common goals of the state to improve the status of women in Madhya Pradesh.

Considering the fact that very few experiences of collaborative mechanisms exist at the state level, stakeholders welcome WACH with reservations. Most stakeholders found it difficult to look beyond the present set-up of state-run health service delivery. No strong resistance has been found from any group; however, so, with the progress of the project, it is probable that many of the stakeholders will change their views.

The collaborative mechanism needs to be clearly defined, including roles for each agency and mechanisms for support, capacity-building, monitoring, and coordination. The funding mechanism will also determine the nature of and extent of interest and quality of involvement of the various actors in the project.

11.2.4 Funding Mechanisms to Foster Partnership of Actors

Because they define WACH as an innovative design of implementation which involves equal and active participation of the government, NGOs, and private providers, stakeholders believe strongly that funding mechanisms will play important roles in determining the nature of relationship. A knife-edge balance of accountability and flexibility has been noted by the stakeholders, who believe that the government should promote flexible mechanisms of funding. Alternatives discussed in the report state that there should be either an institutional entity within the framework of the government system, or a NGO system should be created with representation from the government, NGOs, and private providers at the state or district level. The executive committee of the institution, which may be a registered society, will have decision-making authority regarding fund management, program planning, implementation, and monitoring, as well as the operational details of project implementation. The committee will also determine partnership norms for NGOs, government, private providers, and PRIs through a consultative process.

11.3 Strategic Issues for WACH and Health Service Partnerships

Several issues were raised by the stakeholders, which have strategic implications for the implementation of WACH project. These are as follows:

11.3.1 Innovation versus Performance

WACH project design reflects many innovative features. For example, it attempts to form a collaboration between the government, NGOs, and private providers. If WACH attempts to focus on innovations, it is an investment with long-term gains. The performance of the project in attaining quantitative goals of reduction in maternal and infant mortality might be affected in the short run. Moreover, concentrated inputs will be required for capacity-building of various actors. It would also imply testing various collaborative models.

Alternatively, WACH can be viewed only as a valuable addition to the existing health delivery system to accelerate improvements of the public health delivery system in the short to medium term. Inputs can be designed to strengthen capacities and systems of the public health delivery and selective NGOs and private providers who are actively involved in women's and children's health services and programs. This approach of attaining high performance will not provide any opportunity for innovation and will involve many well-meaning and potential groups, NGOs, cooperatives, and networks. A large base of such institutions, if they take up the women's and children's health issues on their agenda, will provide long-term sustainability of the program objectives.

11.3.2 In-Depth Quality Inputs versus an Extensive Coverage Approach

The design of the WACH Project highlights improving the quality of services of the health delivery system by capacity-building efforts. Quality inputs can be provided in selected clusters of villages, even in a district, depending on the area of coverage of each agency or organization identified for WACH implementation. Therefore, innovative designs have to be backed up with quality inputs to generate meaningful lessons for replication. WACH can also view a district as a small unit of experimentation, considering the large size of the state. A strategy can be designed for extensive coverage using all possible actors who can be potentially involved in health. This approach might compromise the innovative experimentation and quality of inputs to attain desired performance levels in health.

11.3.3 Complementary versus Substitution Approach

Considering a collaborative model of Government–NGO–Private Providers–Panchayats as key to WACH design, it will be important to determine complementary roles of various actors. In a particular area, block, or village, all three agencies, whichever are available, should work out a plan of implementation based on their core competencies. NGOs are perceived to be strong in community mobilization and awareness-raising, whereas private providers can be helpful in providing emergency services and qualitative advice as well as curative services. Similarly, the government has a well developed network of health workers and intensive immunization program. Panchayats can help develop a sustainable community-based health management system for women's and children's health. Core competencies of various stakeholders and agencies need to be identified, and a comprehensive plan at the block level must be prepared. This approach involves enormous coordination and management of the project teams.

Alternatively, WACH can determine gaps in terms of coverage in the project districts, and such gaps may be assigned to actors other than the public health delivery system. This approach will help enhance coverage of the project and demonstrate relative performance of various actors for wider replicability of the project. Considering the low capacities and coverage of the NGOs and limited interests of the private providers for extensive preventive and community mobilization support, independent handling by each actor in a selected area might be an ineffective solution.

11.3.4 Piecemeal vs. Comprehensive Role

The WACH Project has emphasized a number of components, (i.e., access to services, quality of services, institutional capacity-building, research, monitoring, and evaluation). To design project implementation in a holistic manner, as well as generate meaningful learning from project experiences, certain components of the project should be assigned to selected lead agencies, such as NGOs, government, research and training institutions, in a comprehensive manner. A single agency at the state or district level should be responsible for training, research, or monitoring. A comprehensive plan of action for each component may be prepared by the lead agency, highlighting collaborating organizations and their roles, which should be consistent to the overall strategy of WACH.

