MITANIN PROGRAMME

Conceptual Issues
Operational Guidelines

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MITANIN PROGRAMME-
Conceptual Issues and Operational Guidelines

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AJIT JOGI
Chief Minister

Government of Chhattisgarh
RAIPUR - 492001

Foreword

The Mitanin programme is an ambitious innovative programme launched by the government of Chhattisgarh with the active partnership of civil society and with the financial support of the European Union.

This issue of SHRC working papers documents the philosophy and methodology of the programme, the outcomes aimed for and the operational guidelines, which have been evolved. The aim of this publication is to place on public record, the understanding on which this programme is based so that it could be a benchmark against which eventual outcomes are measured. It also provides for a wider state level and national discussion on this approach - a discussion that should enrich this programme which is still in its infancy.

The State Health Resource Center is itself an innovative institutional framework created to assist the health sector reform programme and guide the Mitanin programme. With the publication of this volume one more important milestone has been attained in its assignment and I would like to congratulate them for this singular achievement in designing the programme and all the tools - like training material and training strategy-for this programme, in such a brief period in time.

The ultimate test of efficacy of the Mitanin programme would lie in the public health interventions where it matters most - at the level of the habitat; and a programme so robustly designed, I am certain, would ensure so.

(Ajit Jogi)

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MITANIN PROGRAMME

Conceptual Issues

MITANIN PROGRAMME

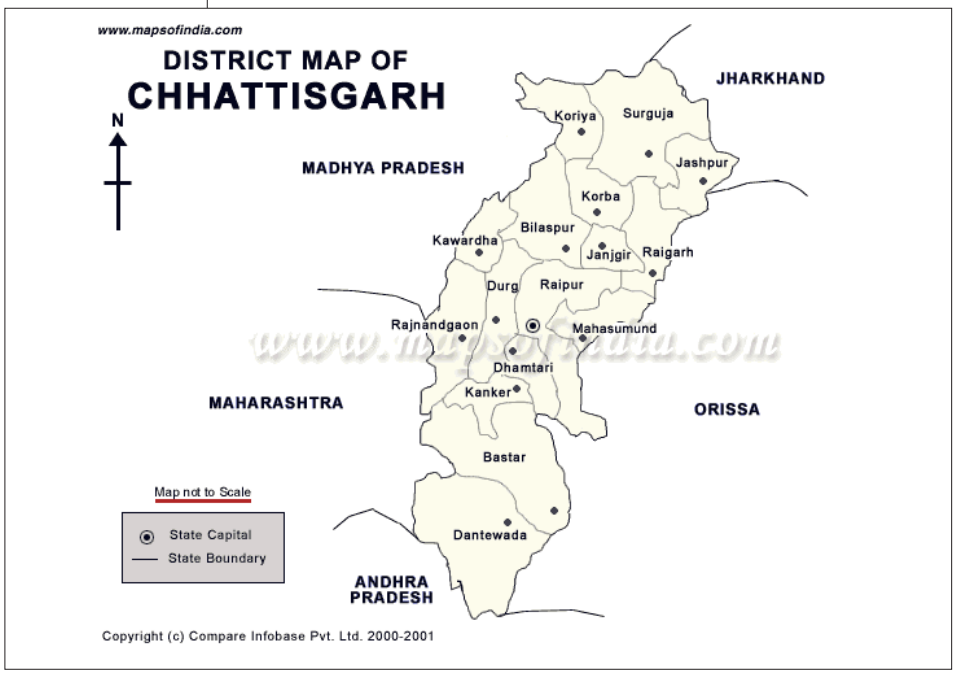
The Context, Approach and Policy Perspective

Dr Alok Shukla,
Secretary, Government of Chhattisgarh,
Department of health and family welfare

Chhattisgarh is a new State carved out of Madhya Pradesh on 1st November 2000. It is the 9th largest State in the country. It has a population of a little over 2 crores. Chhattisgarh has 16 districts, 96 tehsils, 146 blocks, and approximately 9,129 village Panchayats. It has about 19,720 villages, and 54,000 habitations. The State has 9 Municipal Corporations, and 66 other Municipal bodies.

Chhattisgarh has relatively poor health infrastructure. It has only 9 District Hospitals. Only 114 Blocks out of 146 have Community Health Centers. It has 786 Sectors and 3878 Sections. Large number of posts of doctors, and paramedical personnel are vacant. Many PHCs in the remote tribal areas do not have doctors.

Chhattisgarh has approximately 34% Scheduled Tribe population, 12% Scheduled Caste population, and more than 50% Other Backward Classes. People are relatively poor. The State is rich in natural resources. It has large reserves of coal, and iron ore. It also has a lot of lime stone and Bauxite.



