HNP DISCUSSION PAPER

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March 2010

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## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## Political Economy of Health Workforce Policy: *The Chhattisgarh Experience with a Three-year Course for Rural Health Care Practitioners*

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**Abstract**: This case study analyzes the reasons for adoption and the implementation process of a key policy in Chhattisgarh state, India, to create a rural cadre of trained physicians in order to address the acute shortage of doctors in the state's primary health facilities. It documents the experience specific to Chhattisgarh state, but with its attention to the policy processes and implementation challenges associated, it also highlights the necessity of a political economy perspective currently missing in much of the published literature on human resources for health. A principal lesson of this case concerns why it matters how interests of various stakeholders who had interests in the three-year course are included early in the policy process, namely the anticipated opposition of the medical doctor community represented by the Indian Medical Association (IMA) and the interests of the students themselves and their desire to be given appropriate status as medical doctors. This case study addresses the legal hurdles faced and the importance of institutional support structures to maintain quality standards and provide for grievance procedures. Through this case study, it also becomes apparent why the role of institutional ownership of policy matters rather than success or failure of policy that is linked entirely to the authority of a few key appointed officials.

**Keywords**: Rural health care providers, rural cadre, policy implementation



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# ABBREVIATIONS

| | |
|---|---|
| ANM | Auxiliary Nurse Midwife |
| AYUSH | Ayurveda, Yoga, Unani, Siddha and Homoeopathy (Indian Systems of Medicine) |
| CCM | Chhattisgarh Chikitsa Mandal |
| CHC | Community Health Center |
| DH | District Hospital |
| IMA | Indian Medical Association |
| LHV | Lady Health Visitor |
| MBBS | Bachelor of Medicine |
| MCI | Medical Council of India |
| MPW | Multi-Purpose (Health) Worker |
| NRHM | National Rural Health Mission |
| OSD | Officer on Special Duty |
| PHC | Primary Health Center |
| RMA | Rural Medical Assistant |
| TYMIAC | Three Year Medical Institute Association of Chhattisgarh |

# INTRODUCTION

"It was not the basic idea that failed; it was the execution of the policy that failed"

- A Senior Government Health Official

Shortages of qualified health workers in rural areas are a critical barrier to scaling up health services and addressing the needs of the poor. Cross-national evidence shows that staffing levels are closely linked with service delivery coverage and health outcomes (Anand and Barnighausen, 2004; WHO, 2006; Farahani, Subramanian and Canning, 2009). Within countries, areas with the lowest staffing levels tend also to be those with the worst health outcomes. For example, urban Mexico has three times the health workers per capita than rural areas, and has a life expectancy 16 years higher than the average person in rural areas (Cercone, J.et al., 2001). Though many other factors contribute to poorer health in rural areas, human resources for health appear to be an important contributor. Addressing rural shortages is a critical strategy for overall health gains.

International experience has shown that there are many policy options to attract and retain health workers in remote areas. These include, very broadly, education and continuous professional development; regulatory interventions; financial incentives (direct and indirect); and management, workplace environment, and social support (Table 1). The international evidence base for these interventions is fairly weak, particularly in developing countries (WHO, forthcoming). Moreover, the published evidence has paid little attention to the policy processes and implementation challenges associated with each of the policy options. These are of particular interest to policy makers as knowing what to do is obviously important, but knowing how to do it often matters more.

**Table 1: Policy options to attract and retain health workers in remote areas**

| Category of intervention | Examples |
|---|---|
| **A. Education and continuous professional development interventions** | Preferential recruitment of students with a rural background |
| | Medical and other health professions schools located in rural areas |
| | Clinical rotation in rural areas during medical or health-related studies |
| | Changes in curricula to reflect rural health issues |
| | Continuous professional development, including career paths |
| **B. Regulatory interventions** | Compulsory service in a rural area, alone or with incentives |
| | Scholarships in exchange of rural service (bonding) |
| | Producing new types of cadres (task shifting, substitution, mid-level workers) |
| **C. Financial incentives (direct and indirect)** | Rural or remoteness allowances, including other indirect financial incentives (housing, transport, children's schooling, etc.) |
| | Financial support for young doctors to open private practices in rural areas |
| | Performance-related pay |
| **D. Management, workplace environment, and social support** | Improved working and living conditions |
| | HR management system, including improved supervision |
| | Reduce feeling of isolation through professional support networks, specialist outreach programs, and telemedicine |
| | Social recognition measures |

Source: WHO (forthcoming).

This paper discusses the policy process for designing and implementing one of the regulatory interventions: creating new cadres of health workers in order to improve access to health workers in remote areas. Specifically, it highlights key political economy issues surrounding the establishment and later termination of a three-year course to train a physician to serve rural and tribal areas in the Indian state of Chhattisgarh.

## BACKGROUND TO CHHATTISGARH

The state of Chhattisgarh was carved out of the central Indian state of Madhya Pradesh in November 2000. In key socioeconomic and health indicators, including the infant mortality rate and maternal mortality ratio, this new state lags behind the rest of the

country. Although geographically a large state covering 135,194 sq. km, its population of 20.83 million (Government of India Census 2001) is half that of the national average (154 for the state as against 312 per sq. km for the country). With a significant tribal composition, the population is also reported to be growing more slowly than the national rate. In fact, of the 18 districts, 12 are classified as remote, tribal areas with extremist insurgencies.

Providing health care is a human resource–intensive activity and in Chhattisgarh state the shortage of trained health care providers is among the most acute in the entire country. Almost one-third of the officially sanctioned posts of auxiliary nurse midwives (ANMs) are currently not filled. Only 540 staff nurses are available against the required 1,344 for working in public health facilities in Chhattisgarh (Academy of Nursing Studies and NHSRC, 2009). The shortfall for doctors, both Bachelors of Medicine (MBBS) and specialists, is about 72 percent, with 1,455 medical officers posted at primary health centers (PHCs) against the officially sanctioned posts of 1,737, and only 247 specialists available against the sanctioned 637 posts (Chhattisgarh State PIP 2009–10). The shortfall in doctors is even more severely felt as the vast majority of the inadequate numbers that do exist are located in urban or semi-urban areas, with certain large tracts of rural and tribal areas almost devoid of a single MBBS-trained doctor.

At the time of its separation from Madhya Pradesh, Chhattisgarh had no government nursing college and only a single private college of nursing admitting 30 into the nursing bachelor of science program. The Government College of Nursing at the state capital, Raipur, opened in 2004 with an annual intake of 33 students. In addition, there were two public masters of science nursing colleges, 10 public general nursing colleges, and four private nursing schools. In 2000, there was only a single medical college in the entire state admitting 100 students, but the institution itself was relatively poorly staffed with a limited reputation for quality of training before the separation from Madhya Pradesh. This college had to be strengthened after the creation of the state, and a second public medical college opened in August 2002 and a third was initiated in July 2007. Two further medical colleges remain in the pipeline.

Though for a state these were rapid strides forward, it was quite some time before these new colleges were producing sufficient numbers to fulfill state needs. In 2001 only 516 medical officers were available at PHC level out of total of 1,455 sanctioned posts. By 2005 availability of medical officers had increased to 1,345 but this was still only about half the number of sanctioned posts. As the number of facilities rises to meet the national norms, and as the number of posts rises to meet the recently framed Indian Public Health Standards, the gaps between what is posted and what is needed would become even greater. For example, Table 2 shows that 6,470 posts of ANM and lady health visitors (LHV)[1] are sanctioned, but if the post of second ANM as mandated by Indian Public Health Standards is sanctioned, this would further push up requirements of ANMs.