Alternatively, based on the core competencies, capacities, and various roles being played by different agencies, distribution of components can be made on piecemeal basis. Many institutions are willing to conduct research or training in technical and community mobilization, depending on their specialization and proximity to the project area. This could enhance the project by enabling a large number of institutions to become involved, or it could constrain the possibility of one entity gaining a rich, holistic experience of managing various components of the project. More realistic and practical combinations for implementing WACH could be determined through a participatory, consultative operational strategy design process.

11.3.5 Summary of Conclusions

The strategic choices closely reflect positions of various stakeholder groups. The NGOs, media, and political groups are in favor of more innovative designs and improved quality of the health services for the people. Therefore, such groups feel that the WACH Project should take risks and implement the proposed design.

The bureaucracy and government argue in favor of the need for better performance and extensive coverage through the existing health delivery system to highlight their commitment to health. Therefore, the vision for the project is to augment their own capacities, utilizing the project as an input for their existing program on health. With major portions of the resources of the existing health delivery system going for payment of salaries and maintenance of infrastructure, a heavy investment in this system will not be an effective strategic choice.

Stakeholder groups outside the bureaucracy and government are looking for alternative designs and mechanisms for health services. Limitations of the government's massive health delivery system is seen in terms of its effectiveness, commitment, and proximity to the disadvantaged sections of the society. Selected stakeholder groups, NGOs, and private providers are willing to take up challenges of experimenting with new and collaborative designs. The NGOs have experimented with community-based health delivery system on a small scale in Madhya Pradesh, and have not received enough attention to provide greater exposure to the people at large on the possibilities of NGOs' involvement in health.

The issues of weak capacities of NGOs or weak professional competencies of the private providers are being used as justification for preventing experimentation with community-based health service delivery. Moreover, mechanisms to promote volunteerism within a government-created outfit for voluntary action are hindered by limitations on collaboration with well-meaning NGOs. Onerous procedural requirements and norms that have been introduced in the name of accountability may squelch the sprit of innovation and experimentation with new alternatives.

Many large-scale programs have realized the advantages of assigning comprehensive roles to one or two organizations or institutions while the experiences bilateral programs shows that multiple levels of subcontracting do not necessarily generate added value or yield positive impacts on the long-term objectives of the programs. In projects like WACH, which has limited coverage and envisions intensive inputs and back-up support, comprehensive roles for various entities need to be identified.

Annex A: List of Stakeholders Interviewed

State Level

A) POLITICAL

Mr. Prem Narayan Thakur, Minister of Health

Mr. Narendra Kumar Nahata, Minister of Human Resource Development

Mr. Ajay Mushran, Minister of Finance

Ms. Jamuna Devi, Minister for Women and Child Welfare

Mr. Madhav Singh Dhruv, Minister for Panchayati Raj & Rural Development

Mr. Derahu Prasad Dhritlahere, Minister for Public Health, Planning, and Environment

B) BUREAUCRACY

Ms. Alka Sirohi, Secretary, Women and Child Development

Mr. Sumit Bose, Secretary, Health Education

Mr. N.B. Karhelkar, Additional Secretary, PHED

Mr. P.K. Bajaj, Director, Medical Services

Mr. Arun Gupta, Principal Secretary, Panchayat & Rural Development

Dr. T. Radhakrishnan, Commissioner, Women and Child Development

Ms. Snehlata Srivastava, Deputy Secretary, Finance

Mr. P.K. Mathur, Director Public Health and Family Planning

Mr. Shivraj Singh, Commissioner, Health Services

Mr. P.K. Meherotra, Principal Secretary, Health and Family Planning

C) NGO

Mr. M.N. Buch, Director, National Council Human Settlement and Environment (NCHSE), Bhopal

Mr. R.V. Wala, Project Director & Dr. Sanjay Sinha, Programme Incharge, CARE INDIA, Bhopal

Ms. Archana Baudriya, Director, Mahila Samakhya, Madhya Pradesh, Bhopal

Dr. M.S. Phogat, Director, Centre for Rural Development and Environment (CRDE), Bhopal

Mr. Kashina Bhooshnurmath, Programme Coordinator, Lupin Human Welfare and Research Foundation (LHWRF), Bhopal

Mr. Jaspal Washeer, Director, Swastha Sampada, Bhopal

D) MEDIA/OTHERS (Including Academic, Research, and Training Institutions)

Mr. G.S. Date, Director, Local Self-Governance Institute, Bhopal

Ms. Devender K. Uppal, Reader, Makhan Lal Chaturvedi University of Journalism, Bhopal

Mr. Kamal Dixit, Professor & Principal, Makhan Lal Chaturvedi University of Journalism, Bhopal

Mr. M.U. Yadav, Professor, Department of Economics, Barkatulla University , Bhopal

Mr. Umesh Trivedi, Bureau Chief, Nai Duniya (Daily newspaper)

Mr. Mahesh Srivastava, Chief Editor, Dainik Bhaskar (Daily newspaper)