Recently Diamond has been found in Chhattisgarh. Chhattisgarh has approximately 40% forest cover. The Literacy levels of Chhattisgarh are quite high. Health Statistics are on the other hand, still poor. Some important figures from the 2001 Census are given below: -

Indicator	Ind	Cg
Population	*102.70*	*2.07*
Decadal Growth Rate	*21.34*	*18.06*
Sex Ratio	*933*	*990*
Literacy Rate	*65.38*	*65.18*
Female Literacy Rate	*54.16*	*52.40*

Some other important Health Indicators are : -

Indicator	Ind	Cg
Population	*98.13*	*2.06*
HDI	*45*	*39*
Sex Ratio (1991)	*927*	*985*
Crude Birth Rate (SRS 2003)	*25.4*	*26.3*
Crude Death Rate (SRS 2003)	*8.4*	*8.8*
Total Fertility Rate (1997)	*3.3*	*3.6*
IMR (SRS 2003)	*66*	*76*
Couple Protection Rate by Sterilization %)	*30.2*	*29.5*
Adult Literacy Rate (age 15-34)		
Total	*56.86*	*46.62*
Male	*69.56*	*64.13*
Female	*43.48*	*29.14*
Scheduled Caste Population (%) 1991	*16.73*	*12.2*
Scheduled Tribe Population (%) 1991	*7.95*	*32.46*
Urban Population (%)1991	*25.7*	*17.4*
Percentage of Married Women in 15-19 age group (1991)	*35.3*	*41.89*
Proportion of Women in Work Force (1991)	*22.30*	*40.99*
Proportion of Farm Labor in work force (1991)	*26.10*	*23.06*
Houses with Electrification (%) 1991	*42.40*	*31.67*
Houses with Safe Drinking Water (%) 1991	*62.30*	*51.1*
Villages connected with metalled roads(%)1991	*36.96*	*20.84*

Though we have progressed a lot in the field of health, yet we still have a long way to go. Diseases like diarrhoea, malaria, leprosy, and tuberculosis still present a major health problem in the State. Measles still causes death of children in the State. Our Infant Mortality Rate is 76, which is very high in comparison to the developed States of the country. Many women still die during pregnancy, and labor for want or proper care. Anaemia, and malnutrition are present in the State on a large scale.

The system of Public Health, which has developed in the last few decades, has been constrained by an increasing distance between the people, and the health services. Underlying this is the increasing complexity of the health system itself. The result of this is that people are not able to benefit fully from these public health services. On the other hand after being educated in the ultra-modern, mechanized, and urban environment, doctors are not interested in working in rural areas. As a result of this today there is a great shortage of trained doctors, and health workers in rural areas. On the other hand incompletely educated quacks are taking advantage of the public in these areas. On the one hand the Health Department feels that people do not take advantage of the services offered by the Government and on the other hand people feel that Government is not able to provide even basic health care services to them. The reality lies somewhere in between, and there is gap both on the supply side as well as on the demand side. Present policies have instead of empowering people, increased their dependence on the Government machinery. Our present system is wholly hospital based. In this system, treatment of diseases has got precedence over prevention of diseases, and programmes of improvement of Public Health. We must remember that all our policies should be made keeping communities in focus, as empowerment of people is out ultimate goal.

Health infrastructure is very limited in Chhattisgarh. 10 of our 16 districts do not still have a functioning district hospital though government sanctions for converting them to a district hospital have now been accorded to all of them. There are 146 blocks in the State, yet there are only 114 Community Health Centers. Most hospitals do not have modern equipments. There are only two medical colleges in the State. Even the hospitals of these medical colleges do not have adequate modern equipment. Health department gets a very limited amount of money for medicines. Because our programmes are not focused on the community, the poor do not get the desired benefit of even these limited resources. Though programmes are made to benefit the people living below the poverty line, in reality it is only the middle classes who are able to take advantage of them. The real poor often times are not able to access government health facilities, and lose both money and health at the hands of quacks.

Being a new State we have no infrastructure in many fields. There is no drug-testing laboratory in Chhattisgarh. Medicines can therefore not be tested in the State. Similarly there is no facility to test food adulteration in the State. There is no institute to train health workers in the State. A good system to collect health statistics also does not exist in the State. A good Information, Education, and Communication machinery is need to ensure community participation in health. It is simply lacking in the State.

Needs of Primary Health

At present Health Services are focused on cure of diseases. Enough attention is not paid to promotion of health, and prevention of diseases. Though a big system of Primary Health, having Sub Health Centers, Primary Health Centers, and Community Health Centers, has been created, during the last

few years, yet this system is not able to work according to expectations. It is necessary to improve this system. The following needs to be done for this: -

1. Make a system of Public Health based on the community, in which people should be able to solve their day-to-day health problems themselves with the help of local doctors. The help of many Non-government organizations existing in the state and the Private Sector should be taken for this.

2. In order to empower communities for Public Health it is necessary to develop an understanding of Public Health among the social workers, and communities, and develop capacity to solve ordinary health problems at local level. Training of voluntary workers, and people working in social sectors will have to be organized for this. This will have to be done on a large scale, and the efforts of voluntary workers will have to be integrated with governmental efforts.

3. A good referral system will have to be developed for such decentralization of Health services, so that people know clearly where they have to go for solution of problems, which they cannot solve at local levels.

4. Full assistance of Local Government institutions should be taken for the decentralization of Health Services. There is a very developed and capable system of Panchayati Raj institutions and Urban Local Bodies in Chhattisgarh. These institutions have been given full responsibility for Public Health by law. It is necessary that these institutions are trained to make their full use in the health sector, and adequate powers are delegated to them.

5. While planning for expansion of health services it is necessary to keep in mind the rights of the disadvantages classes. Many studies have shown that the poor are not able to take advantage of the schemes, which the government has made for the poor. Therefore we must ensure during the planning process itself that the benefits of the scheme go to the target group. New strategies, making use of the private sector will have to be examined for this.