[1] LHVs are the supervisors of ANMs, who are village-level workers. At times, ANMs are also referred to and categorized as multi-purpose workers (MPWs, female), while the supervisor functions similar to a LHV. Changes in nomenclature and categorization are due to the history of the community health program in India, when in the late-1970s all ANMs were classified as MPWs (female).

**Table 2: Changing Human Resources for Health Situation in Chhattisgarh State**

| Facility | In year 2002–03 | | In year 2006–07 | |
|---|---|---|---|---|
| | Sanctioned | With sufficient infrastructure and facilities | Sanctioned | With sufficient infrastructure and facilities |
| **Sub-centers** | 3818 | 1458 | 4692 | 1853 |
| **PHCs** | 513 | 327 | 717 | 400 |
| **CHCs** | 114 | 34 | 133 | 70 |
| **District Hospitals** | 6 | 6 | 16 | 14 |
| **Cadre** | **In year 2002–03** | | **In year 2006–07** | |
| | Sanctioned | In position | Sanctioned | In position |
| ANMs + LHVs | 5729 | 4667 | 6470 | 5275 |
| MPW + supervisor | 3785 | 3121 | 4467 | 3149 |
| Medical Officers | 1455 | 516 | 2571 | 1345 |
| Specialist | 291 | 103 | 1006 | 291 |

Source: Data obtained from State Health Resource Centre, Raipur.

As evident from Table 2 above, at the formation of Chhattisgarh state, the single largest challenge the state government faced in the health sector was human resources. It is in this context that the state government considered the option of a three-year course to train health care practitioners to serve in rural areas.

## THE POLICY OPTIONS IN CHHATTISGARH[2]

The initial idea of a three-year diploma course for training health care practitioners for rural areas came from the office of the Chief Minister and was a result of his direct intervention. The logic was that if candidates from rural areas were brought into the proposed three-year diploma, they would be more likely to return and serve in such areas. This has shown some success in other countries (Dussault and Franceschini, 2006; Grobler et al., 2009; Henderson and Tulloch, 2008; Lehmann et al., 2008; Wilson et al., 2009). It was reasoned that opportunities for three-year diploma graduates to work in the urban private sector would be limited, encouraging them to remain in rural areas. Another rationale that was articulated was that a formally trained skilled provider in the underserved areas of Chhattisgarh would serve as competition to the "*jhola chaap*" doctors practicing in these regions. This is a term that derisively refers to the unqualified practitioners of modern medicine that has mushroomed in many villages.

Given the fact that the graduates from new medical colleges would take over six years to be available to work, a three-year course would yield results within the political lifespan of the government of the time. Moreover, starting new medical colleges, conforming to guidelines of the Medical Council of India required significant capital investment from the government and recruitment of qualified human resources as medical faculty. Even if the financial resources were to be found, the human resources would be difficult, for even the existing state college in the state capital was facing shortages of key faculty members.

To face the acute shortage of trained health care providers in the state, the state government attempted several different policy options, including constructing new medical colleges. Two colleges opened and two more, including a centrally sponsored one, remain in the plans. A second policy option was to focus on nursing schools and ANM schools. A third was a community health volunteer program, called the Mitanin program, which focused on training a woman health activist in every village. The success of the Mitanin program in Chhattisgarh state drove the central government's policy plan to train accredited social health activists under its National Rural Health Mission (NRHM) program—a collaborative major initiative between the federal and state governments. A fourth policy option that the state government pursued was to train the existing village health care providers who were not fully trained MBBS physicians. These informal medical practitioners were to be nominated by the *panchayat* (village council) and sent to the district hospital, where they would receive six months of training and a certificate. About 1,100 persons were trained in the process, but they returned to the village to practice as before and not as government doctors. There has been no

[2] This case study is a result of information collected through extensive interviews with key informants representing different stakeholder interests within government and outside, including a focused group discussion with over 40 graduates from the three-year courses and 12 "Rural Medical Assistants" (RMAs) currently in government employment. In addition, all published documentation related to the three-year course or to the RMA postings has been drawn on. Finally, the Case also contains primary data collected and expressed here for the first time. The authors are grateful to all who participated in this study, in providing or facilitating information on this case.

documentation of the impact of this training, if any, for health services provided at the village level.

The creation of a three-year course to train health care practitioners to serve in rural areas therefore developed even as these other policy options were implemented by the Chhattisgarh state government. The strategy to have only private entrepreneurs run these educational institutes was part of the state government's experiments at the time with public–private partnerships in the entire educational field.[3]

## THE IMPLEMENTATION PROCESS OF THE THREE-YEAR COURSE

### FORMATION OF THE CHHATTISGARH CHIKITSA MANDAL

From early 2001, when discussions within government on the three-year course began, opposition from the Medical Council of India (MCI), the professional body regulating medical education, was anticipated. Ever since the Indian Medical Council Act (1956) stipulated the functions of the MCI, it has always opposed any dilution to the status of doctors trained in western allopathic medicine and registered by the MCI. Therefore, MCI has consistently opposed both the induction of doctors trained in traditional Indian medicine and the prospect of three-year courses training physicians entitled to doctor status. Consequently, to avoid this likely rejection the Health, Law and General Administration Departments in Chhattisgarh agreed that the powers of recognizing and approving the three-year course should be given to a new body specifically created for this very purpose through an act passed in the state legislative assembly. It was through this mechanism that the state intended to bypass the MCI.

Such a state act could be passed by the state assembly to be valid only in Chhattisgarh state without requiring the approval of the federal government or official sanction of the President of India, as required for all legislative bills that are applicable across the country. MCI was, however, contacted and it formally rejected this three-year course, even prior to any discussion of objectives or course content. The Chhattisgarh government instead used the precedent of West Bengal having briefly implemented a similar course in the 1980s as justification for its own action.[4]

The operationalization of the plan was given great urgency by the political leadership. Within days a committee to take charge of the initiative was formed in the Health

[3] Over 125 universities, all private, had been sanctioned under another planned state law in Chhattisgarh, but most of these closed when a new government took over in 2004.

[4] The states of Maharashtra and Karnataka had also seriously considered similar three-year courses, but had not been able to implement them. In West Bengal, the state legislative assembly permitted the state government and state medical council to register students trained in a Diploma Course in Community Medical Service, even though the MCI had opposed such a diploma. See the notification published in the *Calcutta Gazette, Extraordinary, Part 1, No. 787, dated October 15, 1980*.

Department. Within a month a committee of senior secretaries presided over by the Chief Secretary forwarded a letter of go-ahead to the Chief Minister. Within the same month, the Chief Minister signed for the legislative assembly to meet to consider a proposed bill for enactment. In the following month, the procedure for presentation to the legislative assembly was completed. As a continued expression of priority lent to the passing of the act for creating a separate state registration institution, the notification rules were drawn out and printed as an extraordinary Gazette on 18 May. The state assembly accepted these four days later and the Chhattisgarh Chikitsa Mandal (CCM) charged with approving and regulating the three-year course became a legal new institution in Chhattisgarh state.

The CCM is a licensure body that has been sanctioned to register graduates trained in the three-year courses. The CCM, however, is not solely a licensure body such as the MCI, but authorized at different times to conduct examinations as well as inspections of the private training institutes. The quick birth of CCM was certainly due to the political support of the Chief Minister. Another important reason for the quick process was the clearance or no objection from the Finance Department.

