Strengthening the Haat Bazaar Clinic Yojana in Chhattisgarh
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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
</tr>
<tr>
<td>AYUSH</td>
<td>Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy</td>
</tr>
<tr>
<td>BMO</td>
<td>Block Medical Officer</td>
</tr>
<tr>
<td>CGMSC</td>
<td>Chhattisgarh Medical Services Corporation</td>
</tr>
<tr>
<td>CHC</td>
<td>community health centre</td>
</tr>
<tr>
<td>CHO</td>
<td>community health officer</td>
</tr>
<tr>
<td>CHW</td>
<td>community health worker</td>
</tr>
<tr>
<td>CMHO</td>
<td>Chief Medical and Health Officer</td>
</tr>
<tr>
<td>DH</td>
<td>district hospital</td>
</tr>
<tr>
<td>DMF</td>
<td>District Mineral Fund</td>
</tr>
<tr>
<td>FLW</td>
<td>Frontline Health Worker</td>
</tr>
<tr>
<td>HBC</td>
<td>Haat Bazaar Clinic</td>
</tr>
<tr>
<td>HBY</td>
<td>Haat Bazaar Yojana</td>
</tr>
<tr>
<td>HWC</td>
<td>health and wellness centre</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education, communication</td>
</tr>
<tr>
<td>JAES</td>
<td>Jay Ambe Emergency Services</td>
</tr>
<tr>
<td>KII</td>
<td>Key informant interviews</td>
</tr>
<tr>
<td>LHV</td>
<td>Lady Health Visitor</td>
</tr>
<tr>
<td>LWE</td>
<td>Left-Wing Extremism</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine and Bachelor of Surgery</td>
</tr>
<tr>
<td>MMU</td>
<td>mobile medical unit</td>
</tr>
<tr>
<td>MO</td>
<td>medical officer</td>
</tr>
<tr>
<td>MPW</td>
<td>multipurpose worker</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-patient Department</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health centre</td>
</tr>
<tr>
<td>RBSK</td>
<td>Rashtriya Bal Swasthya Karyakaram</td>
</tr>
<tr>
<td>RMA</td>
<td>rural medical assistant</td>
</tr>
<tr>
<td>SC and SHC</td>
<td>sub-centre and sub-health centre</td>
</tr>
<tr>
<td>SHC</td>
<td>sub-health centre</td>
</tr>
<tr>
<td>SoP</td>
<td>standard operating procedure</td>
</tr>
<tr>
<td>UID</td>
<td>unique identification</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Acknowlegements

The documentation of the Mukhya Mantri Haat Bazaar Clinics was undertaken in the Bastar region of Chhattisgarh state.

WHO gratefully acknowledges the support provided by the Department of Health and Family Welfare and the National Health Mission, Government of Chhattisgarh for providing the secondary data and access to health facilities and all the respondents for their important contributions which include the Health Personnel, District Health Administration, and community members in Dantewada, Bijapur, Narayanpur, and Bastar districts.

Sincere gratitude to Mr. Vilas Bhoskar Sandeepan, the Mission Director of the National Health Mission, for his leadership and unwavering commitment to improving access to healthcare for vulnerable communities in the state. His encouragement has been a source of motivation for the entire team during the assessment. Special acknowledgment is also due to Dr. Abhyuday Shakti Tiwari, the State Nodal Officer for the Mukhya Mantri Haat Bazaar Yojana in the State, for his immense contribution and support to this endeavor.

The technical partner, Chaupal is a voluntary organization based in Chhattisgarh and works primarily with tribal communities in the State. The team members included Sulakshana Nandi, Deepika Joshi, and Gangaram Paikra. The Chaupal team documented the Haat Bazaar Clinics and undertook field visits for primary data collection as an evidence generation exercise covering several Haat Bazaars which were set up in the conflict affected region of the State i.e., popularly known as Bastar Division.

The technical contributions and overarching guidance provided by colleagues at the World Health Organization (WHO) Country Office for India are recognized; Dilip Singh Mairembam, Hilde De Graeve, Rakshita Khanijou, and Varun Kakde. Furthermore, appreciation for the crucial on-field efforts aimed at generating actionable evidence collectively by the WHO team in the State; Urya Nag and Kumar Gaurav have been instrumental in leading this initiative.
Haat Bazaars are common marketplaces which are often set up in pre-designated areas on a fixed day of the week. The local and tribal communities use these trading hubs to sell their produce and purchase household items for their daily needs. These bazaars can be a congregation of a few sellers from within the community or suppliers who travel from faraway places using local transport or who walk for miles to reach them. Sometimes, a few of them will rent a vehicle or pool one among select families and reach the location with their produce. The Haat Bazaar Clinics (HBC) are set up within the same premises as these Haat Bazaars. The intention is to bring health care services closer to the community, especially for those with limited, or no access to them. These HBCs are run by a team of primary health care (PHC) providers which include a medical doctor along with paramedical staff. Together, they work to improve access to diagnostic and health care services.

The study, ‘Strengthening the Haat Bazaar Clinic Yojana in Chhattisgarh’ was undertaken to assess and review the implementation of the Chief Minister or Mukhya Mantri Haat Bazaar Clinic Yojana in the Indian state of Chhattisgarh. The HBC Yojana was launched in Chhattisgarh on 2 October 2019 with the aim of improving access to health services for people living in the remote rural and tribal regions of the state.

To understand the impact of these HBCs, an assessment was conducted in the Bastar region which includes the districts of Dantewada, Bijapur, and Narayanpur. Jagdalpur is the district headquarters, and the region is bounded on the northwest by Narayanpur district, on the north by Kondagaon district, and on the east by Nabarangpur and Koraput districts of Odisha. On the south and southwest, it is flanked by Dantewada and Sukma districts.

The Bastar division possesses a unique blend of tribal and Odia culture. The HBC model is based on setting up mobile medical units (MMUs) in the identified Haat Bazaars. They provide different preventive and curative services to the community in areas with limited or no access to health care services. Earlier, patients often had to travel to urban and/or semi-urban areas to access their routine health care services. But now, many of these services are being provided closer, at these very HBCs. This has reduced the distance and minimized their financial hardships related to transportation.

Limited health care infrastructure in the region, combined with constraints of availability and retention of health-care providers in hard-to-reach areas, impacts service delivery. The hardship faced in reaching these habitations in remote parts of the region also makes it challenging for health care workers to provide services through their outreach.

For the purpose of the study, the HBCs in these districts were visited and primary data collected through key informant interviews (KIs) and group interviews with health service providers, officials, and community members. This was supported by undertaking a review of the secondary data analysis, provided by the state and district.

The study found that the location and identification of Haat Bazaars for running the clinic along with an initiative-taking medical team are key determinants of a well-functioning
HBC. These clinics are providing treatment for routine, common and less serious illnesses such as fever, scabies, cold, cough, diarrhoea, malaria, and screening, along with management for noncommunicable diseases (NCDs). Therefore, HBCs are useful for preventive and promotive health care where precautionary check-ups can be done before the illness becomes serious (for example, malaria) or screening of diseases in case of NCDs.

Also, HBCs are found to have advantages over other public health care facilities, as there are no user fee charges for services. Moreover, the community faces fewer barriers to access care, as compared to entering a hospital building. Thus, HBCs have not only helped improve access to health care services in difficult areas but have optimally used the platform to create awareness in the community. Overall, they have initiated preventive and promotive health care services.

The functioning of a HBC is intricately linked to the regular health system functioning, which includes the health workforce comprising community health workers (CHWs), sub-health centres (SHCs), PHCs and linkages to higher facilities. For example, the study found that an ample supply of essential medicines was available at these facilities with negligible drug stock-outs, contributing significantly to the smooth functioning of HBCs.

Similarly, human resource recruitment is crucial for the functioning of HBCs. Therefore, districts that have filled most of their posts and have an adequate health workforce in place are in a better position to run the HBCs without compromising or disrupting routine health care services.

Since this scheme is still in its initial years of implementation and is being expanded, it needs to further improve its functioning. This improvement can happen if the HBCs are planned and coordinated by the district health and block health officials in a way that prioritizes areas which are not served by the regular health system or where the health workforce is unable to reach routine outreach health care services.

Against this backdrop, there is a norm that has been established by the Government of Chhattisgarh that must be adhered to, namely, to not plan the HBCs within a 3 km radius of a public health facility. This would ensure maximum utility and benefit to the communities who need it the most.

The HBCs have the potential to serve as a crucial factor in building trust in public health systems while mitigating the fear of visiting a hospital-based setting. In remote areas where people have less access and familiarity with government health services, there is inevitably lesser uptake of public health services. It is here that HBCs can help build awareness and serve as a trust-building platform for the health department.

Thus, the location of the HBCs is crucial, along with ensuring a complete complement of health workforce that can provision health care service delivery, including essential medicines and point-of-care diagnostics.

The HBCs play a pivotal role in providing primary health care services. Simultaneously, they function as a screening centre for common NCDs and cancers for community members who visit the HBC or are spotted by health care teams. These patients are diagnosed and provided lifestyle modification counselling and medication with regular follow-up for adherence.
However, the mechanism to ensure regular follow-up of these individuals back into the community must be established, either with the PHC teams or frontline health workers (FLWs) who provide care to them.

To make health care service delivery sustainable, it will be ideal to empower the FLWs to reinforce community outreach services in a planned manner, along with community-based follow-up. This will not only ensure continuity of services but also warrant that community members rely more on the public health systems. This will in turn make the system more responsive to the health care needs of the community.

To make the information more accessible and easier to track, it will be ideal to have a unique identification (UID) number for each HBC in the portal\(^1\) that has pre-determined linkages with MMUs and other mobile clinics. These have been designated to provide health care services, including health facilities for referrals. Mapping all MMUs in the area (block and districts) that are run under different schemes will enable the designation of only one MMU for every HBC. This will ensure the engagement of all MMUs on all six days of the week. This process has been followed manually in the Narayanpur district with all the levels, from the block to the district being involved in route planning and mapping. The live updation on the portal will not only streamline the health workforce who has been engaged but also pre-inform the MMU staff about its location.

The HBCs are a single point of portal entry for reporting the location of the HBC and facilitating referrals to linked facilities, if required. In addition, line listing of beneficiaries must be done for those who have availed services at the HBC. To manage this situation better, it is suggested that a team located within the district and block health system (like Rashtriya Bal Swasthya Karyakram or RBSK) be set up to provide services at the HBCs.

There is need to further strengthen the regular monitoring and oversight of the HBCs, MMUs and teams that have been positioned at the block and district level. Including this as part of the district-level review will enable a better oversight of its functioning and streamline the continuity in care provision while optimally utilizing the health workforce and health services. This platform can also be used to smoothen the inter-district patient referrals and facilitation to the required health speciality.

The key for sustaining these efforts in difficult-to-access areas is to ensure the HBCs continue to be equipped, with adequate human resources, essential medicines, and diagnostic facilities. This must be done along with the planning of the HBCs in the areas which do not have regular health care services via the health facilities or outreach activities.