(E) GOVERNMENT HEALTH INSTITUTIONS

Dr. A.K. Agrawal CMO, Jaiprakash Narayan Hospital, Bhopal
Dr. S.C. Tewari, Professor & HoD of Preventive Health & Community Medicine, Gandhi Medical College, Bhopal
Dr. Alok Chaurashia, Director Medical Services and Training, State Training Institute, Bhopal

(F) PRIVATE PROVIDERS

Dr. Gopi Bajaj, President, Private Medical Practitioners Association of MP, Bhopal
Dr. M. Dewani, President, Private Nursing Home and Hospital Association, Dewani Nursing Home, Bhopal.
Mr. Narendra Kumar, Manager-in-Chief, FPAI, Project Management Office, Bhopal

District and Block-Levels Stakeholder Groups

(A) POLITICAL

Mr. Kamal Singh Lodhi, Zila Panchayat President, Begumganj, Raisen
Dr. Gauri Shankar Sezwar, Member of Legislative Assembly, Raisen
Ms. Munni Bai Johare,Vice President-Janpad Parishad, Block-Sanchi, Raisen
Mr. R.P. Thakur, Janpad Parishad Member, Block-Bari, Raisen
Mr. Santosh Kumar Jain, Janpad Parishad Member, Ambedkar Ward, Block-Silwani, Raisen
Mr. Vati Mohammed, Janpad Parishad Member, Block-Sanchi, Village, & Post Umaria, Raisen
Mr. Brijesh Samadhiya, Janpad Parishad Member, Block-Sanchi, Raisen

B) BUREAUCRACY

Dr. G.D. Aggarwal, District Chief Medical Officer, Raisen District
Ms. Alka Upadhyay, Chief Executive Officer, Rural Development, PRI & DRDA, DRDA Office, Raisen
Mr. A.N. Tiwari, District Magistrate & Collector, Raisen
Dr. Kalolkar, Training Officer, District Medical Training Centre, Raisen
Dr.(Mrs) N. Choudhary, District Project-in-Charge, MCH, Raisen
Mr. Sushil Mishra, District Ayurvede Adhikshak, Raisen
Mr. M. Das, Training Officer, District Medical Training Centre, Raisen
Mr. V. P. Srivastava, Block Development Officer, Block- Sanchi, Raisen
Mrs. Kalpana Srivastava, Women & Child Development Officer, Block-Sanchi, Raisen

C) NGO

Mr. Anant Kumar Gangola, District Project Coordinator, Rajeev Gandhi Literacy Mission (DPEP), Raisen
Ms. Sarvar Sultan, Member, District Committee of Nehru Yuvak Kendra, Raisen
Ms. Saraswati Chakre, District-in-Charge/Consultant, Mahila Samakhya District Project Office, Raisen
Mr.Santosh Kumar, President, Oilfed Cooperative Society, Block-Silwani, Raisen
Fr. E. Sebbastian, Director, Rural Development Service Society, Missionary Hospital-Silwani, Raisen

D) GOVERNMENT HEALTH INSTITUTIONS

Dr. N. Patni, Civil Surgeon, District Hospital, Raisen
Dr.Nalini Gaur, Doctor, MCH Department, District Hospital, Raisen
Dr. Sumit Jain, Doctor, District Hospital, Raisen
Dr. A.K. Upadhyay, Doctor-in-Charge, Primary health center-Sanchi, Raisen
Dr. (Mrs.) S. Krishnani. Doctor, Primary health center-Sanchi, Raisen

Dr. Anil Gupta, Doctor, Subcenter, Sanchi, Raisen

E) PRIVATE PROVIDERS

Mr. M Ali, RMP, Doctors Clinic, Raisen
Mr. Saurabh Shrivastava, Saurabh Clinic, Old Bus Terminas, Raisen
Mr. Vasir, Chance Clinic, Raisen
Dr. Shrivastava, BMS, Doctors Clinic, Ganj Bazar, Raisen
Dr. S. C. Gaur, MBBS, Gaur's Clinic, Ganj Bazar, Raisen
Mr. N. L .Sharma, Sharma Medical Store, Dewangunj, Block-Sanchi, Raisen
Mr. Himmat Singh, (Compounder) Dewangunj, Block-Sanchi, Raisen

Community-Level Stakeholder Groups

A) POLITICAL (PRI)

Mr. Bhanupratap Singh, Sarpanch, Village: Partalai, Block-Bari, Raisen
Mr. Roshan Singh, Sarpanch, Village: Dhakna-Chapna, Block-Sanchi, Raisen
Focus Group Discussion with Sarpanch, Panchayat members, youth groups & community members, Village Mudia-Khedi, Block-Sanchi, Raisen

B) GOVERNMENT FUNCTIONARIES (Teachers, ANMs, etc.)