The principal reason for the Finance Department's quick clearance was an explicit understanding that the CCM would be an autonomous body with no financial burden on the state government. The CCM was expected to raise its own finances through fees charged from private agencies in return for being given permission for starting institutes that would run these three-year courses and later to be supplemented through registration fees charged to graduating three-year doctors. Private managements of these institutions were expected to recoup these losses and make a profit through tuition fees. The costs to the government of running the CCM were expected to be minimal with a total of only three officials assigned to the new registration body, all of whom were already on government payrolls and were being seconded for the task. The CCM was made up of the Director of Health Services as President, the Dean of the Medical College in the state capital as Vice-President, and a district chief medical officer to be seconded in as Registrar. With such limited initial capital and human resources in CCM, the new registration body was an institution with limited capacity.

The powers that the CCM was authorized, nonetheless, were not so limited. It was initially given several responsibilities: (i) to inspect private bids made for starting the new institutes for the three-year courses, (ii) to be the nodal authority in charge of the admissions process of the students to these institutes, (iii) to have power to change the syllabus of the course, (iv) to fix norms and guidelines for charging tuition fees for the three-year course, (v) to be the authority charged with undertaking the examinations process for the course, and (vi) to be the registration body for graduates from the three-year course (Table 3). These were far more powers than the state medical council had and even more than the MCI had for its regulation of medical courses.

**Table 3: Mapping of key functions to agencies responsible for three-year course**

| Key Function | Agency Tasked |
|---|---|
| Syllabus content | CCM |
| Fix norms and guidelines for charging tuition fees | CCM, but in practice the private institutes could impose higher capitation fees especially in admissions of the second and third batches. |
| Admissions process | CCM for first batch, through TYMIAC at Raipur for the second batch, and undertaken at individual private institutes for the third batch. |
| Examinations | CCM initially tasked, but transferred to medical universities of the state |
| Registration of graduates | CCM |
| Inspection for new institutes | CCM |
| Periodic inspections for ensuring quality standards | No agency tasked, but two inspections by committees formed by state government in 2004 and 2005 |
| Recruitment of faculty | Norms existed but institutes undertook faculty recruitment on their own |
| Finance for running institutes | Student fees and investments from entrepreneur owners of the institutes (but no government funding existed) |

## OPENING OF THE INSTITUTES

Since the three-year course was not going to be publicly funded, the institutes for imparting this education were all planned to be private. The locations proposed were in rural/tribal districts, but with access to a large government hospital, usually the district hospital, in order to make clinical teaching and internships possible. Fifteen applicants responded to an expression of interest advertisement by the government. It is notable that although the CCM was charged with the responsibility of initially inspecting the infrastructure and facilities available for the first year of non-clinical teaching alone, the final selection of the initial three private institute locations was made by the state government.

The first three colleges were inaugurated in October, 2001 at Ambikapur, Jagdalpur, and Pendararoad. At this stage, the syllabus for the remaining two years was still not prepared. Three further institutes at Kwardha, Katghora, and Kanker opened a year later at the end of 2002, with two going to two owners of the first batch of institutes opened. Although initially it was decided that each institute would have a maximum of 100 students, all six institutes were allowed to admit 150 students per year. The student admission was in three categories:

1. 50 percent free merit seats—75 seats[5]
2. 35 percent payment merit seats—53 seats[6]
3. 15 percent nonresident Indian seats—22 seats.

In the absence of candidates to fill the available seats reserved for nonresident Indians, the rules converted these 22 seats to payment seats. Since there was no nonresident Indian interest in applying for the three-year course in Chhattisgarh, in effect half of the 150 seats in these institutes were filled through significant fees that the private institutes charged from the students. In addition, of the 75 "free merit seats," 37 were expected to be "reserved," under India's social affirmative action program, for "Scheduled Castes" (11 seats), "Scheduled Tribes" (16 seats), and "Other Backward Castes" (10 seats).[7]

There was only a 20-day period for applications to the first three institutes, but even in this short time there were over 9,000 applicants. For the first year, CCM conducted the admissions as per the provisions of the CCM Act. In subsequent years the institutes took the lead through an association they formed called the Three Year Medical Institute Association of Chhattisgarh (TYMIAC). For admissions to the first batch, students were eligible only if they had a minimum 75 percent score in their secondary school-leaving examination, with inclusion of biology compulsory. In the first two years, eligible candidates were called for interview in the order of their scores in the school-leaving examination, and given the seats in the institutes of their choice, against vacancies that existed at the time of their appearance—a process that has of late been called "counseling." This counseling was centralized and held at Raipur. In the third year of admissions, even this centralized counseling was given up and admissions were directly undertaken at each institute. For entry to the third batch, there was a significant fall in the number of interested applicants compared to the first batch. The reasons for both these developments are explained below.

## THE INFLUENCE OF LEGAL ISSUES ON THE NAME AND CONTENT OF THE COURSE

The Indian Medical Association (IMA), representing largely private doctors, opposed the idea of a three-year course of medical education as a dilution of the standards of the medical profession. Not surprisingly, therefore, the IMA filed a case questioning the legality of the Chhattisgarh three-year course almost immediately after the CCM Act. Even though there was no verdict in favor of the IMA, the state government was preoccupied with the need to survive this legal challenge and to find the legal space to

[5] Candidates seeking admission against the "free merit seats" were compulsorily required to be domiciles of Chhattisgarh state, but were also expected to pay "tuition and development fees," but less than candidates admitted to the "payment merit seats."

[6] The "payment merit seats" were open to all candidates and not only Chhattisgarh domiciles.

[7] Scheduled Castes, Scheduled Tribes, and Other Backward Classes are Indian population groupings that are explicitly recognized by the Constitution of India and consequently by both federal and state governments. Scheduled Castes and Scheduled Tribes together account for over 24 percent of India's population, with Scheduled Castes at over 16 percent and Scheduled Tribes at over 8 percent as per the 2001 Census. In the constitution, Other Backward Classes are described as "socially and educationally backward classes" and Other Backward Classes are therefore entitled to 27 percent reservations in public sector employment and higher education.

start and continue with this course. This preoccupation came at the expense of attention to other issues which turned out to be equally, if not more, important to the actual functioning and to the institutional support the course needed. Above all, there was very limited clarity on three vital issues—the content of the syllabus, the exact professional identity of the graduating students, and the institutional standards and the transparency of processes, especially those related to admissions, hiring of faculty, and maintenance of quality in certification.

The first influence of the pending legal battle caused a change in its formal name, even before the course started. At the time of the CCM Act, the three-year diploma course was called a Practitioner in Modern Medicine & Surgery. Three months later, it was retitled Diploma in Alternate Medicine. This was a direct response to the legal concerns with the use of "surgery" and "modern medicine" in the title, both of which might have required clearance from the MCI, which opposed this three-year course. To justify this claim to "alternative medicine," there were subjects introduced to the syllabus that had not been considered before—namely, biochemical medicine, herbo-mineral medicine, acupressure, physiotherapy, magneto-therapy, yoga, and Edward Bach flower remedies and acupuncture.

## INSTITUTIONAL HURDLES FACED AND CREATED: SPEEDY IMPLEMENTATION AT A COST?

The unusually rapid progress in setting up these courses, despite legal hurdles, was clearly due to the Chief Minister's personal and explicit priority for the course. Internally there was administrative reluctance to rush through such a course. The officer from the Indian Administrative Service (IAS) who was Secretary of Health was relieved of this task and the task was handed over to a faculty member of the Preventive and Social Medicine Department and not a regular career civil servant who was designated as an "Officer on Special Duty" (OSD) reporting to the Health Minister directly and with many of the powers normally assigned to the Secretary of Health. The ostensible reason was that the Health Secretary has several tasks that prevented him from devoting sufficient time to the courses, whereas the OSD could focus solely on the needs of the courses.