In addition to the 104-call centre follow-up, the HBC initiative can be supplemented with the 108-emergency transportation to undertake coordinated visits and facilitate patient transport to higher centres of care. This is crucial, given the difficulty to arrange transport in the region and the higher costs involved, especially for inter- and intra-district travel. The Government of Chhattisgarh has undertaken an initiative for ensuring continuum of care but is now strengthening it further and integrating it with existing systems which is the need of the hour.

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1. https://govthealth.cg.gov.in/cmhaatbazaar/#/home
To conclude, the HBCs, as envisioned are providing health care services in the remotest areas of the state and now with a supplemental workforce, they can cover multiple health blocks. Going forward, prioritization should be undertaken to set up HBCs in specific locations, based on their local needs and situational context. A combination of factors such as the location and size of the Haat Bazaar (large, small, strategically located in the accessible area or main town), its distance from the PHC/CHC should be evaluated prior to setting it up. Additionally, the community could be involved in initial planning which will help utilize resources optimally, more so for those who need it the most.

The continuum of care linkages for higher care centres should be planned as a next step to ensure forward and backward linkages with the community and HBCs. The portal can be used to track patients and ensure that services remain patient-centric for improved access and to minimize financial hardship.
Haat Bazaars are open air weekly marketplaces which are regularly set-up in pre-designated areas on defined days of the week in rural areas. These bazaars are often considered as a trading venue and hub for exchange of household items and other goods. They have been vital to the lives and livelihoods of rural communities and often resemble multiple pop-up shops that are set up temporarily in each area.

In Barsur village in Dandewada district, the administration has set up a model Haat Bazaar with raised concrete platforms and defined pathways, to convene individual shops in a structured manner.

These Haat Bazaars are accessed not only by the communities which live around them, but also those who stay in adjacent blocks and districts. They are flocked by men, women and children who are given to traversing large distances by foot, laden with their produce or goods which they sell or barter to avail better prices and fair deals.

Few people also reach the bigger Haat Bazaars using local transport like buses, hired vehicles and shared autorickshaws. With multiple people on board, these vehicles are the preferred and more affordable modes of transportation. Moreover, only a handful of community members access the bazaars using personal transport.

At these bazaars, all the items required to run a household are easily spotted and traded. They are full of agricultural produce, utensils, poultry, and household items like soaps. Some of the bazaars keep trinkets and clothes that can be purchased. The bazaars play a vital role in the lives of rural communities and are hubs not only for trade, but also for exchange of news and information. They are fundamental for commerce and provide many opportunities for social and cultural exchange between different communities.

The Chief Minister or Mukhya Mantri Haat Bazaar Clinic Yojana was launched in Chhattisgarh on 2 October 2019. The aim of this scheme has been to improve access to health services for people living in remote rural regions of the state. The HBC is a weekly clinic that is set up at a pre-determined location of the weekly market. The markets are identified by the government as a place where health services can be provided to those who lack regular access to them. The health workforce deputed to these clinics provides care which comprises of ambulatory services, including treatment and provisioning of medicines, conducting of diagnostic tests, and making referrals to centres for higher levels of care. All services are provided free of cost. As of 1 January 2022, a total of 59 435 such clinics were organized in the state, recording over 19 27 351 outpatient visits.

This scheme envisioned a model for bringing health care services nearer to people living in remote and hard-to-reach areas, especially regions affected by dissonance and strife. It
has lessons for improving health service access and equity in similar regions and contexts elsewhere in the country.

This study is an attempt to document the functioning of HBCs and their impact on care that is being provisioned in the region. The document ends with key recommendations to further improve the functioning of the HBCs and their replication in similar contexts across the country.

1.1 Study objectives

- Document the functioning of the *Mukhya Mantri Haat Bazaar Clinic Yojana* in remote and Left-Wing Extremism (LWE)\(^2\) affected districts of Chhattisgarh.
- Provide recommendations to improve the functioning of the HBCs and their interlinkages with the existing health system; and
- Document lessons for the replication of the HBCs in similar contexts elsewhere.

1.2 Location of the study

The *Mukhya Mantri Haat Bazaar Clinic Yojana* is operational in all districts of the Bastar region, namely Sukma, Narayanpur, Kondagaon, Bastar, Dantewada, Bijapur and Kanker.

For this study, the districts of Dantewada, Bijapur and Narayanpur were chosen. Within this, the blocks where the study was conducted are detailed in Table 1. However, the research team also visited the Haat Bazaars in the other districts or non-sampled blocks within the district which they found enroute.

<table>
<thead>
<tr>
<th>District</th>
<th>Blocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dantewada</td>
<td>Dantewada and Geedam</td>
</tr>
<tr>
<td>Bijapur</td>
<td>Bhairamgarh</td>
</tr>
<tr>
<td>Narayanpur</td>
<td>Orchha and Narayanpur</td>
</tr>
</tbody>
</table>

Within these blocks, an attempt was made to visit at least two HBCs in each block and meet the medical team to observe their functioning and service provisioning. In addition, the research team held discussions with health officials at the block level, which included the District Programme Manager (DPM) and the Block Programme Manager (BPM), along with select members from the Mitanin programme.\(^3\)

Facilities such as districts hospitals (DH), CHCs, PHCs, and SHCs under which the Haat Bazaars functioned were also visited. The goal was to understand health systems functioning in the district. This was done along with their comparative differences (if any) and the HBC functioning, within the larger health system design (*Annexure 1 & 2*).

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3. Mitanin programme started in Chhattisgarh in 2002 as a government community health worker programme. Mitanins are women volunteers who undertake family-level outreach services, community-organization building and social mobilization on health and its determinants, while advocating for improvement in the health system
1.3 Sample size

Table 2 presents a list of HBCs visited in six blocks of four districts. A few of the Haat Bazaars that were visited were closed as they operated on different days of the week and therefore excluded in the list below (basing HBC in Orchha block, Chhote Dongar HBC in Narayanpur Block, Bahigaon HBC in Bastanar Block). Table 3 highlights the details of the key informant interviews (KIIs) and group interviews conducted along with the number of respondents interviewed.

**Table 2: List of Haat Bazaar Clinics**

<table>
<thead>
<tr>
<th>District</th>
<th>Block</th>
<th>HBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dantewada District</td>
<td>Geedam Block</td>
<td>Barsur HBC</td>
</tr>
<tr>
<td></td>
<td>Dantewada Block</td>
<td>Pondum HBC</td>
</tr>
<tr>
<td></td>
<td>Dantewada Block</td>
<td>Kawadgaon HBC</td>
</tr>
<tr>
<td>Bijapur District</td>
<td>Bhairamgarh Block</td>
<td>Gudma HBC</td>
</tr>
<tr>
<td></td>
<td>Bhairamgarh Block</td>
<td>Mirtur HBC</td>
</tr>
<tr>
<td>Bastar District</td>
<td>Bastanar Block</td>
<td>Bade Kilepal HBC</td>
</tr>
<tr>
<td>Narayanpur District</td>
<td>Orchha Block</td>
<td>Orchha HBC</td>
</tr>
<tr>
<td></td>
<td>Narayanpur Block</td>
<td>Farasgaon HBC</td>
</tr>
</tbody>
</table>

**Table 3: Respondent information**

<table>
<thead>
<tr>
<th>Type of interview</th>
<th>Category of person/s interviewed</th>
<th>Number of interviews conducted (with persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key informant interviews</strong></td>
<td>Medical officer, PHC</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Staff nurse, PHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Auxiliary Nurse Midwife</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Medical officer, CHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Block Programme Manager</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Block Medical Officer</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>District officials (DPM and CMHO)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Registered Medical Assistant (RMA)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community-level service providers (Mitanin, teachers etc.)</td>
<td>5</td>
</tr>
<tr>
<td><strong>Group interviews</strong></td>
<td>HBC team (Barsur, Pondum, Kawadgaon, Bade Kilepal)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>CHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>PHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>SHC</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MMU</td>
<td>3</td>
</tr>
</tbody>
</table>
Chapter 2

Study methodology and process

The methodology and processes followed for conducting the study included on field data collection and secondary and primary data analysis. All due ethical considerations were aligned and followed.

2.1 Data collection

A case study method was used where primary and secondary data were collected using the following methods:

1. Key informant interviews (KII): Primary
2. Observation of the clinic’s functioning: Primary

For the KII, group and individual interviews were conducted with community members, health workers and health administration. These were done with the help of three interview checklists developed for diverse types/levels of health staff and one checklist for interviews with community members (Annexure 3).

In addition, an observation checklist was developed to guide the observation of the HBC. Secondary data was collected from the state health department and the same was then analysed.

To obtain informed consent from the respondents, a Participant Information Sheet and Informed Consent Form in Hindi and English were developed (Annexures 4 and 5). The Participant Information Sheet provided details of the study along with an assurance to maintain confidentiality for the information being shared with contact details of researchers etc. This was read out and handed over to the respondents. Only after the respondents consented to participate in the interview, was the interview conducted. All participants of the study could converse in Hindi with the researchers.

2.2 Analysis

A thematic analysis was undertaken following which, the notes and findings from the conversations and field observations were categorized under different themes which emerged as per the objectives.
2.3 Ethical considerations

The Participant Information Sheet and Informed Consent Form in Hindi and English were developed (Annexures 4 and 5) and administered to the respondents. This report has maintained confidentiality of respondents and anonymized their names.
Chapter 3

Key findings

The documentation of the Mukhya Mantri Haat Bazaar Yojana led to a nuanced understanding of the policies, processes, and implementation challenges on the field. The findings of the study have been categorized under policy analysis, secondary data analysis, and findings from the primary study. The recommendations that emerged from the findings and through the interactions with the respondents have been listed separately.

3.1 Policy analysis

In order to understand the scheme, government guidelines issued on the Mukhya Mantri Haat Bazaar Yojana were reviewed. This comprised of two letters, contents of which are reproduced below:

Letter dated 9 April 2021 by the Mission Director, National Health Mission (NHM) to all Chief Medical and Health Officers or CMHOs. (Annexure 6)
The letter provided a detailed guideline for the implementation of the Mukhya Mantri Haat Bazaar Clinic Yojana. The details of the scheme were listed under various themes and the same is translated in English and enumerated below.

i. Identification of Haat Bazaars: Districts/CMHOs are required to list all Haat Bazaars block-wise or at sub-district level for the scheme. The Haat Bazaars which are more than three kms away from the nearest health centre and located in a difficult-to-reach area, merit inclusion in the scheme.

ii. Location of the HBC: The clinic should be organized in a specified location within the Haat Bazaar only, so that it is easier for people to access it. If required, a tent, canopy or foldable chair must be arranged at the identified Haat site.

iii. Dedicated MMU vehicle and medical team for the identified Haat Bazaar: Every identified HBC should mandatorily have a dedicated vehicle along with a driver. This should be stationed in such a way that it is sent to one of the Haat Bazaars, six days a week. Every vehicle must also have a dedicated medical team with one doctor (MBBS/AYUSH/RMA), staff nurse/ANM, RHO\(^4\) male and pharmacist each. Ideally, the staff sent to the HBCs should not be changed often, so that it is easier for the team to follow-up on the patients.

iv. Availability of human resources: At the district level at the NHM, vacant posts should be sanctioned on priority so that the HBC’s functioning is smooth.