Focus Group Discussion with teachers, etc., Village: Nilgarh, Block -Obaidullagunj, Raisen
NGO/Other groups
Focus Group Discussion with village education committee members, Village: Ghot, Block-Bari, Raisen

C) GOVERNMENT HEALTH INSTITUTIONS

Mr. Ramesh Kumar, Jan Swastha Rakshak, Gram Panchayat: Dhakna-Chapna, Block-Sanchi, Raisen
Mrs. Mona Bai, MPW, Block/ Primary health center–Obaidullagunj, Raisen
Mrs. Seema Willongton, MPW, Block/ Primary health center–Sanchi, Raisen

D) PRIVATE PROVIDERS

Mr. Hari Singh, Traditional Healer, Village: Chapna, Block-Sanchi, Raisen
Mr.B.N. Adhikari, RMP, Deewanganj, Block-Sanchi, Raisen
Mrs. Kanta Bai (Mohan-ki-Bahu), Traditional Dai, Village: Dudhwani, Block-Obaidullagunj, Raisen

E) COMMUNITY MEMBERS

Focus Group Discussion with women members & mothers, Village: Ghurpur, Block-Sanchi, Raisen
Focus Group Discussion with women members & mothers, Village: Dhakna-Chapna, Block-Sanchi, Raisen
Focus Group Discussion with women members & mothers, Village: Dudhwani, Block-Obaidullagunj, Raisen
Focus Group Discussion with women members & mothers, Village: Ghot, Block- Bari, Raisen
Focus Group Discussion with women members & mothers, Village: Mudia-Khedi, Block-Sanchi, Raisen
Focus Group Discussion with adolescent girls, Village: Mudia-Khedi, Block-Sanchi, Raisen
Focus Group Discussion with heads of households, Village: Dhakna, Block-Sanchi, Raisen
Focus Group Discussion with heads of households, Village: Barla, Block-Sanchi, Raisen

Focus Group Discussion with heads of households, Village: Nilgarh, Block-Obaidullagunj, Raisen

Annex B: Guided Interview Schedule

Guided Interview Schedule for State-Level Stakeholders Analysis	
Issues: Private Providers	**Questions**
• Mechanisms or patterns of referrals (linkages, esp. to women and children). • How well are own, government, and NGO activities working? • What roles do they visualize for themselves in WACH? • How can they improve their capacities in terms of quality and reach?	• To whom do you cater in your activities? What categories of people come for your service (e.g., economic, social)? • What is your opinion about existing government, non-government, and public provider activities? • What are your best areas within the health-related activities? • What role do you visualize for yourself in the WACH project? • Do the objectives of WACH project fit with your frame of activities? • What is the existing mechanism of drug supply? • What are your views about WACH design? • What roles do you visualize for yourself? • How can you improve capacity for quality and reach? What resources do you need? • To what extent is the area of women and child health a problem? • Where do you receive your drug supply? • What type of policy changes would be effective in implementing WACH?
Medical College • Perceptions about the existing systems. • Views on existing capacities of health delivery system capacity building, especially in technical areas. • What support role can be played by the medical college and other institutions?	• How capable are the institutes in providing maternal and child health deliveries? • What are your views about the existing health delviery system? • What support role can be played by medical colleges and other institutions in WACH?
NGO • Perceptions of Health delivery system performance. • Policies that promote or hinder non-government participation. • Kinds of Health activities and willingness. • Affiliation with network? • Links with block and community? • Importance of health agenda in their overall activities? • Perceptions about effectiveness of existing system? What are the constraints? • What are their own capacities or indigenous knowledge system? • With whom would they like to collaborate: PRI, community group, government? • Their opinion about the WACH design. • Existing specialization. • Perceptions their capacities to fulfill new roles under WACH.	• What are the areas of activities ? • Do you have a larger affiliation and network? • What is the priority of health in your agenda of activities? • What are your perceptions about the existing health systems? • In what way would you like to collaborate with the various local institutions, given the objective of WACH? • What are the resources or capacities you require to undertake WACH activities? • Which policies can hinder the implementation of WACH?
Media • What kind of advocacy role is visualized, especially for maternal and child health? • Existing interests and what is being covered. • Perceptions on public and private and NGOs in health.	• Do you do reporting on health issues? • What kind of advocacy role do you visualize for maternal and child health? • What are your perceptions on the current health delivery system? Cite cases.
Government/Bureaucracy **(Chief Secretary & Secretary, Health and Finance, etc.)** • Perceptions of the institutional capacities of the state, private providers, and NGO in health. • Possibility of blending accountability and flexibility to attain WACH objectives. • Meaningful roles that state can play under WACH. • Financial management? • Quality assurance? • Service to the constituents? • Possibilities of involving panchayats?	• What are your perceptions of the institutional capacities of the state, private providers, and NGO in the area of health? • What is your opinion of the WACH design? • How do you perceive the partnership of the government and non-government regarding the implementation of health activities? • What is your opinion about the role of panchayats in implementing WACH activities? • What are the roles that the state can play in the WACH project? • What are future WACH modifications and policy directions?