The Health Secretary, not being the reporting authority for the OSD, had no reason to be involved with this three-year program henceforth. The Director of Health Services, while the officiating President of the CCM, was a senior career government official mandated to oversee much more than the CCM and had an important working relationship with the IAS Health Secretary to preserve. In contrast, the post of OSD, perceived to be a temporary political appointment, commanded far less compliance from the Director of Health Services and other senior career officials compared with the authority of the Health Secretary. This resulted in a working environment where the OSD had limited cooperation within the government—and consequently there was little sharing of information and a lack of broad institutional ownership of this course.

It is also within this strained working environment with other key health officials that the OSD sought to bring two important "corrective" changes that shifted away

responsibilities and authority away from the CCM and toward the private institutions implementing the courses. The first change was to affiliate the private institutes to the established universities in Chhattisgarh and to bring the exams under the purview of these universities instead of the CCM as stipulated in the May 2001 Act. The second change was to shift responsibility for admissions to the three-year diploma course from the CCM (as under the CCM Act) to the private institutes. These changes were designed to weaken the CCM in favor of the private institutions and to separate these functions from the supervisory role of the CCM.

These changes, however, had unintended but deleterious effects on the course. First, the attempt to link the course to the universities delayed the first-year examinations by nearly half-a-year and became the initial cause for the course getting derailed in its schedule (Appendix Table 1). Second, the CCM or any single independent nodal agency was far less directly involved in the admission of the second batch to the diploma course and indeed for the admission of the third batch in 2003, many seats were "filled on the spot" without counseling, with no quality standards on an almost walk-in basis.[8]

As part of this revised perspective on the CCM, the name of the three-year course was changed yet again to the Diploma in Holistic Medicine and Paramedical Course in March 2003 through an internal government order. The thinking behind this change was that the change of name would pave the possibility for graduates of this course to be registered with the State Paramedical Council and not under the CCM. This would have further removed from the CCM its role as a licensure body of the three-year course and indeed the very function for which it had been initially created. The assumption for this changed perspective was that the State Paramedical Council would be less legally challenged than the CCM, since it would be clearly outside the purview of medical councils and associations.

The name change, however, struck a problem from a different quarter—the students. The students launched a strike declaring that the term "paramedical" was a dilution of the status of the course, away from the medical profession to which they desired affiliation. The name of the course instead was revised yet again following the July 2003 student strike to the Diploma in Modern and Holistic Medicine. Therefore, legal and political issues, rather than any dialogue over the aims and purposes of the course, governed the decisions to change the name of the course several times and with it, its stated curriculum. Lacking clarity in objectives from the very beginning, these changes only added to the confusion.

## CHANGING CURRICULUM: THE INFLUENCE OF LEGAL BATTLES

The legal and political challenges faced during the implementation of the course led to constant redefining of the syllabus and contributed to a lack of clarity on the syllabus of the three-year course. The initially designed syllabus for the course was a scaled-down and trimmed version of the MBBS curriculum with some additional subjects of AYUSH

[8] Moreover, anecdotal evidence suggests that the vacant free and management seats were converted into nonresident Indian seats with a fee structure of Rs.150,000 per year.

(i.e., the indigenous streams),[9] alternative medicine, and public health to justify the term "alternate" and thereafter "holistic." Two inspection committees in 2004 and 2005 examined the syllabus and recommended changes to make it more appropriate for the epidemiological and demographical needs of the rural and tribal population. Although the syllabus was modified twice to justify the new names of the course and to include subjects related to alternative and holistic medicines, it was never modified on the lines of these two committees' recommendations.

The change in state government after the November 2003 elections brought all issues of course objectives and identity of the graduates into a fresh review. The new political regime dropped the officer in charge of the course (the OSD) as a political and irregular appointment. The Health Secretary who had been pushed aside to make way for the OSD was brought back to reformulate policy on the course after a gap of almost two years. To define the course objectives more clearly, the new government revisited the fundamental purpose of the course and its curriculum (Table 4), but at a time when the courses were in an advanced stage with three batches of students studying.

The new challenge was from students resorting to agitation to safeguard both their identity as doctors and to gain employment prospects from the government. More significantly, following vociferous increases in student agitation, the future identity of enrolled students and their employment prospects had become a serious issue, separate from getting the course and curriculum legally accepted that had earlier been the principal concern of government.

[9] Ayurveda, Yoga, Unani, Siddha and Homoeopathy (Indian Systems of Medicine).

**Table 4: The Curriculum of the Three-Year Course**

| YEAR | SUBJECTS | COURSE DESCRIPTION |
|---|---|---|
| **First Year** | • Anatomy<br>• Physiology<br>• Biochemistry | Teaching of basic science based under alternative medicine. In addition to subjects mentioned, community medicine |
| **Second Year** | • Pathology & Microbiology<br>• Pharmacology<br>• Preventive & Social Medicine | Teaching based under alternative medicine—in addition to subjects mentioned, essential drugs minor surgery, diseases found in community and national health programs |
| **Third Year** | • Medicine & Pediatrics<br>• Obstetrics & Gynecology<br>• Elementary knowledge of Surgery, ENT, Ophthalmology, Orthopedics | Teaching based under alternative medicine. In addition to subjects mentioned, symptomatology practice of medicine and primary knowledge of orthopedic, along with orthominer surgery as well as biochemical medicine, herbo-mineral medicine, acupressure, physiotherapy, magneto-therapy, yoga, batch flower remedies and acupuncture |

Sources: Prospectus 2002–2003 and Syllabus, Chhattisgarh Chikitsa Mandal, Raipur.

Unlike for MBBS graduates, the one year of internship for the course had significant exposure to rural public health with one month of training at a subhealth center, three months at a PHC, four months at a community health center (CHC), and four months at a district hospital. At the district hospital, there were rotations in the departments of surgery, medicine, obs & gyn, as well as ortho & pediatrics for 20 days each and for 10 days each in the orthopedics, ENT, ophthalmology, and casualty departments. Students gained thereby from field-based learning of the public health systems and the internship further enabled them to develop skills to provide health care services even with poor availability of equipments and facilities.

## DELAYED CLARITY: STUDENT AGITATIONS AND CLOSURE OF FURTHER ADMISSIONS

At its inception and when the course was initially for training a Practitioner in Modern Medicine & Surgery, it was not clear whether the three-year course would be a diploma or certification course. The precedent in West Bengal, that the Chhattisgarh state government used to justify making the three-year course, was a diploma program. The state government once again followed this precedent in West Bengal, classifying its three-year course a diploma program.

At the time of admissions, almost all the students were given to understand that they would graduate as a three-year trained doctor with a high likelihood of a government job

in rural and tribal areas due to the significant vacancies existing in PHCs. This belief was based significantly on media commentary (such as newspaper articles) and on verbal assurances of the state government, but no official government order to this effect had ever been issued. As the verbal assurances failed to be followed up and as larger numbers of students enrolled, after paying fairly high tuition fees or in some cases capitation fees, a section of the students were given cause to begin agitation. There were several such agitation movements, promoted by institution owners and supported by political interests of districts in which the institutions were located and from where the students came. In total there were three major strikes.