4. Bachelor of Medicine and Bachelor of Surgery (MBBS), Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH), Rural medical assistant (RMA), Rural health officer (RHO)
v. **List of services (facilities) to be provided under the HBC**
- list of diseases and conditions to be treated at HBCs.
- medicines that are to be given free of cost.
- patient’s information to be given to their respective ANMs and Mitanin; and
- patients who need specialized care at a higher facility, are referred to the facility
and for this, special referral cards have been provided. This includes a yellow card for
patients needing referral to PHC and CHC and pink card for those needing referral at
DH and medical college. At the facility-level, records need to be maintained for patients
who come with such referral cards, so that their data can be analysed.

vi. **Medical supplies:** The letter also contains a list of minimum required equipment;
disposables, consumables, reagents, and kits which need to be made available in the
dedicated vehicle. The letter states that the BMO must ensure that all medicines and
consumables are always available in the dedicated vehicle in sufficient quantity.

vii. **Branding of the scheme:** This section provides the detailed branding for the scheme,
including the MMUs.

viii. **Monitoring of the scheme:** The letter mentions a separate web portal and mobile app
for online monitoring.

**Letter dated 5 May 2022 from the Mission Director, NHM to all CMHOs**
The letter provided the standard operating procedure (SoP) for the referral and follow-up of
patients coming to the HBC. This was done because they had to be linked to appropriate
higher-level referral facilities. The letter noted that there was no uniformity in the way
different clinicsdistricts were maintaining their records and following-up with their patients
at the district-level. This created difficulty in tracking and understanding the status of referrals
and follow-up of patients. This letter laid down SoPs for all districts to follow in ensuring
continuum of care as enumerated below.

i. **Line list and record of referred patients:** The Haat Bazaar medical team will keep a
record along with the details of patients who have been referred for further treatment
in the HBC out-patient department (OPD) register. These include mentioning the centre
where the patient has been referred. The information will then be uploaded on the
online portal meant for the HBC scheme. If a special drive is being organized for any
disease at that time, the information will be uploaded on the portal. This will make sure
that the disease-wise information for the patients being referred to is available on the
said portal.

ii. **Follow-up of referred patients at a lower level of care:** The list of patients referred
by the HBC team will be made available on the portal (as mentioned above). This list
can be viewed by all health facilities in the districts. It will be the responsibility of the
health facility in-charge (where the patient has been referred) to arrange their follow-
up. This will be undertaken by the ANMMPW, Mitanin, LHV/ Sector supervisor who will
be provided with a list of these patients with directions for their continued follow-up.

iii. **Information:** Details regarding services provided and treatment administered to
patients after they have visited the concerned health centre again need to be uploaded
in the portal. This will ensure reporting on their further treatment, with the respective
facility in-charge taking responsibility for it.
iv. **Referrals:** For the referrals made to the health facility at the district-level, patients will be monitored on a weekly basis, by the concerned district nodal person deputed for the scheme. Similarly, the CMHO will be tasked with conducting review meetings to take stock of the actual situation and ensure follow-up of patients.

v. **Confirming services provided to patients referred by the HBC:** The district nodal officer will upload/send monthly information on referred patients to the state nodal officer of the HBC Yojana. S/he will send this information to the 104-state nodal officer (state operated online teleconsultation) for necessary appropriate action. The 104-call centre will telephonically follow-up with patients and encourage those who do not visit the concerned health centre for further treatment and to seek feedback from beneficiaries.

A review of both the above letters highlights the comprehensive guidance they provide on the processes and procedures for conducting HBCs. During the study, questions were based on the above guidelines and respondents were assessed to understand the extent of implementation of these guidelines and the challenges being faced. The data is presented in the sections below.

### 3.2 Secondary data analysis

The data was accessed and provided by the state health department for the period October 2019 to December 2021 (27 months), for the twenty-eight districts of the state. It showed that 19,273,511 patient visits were recorded at the 59,435 HBCs which were set up. All the districts in the state have been covered predominantly, as the administrative bifurcation of the newly formed districts was being undertaken for the health department.

**Comparing patient’s visits per Haat Bazaar in the different districts**

Based on the above information, an average of about thirty-two patient visits are taking place in each of the HBCs in the state. The Balrampur HBC reported the least number of visits i.e., sixteen patient visits per HBC, while Bemetara reported 127 patient visits per HBC. The latter, however, could be considered as an outlier since the districts with the next highest number of reported patient visits per HBC were Bilaspur and Surguja, with approximately sixty patient visits per HBC.

In addition, during this period, the Narayanpur district had the least number of HBCs (637 clinics) set up while Balod district had the highest number (5692 clinics) set up during these bazaars.

In twenty-one out of twenty-eight districts, the number of patient visits per HBC held improved over a period which was evident when the data from two time periods i.e., 2020 and 2021 were compared (outlined in Figure 1). The state average for the number of patient visits recorded per HBC held increased from 26 to 38 in the last one year. The most recent data showed that the average patient visits per HBC held increased to sixty-three in the period April 2022 to June 2022.
3.3 Findings from the primary study

The findings from the secondary data review indicate that the utilization of health care services at the HBCs increased over the last few months. It is therefore imperative to study the details of its service provisioning, impact on improving health care access in the remote areas of the districts without regular health facilities and extracting key implementation lessons.

The study was undertaken in the Bastar division, which is the southernmost region of the state. It has tribal communities such as Gond, Maria, Muriya, Bhatra, Halba and Dhruva and they form 70% of its total population. The interior areas of Bastar are not easily accessible due to lack of infrastructure and adequate transport. This is further aggravated by the armed conflict which exists in the region.
The Haat Bazaars offer a platform for the communities to engage in trade, commercial and social activities. They remain vital to the culture and economy of the rural population. The origin of the HBC Yojana can be traced to similar initiatives in various districts over the last two decades, with more uniformity in its current form of implementation. Interviews revealed that the health department had been organizing clinics in weekly markets to provide services to otherwise ‘underserved’ populations. Many government health professionals said they used to set up such camps during bazaar days or in the far-off ‘under-served’ areas. However, with this HBC Yojana, things have become more concretized and streamlined across the districts. For instance, the Bedre PHC team has been setting up clinics nearly five years before the HBC Yojana formally started.

“Nadipaar ke log haftamei ek baar aate hai aur ilaaj kara lete hai.”

[People come once a week from across the river and get their treatment done]. (GI1)

In Orchha, the HBCs were initially started for the purpose of routine immunization (RI) and then expanded to provide other health care services. Respondents also shared that people from far-off villages expressed their need for health clinics at the weekly haats as they were not able to access the health centres.

Respondents in Narayanpur district believed that the concept of HBCs was initiated from their district since it was evident that patients were not able to reach the health centres. (Resp 21 Block official)

The main difference that was noted now related to the fact that earlier ANMs/ other health workers would visit far-off villages/haats to provide services. However, after the HBC Yojana, the entire medical team was being sent. (Resp 6, BPM; Resp 12)

Therefore, the HBC Yojana emerged as a state-wide upscaling of practices that existed in some districts at different points of time over the last two decades. This benefitted communities who had limited access to health services. The first HBC Yojana pilot was implemented in October 2019 in Dantewada district and later expanded to other districts. (Resp 6, Resp 16)

i. Implementation and functioning of the Haat Bazaar Clinic Yojana

The HBCs are run on a fixed day as per the weekly market /HB scheduled in that area. The medical team from the nearest PHC provides services at the clinic and comprises of the MO, RMA, and staff nurse. The same staff from the PHC could be providing health services at two different HBCs every week and these could be located within its mandate of care.

At some places, a semi-permanent structure exists for the medical team, but most of the times, the medical team sits in a temporary structure/open area where they are visible to market visitors. Often the team puts up banners to demarcate the HBC location.

ii. Identifying Haat Bazaars for clinics

The guidelines from the state dated 9 April 2021 (Annexure 6) envisages the HBC medical team as a standalone dedicated MMU vehicle with a dedicated medical team facilitated with required equipment, supplies and consumables. Any association with the nearest health centre in the area, if intended, is not explicitly defined in the letter. However, it was observed that out of all districts that were visited, the nearest PHCs and CHCs were engaged in running the HBCs located in their area. Moreover, even though the
guidelines specify that the HBCs are not supposed to function within three kms radius of the health centres, almost all were located very close to the health centres (HWC/PHC/CHC).

iii. Location of Haat Bazaar Clinics

The interviews and observations during the study revealed that the location of the HBC is a critical factor in the performance of the clinic. It also determines how effective it will be in serving the population. Some of these aspects are elaborated below:

HBCs located in villages that already have a PHC in the main market area and/or one that is functioning well with a good OPD: The usefulness of having HBCs in villages close to existing health facilities (PHC, SHC and CHC) was often determined by the distance of the facility from the bazaar site within the village. It was also determined by the extent of familiarity which the community had with respect to utilizing the health facility.

For instance, the Kutru and Mirtur HBCs despite having large Haat Bazaars did not see much utilization of their HBCs since their PHCs were located close-by. The PHCs were well-functioning, and the community found it convenient and comfortable to utilize facility-based health services.

The Kutru PHC is in a village that already has a PHC in the main market area and well-functioning. Despite this, the Kutru HBC in the village did not see much utilization. However, the Kutru PHC was well-functioning, and the community found it convenient and comfortable to utilize facility-based health services.

For instance, the Kutru and Mirtur HBCs despite having large Haat Bazaars did not see much utilization of their HBCs since their PHCs were located close-by. The PHCs were well-functioning, and the community found it convenient and comfortable to utilize facility-based health services.

The Mirtur PHC caters to many villages that are cut-off from routine health services due to local conflict. On the day of the Haat Bazaar, the PHC was bursting with patients. Further, the location of the PHC helped attract people, as it was located on the way from the remote villages to the bazaar. The medical team of Mirtur HBC (which comprised of staff from the PHC) was stationed in the HBC since morning but very few people visited them for care. Moreover, health workers said that people often wanted only injections for which they had to be sent to a PHC, located one hundred metres away. (Resp 13, Resp 14)

Some respondents said that despite having SHCs close-by, the HBC still had a role to play in attracting patients. This was largely because there were fewer barriers to access care, no user charges, and availability of health-care providers right next to where they came regularly to buy household items and other goods.