6. Our programmes should help innovations, and provide full opportunities to new ideas.

7. Training of people working in the government system will also be necessary, so that they are able to work in partnership with Local Government institutions, Non-government organizations, and Private sector for empowerment of people to benefit the disadvantaged classes.

8. There is a big challenge to bring the doctors of Indian Systems of Medicine, and other systems of Medicine in the mainstream of Public Health. People in villages often times have great faith on these systems of Medicine. These systems of Medicine have sufficient human resources too. It is necessary to plan for their maximum development, and maximum use in Public Health.

"Mitanin": The Community Health Worker Scheme

It is a generally accepted fact that improvements in Primary Health can be made only through the involvement of communities in the delivery of health services. However different people mean different things when they talk of community participation. Some of these different meanings are described below: -

1. To some persons the meaning of community participation is wholehearted acceptance of Government schemes by the people. They feel Government knows what is best for the people, and therefore makes the policies and programmes, which are best suited for their good. If people do not benefit from such programmes it is their own fault, as they do not participate fully in Government schemes.

2. Some people feel that community participation means demand generation for the services provided by the Government. If this view is accepted it will mean that though all services are readily available to the people, they do not make use of these services, as they do not know what is good for them. Government should therefore launch Information, Education, and Communication (IEC) programmes, so that people understand the importance of using the services. According to this view also the blame rests squarely at the people for not using services.

3. Still other people feel that the community can participate in Government programmes in service delivery as well. These people acknowledge that the service delivery mechanism of the Government may not be foolproof, and therefore people may not have access to services. They thus feel that Community can help the Government in service delivery. The concept of depot holders of simple medicines, and contraceptives is such a concept. Most planners in Government now realize that the outreach of Government staff is limited. They also accept that increase in the numbers of Government employees to increase the outreach to all the habitations is not cost effective. The decision of the Planning Commission of India to freeze the number of Sub-Health-Centers at the 1991 population level is the result of such realization and a very real resource crunch. Still these people do not really accept the ability of communities to plan and work for their own good. They do not believe in the "Empowerment Approach"

4. There is a very small group of people who have faith in the ability and the power o the communities to shape their own destiny. This group of people feels that community participation should mean empowering the community to plan and work for their development. They feel that Government should help the community in making their own village health plan, and implement it. This should however not become an excuse for withdrawal of the Government, but should the lead to a more meaningful partnership between the Government and the Community. "Right to Health" is an inalienable right

of the people, and it is the duty of the Government not only to make all the services available to the people, but also empower the communities so that they can demand, and get what is due to them.

We are a firm believer in the Empowerment concept of people's participation and are committed to ensure this the field of Public Health. Government of Chhattisgarh has launched the "Mitanin" scheme for this purpose. Mitan in Chhattisgarhi means a close friend. Mitanin is a female friend.. In this scheme it is proposed that one woman will be identified in each habitation in villages, and in each lane in cities, to work as the main link person between the Government and the community. This person will be a friend of the community, and will therefore be known as the "Mitanin".

This scheme involves some guarantees to the community from the Government, and some responsibilities, to be taken by the Community, and Panchayati Raj Institutions. These responsibilities are described below.

1.Responsibilities of the Community and Panchayat:

1.1. Publicity of the scheme in the communities.

1.2. Mobilizing the communities for Health.

1.3. Helping the communities to identify one "Mitanin" for each habitation. The Mitanin can be any woman living in the habitation acceptable to the community. It is not necessary that she should have formal education, but it will be helpful if she knows how to read and write. She should be willing to devote her time to activities relating to the health of the community.

1.4. Helping the community in deciding a compensation package for the Mitanin. The Mitanin will be a volunteer, who will not get any honorarium or salary from the Government. However she will need to be compensated for her time and efforts by the community. No uniform compensation package is being suggested in the scheme. The compensation package should be agreed between the community and the Mitanin.

Some suggestions for the compensation package are: -

The community may pay the Mitanin directly a fixed amount, either in cash or in kind (in the form of grain). This can be monthly or yearly. Payment to be made in kind every year at harvest time. The Panchayat may decide to pay the Mitanin something from their funds. The community may decide to pay the MItanin a certain amount either in cash or kind for services rendered as user fee.

The Panchayat may decide to allocate five acres of land along with a source of irrigation as "Mitanin land". This land will not be transferred in the name of the Mitanin, but she or her family will be allowed to cultivate this land and take the usufruct till she is working as the Mitanin of the habitation. This is similar in concept to the "Kotwari land"

Cash contribution by each family to be paid to the "Mitanin" every week/month/year or cash fee at predetermined rates for services to the individual families. Any other method of compensation, which the community and the "Mitanin" agree upon.

One should attempt to get the agreement reached between the "Mitanin" and the community of the habitation to be in writing. The scheme recognizes that this is a difficult process and may be possible to initiate only after at least one year of the programme has passed and its utility is visible to the community. If she regularly gets the drug supply and the slides she sends get reported in time and her referrals gets honored, then the community would be much easier to convince for supporting her.

1.5. Provide space in each habitation for health related activities, including immunization, labor, storing of medicines, etc.

2. Guarantees by the Government:

If the Community and the Panchayat fulfill their responsibilities, they can make an application to the collector of the district for the Government to fulfill its guarantees, and the Government will then guarantee the following: -

2.1. Government will train the Mitanin identified by the community and the Panchayat.

2.2. Government will give refresher training to the Mitanin as often as is necessary, and till such time as the Mitanin is fully competent to do her job well.