The main reason for the first strike of students in January 2003 was a demand to change the name of the course from Alternative Medicine and to secure guaranteed government jobs. The name of the course was changed following this strike.

The second major agitation was in July 2004 for change of the name from Diploma in Modern and Holistic Medicine to Practitioner in Modern and Holistic Medicine and to increase the duration of internship from six months to one year. Students also sought a stipend for the period of internship (much like MBBS students get), security of a government job, and recognition of the course by the State Medical Council. This led to the change of name for the final time and an increased duration of internship to one year.

The longest strike lasted one month in December 2006 with the main demands remaining the same, including recognition of the course by State Medical Council in order to practice allopathy.

All these student agitations led to further delay of the annual exams and further derailed the course schedule (Table 5). The legal and political issues along with the various strikes of the students also contributed toward the growing unpopularity of the course in the state, which led to far decreased numbers of applications, especially for the entry of the final 2003 batch. The entry requirement of 75 percent in school-leaving examinations mandated essential for the first batch dropped to 65 percent and 40 percent for the second and third year batches, respectively. There were also around 809 dropouts from the six institutes out of a total of 2,200 admissions.

Faced with this scenario, the new state government no longer felt ownership since it did not initiate the program. The Health Minister who had been bypassed with the creation of the OSD was now responsible for the course again and found it opportune to immediately halt any further admissions to the course. Managing three batches of students, a total of 1,391 students, was complex enough and so the state government focused more on how to minimize the agitation of these students. Consequently, on September 1, 2008, the course was officially ended. Attention instead shifted to the question of what should be done with these 1,391 students.

**Table 5: Derailed Timeline for the Different Batches admitted to the Three-year Course**

| | Admission | 1st-Year Exam | 2nd-Year Exam | 3rd-Year Exam | Delay in completion |
|---|---|---|---|---|---|
| First Batch | Nov 2001 | Mar 2003 | Oct 2004 | Jan 2006 | 1 year, 2 months |
| Second Batch | Nov 2002 | Oct 2004 | Dec 2005 | Feb 2007 | 1 year, 3 months |
| Third Batch | Nov 2003 | Mar 2005 | Sep 2006 | Oct 2007 | 11 months |

Source: Chhattisgarh Chikitsa Mandal, Raipur and corroborated in interviews with students of different batches, May 23, 2009.

## SEARCHING EMPLOYMENT OPTIONS FOR ENROLLED GRADUATES: BIRTH OF THE RURAL MEDICAL ASSISTANT

The challenge initially for policy makers was to avoid the problems with MCI in order to get the course started. CCM had been formed as a consequence. The main motive for the formation of CCM bypassing the State Medical Council (that required MCI approval) was to avoid lengthy legal conflict with MCI and to initiate the course as quickly as possible and in the most convenient manner. The focus was more on getting the course started rather than the future prospects of the graduates. From the time of course conceptualization, it was decided that this course would prepare middle-level health care providers for the underserved rural and tribal areas of Chhattisgarh but clarity about their employment options was never developed; no document exists from this early stage to suggest otherwise. The issue surfaced only in January 2003 after the agitation of students demanding security of employment after completion of the course.

The May 2001 Act in Chhattisgarh created the CCM as the only deemed body to register the three-year course graduates, which allowed the course to legally begin even though it was not officially recognized by MCI, the licensure body authorized by the federal government to regulate medical education in the country. The creation of CCM, however, did not similarly facilitate legally the status of the graduates as practitioners of allopathic medicine. Education is constitutionally in the Concurrent List (subjects shared between federal and state governments). This implies that if there is a federal act already in existence, states cannot contradict the act. As per the federal MCI Act (1956), MCI and state medical councils have the sole authority to allow registered physicians to practice allopathic medicine.

With the Chhattisgarh State Medical Council having no role in the registration of the three-year graduates, the students could not be recognized to independently practice

allopathy. This was clearly stated in a federal Supreme Court ruling of February 2003.[10] This particular ruling noted a precedent[11] when by virtue of such qualifications as prescribed in a state act (such as the CCM Act) and on being registered *in a separate State Medical Register* with the State Medical Council (i.e., not a body such as CCM), a person was "entitled to practice allopathic medicine under Section 15(2)(b) of the 1956 [MCI] Act."[12] The CCM Act was a state act, but since it was not registered with the State Medical Council, it could not confer the rights to practice allopathic medicine.

To avoid this problem, the state government first considered allowing the three-year graduates to practice as paramedics under the Paramedical Act. The Paramedical Act specifies that the paramedic could provide that medicine or that care which he or she was trained to provide, which could secure the legal status the students required to practice. The problem with this solution was that the graduates of the three-year course, who aspired to be called doctors and medical professionals, would not accept the terms "paramedics" or "alternative medicine."

With the clarity that no legal independent practice in allopathic medicine was possible for these students, a bipartisan high-powered committee was tasked to find viable employment for them. One suggestion that this committee considered was to revive the post of assistant medical officer, an earlier post which had been abolished in 1976. In other states, this post had been occupied by the three-year licensed medical practitioner of West Bengal and the registered medical practitioner of Maharashtra. The proposal in Chhattisgarh was to create a third post of assistant medical officer in addition to the two medical officers (medical officers) that had been already sanctioned per PHC. This proposal, however, was rejected by the Finance Department on grounds that such an increase in health personnel expenditure was not justifiable.[13]

The next option considered was to post them as Block Extension Educators. This is a post which is financed by the federal government and which has duties not only of health education but of assisting the block medical officer in management tasks. Being a centrally funded post, it would create no additional financial burden on the state exchequer. The post of the Block Extension Educator is considered higher than a field supervisor but immediately under the medical officer in hierarchy. However, this solution was rejected by the students who were not ready to accept any post without the word "medical" in it. This was at best a limited solution from the start since the central government would fund only about 250 Block Extension Educators and many of the posts were not vacant, while the number of graduates from the three-year course seeking employment was several times more.

[10] Supreme Court of India decision on *Subhashis Bakshi v.West Bengal Medical Council* (Civil Appeal No.152 of 1994).
[11] Cited as *Dr. Mukhtiar Chand v. State of Punjab*, (1998) 7 SCC 579.
[12] Supreme Court decision on *Subhashis Bakshi v.West Bengal Medical Council*, pp. 287-288.
[13] The process of sanctioning two medical officers per PHC had already taken two years (2004–2006) to get budgetary approval. Interview with Dr. D.K. Sen, May 22, 2009.

A solution to the employability of these three-year graduates was finally realized through posts paid from the finances the federal government's NRHM made available to the state. The posts came to be titled Rural Medical Assistants, or RMAs, and were sanctioned for selective PHCs classified as "remote" or "tribal" in districts with the most acute shortage of doctors.

In mid-2009, the state government's policy was therefore to appoint the graduates as RMAs, with the second medical officer post kept in abeyance.[14] Since the salary of the RMA was half that of the MBBS doctor appointed as a medical officer (Rs8,000 as against Rs15,000), the government in fact was able to fill a vacant medical officer post at half the cost. By the letter of the law, as "medical assistants" they were not to be posted where there was no medical officer. However, in practice, no medical officers would join in many of the remote PHCs where RMA posts were sanctioned and thereby these RMAs often had to function independently. This situation was acceptable since the RMA was understood to be officially still under the supervision of the medical officer posted at the nearest health facility to the particular remote or tribal PHC.