Bade Kilepal HBC (under Bastanar block of Bastar district) is on the main Raipur-Jagdalpur highway road within the town but not immediately next to a health facility. Despite this HBC being small, the team providing services felt that it was useful (located within the town with more footfall). A CHC staff opined that even if the CHC is 1 km away from the HBC, it would still be useful to have the HBC. (GI 3) The RMA respondent shared the example of Pinkonda, where even though the health centre was barely two hundred metres away, people still found it useful. (GI3)

A few others believed they did not see the reason the patients could not come to the health centre located nearby if they were travelling to the Haat Bazaar from far-off areas, especially when the health centres had more facilities to provide care. For instance, even though the Kutru Haat Bazaar is big, its HBC does not see many patients as the Kutru PHC is located nearby. (Resp 10 and HBC team) On the other hand, Pinkonda HBC
(mentioned above) was cited as an example where people would visit the HBC despite the health facility being close-by, as the patients found it more convenient.

Usually, the HBCs in the main market areas were seen to provide routine health care services along with preventive screening for diseases. However, their functioning seemed to be dependent on the initiative and motivation of the medical team of that HBC.

The Barsur Model HBC is an example of a well-functioning HBC next to the busy Barsur Haat Bazaar that also has a functional PHC located nearby (little less than 1 km).

Respondents stated that people find it easier to utilize health care services within the market premises. They felt that “patients’ market aate hai and wahi se HBC aa jate hai” [patients come to the market and access the HBCs from there]. (Resp 2) Also, in this case, the Barsur PHC is located about two kms away from the Haat Bazaar. People hire pick-up trucks to come to the haat directly. They found it to be more convenient to visit the HBC which was right next to the bazaar. Travelling to Barsur PHC (about two kms away) is a slight inconvenience, especially with the limited transport available in the region. (Resp 4)

Members of the medical team at the Barsur model HBC mentioned that through the HBC they could attract more patients. Even though they had an HBC structure [building], people did not come as much when they were sitting inside. So, they would sit outside with their table in full view and watch the patients/people arrive. At other times, they noticed patients in the bazaar who looked unwell and called them to their table. For example, if they saw any cases of chronic anaemia, which was prevalent in the region, they would tell people to come for testing. They also did the test for sickle anaemia and provided iron tablets. If the person or child was extremely malnourished, they would take them to the facility [PHC]. (Resp 4 and Resp 5) The HBC, in this case performed the function of screening patients.

While some respondents communicated that people preferred going to the hospital/health facility, others felt they may not want to be seen visiting government health facilities, especially in conflict zones.

In Narayanpur district, almost all the Haat Bazaars are located near a health facility. Initially, there were 18 HBCs being run in the district. Three HBCs were discontinued as they were situated very close to the SHCs and DH and were able to provide services to few patients. According to a district health official of Narayanpur (Resp 22, District official), if one follows the government order that no clinics are to be run in minimum three kms of the health centre, only two HBCs would be found functional. Nevertheless, in October 2022, it was decided to operationalize HBCs in all the Haat Bazaars. Plans were afoot to plan more HBCs. An exception to the rule above was observed at the Kirusnaar Bazaar, which is one of the biggest in the district and there is no health facility located within forty kms of its radius. (Resp 22)

**HBCs located in the bazaar area with no nearby PHC or SHC:** Usually, HBCs that are located in haats with no PHC or SHC nearby are in remote but strategic locations (across
the river or hill). Here, people come once a week for the Haat Bazaars and utilize the health services provided by the clinic. This is done because there are no health facilities in the vicinity. People mostly come from villages which are otherwise not served by regular health staff and its system, or through outreach services. For instance, the Bedre HBC is useful for people visiting it, as it does not have a PHC nearby. Also, this bazaar has people coming from villages situated across the river. Another example is Cherpal situated in Geedam Block. They are the most successful and useful models to ensure health care services to those who are unable to access regular health facilities and often live in difficult geographical locations.

The Cherpal HBC that comes under Chhindnar PHC (15 kms away from Geedam block, Dantewada district) is one such example of an HBC site with no existing PHC or SHC and is considered useful by health-care providers. The Cherpal HBC site is seven kms from Chhindnar PHC on the other side of the river. The health staff in Chhindnar began with a health camp for which they received good response following which the HBC was started in the last week of February 2022. (Resp 3) There are seven HBCs in Geedam and two of them are providing care to areas situated across the river. (Resp 6)

However, such HBCs do not seem to be particularly useful, especially if the bazaar is small or is situated on the main road or if the higher health facilities (e.g., PHC) are in the neighbouring village. The bazaars which are small have only a few shops and see fewer footfalls.

Gudma HBC was made functional before the COVID-19 pandemic. It is located next to a bazaar which is small and has barely a few shops. People in the area prefer to go to the bigger Neymad Bazaar or the Kutru HBC/PHC itself (located near Gudma). Therefore, even though the staff sits in the Gudma HBC, there is hardly any utilization, as only less people visit this HB. (Resp 10)

The health staff opined that even though both Gudma and Bedre are small bazaars and fall under Kutru PHC, their utilization and usefulness vary greatly. Gudma HBC has exceptionally low utilization, but Bedre HBC is useful as it covers a lot of patients/villages who come from the other side of the river to the Bedre Haat Bazaar. These villages do not have any Mitanin or ANM but only an anganwadi worker (AWW). Bedre SHC has on an average 70–80 outpatients which reduces significantly in the mahua season and could amount to roughly fifty. (GI2)

**Location of the clinic within the Haat Bazaar:** In some bazaars, few buildings or a structure has been built so that the HBC can be conducted, and health-care providers can sit and be physically accommodated. However, these were mostly unutilized as they were located where it was not optimal for the team to sit and provide care or it had been constructed at the back end of the Haat Bazaar. A few respondents from the health staff suggested that the HBC structures could have been built in consultation with the PHC or health staff posted in the nearby facilities. In a few instances, the health staff came to know about these constructed structures only much later. These structures were

5. Buttercup or mahua (Madhuca longifolia) is a large shady, deciduous tree dotting much of the central Indian landscape. March and April are the mahua collecting season for indigenous people.
often not utilized because they were not built at a place where they could be visible to people coming to the market. Nor was it possible for them to facilitate the approaching medical team with ease.

iv. Dedicated vehicle/ mobile medical unit

According to existing guidelines, the MMUs will be used for HBCs. However, it was observed that diverse types of vehicles/MMUs supported the functioning of the HBC scheme.

A fleet of these MMUs are being run in partnership with private agencies. One such contract is with the Bhavya Foundation and Jay Ambe Emergency Services or JAES. (Resp 6, Resp 11) All the three districts of Narayanpur, Bijapur and Dantewada had two MMU vehicles each, though it was not clearly demarcated whether they were for rural or urban areas. A district-level official of Dantewada clarified that the rural MMU with medical staff is run by JAES, while Bhavya Foundation runs the urban MMUs.

These urban MMUs or Nagreey Nikaay MMUs are separate and do not come under the CMHOs. Where the quantum of these markets is bigger, both vehicles are sent to provide care to patients who come to seek care (MMU and Jeep). Often, these MMUs are modified buses that come with their own health staff hired by the private company and are equipped to conduct diagnostic tests.

The linkages and coordination between the outsourced MMUs and the HBC Yojana differed among the districts. In Dantewada, the research team observed that the MMU being operated by Bhavya Foundation was located separately and stationed away from the Barsur Model HBC. It was functioning on its own and had no coordination with the HBC which was operating within the Haat Bazaar. The schedule/route chart for the Dantewada HBCs and the MMUs was being planned in the district. On the other hand, the scheduling in Bijapur was planned and coordinated at the block-level and the two MMU vehicles were stationed at the CHCs.

One MMU provides services in two blocks which accounts for 25 days in a month. The distribution entails their being for 12 days in one block and 13 days in the other block. The route chart is made by BPM. (Resp 11) The District Health Officer stated that instances like Barsur (where private MMU was not being utilized) will be resolved in due course and the same will not be happening in Bijapur as they will be well coordinated over a period of few weeks/months. (Resp 11) A medical officer of a CHC further added that the coordination of private MMUs is undertaken by the district and the final concurrence is provided by the block. (Resp 9)

The coordination in the Narayanpur district was better and the route plan prepared by the blocks and districts together. The overall coordination and review of the MMU health team is undertaken at the district level. For example, the Bhavya Foundation vehicle was being utilized by the Orchha HBC and the medical team was providing support for its functioning. It was observed that the medical team of the vehicle was co-working with the CHC medical team at the HBC. (Resp 21)

Similarly, the MMU team was deployed to run the Farasgaon HBC so that the team posted at the health facility did not have to visit the HBC, and this in turn ensured the
functionality of the facility. In the Narayanpur district, the MMU health team is called to participate in review meetings conducted by the BMOs and CMHO, while their route chart is made by the DPM and CMHO office. (GI10)

Farasgaon Haat Bazaar of Narayanpur block is on the main road towards Orchha. The Haat Bazaar Clinic is run by the private MMU and its medical team. The MMU functions 25 days a month. This is one of the two MMUs that the district has, and it is run by JAES. The MMU has been operational from 2 Oct 2019. The medical team has an AYUSH doctor, pharmacist, ANM, LT and driver. The team had provided care to nineteen patients in the three hours that they were stationed at the Farasgaon HBC i.e., from 11 am to 2 pm. Usually for a relatively smaller market like Farasgaon, the OPD is around forty while for a bigger market it goes up to sixty. (GI10) This was one of the places where it was observed that clear roles and responsibilities are defined and coordinated between the MMU vehicles for the HBC Yojana. Therefore, instead of sending a medical team from the PHC, the MMU team was being utilized for the HBC. This was in contrast to Dantewada and Bijapur districts where there was no such clear coordination with MMUs, often resulting in duplication of roles.

The research team conducted a discussion with the staff of MMU being run by Bhavya Foundation (stationed at Barsur and Geedam). The MMU had 1 ANM, MBBS, LT, pharmacist, and driver each. It had been only five days since the vehicle had been operationalized and the team informed about 70–80 such MMUs deployed in Chhattisgarh. Their team had 11 OPD patients on the day when they visited. (Resp 15)

Other than the Bhavya Group MMUs, there are also Haat Bazaar vehicles. In Bijapur district, six such vehicles have been bought from the District Mineral Fund (DMF). The DMFs are set up as not-for-profit bodies in mining affected districts of the country as per a 2015 Central Government Act. They are supposed to work for the interest and benefit of persons and areas affected by mining related operations. The foundation manages the DMF which is funded with contributions from mining companies in the area. Four of these vehicles are placed at four different CHCs and the other two are stationed at pre-determined locations. (Resp 11 DPM) Chhindnar, Barsur and Tumnar HBCs in Geedam block have been given a special SUV for this Yojana. (Resp 6, BPM; Resp 3) Similarly, there are three Sumo-like vehicles, especially for HBC purpose in Bhairamgarh block. (Resp 9 CHC MO) Some of the Haat Bazaars like Barsur were provided an SUV with oxygen facility.

Few of these vehicles were also funded through the Members of Parliament Local Area Development Scheme (MP LADS)/Member of Legislative Assembly Local Area Development Scheme (MLA LADS) funds, such as the one located at the Kutru PHC. (Resp 10) In some cases, the vehicles provided to the PHC were also re-branded for the HBC Yojana (GI4) and utilized to cater to the health care needs of the community who were visiting the HBC. In Narayanpur, two minibuses were received from the pradhikaran fund (Resp 22), while many of the HBCs were also utilizing the PHC vehicle.
v. Human resources

While no separate HR was recruited for the HBC scheme, the private MMUs are required to post additional HR employed by the private agency. This includes doctors (mostly AYUSH), nurses, lab technicians and a driver for the vehicle.