2.3. Government will integrate the Mitanin in the Government Health delivery system.

2.4. Government will provide all the free medicines, other materials, and services to the community through the Mitanin.

2.5. Government will provide an essential equipment and medicine kit to the Mitanin for Maternal and Child Health, Reproductive Health, Family Planning, safe drinking water, sanitation and epidemic control.

There are 54,000 habitations in approximately 20,000 villages, and 10,000 village Panchayats of Chhattisgarh. Ideally, when the scheme is fully implemented, we hope to have a trained Mitanin in each of these 54,000 habitations, and also in every lane of the slum areas of the cities. Thus we are aiming at training approximately 60,000 Mitanins. It is hoped that these trained Mitanins will be the cutting edge of actual delivery of all Primary Health related services to the community. They will work in close coordination with and under the supervision of the ANM. They will be compensated for their services not by the Government but by the community.

In order to implement the scheme the following steps were taken:-

1. *Action Aid India was identified as a strategic partner NGO for the scheme, and the State Government entered into an agreement with Action Aid India for this purpose.*

2. *A dedicated core team of professionals was developed at the State level for the implementation of this scheme. This team is called the State Health Resource Center (SHRC). The personnel for this core team have been drawn from NGOs working in the field of Health from all over the country.*

3. *Training modules for the Mitanin were developed. The training module is in Hindi, and has been made keeping in mind that the trainee is a neo-literate. The module has lots of practical exercises, and field work. Difficult concepts should are explained with examples from the local environment. The training has a provision of being run at the pace of the learner.*

4. *Development of a training package of training of trainers (TOT) and Training of trainers.*

5. *Publicity of the scheme, and training of Panchayati Raj representatives.*

6. *Community Mobilization.*

7. *Identification of Mitanins. More than 20000 Mitanins have already been identified, and have undergone the first phase of training.*

8. *The continuing training of the Mitanin and her integration with the Health Delivery System is an ongoing activity in all the Mitanin blocks.*

9. *Certain activities which are important for the programme include Training of PHC doctors and training of MPW (M) and ANM. These activities have been started in parallel.*

Role of "Mitanin"

"Mitanin" in Chhattisgarhi means a friend. In fact She is much more than a friend. It is an age old tradition in the villages of Chhattisgarh, that people make other people their "Mitan" or "Mitanin". It is customary in the villages of Chhattisgarh for girls to become Mitanin of their close girl friends. This is done ceremoniously. Once the two girls have become Mitanins, they are closer to each other than real sisters. This relationship continues for the rest of their life, even after they are married, and becomes a bond between families The "Mitan" or the "Mitanin" is a friend not only in this life, but even in heaven. The friendship continues even after marriage, and becomes a bond between families. The "Mitans" and "Mitanins" are ready to sacrifice everything for each other. It is this tradition that the scheme seeks to revive. The "Mitanin" therefore is not just a voluntary worker, but will be a friend, philosopher and guide for the community of the habitation. The community of the habitation should have full faith and confidence in the "Mitanin" and they should have a rewarding, friendly relationship, which may also have a sentimental element. In this sense the "Mitanin" will be a true guide to the community of the habitation in all their endeavors. In the field of Public Health the "Mitanin" will have the following functions: -

1. *She will give health education to the community of the habitation.*

2. *She will take on the leadership role in all Public Health activities of the village, and will encourage community service for public health specially in -*

a. *Cleanliness of the village.*

b. *Ensuring safety of drinking water.*

c. *Making a parapet wall on all wells and covering all wells.*

d. *Making soak pits and proper drainage system in villages.*

e. *Teaching proper drinking water storage practices to the people.*

f. *Encouraging people to make and use sanitary latrines.*

g. *Taking care of the health of women and children specially promoting good health practices by -*

i. *Teaching good nutrition practices.*

ii. *Teaching good breast feeding and weaning practices.*

iii. *Taking care of iron and iodine deficiency by propagating the use of iron folic acid pills, and iodized salt.*

iv. *Propagating the use of iron and Vitamin A rich foods, and giving supplementary Vitamin A to children.*

v. *Ensure regular weighing of children to monitor growth and development.*

vi. *Ensure at least 3 Ante natal checkups for all pregnant women.*

vii. *Ensure that all deliveries are institutional deliveries.*

viii. *Ensure 100% registration of births, death, marriages, and pregnancies.*

ix. *Provide consultation on MTP services.*

x. *Provide consultation on Family Planning services, and ensure regular supplies of contraceptives.*

xi. *Help women in reproductive health.*

xii. *Provide counseling to youth on matter related to adolescence, puberty and sexuality, with special reference to STD, and HIV AIDS.*

h. *Organizing community participation for the control of diseases like Malaria, Leprosy, Tuberculosis, Diarrhoea and Dysentery.*

i. *Be a link between the Government Health system, and*

the community for all National Health Programmes.