Government employment for the three-year graduates with medical functions was therefore now possible, but private independent practice by these graduates was still not permitted. The IMA found this truce acceptable and so did the students who got the title of "medical" in their designation and a government job—their two key demands during agitation. The funds were from the central government through the NRHM mechanism and therefore the state finance department found it easier to accept the arrangement as well, although state finances would have to fund these posts if NRHM funds cease.

[14] Since the RMA posts for the second medical officer post are officially kept in abeyance, it is assumed that once there are MBBS-qualified doctors available and willing to take these second medical officer posts, the post of the RMA will automatically lapse. In reality, this is unlikely to occur in the foreseeable future in the present terms and conditions of service at these remote PHCs, and so the RMA posts are likely to remain.

**Table 6: RMA Postings in Remote and Tribal Districts (classified "difficult") in Chhattisgarh State**

| S. No | District | Classification of District | Sanctioned Positions of RMAs (first two recruitment rounds) |
|---|---|---|---|
| 1 | Bijapur | Difficult | Yes |
| 2 | Narayanpur | Difficult | Yes |
| 3 | Dantewada | Difficult | Yes |
| 4 | Jashpur | Difficult | Yes |
| 5 | Surguja | Difficult | Yes |
| 6 | Koriya | Difficult | Yes |
| 7 | Kanker | Difficult | Yes |
| 8 | Kawardha | Difficult | Yes |
| 9 | Raigarh | Ordinary | Yes (only at PHCs deemed "difficult") |
| 10 | Rajnandgaon | Ordinary | Yes (only at PHCs deemed "difficult") |
| 11 | Jagadalpur | Ordinary | Yes ( only at PHCs deemed "difficult") |
| 12 | Korba | Ordinary | Yes ( only at PHCs deemed "difficult") |
| 13 | Bilaspur | Ordinary | None |
| 14 | Dhamatari | Ordinary | None |
| 15 | Durg | Ordinary | None |
| 16 | Janjgir Champa | Ordinary | None |
| 17 | Mahasamund | Ordinary | None |
| 18 | Raipur | Ordinary | None |

## THE IMPACT: RECRUITMENT OF RMAS TO RURAL POSTINGS

There were two significant effects of the three-year course visible in the health system of Chhattisgarh: first, there was an overwhelming response to recruitment of RMAs to the most rural and tribal PHC postings, where previously no trained physician existed; and second, the aspirations of the three-year graduates appeared to be different from MBBS students in spite of largely similar socioeconomic backgrounds but due to greater exposure to public health in rural areas. Both of these are further elaborated below.

### RECRUITMENT AND POSTINGS OF THE RMAS

RMAs in non-tribal areas were supposed to get an honorarium of Rs.8,000 per month (notably less than the salary of a MBBS-trained doctor, as noted above) and those in tribal areas were appointed on honorarium of Rs.9,000 per month as per the approved NRHM Project Implementation Plan for Chhattisgarh state. The government appointed them subsequently at a uniform salary of Rs.8000 per month. Appointments were

contractual and for a period of two years. In 2008, the CCM conducted the first round of interviews for recruitment to 398 sanctioned posts of RMAs in the identified 12 large tribal and remote rural areas (Table 6). There were 225 candidates selected and posted (Table 7). Preference was given to their native districts if that "home district" was among the 11 districts selected for RMA postings. The scope of practice of RMAs is summarized in Box 1.

The remaining 173 posts were re-advertised in 2009 and 529 applications received, with another 78 finally recruited. About 303 out of 398 RMA posts are filled. The 95 posts of RMAs which were not filled came under the Scheduled Caste and Scheduled Tribe categories. They remained vacant, not because of a dearth of interested applicants, but due to the absence of adequate numbers of Scheduled Caste and Scheduled Tribe students ever trained in these institutes. The reservation rules at the time of admissions were either insufficient or poorly implemented. These first RMAs have been posted in the most remote and difficult areas of Chhattisgarh to provide health services.

**Table 7: Postings of RMAs in First and Second Recruitment Drive**

| District | Sanctioned Posts | Positions filled during the First recruitment round in 2008 | Positions filled during the Second recruitment round in Feb. 2009 | In Position | Vacant |
|---|---|---|---|---|---|
| Bijapur | 13 | 3 | 5 | 8 | 5 |
| Narayanpur | 7 | 7 | | 7 | 0 |
| Jagadalpur | 55 | 33 | 9 | 42 | 13 |
| Jashpur | 32 | 18 | 4 | 22 | 10 |
| Surguja | 77 | 54 | 1 | 55 | 22 |
| Koriya | 27 | 12 | 10 | 22 | 5 |
| Kanker | 28 | 12 | 15 | 27 | 1 |
| Korba | 31 | 29 | 2 | 31 | 0 |
| Raigarh | 47 | 31 | | 31 | 16 |
| Rajnandgaon | 33 | 20 | 7 | 27 | 6 |
| Dantewada | 24 | 2 | 10 | 12 | 12 |
| Kawardha | 24 | 4 | 15 | 19 | 5 |
| **Total** | **398** | **225** | **78** | **303** | **95** |

Sources: Chhattisgarh Chikitsa Mandal, Raipur and State Health Resource Centre, Raipur.

In light of this positive experience of posting RMAs in underserved remote areas and the existing 740 vacancies of medical officer, in 2009 the state increased the total RMA posts to 858. With the policies of contractual appointments of MBBS doctors and recruitment of contractual AYUSH doctors at the post of medical officers, only 1,407 posts could be filled, out of total medical officer posts of 2,147. Therefore, to make up the gap, the state government introduced one RMA post at all PHCs and an additional post for lady RMAs at CHC level in all the 18 districts of Chhattisgarh, irrespective of the difficult, rural, or tribal status of the districts.[15] About 74 RMAs who had joined in the second round of

[15] Interview with Chhattisgarh Health Minister, Shri Amar Agrawal, Raipur, May 22, 2009. The Minister expressed a vision of recruiting all the current 1,391 graduates from the three-year courses in the coming

recruitment also appeared in the third counseling, seeking change of posting location. Accordingly, 629 posts were filled through the counseling sessions conducted by CCM in early October 2009. Therefore, of the total sanctioned posts of 858 RMAs, 229 were recruited from the initial two rounds and 629 recruited after the third round. Even though the third round of recruits were in the process of joining, in 2009, no vacancies were officially declared from those joining previous rounds of recruitment and all posts were reported filled.

**Box 1: Scope of the Rural Medical Assistants**

- Assist in implementation of all National and state level health programs.
- In case of any emergency situation, RMAs have to provide primary health care services and then refer the patients to higher level of public hospitals based on the requirement.
- Provide preventive health education and measures to attain good health.
- Provide limited primary level treatment for some of the conditions.
- Provide basic maternal and child health care, conduct delivery, basic management of complications of pregnancy and childbirth, suturing of first degree perineal tears.
- Perform simple operative procedures—repair of small wounds by stitching, drainage of abscess, burn dressing, applications of splints in fracture cases, application of tourniquet in case of severe bleeding wound in a limb injury.
- Provide primary level treatment for 5–7 days only if the improvement is visible in the health of the patient else they should refer the patient to the nearby CHC for further treatment.
- Permission from the High Court and Supreme Court to dispense certain over-the-counter drugs
- Linkages with communities to increase the service delivery.
- Regular meeting with the peripheral staff.
- Follow-up in treatment diseases initiated by Medical Officers of CHC and PHC.
- Follow-up of all National Health Programs in Coordination with the block medical officer.

years and hoped that their successful posting in such remote and tribal areas would provide the necessary evidence to restart such a course at some later date.