The existing staff from the public health facilities is also being utilized for the scheme. They are responsible for setting up the HBCs in their areas and for providing services. Depending on the coordination between the teams, the MMU staff is deployed exclusively for the HBCs. For example, in Cherpal HBC, the MMU comes with its own RMA, SN, pharmacist etc. (Resp 3) Whereas in Farasgaon (Narayanpur), the MMU team was looking after the HBC in the bazaar without support of any staff from the facility. They were required to carry some essential medicines and RDT kits which allowed on-the-spot diagnosis of certain common conditions. They also provided medicines to member/s of the community who sought care. This allowed the staff at the facility to perform their duties while continuing to provide services at their respective health centres. They were also available to support the referrals from the HBC and provide facility-based care, if needed.

However, in many cases the medical team at various HBCs is made up of existing PHC/SHC staff that visit these HBCs as per the roster, supply medicine from their facility’s stock, and undertake the administrative work and other tasks. No additional or specific hiring has been done for HR for running the HBCs. This has an implication for the day-to-day functioning of the health facilities. As the existing staff is required to perform functions of the HBCs, this impacts the service delivery of the respective facility on that day. This problem becomes acute if adequate HR (MOs, LT, staff nurses) is not available at the health facility. Therefore, the facility that is already facing shortage of staff must deploy its available staff at the HBC for providing services. At times, it also leads to health care workers missing the HBCs if there is pending work at the facility or the staff is on leave.

Bahigaon PHC has three MOs and based on rotation, one or two of them are deployed to go to the HBC while others remain at the PHC. (Resp 1, Bahigaon) For Barsur PHC, most of the health care staff attends the HBC as it is one of the biggest HB in the district. Moreover, the MO from Chhindnar PHC nearby is deputed to Barsur PHC on fixed days to provide services at the facility. This arrangement has been made possible as the Chhindar PHC has two MOs, and one is repurposed to this PHC as per the HBC schedule. This not only ensures continuity of services at the facility, but also helps the referral cases from the HBC to be sent for treatment at the facility, since the same cannot be provided at the site.

However, this arrangement is an informal one and is not something that has been institutionalized. Therefore, one of the common concerns raised by health workers at the PHCs without adequate staff is that the health centre remains vacant when the MO, LT and others go for HBC duty. This is specifically true for LTs as most PHCs have more than one MO in-position but there is only a single LT to provide services. Therefore, it was found that often the LT or pharmacist stayed behind at the health centre to provide services to those who were coming for care at the facility and to others being referred from the HBC. This was also more viable as the PHC had the required equipment and consumables required for conducting diagnostic tests.
There were some variations in the number and type of health workers who were providing care at the HBC. In the Bhairmgarh block, the HBCs are served only by the RMAs, AYUSH MOs etc. (Resp 9) which was not the case in Geedam. Similarly, from some facilities, the pharmacists and LT do not go to these HBCs and are stationed at the facility itself. (Resp 10) Only the RMA, staff nurse and RHO visit their neighbouring HBC. (GI1, Sector meeting in PHC)

The Mitanins played a vital role in conveying information about facilities being provided at these HBCs (Resp 1, Bahigaon; Resp 3; Resp 5) and mobilizing pregnant woman for their antenatal care (ANC) check-ups. (Resp 4) The Mitanins urged the communities to visit these HBCs as they were conveniently located in the same area which they visited to purchase their daily household items. They also informed community members on availability of doctors, medicines, and diagnostic tests at these HBCs.

Since the Mitanins belong to the community and understand the apprehensions of visiting the health facility, they can use the platform to encourage those patients who do not visit the health facility to seek care. In addition, they can provide follow-up care which is required once the patient returns to the community. They can not only monitor the patients, but also facilitate their engagement with the health workforce for any advice or care.

vi. Services being provided
As the study was being conducted during the peak of summer season, majority of the patients coming to the HBCs bazaar were reporting with fever and diarrhoea. Moreover, it was observed that cases of malaria, scabies and eye-related issues were the other common ailments being treated at the HBCs.

Many health workers believed that the best impact could be seen if the HBCs worked more as screening centres that refer patients to the health centres. (Resp 1; DPM; Resp 16) They felt that an unwell patient will not wait for an HBC and would prefer to go to a facility. Only mild illnesses such as cold, cough, fever, malaria, and diarrhoea can be treated at the HBC, though sometimes the medical team catches asymptomatic cases too. Even though these HBC provide care for common conditions, they are a convenient platform for the community to access care easily which helps bring care closer to them. The team also visually screens the community members who visit these bazaars and conducts diagnostic tests (e.g., anaemia). Thus, these HBCs may be functioning as extensions to the health facilities but are offering health care services to the communities in settings which are most convenient and comfortable to them.

“Diseases are identified/screened before complications happen.” (Resp 9, MO CHC; Resp 17)

“For serious ailments people go to PHC only.” (Resp 17)

The NCDs are another set of conditions that are screened/treated at the HBCs. The health care workers informed that for all patients aged 30 years and above were screened for hypertension and diabetes and as a result could identify patients suffering from these conditions but were unaware of the same. (Resp 5 and 17)

“Our main focus in HBCs is NCDs. The ANMs need to make people aware so they come to
However, some of the HBCs did not see many cases of NCDs. For example, the MO providing health services at the Cherpal HBC reported that the NCD cases were lesser in her area compared to other areas. (Resp 3) Similarly, the HBC team in Orchha said that they do not have many NCD cases in their area and are able to identify barely one or two cases in a village. (Resp 21)

While in Bedre HBC, health camps used to be set up even five years ago, screening of NCDs began once the HBC Yojana started. (GI1) This could be related to increased disease burden and higher incidence of these conditions in recent years and now with specific health programmes focused on NCDs.

Health care-providers felt ANC services could be better facilitated because of the HBCs. The HBC team at its level can identify cases without ANC check-ups and vaccinations. They administer care, including vaccines (Resp 6, GI3, Resp 22) to patients, especially those hailing from inaccessible areas which are not served by Mitanins, AWWs or ANMs. For example, there are 26 Haat Bazaars in the entire Bijapur district, with each aiming to administer child vaccination in these bazaars whenever possible. This is particularly true because around 40% of the district is inaccessible to health workers. However, the problem is that often people do not get their ANC vaccination card with them. On these occasions, the health workers are unable to identify the vaccination schedule that has been completed. (Resp 6)

Sometimes cases with more severe conditions were also identified by the HBC teams. For instance, in Potali HBC, the medical team identified a case where a man had fallen from a tree and was suffering from fractured bones that remained untreated. He was properly examined, and treatment was facilitated by the team.

vii. Medicines and diagnostics

Almost all the respondents reported that most of the required medicines were available and there were no shortages or lack of stock. (Resp 3, Resp 1, GI3, Resp 16, GI9)

Here it was barely one respondent who said that sometimes people are required to purchase medicines from outside. (Resp 1, Bahigaon) Only in the Narayanpur district, it was reported that one medicine was in short supply, namely malaria ACT for 5–8-year-olds. Therefore, in this case, the district buys it from the state’s funds for HWC and provides the same to the HBC that falls under its jurisdiction. (Resp 22, GI10)

Medicines without the CGMSC labelling are sent specially for the HBCs. There is a separate carton for it and usually medicines like Albendazole, Vitamin tablets come under it. (GI4) However, it was noted that in some places, several vitamins, calcium, and other such supplements were being distributed to the patients who required them.

Medicines are not received/allocated separately for the HBC but are often taken from the HWC/PHC itself. (Resp1, Bahigaon; Resp 3, Chhindnar) For example, the PHC at Kutru does not get any medicines specially for the HBC. However, while distributing the medicines, the PHC separately allocates medicines for HBC to SHC. (GI1) In addition, the
MMUs (may be the private ones) come from Chhindnar and they too get some medicine. (Resp 3)

Thus, the MMUs being run by the private vendors are required to provide a list of medicines which are pre-defined as per the contract, under which they function. Although, it was observed that these were not being monitored for their expiry or to ensure that adequate stocks are available. In fact, the purchase and distribution of medicines was often delayed at the MMUs. One of the doctors raised concerns of the mediocre quality of medicines supplied and the absence of quality check parameters in the district. (Resp 4)

A district-level official raised the concern over irrational prescription at the HBC and not adhering to the proper protocol for testing (Resp 11). According to him, 75,000 out of 250,000 population in Bijapur district being treated at the HBCs happens to be too high. (Resp 11) He shared his concerns over the prescription of Tetracycline and Pantoprazole to the community.

According to him, the state is working on the portal to obtain individual or beneficiary-level information to ensure patient follow-up and continuity of care. The total number of patient visits also includes vaccinations, screenings conducted for malaria, anaemia, hypertension, diabetes, common cancers etc. and will not always translate into medication. Thus, these number of patient visits are to be understood with caution and the standard treatment guidelines must be ensured for any prescriptions to be made/suggested.

Tests for malaria, haemoglobin, random blood sugar etc. are done with the help of rapid tests/kits at the HBC. (Resp 2, Barsur, GI10) Tests which are not being done at the HBC include urine, pregnancy or eye related, as they require proper equipment and multiple apparatus, so they are sent to their nearest PHC. (Resp 2) The first sputum collection tests for tuberculosis are also undertaken at the HBCs. It was (Resp 22) shared that one leprosy case was detected during a routine visit at the HBC and referred to the DH for further management and care after proper diagnosis.

The Orchha HBC team had a dentist on their team who helped undertake screening for oral cancers and simple dental ailments. The prevalence of tobacco chewing is high among tribals in the region and providing care for an expanded range of services at the HBC enables the team to reach out to the larger population for preventive and promotive care.

viii. Referrals and linkages

The response received to the question on referrals of cases was mixed. Some respondents shared that referrals are mostly provided for complicated deliveries and high-risk pregnancies in addition to complications of pneumonia, snake bites, malaria, and dental ailments, among others. At one of the HBCs, the team mentioned that if the patient requires treatment at the higher facility, the HBC vehicle is used to transport the patient. (Barsur HBC)

However, the staff also reported that there are not many referrals from Kawadgaon HBC to PHC Metapal (which is otherwise an active PHC and does 15–20 deliveries a
A respondent in Orchha block mentioned that referrals from the HBC to the nearest CHC are planned but not yet implemented. (Resp 21) Even through referrals are made to the closest higher centre, these are not as systematic as envisaged in the guidelines so far (colour-coded cards, analysis of referral data).

Infact, no systematic entry for referrals is being maintained in the registers. (Resp 9, MO CHC) However, these colour-coded referral cards are found in adequate numbers at the HBC with a well-defined mandate. They can be useful in prioritizing patients at HWC priority windows at higher centres, which is unique in the case of Chhattisgarh that ensures continuum of care. They can also be utilized to facilitate the treatment of patients referred from the HBC.