3. *She will provide first aid, and over the counter (OTC) drugs for minor ailments.*

4. *She will be trained in taking care of common illnesses in the village, and will gradually take on the responsibility for treating these diseases in the village. This will be done gradually during the refresher training organized every fortnight in the sector hospitals. The emphasis in these trainings will be on skill development. The "Mitanin" will be allowed to treat diseases only when she has attained the required proficiency levels in both knowledge and skills. She will be examined periodically, and given certificates of proficiency. The important thing in deciding whether she should be allowed to treat a disease is the confidence, which she has in her own ability, and the confidence, which the sector health team has in her ability. A detailed system of examination, and certification will be worked out.*

5. *She will be given the knowledge to refer all cases beyond her competence to the proper place where they can receive proper health care.*

6. Relationship with the ANM and other Health Staff

The ANM and other health staff will look at her as the most important asset in the habitation through which they can reach out to the community. The "Mitanin" will look at the ANM as her chief source of knowledge and strength. The two will not be competitors but will complement each other. Essentially the interrelationship of the "Mitanin" and the ANM or other sector health staff will be positive fulfilling, rewarding, friendly and supportive.

a. The ANM will do the following for the "Mitanin" -

i. *Train the "Mitanin" in the fortnightly refresher training courses.*

ii. *Teach skills to her by making her do things under supervision.*

iii. *Conduct examinations at frequent intervals for certification.*

iv. *Be the main link between the "Mitanin" and the health system.*

v. *Provide support to her in all difficult situations.*

vi. *Build confidence of the "Mitanin" in taking care of the village community.*

vii. *Be the chief spokesperson of all the "Mitanins" in her area to the government system.*

viii. *Ensure supplies of health education material, essential drugs, record keeping material, contraceptives, etc.*

ix. *Counsel the "Mitanin" in her work specially in unforeseen situations.*

x. *Provide legitimacy to the health related work of the "Mitanin" in the community.*

xi. *Help the "Mitanin" in all referrals.*

b. The "Mitanin" will do the following for the ANM -

i. *Provide support to her in the community of the habitation for all Public Health work.*

ii. *Provide her basic data about the community of the habitation.*

iii. *Help her in the registration of marriages, pregnancies, births and deaths.*

iv. *Determine the contraceptive preferences of the community and help the ANM in the CNAA strategy of family planning.*

v. *Be the main source of information about the community of the habitation.*

vi. *Create an environment in favor of positive health in the community.*

vii. *Help the ANM in staying in the village, and organizing camps and other health related activities.*

viii. *Provide legitimacy to the Public Health work of the ANM in the community.*

ix. *Help the ANM in surveillance of important diseases.*

x. *Help the ANM in organizing relief, and in the prevention of epidemics.*

xi. *Help the ANM in all health related campaigns.*

7. Relationship with PRIs –

"Mitanins" will work in close association with PRIs. The selection of "Mitanins", and the agreement between the "Mitannin" and the community of the habitation will be approved by the Gram Sabha". Public Health is an important function of PRIs under the 73rd Constitution amendment. At present the PRIs do not have any mechanism of performing this important function. With the introduction of the "Mitanin" scheme the PRIs will be able to discharge their duties easily. Civil society, and a free press are important pillars of a democracy. These two do not really exist in a village. The "Mitanin" can perform the functions of both "organized civil society", and a "free press" in a village to provide succor to and sustain democracy at the Village Panchayat level. She will be in constant dialogue with the people of the village on all important issues, and therefore she is competent to be the voice of the civil society. Similarly she will the main source of transmitting information about development schemes, and work of the Panchayat, and government to the people. In this manner she is similar to the free press.

a. Panchayats will do the following for the "Mitanin" -

i. *Gram Sabha will approve the selection of "Mitanin", and also the agreement between the "Mitanin" and the*

community of the habitation.

ii. Panchayats will ensure that the community of the habitation honour their side of the agreement.

iii. Panchayats may decide to pay the "Mitanin" something for the services they render.

iv. Panchayats will help in the irrigation of the "Mitanin land" if provided by the community of the habitation or the collector.

v. Panchayats will monitor the work of the "Mitanin", and if they find that the "Mitanin" has not performed her duties well, the Panchayat may remove her, and ask the community of the habitation to select a new "Mitanin".

vi. Panchayats will ensure that the "Mitanins" get good training, and get regular supplies of publicity material, contraceptives, essential drugs, and other things.

vii. Panchayats may use the "Mitanin" in the implementation and monitoring of other welfare, and community empowerment schemes.

b. "Mitanin" will do the following for PRIs -

i. She will send regular reports to the Panchayat about the health status of the community.

ii. She will attend meetings of the Panchayat whenever she is asked to do so by the Panchayat, and will give all information about the health status of the habitation, which is necessary for the Panchayat to make informed decisions about the programmes, and schemes being run in the habitation.

iii. She will help the Panchayat to implement, and monitor such other welfare schemes, and community empowerment schemes, as the Panchayat may require her to.

iv. She will follow all lawful instructions of the Panchayats.

8. The "Mitanin" will gradually take on such other responsibilities, and perform such other functions as the Panchayats and the district administration may decide. She will be trained for performing these duties, and duly compensated for them by the concerned departments.

The "Mitanin" will be the main link between the government and the people in a habitation. It must be stated here that in order to derive full benefit of the scheme it will be necessary that health department delegates full powers of programme planning, and implementation to PRIs. Capacity building of PRIs will also be necessary.

Selection of "Mitanins"

"Mitanins" are to be selected by the community of the habitation. The selection has to be formally approved by the "Gram Sabha". However, just a formal approval of the Gram Sabha without involving the community will defeat the very purpose for which the "Mitanin" scheme has been conceived. The selection process described below is to ensure that the community actually decided who the "Mitanin" will be, and the process of community participation does not remain on paper. It is therefore important that the process is followed in letter and spirit.