Guided Interview Schedule for State-Level Stakeholders Analysis

Issues: Private Providers	Questions
Ministers • Perceptions on existing health services? • Current and future policy directions for: - Panchayats - NGO promotion - PHD system and private providers • Possibilities of private or public partnership in health (WACH). • Capacities of Panchayats to play role in health. • Current and future resource allocations for maternal and child health.	• How do you see a shift in the role of the public sector system, given the implementation of the WACH project? • What is the possibility of a private and public partnership in health? • What role do you think the panchayat can play in health service delivery ? • What are current and future resource allocations for maternal and child health?
STAKEHOLDERS AT DISTRICT LEVEL **Private Providers: Private Hospitals/Nursing Homes, Registered and Unregistered**	
• Mechanisms and patterns of referrals (linkages, esp. to women and children). • Perceptions about how well own, govt., and NGO are they working. • What roles do they visualize for themselves in WACH? • How can they improve their capacities in terms of quality and reach? • Technical content of maternal and child health as compared to other health problems.	• To whom do you cater in your activities? What categories of people use your service (e.g., economic, social)? • What is your opinion about existing government and non-government and public provider activities? • What are your best areas within the health related activities? • What role do you visualize for yourself in the WACH project? • Do the objectives of the WACH project fit with your frame of activities?
Drug Houses •. Existing and possible mechanisms of drug supply, with focus on family planning, ORS, TT, and Dai kits. • Introduction of WACH	• What is the existing mechanism of drug supply? • What resources do you feel you need to further improve quality and outreach?
District Hospital • Mechanisms and patterns of referrals (links, esp. to maternal and child health). • Perceptions about how well own, government, and NGO are they working. • What services do they perform (their role)? • Their willingness and linkages to provide space for private providers and NGO in the health delivery system, and their attitude towards them. • Their linkages and the contradictions and frustrations that have resulted. • Referral and preventive services. • To what areas would they like to restrict their role? • Services regarding family planning. • How do they view their role, especially regarding WACH, with a focus on monitoring and coordination? • Their views about the existing mobile health unit. • What are the demands from primary health centers, and their mechanism of linking with primary health centers?	• What are the services, especially regarding maternal and child health, offered by the hospital? • What functional problems do you face? • What are the services that the primary health center can best offer? • To where do you refer cases? • How do you perceive your role in the health intervention in WACH? • If you receive cases from primary health centers, what kind are they? • How do you visualize your role in WACH? • Do you see a role in monitoring the project? • Do you feel the need for collaborating with NGO and private providers for improving the health delivery system? • What are the best areas of your activity?
Small NGO • Kinds of health activities and willingness. • What is their affiliation with the network? • Do they have linkages with the block and community? • Importance of health agenda in their overall activities. • Perceptions of the effectiveness of existing system and constraints? • Their own capacities and indigenous knowledge system. • With whom would they like to collaborate: PRI, community groups, government? • Their opinion about the WACH design.	• What are the areas of activities in which they work? • Is health an area in which you would like to work? • Are you part of large network? • Do you undertake activities in conjunction with the block or community level? • What are you best areas of activities within health? • Cite examples from your experience of the various issues. • Do you hear complaints about health or maternal and child health from the groups with which you work? • How would you visualize your role in WACH? • Is the mechanism of collaboration desirable?
Government Officials: DM/CMO/Other Officials • Performance/mechanism of existing health delivery system/ government/private, NGOs (curative/preventive). • Their perception about existing competencies. • Role of a partnership with NGO, private providers, and government. • Their opinion about the WACH project. • Role of PRI in this project. • Linkages with other programs.	• What is your opinion of WACH objectives? • Role of partnership with NGO. • How do you see linkages with panchayats in this project?