The referrals to the PHC can be provided with the help of the vehicle available with the team, especially for those who need to be referred to higher centres of care, already being undertaken in certain areas. This will ensure that patients are provided with the care that is needed and they do not face any barriers to access services at the nearest PHC. Some funds from the untied budget of the facility can be earmarked for this transportation or they can be supplemented under the DMF to cover the additional travel costs.

Currently, the linkages for back referral at the lower level of care (SHC with ANMs or back into the communities) are not being implemented in many places. The only HBC which has implemented the linking of patients to ANMs is the Orchha HBC and they have been practicing this for quite some time. The staff at the HBC register the patients and categorizes them based on their village and the respective information is then provided to their ANMs. (Resp 21)

It is essential that village-wise information is provided to the corresponding SHC, and the primary health care team led by the CHO’s is given specific follow-up instructions. The CHO’s and ANMs must communicate with the concerned Mitanins and ensure a community-based follow-up is done. This could further include a community-based follow-up for NCD management, adherence to the TB treatment regimen and follow-up for ANC check-ups etc.

A mechanism also needs to be developed for those beneficiaries who only seek care at the specific HBC and do not fall under the authority of a health facility or any outreach activity being conducted by the health staff. In this case, with the help of the portal, a beneficiary linked follow-up can be initiated which pertains to every HBC, duly linking the patient and ensuring follow-up during their visits.

ix. **Data collection and monitoring**

The OPD data collected in HBCs is required to be entered into an online application system the same day. This data is separate from the OPD of the PHC/SHC under which the HBC falls. The GPS coordinates of the medical team/ vehicle are also collected. (Resp 6) The Farasgaon HBC, MMU health team (Narayanpur) shared that they made the daily data entry in the app where disease-wise monthly entry is also being done. (GI10) Few respondents informed that sometimes for HBC in remote areas there is no internet connectivity. In such cases, the required data can neither be entered on the portal nor GPS coordinates be updated.
In such cases, the team comes back to an area with a better connectivity and then enters the required data. One of the respondents claimed that digital reporting has made evaluation easy. (G13) Further, the staff in the Dantewada block office informed that at times the block staff cannot access full block-level data and that different people in the block have access to data for different bazaar days. They face similar issues on the IDSP portal. (Resp 6 along with his staff)

However, this does not persist at the district level. The portal which facilitates online entry of the beneficiaries and case data is new and the state is undertaking steps to streamline its functioning. Thus, with the passage of time, the use of portal and its various features will improve its utilization, as with most information technology (IT)-based platforms.

x. Availability of finances under the HBC Yojana

There is not much additional resource allocation for the HBC scheme. Additional money for vehicle fuel is provisioned for separately. (Resp 16, Resp 11) The Dantewada district officer told the research team that they had received separate funds under the Haat Bazaar Clinic Yojana only two months ago for the first time to buy fuel and medicines. Another district official informed them that medicines at the HBC are distributed as per their OPD loads and that these medicines are still not enough. In which case the HBCs need to be provided their own stock based on their indent and requirement. (Resp 11, District official)

Moreover, as mentioned above, no separate HR recruitment had been done for the HBC scheme. The supply of medicines and diagnostic kits for the HBCs had to be provided separately and not be included under the indent of their linked health facility. This would ensure that their utilization patterns were understood, and any medicines required additionally could be procured.

xi. Relevance of the HBC scheme compared to provision of these services through regular SHCs, HWCs and PHCs

As detailed above, most HBCs are located near villages that already have a health facility or alternately, have a health facility that is located close-by. Therefore, it is important to gauge the extent of services which are being provided at the HBCs or additional services or if they are duplicating services that were being provided by those facilities. When asked what functions the HBC performs which are different than the PHC or SHC, a respondent opined that HBCs are only complementary to regular PHC services and cannot function as a substitute. He emphasized that one cannot run HBCs by compromising on the regular functioning of the PHC. For example, health staff is needed in PHCs on the HBC day, and it cannot be left bereft of health staff.

“If the PHC remains vacant, it is a disadvantage as the gains you make in HBCs, you lose in the PHC. (Resp 4, PHC MO)”

According to a district-level health official, the HBC scheme related resources could be better spent on strengthening HWCs themselves. He also felt that there was a duplication when both HWC and HBCs identified the NCDs. (Resp 11)
During the study, it was observed that there have been significant improvements in infrastructure and human resources in health facilities at all levels and especially at the level of primary care. This has led to increase in health services being provided at the public health facilities in these areas. Previous studies conducted have also documented these improvements.

The HBCs are most useful in areas where existing health facilities and centres are difficult to access and there is lack of health infrastructure, including human resources. They provide a comfortable environment where the community can approach health care services to meet their basic health needs. These HBCs provide diagnostic services and essential medicines to communities and promote a change in their health-seeking behaviour, making the community more aware of the health conditions they suffer from. There is an underlying understanding that HBCs should only be complementary to the existing health system and not try to replace them.

xii. Perspectives of service providers about the HBC scheme

Most respondents agreed that the HBC scheme is a positive intervention and is useful for people who reside in remote, hard-to-reach areas and have issues of access. Resp 16 said that even today, people wait for the bazaar day to receive treatment (this is probably true for less serious diseases). One reason according to them, is that people are more likely to visit a medical team when it is sitting outside in the Haat Bazaar rather than make a visit to the facility, even if it is close-by. In such cases, people who specially come from the interior areas to visit the HBCs get themselves treated or assessed. For example, for Pondum HB and HBC, people come from around a ten kms radius.

“If a doctor is sitting in a Haat Bazaar, people go and get a check-up and may not plan a facility visit otherwise.” (Resp 1, MO; Resp 8 Mitanin)

Another reason that came up in some of the conversations was that people continue to feel certain barriers and hesitancy when entering a hospital building. In such instances, HBCs are useful. Also, the services provided in HBCs are more informal and prompter. (Resp 20) Further, some PHCs continued to take a Rs 5 user charge, whereas HBC services are free, and medicines are being provided to patients who require them. Thus, the familiarity of the environment and functioning of HBCs within the settings most familiar to the community are an added advantage in areas where literacy rates and hesitancy to access modern methods of care are still a challenge. This is keeping in view the cultural practices which exist in the region and the allopathic system of medicine which is gaining acceptability amongst members of the community.

“People come to the HBC, but they do not want to go to a hospital unless it is very serious.” (Resp 3, MO PHC)

The informal setting of the HBCs is conducive to provide walk-in services for minor ailments and illnesses that are less threatening in nature. These conditions often form a large chunk of health care needs that arise in the lifetime of an individual and if treated in a timely manner, can avert major health illness.
“Bahut log hospital jaane mei hichkichate hai, suvidha bhee hai ab Haat Bazaar mei” [Many people are reluctant to go to hospitals and now it is convenient in the haat bazaar]. (GI7)

Another respondent from Orchha Haat Bazaar (1 km from the CHC) said: “CHC jane se log hichkichate hai. Kya pata unhe admit kar de” [People are reluctant to visit the CHC as they are worried, they might be admitted]. (Resp 21)

One of the respondents said that HBCs work as an advertisement for the government health department. (GI3) This was useful for the interior areas, like in Narayanpur, and it could be a way for the health system to build trust among people. Clearly, the HBCs are a way to reach the community when the community is unable to access services at a facility.

A respondent shared that some PHCs in the district that were not functional and became so due to the presence of the HBCs, at least for the day when the patients got referred. She gave the example of PHC Kutru. (Resp 22)

However, there were few respondents who did not perceive the HBCs to be particularly useful. A PHC MO said that often they end up organizing HBCs as a protocol that is mandatory and must be followed. (Resp 1) But he still recognized that the HBCs function well as screening centres and provide preventive promotive care. As mentioned above, a district-level official said that the resources invested in the HBCs are better invested in regular health facilities. (Resp 11)

Many of the respondents highlighted the need for additional staff for HBC functioning (Resp 4; Resp 6; Resp 11), such as LT, ANM, MPW, OA, MO, and RMA. (Resp 11) They emphasized the importance of choosing the right location of HBC and said that HBCs should be next to bazaars that are big, and which report higher footfalls. On the other hand, HBCs close to CHC and PHC are not found to be useful.

### 3.4 Key recommendations

- Set-up a laboratory facility to ensure more investigations can be conducted at HBCs. (Resp 9)

- Operationalize a mechanism for community-based follow-up of patients coming to the HBCs. (Resp 4)

- Clean the HBCs on a regular basis. Like for instance, Dantewada district has provision of an HBC set-up (canopy, building etc.) but other than clinic days, it did not get cleaned/taken care of). (Resp 16)

- Focus on having separate infrastructure in closed spaces where screening for urine pregnancy test etc. can be done. (Resp 3, Chhindnar)

- Strengthen linkages with SHCs and for that create systems for the ANM to follow-up on the patients diagnosed with TB, new mothers, and new-born children. (Resp 11)
Simplify the process of indent and supply to reduce time taken. Even though there was no shortage of medicines, the process of indent and supply would take time. For e.g., a block-level official shared that they made their own arrangement to speed-up the process where three NOCs were needed to be issued to buy medicines from Jeevan Deep Samiti. (Resp 21)

Further streamline running of the HBC Yojana based on feedback received. A district-level health official (Resp 11) shared that the HBC Yojana should be run on felt local needs. It should not follow a target-based approach to run a district-based centralized scheme. For example, in the main town centres, HBCs are not required (Resp 11). Similarly, a district-level official in Narayanpur suggested that all HBs in the district were near the health care facility and an HBC was not needed where there was a PHC or SHC close-by. (Resp 22) An example of this could be Tambodi and Metapal villages which do not come under any of the two SHCs of Kutru PHC (Dantwewada block). They do not have a Mitanin from their village and therefore conducting an HBC there would be useful. (Resp 13)

Need for regular capacity building. The Farasgaon (Narayanpur Block) MMU medical team did not come from the facilities. Instead, the MMU run under the state was deployed to provide HBC duties under contract with JAES. They shared that they do have a CBC investigation machine, but do not use it. The LT who was assigned there required capacity-building for operating the machine. He informed that a higher level of training would help him become more confident in operating the machine.

More effective grievance redressal mechanisms are needed. For instance, the eye lens of the mini microscope (used for malaria, sickle-cell) was faulty since its installation and had not been rectified. JAES was informed about the issue but found no response/resolution. (GI10) Hence, a well-functioning grievance redressal mechanism is needed to ensure issues related to equipment, medicines etc. are established for health staff to flag their concerns and find a resolution. The specific responsibility should be tasked to individuals in authority to ensure medicines, diagnostic and other essential items are not out-of-stock at any given point in time.
The study found that the location of the Haat Bazaar is crucial to determining its successful and optimal functioning. HBCs are providing treatment for routine, common and less serious illnesses such as fever, scabies, cold, cough, diarrhoea, malaria, and screening for NCDs. Extremely sick patients normally visit the higher centres for care.