The selection process follows the following steps: -

1. A series of workshops and sensitization meetings were held at the state level and district level to orient the representatives of PRIs and key officials and convince them about the scheme. PRI representatives not only understood the full import of the scheme, but are also committed to its success.

2. A team of facilitators was then selected and trained to sensitize the community in each habitation, and help the community in the selection of the "Mitanin". One team of facilitators was trained for each block. It was ensured that facilitators know the local language well, understand the local culture, have positive social attitudes, and faith in the inherent strength of communities, are good communicators, know how to work with groups and are willing to live in villages with the villagers, and make night halts in villages. Some examples of persons selected as facilitators are: -

i. CDPO or Supervisor of ICDS.

ii. ANM or LHV.

iii. Village level workers of various government departments.

iv. Panches.

v. Members of Didi Banks (Credit and thrift groups of women)

vi. Members of Zila Saksharta Samitis.

vii. Members of Watershed committees or JFM comittees.

viii. NGO workers.

3. The facilitator then visited the selected habitation as many times as necessary. Often they made night halts in the habitation. They spent time with the community, so that the community feels that they have become one with them, and freely share their joys and concerns. This is a rather prolonged process, and should not be hastened.

4. Once the facilitator has the confidence of the village community, the subject of the "Mitanin" scheme is discussed with them. The concept is explained in detail. The facilitator then discusses the possible choices, and the pros and cons of choosing various prospective women as "Mitanins" These discussions are held in an informal environment. The facilitator tries to develop consensus amongst the members of the community on the choice of the "Mitanin". The facilitator also discusses with the prospective "Mitanins" the things, which the job entails, and the responsibilities, which they will

have to undertake.

5. Once the facilitator is convinced that a consensus is emerging on the choice of "Mitanin", the facilitator calls a meeting of the community of the habitation to make a formal choice. In this meeting the voluntary nature of this work and the possible different ways of the community compensating the "Mitanin" for her services are also discussed freely.

6. A number of village level activities, which are mobilisational in nature, are carried out. Of this the use of the kalajatha for spreading the spirit of the programme and enthusing the people to participate in this programme is one major step. There can be other major publicity and mobilisational activities like wall writings, posters, meetings, cultural events etc to build interest in the programme.

7. Once this stage has been reached, a formal meeting of the Gram Sabha may be called, and the agreement approved by the "Gram Sabha". The sarpanch of the Panchayat will then endorse the agreement, and then send a request to the Block programme team to train the "Mitanin"

Training of "Mitanins"

After a "Mitanin" is selected, and a formal agreement is signed between the "Mitanin" and the community of the habitation, and approved by the Gram Sabha, the Village Panchayat endorses the selection and in effect sends a request to the Block Medical Officer to train the "Mitanin". All the expenditure on the training is borne by the Government. "Mitanins" are provided training in many stages. First stage of the training, made of six rounds, is institutional. The second stage of the training will be a series of refresher trainings organized at regular intervals at the panchayat or cluster level or PHC through suitable training institutions and training arragnements.

*First Stage : Institutional Training***: -** *This training will include the following: -*

1. Attitudes: **-** *The training is designed to bring in positive attitudes in the "Mitanin" about the power of people, empowerment of women, the strength of community work etc.*

2. Knowledge: **-** *She is given knowledge about basic concepts in Public Health, various Government schemes, and programmes, National Health Programmes, Signs and Symptoms of common diseases, etc.*

3. Skills: **-** *Skills relating to communication, management, group behavior etc. will be developed during the course of the training. Skills relating to disease treatment are also developed.*

The "Mitanins" are trained through a participative process of group work, field visits and studies, visiting areas where community health volunteer scheme has been successful, practical demonstrations, and field exercises. After each round of training they are deployed and supported in a set of activities at the village level. The first two rounds are on health rights and knowledge of available public health services and on child health. The third round is on women's health. The fourth round is on control of communicable disease and the fifth and sixth rounds are on first contact curative care. At the end of an year they would also have a training on village level health planning.

Second Stage : Refresher Trainings **:-** *Refresher trainings are organized monthly at the sector PHC/ cluster level. This training will concentrate on reinforcing what was learnt in the first stage plus further practical aspects of diagnosis and treatment of common illnesses and a lot of troubleshooting and on the job training. It will aim at skill development and practice so that the "Mitanin" gradually develops confidence and is able to take care of the health needs of the community. This training will need to go on indefinitely- it is a continuous process.*

The specific skills she would be trained in include: -

1. *Making of peripheral blood smears.*
2. *Detection of anemia.*
3. *Antenatal care.*
4. *Weighing of children.*
5. *Recognizing malnutrition and being able to counsel the family on integrated management of childhood illness with a focus on malnutrition.*
6. *Recognizing Acute Respiratory Infections, and giving specific drug from her kit when required.*
7. *Recognizing fever, and giving choloroquine presumptively.*
8. *Recognizing when a patient should be referred to a hospital.*
9. *Recognizing signs of dehydration, and administration of ORT.*
10. *Conducting local level health education meetings for specific groups.*

The Sector/cluster training team will make an assessment of the knowledge and skills of the "Mitanin" from time to time, through an assessment system,on the basis of which she will be provided refresher training and allowed to take on more of the responsibility of health care of the community gradually.