Guided Interview Schedule for State-Level Stakeholders Analysis

Issues: Private Providers	Questions
Political Stakeholders: MLAs/MPs/Zila Parishad Members • Perception on the performance of the health delivery system with a focus on perceptions from their constituents, including public, private, NGO, and maternal and child health. • What role do they perceive for NGO and the private sector? • Mechanisms and roles to strengthen the existing health delivery system in relation to PRI? • Their opinion about WACH. • Health resource mobilization? • Technical content of maternal and child health as compared to other health problems. • Existing and possible mechanisms of drug supply, with a focus on family planning, ORS, TT, and Dai kits. • Perceptions about the existing system. • Favorable policies and perceived bottlenecks. • Links and mechanisms at district and below. • Views on WACH design.	• What services are benefitting your constituency? • What are the reasons for their effectiveness? • How can NGO and government best serve the public? • WACH includes new roles for panchayat. How does this fit into your area of activities? • How can the WACH activities reach the women and children? • What are the sources and quantity of resource mobilization for health?
STAKEHOLDERS AT BLOCK LEVEL **Unregistered Practitioners, Provision Stores, Local Chemists Their clients and services provided**.	
• Their linkages with the government and non-government primary health centers. Where do they link for their referrals? • Their capabilities, willingness to learn,and how they can provide better services. • Their views about the functioning/service delivery system of the government vs. non- government • Their own linkages for supply. • Introduction of WACH.	• What kinds of services do you provide? • Which economic and social groups are referred to you? • Are you able to handle all cases which come to you? If not, where are they referred? • What services are you best at offering? • Have you undergone any training? • Do you need to build more knowledge with regard to certain areas in health? • Where do people usually go with various health problems? • If you feel there is a need to improve the existing health delivery system, how would you improve it? • Where do you get your supply of medicines? • What role can they can play in the WACH project?
Primary health centers/Subcenters • What services do they perform and what is their role? • Their willingness to provide flexibility for private providers and NGO in the health delivery system, their links with them, and their attitude towards them. • Referral and preventive services. • Introduction to WACH.	• Describe a routine day in your primary health center. • What are the services offered by the primary health center especially for maternal and child health? • What are the functional problems you face? • What are the services that the primary health center can best offer? • Where are cases referred? • How do you perceive your role in the health intervention in WACH?
Unregistered Groups / Associations/ Cooperatives • Their roles, linkages, and coverage. • Their views and experience with the existing health delivery system (public and private). • Introduction of WACH. • Is there a possibility of linking with WACH or health delivery system, and how?	If they are they involved in any health specify them. • What are their collaborations with the other groups? • What is your opinion about the existing health delivery system? • How would they like to develop their capacities to improve health services?

Guided Interview Schedule for State-Level Stakeholders Analysis

Issues: Private Providers	Questions
PRI Members, Block-Level Committee Members • Role in health-related issues (preventive & curative) and existing maternal and child health problems. • What strengths and constraints do they perceive in their role? Perception on their linkages, i.e., district level, committee/Zila Parishad. • Their perception of traditional healers, quacks, and government and non-government health systems and services. • Other experiences regarding their linkages with government and non-government health systems and services. • Introduction to WACH.	• What issues related to health are raised in block and community meetings? • Where does the community usually go to receive health services? • Is your block involved in improving the health situation of the people? In what ways? • What initiatives have been taken to take care of women and children seeking medical help? • What are the difficulties you face? • As a member of the block panchayat, how would you prefer to relate with the village panchayats? • What are your perceptions regarding traditional birth attendants, traditional healers, quacks, government and non-government health services? • Do you feel the community is satisfied with services provided by the government, NGO, and private providers? • What are the available resources for the activities of the PRI related to health? • What alternate sources for resources can be mobilized? • WACH envisages a greater role for Panchayati in maternal and child health. What in your perception will be your role. • What kind of support would you require for implementing this role ? • To whom would you like to relate to for the health services • How would you like to use the 'private' services. • What constraints in resources, knowledge etc. do you face ? • What alternative mechanisms do you perceive.
For Women members • What constraints and advantages do they feel about what the panchayat as an institution is going to do / willing to do / are doing.	• Where do services related with women and child health rank in the health activities of the Panchayat ? • Do you think maternal and child health issues should be accorded more consideration.
STAKEHOLDERS AT THE COMMUNITY LEVEL **For Focus Group Discussion: Introduction**	
Methodology	• Why we are here and focus of discussion. • Respond to their questions. • Getting the group together. • Using existing resource person or group for introduction (e.g., Mahila Samakhya).
Issues Broad health problems regarding maternal and child health. Perception about the existing health delivery system and various services. Preferred systems and services. Experience with Panchayat in health and health-related services.	
Heads of Household Willingness to pay (in terms of cost sharing). More emphasis on systems and accessibility to health services. Experience with Panchayat in health and health-related services.	