**Table 7: Postings of RMAs after Third Recruitment Drive**

| S. No | District | Sanctioned Posts | In position (PHC) | In Position (CHC) | Vacant |
|---|---|---|---|---|---|
| 1 | Bijapur | 17 | 14 | 3 | 0 |
| 2 | Narayanpur | 9 | 7 | 2 | 0 |
| 3 | Jagadalpur | 67 | 58 | 9 | 0 |
| 4 | Jashpur | 38 | 31 | 7 | 0 |
| 5 | Surguja | 98 | 81 | 17 | 0 |
| 6 | Koriya | 31 | 28 | 3 | 0 |
| 7 | Kanker | 38 | 34 | 4 | 0 |
| 8 | Korba | 41 | 37 | 4 | 0 |
| 9 | Raigarh | 57 | 50 | 7 | 0 |
| 10 | Rajnandgaon | 51 | 47 | 4 | 0 |
| 11 | Dantewada | 30 | 28 | 2 | 0 |
| 12 | Kawardha | 26 | 22 | 4 | 0 |
| 13 | Bilaspur | 84 | 74 | 10 | 0 |
| 14 | Dhamatari | 26 | 23 | 3 | 0 |
| 15 | Durg | 86 | 72 | 14 | 0 |
| 16 | Janjgir Champa | 48 | 39 | 9 | 0 |
| 17 | Mahasamund | 30 | 26 | 4 | 0 |
| 18 | Raipur | 81 | 63 | 18 | 0 |
| | Total | **858** | **734** | **124** | **0** |

Sources: Chhattisgarh Chikitsa Mandal, Raipur and State Health Resource Centre, Raipur.

## DIFFERENCES BETWEEN THE THREE-YEAR COURSE AND MBBS GRADUATES, IN TRAINING AND ASPIRATIONS

The three-year diploma course was designed to prepare skilled health care providers for underserved areas. The course was therefore designed to train the students in rural settings and the locations of the six institutes were as a result selected to be in rural areas. It has already been documented above how the curriculum gave importance to public health from the first year and that the internship, in particular, gave students exposure to the community's problems in rural public health settings. The MBBS graduates, on the other hand, are taught in urban settings focused around a tertiary care hospital. They have tended to therefore develop an urban orientation and preference to practice in the same familiar urban set-up, rather than in rural areas.

It is also significant that in focal group discussions and interviews, the three-year course students expressed their role models to be doctors working in the PHC, CHC, or district hospital, whereas for MBBS students the role models have most usually been their

professors in medical colleges.[16] It has been documented that the vast majority of MBBS graduates aspire to further specialization through postgraduate studies.[17] Although the curriculum for the three-year course and MBBS are similar, it is still the graduates from the three-year course who are more likely to serve in rural and tribal areas, as compared to MBBS graduates. This difference in the aspirations of students is attributed mainly to the design and pattern of the courses.

In terms of performance the difference between MBBS and the three-year doctors was being studied using the sample of the first 50 RMAs who have joined public service.[18]

## CONCLUSION: LESSONS FROM THE CASE

The three-year course to train physicians to serve rural and tribal areas of Chhattisgarh was a policy imperative, given the human resources for health challenges that the new state faced and the urgency of qualified health care providers required. The initial intention for starting the three-year course, therefore, had significant merit for reasons elaborated earlier. In the translation of such laudable intention into practice, events, however, unfolded in Chhattisgarh that provide important lessons for any future implementation of a three-year course elsewhere.

Some officials interviewed for this study suggested that the speed with which initial implementation of the course occurred did not allow time for substantial consideration of weaknesses (as later revealed in the program). This may be partially accurate as there was keen political support from the Chief Minister to speed the opening of institutes with, consequently, little incentive within government to delay starting the course by bringing all stakeholders on board for discussions. This may have led to oversight that could have been averted had more time been available.

Such an interpretation, however, is at best partially accurate since the course began nearly a year after the initial intention for a three-year course was formally expressed; so although the government file proposing the implementation of the course moved fast when it did move, there were spells of inactivity as well. In this period of time, the doctors' association—the IMA—had already filed a case in the High Court challenging the legitimacy of the three-year course. It may well be argued that the political interest in not further delaying the start of the course was, in fact, precisely to ensure that such opposition to the course did not have the time to scuttle the program altogether. There was also, of course, the urgency of trained physicians required in the state.

[16] Focus group discussions with a group of 30 graduates from the three-year course, Raipur, Chhattisgarh, May 23, 2009. All students expressed their willingness to serve in a rural area if they were given a government job.
[17] The career aspirations of MBBS students and their preference for further specialization upon completion of their bachelors' course are documented in Raha et. al. 2009.
[18] This research was under way in Chhattisgarh in late 2009, with study findings likely in early 2010.

The principal lesson of this case has to do with how best to address and include the various stakeholder interests in the three-year course. The political strategy that appears to have been adopted was one that anticipated opposition of the IMA and therefore attempted to bypass the association rather than negotiate a reasonable compromise to achieve the objectives of creating a viable cadre for rural areas—a compromise which, in fact, emerged later in the process. The strategy failed to anticipate the interests of the students themselves and their desire to be given appropriate status as medical doctors. Once the legal status of the graduates was challenged, the applicants quickly dropped off and those already in the program resorted to a series of strikes to make known their displeasure. It is not certain that involving the IMA early in the process would have led to the consensus that emerged at the end, nor that anticipating the interests of the students would have avoided strikes, but to ignore the interests of such powerful groups from the beginning was a high-risk strategy.

In addition, expediency of shifting responsibilities and authority from CCM and the Health Secretary to politically appointed individuals meant that there was little institutional ownership of the course—something that ultimately proved fatal to the course (which is no longer admitting new students). When authority was returned to the Health Secretary, he scuttled the program.

There are also lessons related to the specific content of the course and the failure to plan for the hiring of the graduates.

- *Future employment opportunities of the students, including their legal status in terms of government jobs need to be clear from the start:* Starting the three-year course was considered the principal legal challenge by policy makers in government. The legal considerations affecting the medical practice of the students trained received little attention in the beginning, if any. There was clarity within the state government when initiating the three-year course that the students would not be guaranteed government employment, but any further clarity on the legal status of the students graduating and their identity remained amiss.

- *Strong institutional support structures are needed to maintain quality standards and provide for grievance procedures:* The course in Chhattisgarh entailed the creation of the CCM that was significantly empowered (as noted above) to oversee processes related to syllabus, admissions, examinations, and registration, but with only a single official assigned full-time to the CCM. The two inspection committee reports raised concerns over quality standards in some of the institutes, but there existed no regulatory institution to oversee quality standards nor did any institutional mechanism provide for closure of an institute if minimum quality standards were unmet. Grievance redress requires an institutional mechanism to be created as well. In Chhattisgarh, students depended almost entirely on news media and not on an official channel of communication between government authorities and themselves, which added to confusion rather than clarity in information.

- *The number of students admitted needs to be linked to facility capacity of the institute:* When the call for interest in establishing institutes was made, the intake of students per institute was limited to 100. The decision to increase the intake to 150 did not consider the requirement of any corresponding increase in size or facilities of the institute already stipulated. Only two out of the six institutes were reported consistently to have functioned much better as they were located closer to government hospitals with a significant patient load that could be used for the clinical training of such large numbers of students.