The HBCs are useful for preventive and promotive health care where precautionary check-ups can be done before the illness becomes serious (ex-malaria) or screening of silent killers, especially NCDs can be completed. A more proactive medical team has a leading role to play in identifying patients in the Haat Bazaar and for conducting NCD screening. With an increased focus on NCDs under government health programmes, this could be one way to complement early detection of NCD. Further, HBCs are also being used for ANC and routine immunization (RI). A positive finding was that almost all the staff and health officials confirmed that they had not faced medicine shortages. According to them, the supply was regular from the CGMSC and if at all anything was needed, the CHC and DH would buy it from their own funds. However, in terms of diagnostics, only rapid tests were being done in the HBCs. Services are provided free at HBCs, whereas many PHCs continue to take user charges.

The community also finds that getting diagnosed and treated at the HBC is easier, quicker and has less barriers than entering a hospital building. People consider going to a hospital only when the patient is serious. The HBCs can help build awareness and serve as an advertisement for the health department, especially in very remote and interior areas where people have less trust and familiarity with availing government health services. Therefore, the HBC offers an opportunity for Information, Education & Communication (IEC) on various issues of health promotion and preventive actions. There are diverse types of vehicles being run by the state government in public private partnership (PPP) mode. In one of the districts, it was observed that there is better scope for coordination with the teams running the MMUs with the district/block so the vehicles and their human resources can be utilized for HBC functioning. The functioning of HBC schemes is intricately linked to regular health systems functioning. This comprises of CHWs, SHCs, PHCS and so on. For example, improvement of medicine allocation and distribution, especially for the HBC could improve functioning of HBCs as they do not have to rationalize the medicines dispensed or ailments being treated. Similarly, the complete complement of human resource recruitment is crucial for optimal functioning of the HBCs. Therefore, districts that have filled most of their posts and have adequate health human resources, are in a better position to run the HBC without compromising or disrupting routine health care services.

To sum up, HBCs should be set-up based on local needs and context, in consultation with the concerned block and district. A combination of factors, such as the location and size (big, small, strategically located in accessible area or main town), and distance from the SHC/PHC/CHC should be evaluated for setting up the HBC. The community too could be involved in such lanning. This will help in utilizing resources more optimally and for those who need it the most.
4.1 Recommendations

1. **Factor in local needs while finalizing location of HBCs:** This is a crucial aspect determining their functioning. Co-location with existing PHCs can be avoided so that services are not duplicated, especially where their uptake is accepted by local community members who are coming to the health care facilities. The guidance provided in the letter dated 9 July 2021 for not establishing these Haat Bazaar Clinics in the vicinity of the health facility i.e., in the 3 km radius should be adhered to.

2. **Review how Haat Bazaars are set up and ensure equitable issues of access:** The identification of the Haat Bazaars for setting up HBCs should be done in close consultation with the block, PHC and SHC team and the concerned Gram Panchayat/village bodies. Operationalizing HBCs on organic felt local needs and reaching those pockets where regular health services are minimal, will improve its relevance and cater to the health needs of the community which does not have access.

3. **Step-up rapport and trust-building with communities for better utilization of services:** The HBCs provide good opportunity to undertake activities on preventive and promotive health. They have information that is relevant for most of the adult population in the area. These clinics also remove access barriers between communities and their perceived reluctance to visit health facilities for preventive check-ups. In these remote areas where people have less familiarity with the availing of allopathic health care services, the HBCs can help build awareness and work as a trust-building platform for the health department.

4. **Serve as a hub for disease screening:** HBCs are seen as serving a crucial function of screening for various diseases, along with providing medical advice and medication, especially in areas that are not otherwise served by government health facilities or their outreach services. This aspect of HBC needs to be strengthened, especially with the current focus on identifying the NCD and ensuring its regular follow-up and disease management with regular medication and monitoring. These mechanisms should be linked with PHC teams or FLWs who cater to these communities. This will not only ensure continuity of services but also warrant that community members rely more on public health systems, in turn making the system more responsive to overall health care needs of the community.

5. **Implement effective data management systems:** The data on OPD patient visits can be collated and entered onto the portal with a single unique identification specific for every HBC location. This will facilitate better coordination of MMUs which has been designated, thereby limiting duplication of resources. As a result, it will enable the designation of only one MMU for every HBC and thereby ensure the engagement of all MMUs on all six days of the week. A live updation on the portal will not only streamline the health workforce which has been engaged, but also provide the details of MMUs which are in position along with their location and cases that have been seen. It will be a single point of portal entry for reporting of that particular HBC (including the MMU).

6. **Assign a dedicated space for physical examination:** The facilities at these HBCs are mostly single rooms constructed units or temporary structures. Here, the team sits outside so they can bring more visibility and guide people to the HBCs. In the constructed
set-up, a separate room for physical examination was established at Barsur. This set-up can be replicated at other similar unit locations to ensure privacy for patients. This will be extremely beneficial for any physical examination that needs to be conducted as part of ANC or routine exams, and counselling sessions performed by primary health-care providers.

7. **Have dedicated HR and well-equipped MMU vehicle:** It will be optimal to have dedicated HR and fully functional MMU vehicle that can be provided at the Block or PHC to cover the HBCs on a pre-defined rotation basis. This will ensure that the regular functioning of these health centres is not impacted due to the HBC scheme in its vicinity and the centres can provide care for cases that cannot be treated at the HBCs. Having a team located within the district and block health system (like RBSK) will help cater to the HBC, ensuring continuum of care. This will not hamper functioning of the regular health systems.

In addition to the 104-call centre follow-up, the HBC initiative can be supplemented with the 108-emergency transportation which can undertake coordinated visits to facilitate patient transport to higher centres of care from the HBC. This is crucial given the difficulty to arrange the transport in the region, distance to be covered and higher costs involved, especially for inter- and intra- district travel.

8. **Focus on better monitoring:** The Government of Chhattisgarh undertook this initiative for ensuring continuum of care. However, strengthening it further and integrating it within existing systems is the need of the hour. Outsourced MMUs require regular oversight and monitoring by district and block officials. This entails monitoring of health staff positioned, medicines and stocks being provided, and record maintenance undertaken by private MMUs and including them in the district-level review. Additionally, the Block health department must be provided the mandate to regulate the MMUs.

9. **Improve referrals and follow-up mechanisms:** Referrals to higher centres and follow-up linkages with CHOAs and ANMs must be upgraded. This will ensure care continuum in communities served by the health care facilities. Referral transport from these HBCs to higher health care facilities should be provided to the patients who need care. Efforts have been made in this direction recently through the letter sent by NHM to districts on 5 May 2022. The monitoring and strengthening of this aspect will ensure unstinted support for patients, better care continuum and reduced financial hardships.

10. **Enhance the corpus of funds:** The performance of any given HBC, must be closely linked to the regular health systems functioning consisting of CHWs, SHCs, PHCs. It must make timely referrals to higher centres of care. Therefore, increased investments on a continuous and ongoing basis will be needed in HR, infrastructure and availability of medicines and diagnostics in these health facilities.

11. **Identify and reduce access barriers:** Further, access barriers in the health facility, such as user fees need to be removed. It would be important to gradually work towards providing free PHC services at public health facilities in the endeavour to bring equitable health care to all.
### Annexure 1: Sample size

<table>
<thead>
<tr>
<th>District</th>
<th>Haat Ba-</th>
<th>Total no. of interviews and group interviews</th>
<th>Health providers (MO, RMA, ANM etc.)</th>
<th>District/Block official inter-views</th>
<th>Mitanin programme inter-views/ community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kondagaon</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dantewada (Dantewada and Geedam Block)</td>
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<td>9</td>
<td>3</td>
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<td>3</td>
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<tr>
<td>Bijapur (Bhairamgarh Block)</td>
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<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Narayanpur (Naraynapur and Orchha Block)</td>
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<td>3</td>
<td>2</td>
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<tr>
<td>Bastanar Block</td>
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<td>1</td>
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Other than the above, the research team visited district hospitals of Dantewada, Bijapur, and Narayanpur and almost all CHCs of the chosen blocks of these districts. PHCs associated with Haat Bazaar Clinics were also visited. Some of the Haat Bazaars visited were closed and are therefore not included in the above table.
### Annexure 2: Respondent information

<table>
<thead>
<tr>
<th>Type of interview</th>
<th>Category of person/s interviewed</th>
<th>Number of interviews</th>
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</thead>
<tbody>
<tr>
<td>Key informant interviews</td>
<td>PHC MO</td>
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</tr>
<tr>
<td></td>
<td>PHC staff nurse</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>ANM</td>
<td>4</td>
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<tr>
<td></td>
<td>CHC MO</td>
<td>2</td>
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<tr>
<td></td>
<td>BPM</td>
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</tr>
<tr>
<td></td>
<td>BMO</td>
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</tr>
<tr>
<td></td>
<td>District officials (DPM and CMHO)</td>
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</tr>
<tr>
<td></td>
<td>RMA</td>
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</tr>
<tr>
<td></td>
<td>Community-level services providers (Mitanins, teacher etc.)</td>
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<tr>
<td>Group</td>
<td>HBC team</td>
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<tr>
<td></td>
<td>CHC</td>
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<td>MMU</td>
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</table>
Annexure 3: Checklists

Checklist 1: Interview checklist for Block/District/State officials
1. Name of respondent:
2. Age:
3. Sex (M/F):
4. Educational qualifications:
5. Total work experience:
6. Present designation:
7. Need/rationale behind introducing the scheme; why was the need felt for introducing this initiative?
8. How is it implemented in your block/district? Who is responsible for it?
9. How is a weekly clinic planned? What is the role/work division between state, district, block, PHC?
10. Status of budgets (is it enough and is it released on time? Also check the manner of payments to district, block, and vehicle staff):
11. Services (are all services as outlined in the letter from NHM to CMHOs being provided? Explore which services are not being provided and why):
12. Concerns related to human resources, equipment, and supplies concerns (check drug supplies with Annexure 2 and also check for vacancies in HR):
13. Was any hiring done at the district level under NHM for vacant posts as envisaged in the original scheme (ref letter from CM to CMHOs); and if so, which cadre was hired?
14. Preventive tasks (the scheme envisaged that along with curative services, preventative actions would be taken such as distributing pamphlets, taking suggestions on preventive care etc. Enumerate what is being done”):
15. Is the referral system as envisaged in the scheme (refer letter from NHM to CMHOs) being achieved efficiently (take photos of referral card)?
16. How does the monitoring system work?
17. What are the major challenges in initiating/operationalizing the scheme right from the advertisement process to implementing and monitoring (e.g., with regard to recruitment of staff, reaching far-off areas, addressing people’s concerns etc.)?
18. What is the role of Mitanins in this scheme?
19. What is the role of the community in this scheme?
20. What kind of data do you collect? Is it analysed? Who analyses it?
21. Have you received complaints on any clinic from the community or others? What action did you take?
22. What is your opinion on the scheme?
23. What are your suggestions for improvement?
24. How do you compare the scheme against providing these services through Health and Wellness Centres and PHCs? What are the advantages and disadvantages?
25. Have any other initiatives been undertaken in recent years to strengthen the regular public health system in these areas? What has been the experience regarding the same?
Checklist 2: Interview checklist for staff of PHC/HWC/HSC in surrounding area