In conclusion:

This chapter only outlines the basic concept of the "Indira Swasthya Mitanin" Scheme, and the broad contours and outlines of its implementation. The remaining chapters of this book will discuss the rationale of the programme design further and describe the processes in far greater detail. It needs to be stated that the scheme is in its infancy yet, and therefore it is premature to assess the impact of the scheme on Public Health. It must however also be mentioned that the scheme has evoked great enthusiasm in all the villages, and peoples' participation is very visible for all to see.

COMPULSIONS BEHIND COMMUNITY HEALTH WORKER PROGRAMMES

On why community health worker programmes keep coming back...!

Introduction

Community health worker programmes have repeatedly been tried by the government– and have repeatedly failed. The surprise is not any longer in its failure. The surprise is how despite the worst prognosis they always do bounce back – in one form or another. In some form or other, some member of the local community - depot holder, link worker, malaria volunteer- always had to be chosen to provide some health related inputs.

It is time to pose different questions of the CHW programme. The first of these that we would like to ask is – why do they keep coming back? And secondly what can be learnt from the past so that they do better in each iteration.

There is a simple explanation for their bouncing back - in the present day Indian context ,such a programme is needed, even essential, to any major effort at public health. Of course there is one premise to this assertion – that the poor and the most marginalized have a right to health and health care, and that the state and society has a responsibility to ensure that this right is realised. If this premise is contested, then of course the case is no longer there. But fortunately things have not yet come to such a pass.

What are these compulsions that keep bringing the CHW programmes back?

The ANMs workload

Let us consider what needs to be done at the village level: A list of such activities that the government drew up for the RCH plan document reads like this:

1. Immunisation
2. Ante-natal care
3. Conduct of home delivery and delivery at subcenter.
4. Post -natal care
5. Advise on neonatal care
6. Vitamin A and Iron-folic acid distribution

7. Family planning advice and services including provision of Oral Pills, condoms and IUD.
8. Health education and counselling on child and maternal nutrition;
9. early detection and refferal of pneumonia and prompt and proper management of diarrhoea, with health education to mothers for the same also.
10. fever survey and presumptive treatment of fever with preparation of peripheral smears for blood smear examination for parasites would be done. Mechanism of collecting reports in time with adequate treatment for smear positive cases would be explained.
11. Identification of possible cases of tuberculosis and collection of sputum .
12. Identification of possible cases of leprosy.
13. Treatment of reproductive tract infections and counselling on family life.
14. Identification of cases of curable blind including cataract.
15. Identification of people with disability with advise on available services.
16. Registration of pregnancies, marriages, births, deaths,
17. Education of adolescent girls
18. School health programmes
19. Village womens meeting on health.
20. Attending some panchayat meetings on health.
21. First contact curative care and replenishment of drug stocks in hamlets.
22. Advise on safe drinking water and sanitation

There are too many activites on the list and some of them are mutually exclusive. Thus if one has to go to different habitations for immunisation and house visits, then one is not available in every hamlet for giving presumptive malaria treatment on the first day of fever or even available at the subcenter for conduct of delivery. Moreover many of these activites involve education and behaviour change where only one person's input is inadequate. None of the above activities are such that one can just take it out of the list to limit it. They are all essential to reach basic improvements in health care.It follows that we need more humanpower at the habitat level to attain our basic health goals.

Of course there is one premise to this assertion – that the poor and the most marginalized have a right to health and health care, and that the state and society has a responsibility to ensure that this right is realised.
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Problems of geography

The problem of outreach is further compounded in a state like Chhattisgarh due to the problems imposed by the natural and social geography of the state. The state has 54000 hamlets and only 4000 female multipurpose workers. A population of 3500 is typically spread out over 7 to 15 hamlets, notionally constituted into 2 or 3 villages. (The distinction between villages in a tribal area is not sharp). These 5 to 10 hamlets may be spread over a wide area of over 10 km- or even more. Roads between them or non-existent . Roads to the hamlets are often there but transport services would be too infrequent. Add to these natural obstacles, rivers that cut off the villages in the monsoons for a whole three months and forests. We can see that the task of visiting all the hamlets even once a month is daunting as it is usually possible to visit a maximum of one or two hamlets per day. And if we require the ANM to visit the hamlet when people are available, when they are not out at work - how can she get back to headquarters the same night. And how many nights per month is it possible for her to sleep out?

In practice therefore, though the list of tasks, is long and impressive, most ANMs are able to only manage immunisation and some degree of family planning services and informally always need to take help of volunteers like depot holders or link workers or just their personal contacts for some other tasks. Many tasks remain on paper.

Limitations in expanding the MPW force

One solution is to increase the number of female multipurpose workers. But in this we are constrained by the general ruling that as per the Planning Commission's recommendations adopted by the health ministry, the number of sub-centre health facilities shall be frozen at the 1991 level of population. So no further sub-centers can be added. Even if we were to add, how much could we add? Could we afford at current salary scales one ANM per thousand population? That would mean raising the workforce from the current 4000ANMs to about 50,000. The creation of a further junior cadre of employee is also not much of a solution. For any category of employee would have a minimum wage and soon would be able to bargain for higher wages progressively. And the state government, which already spends the major share of the budget on salaries, could hardly bear a further burden.

adapted to their culture much better than would be the case for a person from outside.