- *Training needs to be clearly focused on addressing rural public health needs:* The aim of the three-year course was to train practitioners to provide rural health care services, but the syllabus adopted was a mini-MBBS course rather than one drawn specifically to cater to public health needs. Any such future course would benefit from a community-based assessment of diseases and illnesses for which training could be specially stressed. The course suffered from midstream changes, which stemmed from legal or political reasons entirely unrelated to health-related concerns of the target population.

- *There needs to be a clear career path if three-year course graduates are to be employed into the government system:* For the three-year course graduates brought into government employment as RMAs, a career path is an important consideration to retain such providers in government service. In the case of the RMAs, no such career path is considered since they are expected to be entirely contractual workers mapped to a single post. Retention of such providers in the long run may become a problem, where as a planned career path of employment may instead incentivize more students to join any future such similar three-year course.

In the Chhattisgarh experience, a key concern has been that there was no strict enforcement of rules and norms, while no quality management systems supported the functioning of the three-year course. The rules of admission allowed for nonresident Indian seats which were converted to seats filled at the discretion of the management of these institutes. While all educational institutes were privately run, the majority of owners had no experience of running such institutions and reported learning of the legal problems that were present from the outset only as events unfolded.

The most important lesson from the Chhattisgarh experience, however, is that graduates from this program have been recruited and posted to the most remote and tribal PHCs of the state, where no medical officer was previously willing to serve. That the state government has been able to fill these vacancies through creating the posts of RMAs expresses again the important role of the political leadership in deciding the fortune of the three-year course.

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# APPENDIXES

## Appendix Table 1: Timeline of Events

| Time line | Events | Key People |
|---|---|---|
| 2000 | Committee of 3 members—Professors of Medical college—Design of 3 yr diploma course was proposed | |
| January 2001 | Proposal of three-year diploma medical course | Chief Minister, Health Secretary |
| February 2001 | Proposal for formation of Chhattisgarh Chikitsa Mandal | Chief Minister, Health Secretary, |
| 2 March 2001 | Refusal of MCI to recognize the course | MCI President, Secretary Health |
| 2 March 2001 | Approval for the CCM from Law | Additional Law Secretary, Secretary Health |
| 2 March 2001 | Approval from Finance department | Finance Minister, Secretary Health |
| 2 March 2001 | Nomination of 3 members of the CCM—President—Director of Health Services (DHS), Vice President—Dean Medical Colleges, Registrar—1 Nominated Gazetted officer | Chief Minister, Secretary Health |
| 3 March 2001 | Formation of a Committee with DHS, Director of Medical Education, and Senior Secretaries as members | Chief Secretary and Secretary Health |
| 27 March 2001 | Meeting of Chief Secretary, Upper Chief secretary, Principal Secretary, Secretary General Administration Department, Principal Secretary Law, Secretary Health | |
| 29 March 2001 | Approval of the proposal | Chief Secretary, Chief Minister |
| 17 April 2001 | Proposal approved in the Cabinet meeting and the Name of the course—Diploma in Modern Medicine and Surgery | |
| 16 May 2001 | Proposal approved and signed by Governor | |
| 18 May 2001 | Formation of CCM and Gazette notification printed | |
| 22 May 2001 | Minimum standard guidelines for private colleges prepared and expression of interest floated | |
| 26 or 31 may 2001 | IMA Bilaspur filed a petition against the course at Bilaspur High Court | IMA representatives, DHS, Principal Secretary, Additional Secretary Law. |
| 24 August 2001 | Name of the course changed to Diploma in Alternative Medicine, Chhattisgarh Chikitsa Mandal Act—amended | Chief Minister, Health Minister, Secretary Law, Secretary Health |
| 29 August 2001 | Gazette Notification with new the name of Diploma in Alternative Medicine | |
| September 2001 | Inspection of colleges by inspection committee—DHS, Joint DHS, 1 Chief Medical Officer Health (CMOH) nominated by Govt., Registrar CCM, District CMOH | |
| 2 October 2001 | 3 colleges—Jagdalpur, Ambikapur, Pendraroad were inaugurated by the Chief Minister. | |

| Time line | Events | Key People |
|---|---|---|
| November 2001 | Admissions of first batches in 3 colleges through Counseling by CCM | |
| 31 December 2001 | Syllabus finalized | Secretary Health, Director of Health Services, CCM |
| July 2002 | Joining of OSD | |
| July 2002 | 3 colleges—Kanker, Kwardha and Katghora inaugurated by the Chief Minister | |
| January 2003 | First Strike of the students—Issues—Clarity on job prospects & Change of name—(Alternative medicine) | |
| 3 March 2003 | Name of the course changed to Diploma in Holistic Medicine and Paramedical course | OSD, |
| March 2003 | First exams for the first batch were conducted by the Universities. | |
| July, 2003 | Name of the course changed to Diploma in Modern and Holistic Medicine | |
| 6 January 2004 | Orders to form the first inspection committee | Governor, Upper Secretary, Health Secretary |
| 12 February 2004 | Committee report | |
| 2004 | Admissions discontinued | |
| July 2004 | Second strike of students for | |
| 30 July 2004 | Second inspection committee formed | Health Secretary, ---- |
| 8 April 2005 | Second committee report | |
| January 2006 | First batch completed final year exam | |
| June 2006 | Internship of first batch started | |
| December 2006 | Third strike of students (1 month ) | |
| 7 February 2007 | Duration of internship increased from 6 months to 1 year | |
| 23 August 2007 | Name of the course changed from Diploma to Practitioner in Modern and Holistic Medicine. | |
| 1 September 2008 | Gazetted order to stop admissions in all the colleges | |

**Appendix Table 2: Number of Student Admissions, Dropouts, and Examination Results (by institute)**

| S.No. | Name of Institution | Year | Batch | Admissions | Dropouts | Passed Final Year Exam | Failed Final Year Exam |
|---|---|---|---|---|---|---|---|
| 1. | Sh. Kedarnath Institute of Medical Sciences, Katghora, Korba | 2002–2003 | I | 123 | 13 | 90 | 03 |
| | -do- | 2003–04 | II | 105 | 03 | 82 | 14 |
| 2. | Anisha Memorial Medical Institute, Pendraroad., | 2001–02 | I | 152 | 54 | 84 | 10 |
| | -do- | 2002–03 | II | 140 | 22 | 53 | 38 |
| | -do- | 2003–04 | III | 144 | 48 | 75 | 08 |
| 3. | Balgangadhar Tilak Medical Institute, Jagdalpur | 2001–02 | I | - | - | - | 112 |
| | -do- | 2002–03 | II | - | - | - | 78 |
| | -do- | 2003–04 | III | - | - | - | 69<br>131(suppl.) |
| 4 | Mahrishi Ashtang Medical Institute, Ambikapur | 2001 | I | 154 | - | | - |
| | -do- | 2002 | II | 121 | - | - | - |
| | -do- | 2003 | III | 88 | - | - | - |

## Appendix Table 3: Number of Three-year Course Graduates (by institute)

| Institute | Total Students |
|---|---|
| Balgangadhar Tilak Institute, Jagdalpur | 308 |
| Anusha Memorial Medical Institute, Pendra Road, Bilaspur | 264 |
| Ma Bambleshwari Medical Institute, Kwardha | 229 |
| Mahrishi Ashtang Medical Institute, Sarguja | 210 |
| Biken Institute of Medical Science, Kanker | 200 |
| Shri Kedarnath Institute of Medical Science, Katghora, Korba | 180 |
| Total | 1391 |

Sources: Chhattisgarh Chikitsa Mandal, Raipur and State Health Resource Centre, Raipur.

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