1. Name of respondent:
2. Age:
3. Sex (M/F):
4. Educational qualifications:
5. Total work experience:
6. Present designation:
7. How did you get to know about the scheme?
8. Since when has the clinic in your area been running?
9. Why do you think a need was felt for introducing this initiative?
10. Do you play any role in planning, implementation and/or monitoring?
11. Services – what services are being provided? (as outlined in the letter from NHM to CMHOs) Explore which services are not being provided and why.
12. HR, equipment, and concerns related to supplies. Probe each aspect separately.
13. Preventive tasks – the scheme envisaged that along with curative services, preventative actions would be taken such as distributing pamphlets, suggestions on preventive care etc. What is being done in this regard?
14. Is the referral system as envisaged in the scheme (refer letter from NHM to CMHOs) being achieved efficiently (take photos of referral card)?
15. What are the major challenges you see in this scheme? (with regard to recruitment of staff, reaching far-off areas, addressing people’s concerns etc.)
16. What is the role of Mitanins in this scheme?
17. What is the role of community in this scheme?
18. What is your opinion on the scheme?
19. How do you compare the scheme against providing these services through the sub-centre/HWCs/PHCs? What are the advantages and disadvantages?
20. Have any other initiatives been undertaken in recent years to strengthen the regular public health system in these areas? What has been the experience regarding that?
21. What are your suggestions for improvement?
Checklist 3: Interview checklist for staff providing services at the Haat Bazaar Clinic/MMU

1. Name of respondent:
2. Age:
3. Sex (M/F):
4. Educational qualifications:
5. Total work experience (in the clinic and otherwise):
6. Present designation:
7. How did you get to know of the scheme and the related recruitment information? What was the process of recruitment?
8. Since when has this clinic been running?
9. How is a weekly clinic planned?
10. What services do you provide? Check against the letter from NHM to CMHOs (probe which services are not available and why):
11. Are there any concerns related to HR, salaries, equipment, and supplies? Probe each aspect separately. Check drug supplies with Annexure 2. probe if the staff is from the local area or from far-off areas.
12. What is the relationship (financial, monitoring) with the block and district?
13. Preventive tasks – the scheme envisaged that along with curative services, preventative actions would be taken such as distributing pamphlets, suggestions on preventive care etc. Could that be achieved?
14. Referral system – could the referral system as envisaged in the scheme (refer letter from NHM to CMHOs) be achieved efficiently (take photos of referral card)?
15. How many people have you referred to and where has this been done and for what? (probe to get a broad idea):
16. What are the major challenges that you face? (e.g., with regard to availability of staff, reaching far-off areas, addressing people’s concerns etc):
17. What is the role of Mitanins in this scheme?
18. What role does the community play in this scheme?
19. What kind of data do you collect? Is it analysed? Who analyses it?
20. What is your opinion on the scheme?
21. How do you compare the scheme against providing these services through HWCs and PHCs? What are the advantages and disadvantages?
22. Have any other initiatives been undertaken in recent years to strengthen the regular public health system in these areas? What has been the experience regarding that?
23. What are your suggestions for improvement?
Checklist 4: Checklist for group discussion with the community/interview with Mitanins

1. Village name:
2. Group composition for GD (caste, sex, age, any other defining features/characteristics):
3. Name of respondent (for Mitanin):
4. Age:
5. Sex (M/F):
6. Educational qualifications:
7. Total work experience:
8. Since when have these clinics been running?
9. How did you get to know of the scheme and the weekly bazaar schedules?
10. Does the clinic in your area take place weekly? Are there any weeks when they don’t come?
11. Does every medical vehicle have designated staff? Who all are usually there?
12. What all services are provided at the clinic?
13. Are all medicines and tests available there?
14. Are all medicines and tests free?
15. Does every medical vehicle have the minimum equipment and supplies?
16. Where did you usually go for treating these illnesses when the clinic was not running?
17. What challenges do people face in getting services from the clinic?
18. Preventive tasks – the scheme envisaged that along with curative services, preventative actions would be taken such as distributing pamphlets, suggestions on preventive care etc). Could that be achieved.
19. Referral – the scheme expects that the Mitanin /ANM will follow-up with patients treated in the MMU. Also, that the patients will be referred to the PHC and CHC (yellow card, pink card etc)? Could that be achieved? (Take photo of referral card)
20. Have any patients been referred to a higher level from the clinic? Where and for what? What has been their experience?
21. What is the role of Mitanin in the scheme (for Mitanins)?
22. What is your opinion on the scheme?
23. Is it useful, especially when compared to the services being provided through the Mitanin/ SHC/PHC? What are the advantages or disadvantages of this scheme?
24. What are your suggestions for improvement?
Checklist 5: Observation checklist

1. Location of the Haat Bazaar Clinic in relation to existing health facilities, road infrastructure, remoteness etc.
2. Location of the clinic within the Haat Bazaar (accessibility, prominence etc).
3. Physical set-up (adequate space, privacy, systems for check-up, diagnostics and medicine dispensing, cleanliness, shade, drinking water etc):
4. Make a list of HRs attending the clinic that day against HR posted, disaggregated by sex:
5. Type of patients coming (age, gender, type of condition etc):
6. Number of patients coming (observation plus note down daily numbers for last 7 days and total for last 3 months):
7. Observe health worker-patient consultation:
8. Types of services provided (check for curative, preventive, promotive services):
9. Systems of referral observed:
10. Data being collected/forms being filled:
11. Who are the active people organising the clinic (other than health staff)?
12. Who runs the MMU? (probe if outsourced, and to whom)
We, Deepika Joshi, and Sulakshana Nandi, are undertaking an assessment study on ‘Strengthening the Haat Bazaar Clinic Yojana in Chhattisgarh.’ The objective of the study is:
- to document the functioning of the Haat Bazaar Clinic Yojana in remote and conflict-affected regions of Chhattisgarh.
- to provide recommendations to improve its functioning; and
- to document lessons for its replication in similar contexts elsewhere.

It is in this context that I want to speak to you about your experience in utilizing or providing the services under the Haat Bazaar Clinic Yojana and the challenges faced by you. I would also like to request your permission to audio record our interview. After completing the study, the findings will be published as a report or in peer reviewed journals and shared with policymakers.

If you agree to participate, your identity will be kept anonymous and confidential, but the information you share may be used in the study and any further publications. I will refer to you by a pseudonym or an invented name, which you could choose now. Interview transcripts and observations will be coded to anonymize the data.

This research is not designed to help you personally, and your participation in the study will not lead to any personal benefits for you. We hope that the study will benefit our understanding of the Haat Bazaar Clinic Yojana and lead to health systems strengthening in the future.

As participants, you will be treated with respect and dignity; your anonymity protected; contribution to the research valued and due acknowledgement given in the dissemination of findings, as appropriate and negotiated with you.

Participation in this survey is completely voluntary and you can choose not to answer any individual question or all the questions. However, we hope that you will participate in this study since your views are important.

The interview should take about one hour. If for any reason, you wish to stop the interview in the middle, we will halt the interview right away. There will be no negative impact if you choose to do so.

If you have any queries about this process, please feel free to ask questions. You can also get in touch with me later about the research study at 9406090595 / 8454072950. If you wish to participate in the interview, then I will hand over/read the informed consent form.
Annexure 5: Informed consent form (English and Hindi)

Informed consent form for health professionals/community interview
We, Deepika Joshi, and Sulakshana Nandi, are undertaking an assessment study on ‘Strengthening the Haat Bazaar Clinic Yojana in Chhattisgarh.’ Objectives of the study:
• to document the functioning of the Haat Bazaar Clinic Yojana in remote and conflict-affected regions of Chhattisgarh.
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Participation in this survey is completely voluntary and you can choose not to answer any individual question or all the questions. However, we hope that you will participate in this study since your views are important.

The interview should take about one hour. If you do not wish to answer some question/s during the interview, you have the full right to do so. Similarly, for any reason, if you wish to stop the interview in the middle, we will stop the process immediately. There will be no negative impact if you choose to do so.

If you have any queries about this process, please feel free to ask questions. If you wish to participate in the interview, please give your permission/consent about the same.
I am ready to participate in this process.

Name and address of the respondent: _____________________________________________

Signature/thumb impression/oral consent of respondent (tick-mark):
________________________________________

In case of oral consent, signature of observer: _______________________________________

Signature of interviewer: __________________________ Place: ________Date: ____________
Annexure 6: English translation of detailed guidelines for functioning of the Haat Bazaar Clinic Yojana, as per letter from NHM to CMHOs dated 9 April 2021

1. **Identifying Haat Bazaars:** Districts/CMHOs to list all Haat Bazaars block-wise or at the sub-district level for the scheme. Those Haat Bazaars which are more than three kms from the nearest health centre and which are located in a difficult-to-reach area, specially need to be included within the scheme. The clinic should be organized in the specified location within the Haat Bazaar only, so it is easier for people to access. Tent (canopy, foldable chair, and stool to be arranged at the identified Haat site.

**Dedicated MMU vehicle and dedicated medical team for the identified Haat Bazaar:** Every identified HB should mandatorily have a dedicated vehicle along with a driver. This dedicated vehicle should be stationed such that it is sent to one of the Haat Bazaars six days every week. Each dedicated vehicle will have a dedicated medical team with one doctor (MBBS or AYUSH or RMA), 1 staff nurse/ANM, 1 MPW and 1 pharmacist. It should be tried that the staff sent to the HBC is not changed often so it is easier for the team to follow-up on the patients. At the district level at NHM, vacant posts should be sanctioned in a priority manner so that the functioning of the Haat Bazaars is made smooth.

2. **List of services to be provided under the HBC**
List of diseases and conditions. Medicines are to be given free of cost. Patients’ information to be given to their respective ANMs and Mitanins. Such patients who need specialized care at a higher facility, should be referred to the facility and for this special referral cards have been made. Yellow card for patients needing referral to PHC and CHC. Pink card for patients needing referral at district hospital and medical college. Record needs to be maintained at the facility-level of patients who come with such referral cards so their data can be analysed.

3. List of minimum required equipment, disposable, consumable, reagents, and kits which need to be available in the dedicated vehicle. BMO needs to ensure that all medicines and consumables are available in the dedicated vehicle in sufficient quantity at all times.

4. Regarding branding of the scheme.

5. Regarding monitoring of the scheme, make use of the web portal and mobile app for online monitoring.
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The HBC Yojana in Chhattisgarh aims to improve access to primary health care services and provisioning free essential medicine and diagnostic services closer to the communities in hard-to-reach areas and conflict affected zones. This study documents the service delivery mechanism of the HBCs at the common marketplaces popularly known as the haats and the role of the healthcare teams to ensure service delivery and continuum of care in Bastar region of the State.