Guided Interview Schedule for State-Level Stakeholders Analysis

Issues: Private Providers	Questions
Traditional birth attendants, trained and untrained • Linkages with the health delivery system (public as well as private). • Where do they refer complicated cases? • Relationship with the client, focusing on the curative and/or preventive aspect. • About competency, willingness to learn. • Problems regarding the supply side (e.g., medicine.	• How many cases do you attend to in a month? • What are your areas of activity regarding maternal and child health? • Do you work in collaboration with government officers, e.g., ANM workers, doctors, etc.? • Where do you refer complicated cases? If so, what kind of support do they lend each other? • When people are referred to you, what kinds of services do they seek? • How do you attend to clients in remote or inaccessible areas of your village? • Have you undergone training? If not, where do you refer such cases? • Do you consider yourself capable of handling all the cases that are referred to you? • What are the areas in which you need to develop your knowledge? • From where do you get your supply of your medicines? • Is their supply sufficient? • If not, where do you go for the supply?
Traditional Healers • Access the level of influence and their position. • Access their capabilities. • Levels of preparedness and willingness to change to the new, modern health system.	• Who are the people who come to you for your services (e.g., economic or social status, women, men, children)? • For what kind of health problems do they need treatment, with eemphasis on women and children? • Do you think you have the capacity to handle these problems? • If no, do you refer the cases somewhere else ? Where ? • Do you use only herbs or do you also use modern medicines for your curative services? • Considering the development of modern health practices, do you feel the need to adopt to the new system? • Have you undergone training in your area of activity? • What are the areas in which you feel you need to build more knowledge?
Quacks • Assess their levels of influence and position. • Assess their capabilities. • Levels of preparedness and willingness to change to new, modern health system. • Supply of drugs and medicines (especially regarding family planning, etc.).	• Who are the people who come to you for your services (e.g., economic or social, women, men, or children)? • What kind of health problems do patients, especially women and children, seek treatment for? • Do you think you have the capacity to handle these problems? If not,where do you refer the cases? • Are they willing to build their competencies? If so, in what areas would they require training? • Keeping in mind the WACH design is about linking with private providers, what support can you render? • Where do you get your supply of drugs / medicines?
Youth Groups/Women's Groups • What kind of activities with respect to health do they undertake, including promotion of preventive health and hygiene? • What resources do they have or can be mobilized? Cite experiences & examples. • Introduction of WACH.	• What activities you undertake with regard to health? • What is the priority accorded to women and children's health in the community? • Do you undertake any health-awareness activities in your village with regard to women and children's health? • Have you volunteered your services at any time with regard to mother and child care? Cite cases. • What are the resources that you have in your group or which you can mobilize towards promoting health activities in your village? • Do you get support from Panchayats, government systems , or other groups in your activities? If yes, in what way? • What areas in which you can support the initiatives of WACH project, especially localization and sustenance of the project?

Guided Interview Schedule for State-Level Stakeholders Analysis

Issues: Private Providers	Questions
Teachers, ANMs • Role in health-related issues, maternal and child health problems, etc., especially preventive and curative. • Other experiences regarding their linkages with government, non-government, health systems and services. Their perception regarding traditional healers, quacks, and government/non-government health systems and services. • Introduction of WACH	• (For teachers) Do you contribute to any activity related to health, especially women and children's health? If yes, what activities? • To whom do people go to for various health services? • Do you feel that the community is satisfied by the services provided by the government and non-government health services ? • What complaints do you often hear? • What is their opinion of the various activities of WACH? • Where do they see their role in the WACH design? • What do you think will be the response of the community with respect to WACH initiatives?
Panchayat Head/Members • Role in health-related issues (i.e., preventive & curative) and maternal and child health problems. • What strengths and constraints do they perceive in their role? • Their perception regarding traditional healers, quacks, and government/non-government health systems and services. Other experiences regarding their links with government/non-government, health systems and services. • Introduction to WACH.	• What issues related to health are raised in Pancahayat meetings? • Is your Panchayat involved in improving the health situation of the people? In what ways? • What initiatives have been taken to take care of women and children seeking medical help? • What are the difficulties you face? • How can Panchayats play a greater role in maternal and child health? • What or who would help you play this role? • Do you feel the community is satisfied with services provided by the government, NGO, or private providers? • What are the available resources for the activities of the Panchayat related to health? • What are alternate sources for resources that can be mobilized? • With regard to the WACH initiatives how do you perceive your role ? • What kind of support would you require for implementing this role ? • To whom would you like to relate to for the health services • How would you like to use the 'private' services
Women Panchayat Members • What constraints and advantages do they feel about what the PRI as an institution is going to do, willing to do, and is doing?	• Where do services related with maternal and child health rank in the health activities of the PRI? • Do you think maternal and child health issues should be accorded more consideration?

Annex C: WACH Stakeholder Interview Introduction

Thank you for taking the time to meet with us. We are from Samarthan, an NGO based in Bhopal, which provides support to the NGO community in MP and conducts research on a variety of development topics. We are affiliated with a national-level NGO called PRIA, the Society for Participatory Research in Asia.

We have been asked by USAID, the U.S. Agency for International Development, to work on the pre-implementation phase of the Women's and Children's Health Project, WACH. Over the past couple of years, USAID's health office has been developing WACH in collaboration with the government of MP and Indian health specialists. A variety of technical analyses have been completed, a project document has been prepared, and USAID is in the final stages of negotiating approval of the project. WACH is a seven-year effort targeted to seven districts in the Bhopal Division of MP. Because WACH is testing new ways of promoting women's and children's health, the project is to be implemented in several phases, starting with an 18-month diagnostic and pilot phase in Raisen District.

The success of WACH, whose objective is to improve the health of newborns, infants, and their mothers, depends not just on the technical quality of the service packages to be put into place, but also on the support, collaboration, and participation of members of the public health sector, private health care providers, NGO, and local communities. Our task is to conduct a survey of the opinions, expectations, and concerns of these groups relative to what WACH proposes to do, so that a consensus can be built around the appropriate way to implement the project.

We would like to ask you some questions about health issues in MP in general, and in particular, obtain your views on what WACH proposes to do. Our report will be a synthesis of your responses. Your individual comments will be kept confidential, so we hope you will feel free to speak openly and frankly. With your consent, we will be taking notes during the interview.

As background for our interview, let us quickly review for you the major activities of WACH. These activities are intended to be carried out by NGO, private firms, community groups, and panchayats, along with certain MP state agencies at the district and block levels. This means that the project will operate through partnerships among government, NGO, private providers, and communities. Primary WACH activities are:

1. Community mobilization and action in support of health improvement for women and children. Examples of possible activities are integrating health issues into existing groups; helping communities organize for monitoring of health status; and supporting community arrangements for transportation of patients.

2. Health education and media programs to inform and build awareness. For example, these programs could be linked to ongoing literacy programs.

3. Improved access to quality services at the community level. This is where the majority of the partnerships are. Plans include involving NGOs in working with communities, expanding outreach, training private providers, and increasing the effectiveness of the referral system. Possible initiatives for state health facilities include helping to create better linkages with communities and local private providers; working with panchayats; or collaborating with the JSRs. In the private sector, drug houses and local pharmacies could be potential participants for better outreach and services.

Annex D: Villages Visited for Community-Level Interview in Raisen District

1.	Village	Ghurpur,	Gram panchayat	Kakarua	Block Silwani
2.	Village	Dhakna	Gram panchayat	Dhakna Chapna	Block Sanchi
3.	Village	Chapna	Gram panchayat	Dhakna Chapna	Block Sanchi
4.	Village	Barla	Gram panchayat	Barla	Block Sanchi
5.	Village	Mudiakhedi	Gram panchayat	Mudiakhedi	Block Sanchi
6.	Village	Dudhwani	Gram panchayat	Semri	Block Obaidullagunj
7.	Village	Nilgarh	Gram panchayat	Semri	Block Obaidullagunj
8.	Village	Pahartalai	Gram panchayat	Pahartalai	Block Bari
9.	Village	Ghot	Gram panchayat	Pahartalai	Block Bari

Annex E: Stakeholder Form

Interview No.:

Interview Date:

Interview Place:

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I. STAKEHOLDER INFORMATION

A. Stakeholder (Name, Title)

B. Level (State, District, Block, Community)

C. Sector Category (Political, Govt, NGO, Private)

D. Contact Information (address, phone)

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II. STAKEHOLDER RESPONSE SUMMARY

A. Issues Covered, Questions Asked, and Summary of Responses

(Insert issues/questions and summarize responses)

Issues	Questions	Response

B. Other Responses Covering Issues other than the Questions:

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III. STAKEHOLDER ASSESSMENT SUMMARY

A. Nature of interest in WACH
(Specify details)

B. Degree of Support/Concern/Opposition Regarding WACH
(Specify strong, moderate, limited, weak support/opposition; or neutral)

1. Technical Objectives/Activities:

2. Implementation Mechanisms:

3. Emphasis on NGO/Private Sector:

4. Shifts in Roles for Public Sector:

5. Other (Specify):

C. Capacities to Support/Constrain WACH Objectives/Activities
(Specify nature of capacities and rate degree of support/constraint)

D. Importance to Success of WACH Objectives/Activities
(Specify why and rate degree of importance)

E. Other Observations / Remarks

Interviewed by: _____ Date: _____

Annex F: Key Statistics of Madhya Pradesh

	Madhya Pradesh	Raisen *5	India
A. Demography *1			
Population growth	2.40	2.13	2.14
Population density	149.24	103.53	273.60
Urbanization	23.18	15.72	25.70
B. Literacy *1			
All	44.2	40.8	52.2
Rural	35.9	36.1	
Urban	70.8	65.1	
Female (Total)	28.8	25.5	39.3
Female (Rural)	19.7	20.5	
Female (Urban)	58.9	52.4	
C. Health *3&4			
Neo-Natal Mortality *6	67		40.3
Under 5 Mortality	130		109
Life Expectancy (1981)	55.4	46.1	62.8
Crude Birth Rate (CBR)	34.4	39.1	28.7
TFR	4.6	5.3	3.6
IMR	10.6	135	74
MMR*7	711		
D.Infrastructure and Natural Resources * 2 & *3			
District & Civil Hospital (No.)	119	1	
CHC (No.)	190	5	
Primary health center (No.)	1841	23	
SHC (No.)	NA	97	
Safe drinking water —% of total household covered	20.17	17.3	
Safe drinking water—% of rural household covered	8.09	11.7	
Forest Area as % of total area	31.78	39.34	21.82
Net swon area as % of total agricultural area	4.39	49.00	46.30

Source :
*1. Primary Census Abstract, Census of India, 1991.
*2. (1984 - 90 data), Contours of Fertility Decline in India; by PM. Mari Bhal; 1990.
*3. (1981data) Census of India, Primary Census Abstract.
*4. NHFS - 1992 Report, Madhya Pradesh.
*5. Statistical Abstract, Raisen,1994 - 95.
*6. Office of the Registrar General,1995.
*7. UNICEF, 1996 Indirect Estimate based on MMR - IMR linkage.