Health education from within the community

There is also the issue of the effectiveness of the multipurpose workers at the village level even in the areas where they are reaching regularly. Community participation and health education – both remains very weak and as a consequence of this their effectiveness is much less.

Studies from many places repeatedly reiterate the advantages of health education being done by a member of the community for whom the messages are intended. Messages received from a woman of the village have the same language, the same idiom, are adapted to their culture much better than would be the case for a person from outside. This again is much more so in a state where we have so many different tribal groups and dialects. Moreover a woman of the same group would have an instinctive understanding of what women already know and what they do not and why certain beliefs are held or why certain messages are not reaching and can address these much better than a person coming in from outside. The Community health worker will be needed as the major carrier of health education- at least till such time as general education has universalised and reached a quality where health education is completed during their 10 years of schooling and people are literate enough to acquire further knowledge from newspapers and books.

Community Participation

Community participation is another area where the health sector needs a person from the community to exercise leadership, or at least act as a catalyst. Too often health work – is seen as the health departments role. The community falls back. One of the reasons for not paying the CHW is so that this does not happen to her too- that it all becomes her work- as an extension of the department. However sceptical, persons working in the health department may be, about the role of community participation, even its worst critics would admit that a number of programmes- vector control for instance- can just not take place without it. If that is so it follows that it is best to seek a person from within the community itself to initiate it, to nurture it and to guide it.

The challenge of the Mitanin programme is to look carefully at all the constraints in past programmes and find a way of overcoming them. And to learn from the success stories of the past especially in the NGO sector, adapt it to our needs, and build on them.

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Utilisation of health services

One reason that a few NGOs give for introducing a community health worker programme is the failure of the public health system to meet the needs of the poorer sections of society. This dimension is perceived in the government in a different way. The government sees itself as investing in this vast network of health facilities and being faced with the problem of gross under-utilisation of these services. Part of the reasons that underlie this under-utilisation lie in the weak systems management within the health department and poor accountability at all levels, and part of it lie in problems of outreach and health education as described earlier. When the government constructs a CHW programme to improve utilisation by working on outreach and health education, it also stimulates pressures to improve its own systems and accountability. Instead of being an unintended benefit, these pressures are now increasingly perceived within the government as being desirable and related to the larger issues of health sector reform.

Linking with the Panchayats

A further role that community health workers have had to play is in their interaction with panchayats. This has always been central in government thinking ever since the 73rd and 74th constitutional amendments that have made panchayati raj into functional bodies. Almost all community health worker programmes have required selection or at least endorsement by the panchayats. The effort has been to use this as a link with the elected representatives and as an effector mechanism for panchayats in the area of health. Success may have been limited, but as long as we concede that local bodies have a role in health care services, we would need to search for a way to build such capabilities and systems as would help them exercise this role. If we have not found it yet,we would have to find it in the future.

If we accept that there are compulsions that keep bringing back the health worker idea, then we must seek the causes of their failure with renewed determination. Indeed one can posit that but for the frequent failures these compulsions would have driven the governments to make CHWs a permanent feature long back. The challenge of the Mitanin programme is to look carefully at all the constraints in past programmes and find a way of overcoming them. And to learn from the success stories of the past especially in the NGO sector, adapt it to our needs, and build on them.

BUILDING ON THE PAST

The Mitanin Programme's Approach to Community Health Action

Dr T. Sundararaman,
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There are seven conditions for success. Seven cardinal principles that cannot be compromised without seriously affecting programme outcomes....

Introduction

Community health worker(CHW) programmes are by no means a new initiative. They have been around for a number of years.

One category of programmes are those organised by an NGO(also loosely termed voluntary sector), with external support .External support may be from the state or central government or, as is more often the case, an international funding agency. The other category are those CHW programmes organised by the government directly. Sometimes as with the community health worker programme of 1978, or the village health guide programme soon after, the initiative was from the central government with the programme being implemented by the states. On other times like in the Jan Swasthya Rakshak programme the initiative was completely from the state government.

In each of these programmes there have been many strengths and some weaknesses. In this note we try to examine how the Mitanin programme learns from these strengths and weaknesses to sculpt out its own approach.

1.Women as Health workers

One fundamental shift in the Mitanin programme from its immediate local predecessor - the Jan Swasthya Rakshak programme is the choice of all health workers as women.

This is by no means however a new shift in the world of community health action and many programmes in the voluntary sector have always made this choice. The reasons are many and well known. Women reach out to women on health issues much better and easier then men do. And for the focus of health intervention to remain on women and child the need to recruit women as programme implementers cannot be overstated.

Women perceive health care as a major priority for social action. Culturally the health of the children and the men in the household are the womens responsibility. When children fall

sick even in educated families where both are employed, women would stay back to care for them much more often then men. When women fall sick other women in the household - the daughter-in-law or the daughter are more likely to nurse them, then the men. Indeed the problem with such cultural orientation is often that too low a value is set on the woman's own health care needs- that becoming secondary to all other caring roles. This cultural conditioning however makes it easy for women to perceive health care as a priority area for necessary intervention. Studies on women in elected panchayats also bear this out.

To this we may add one more reason that underlies this choice of women as CHWs. There is a lesser trend for women CHWs to settle down as quacks then men. This trend is not well documented enough.The experience of the male CHW settling down into quackery is often due to a number of major design flaws in the programme, and their being men ,is only part of it. Yet the trend is unmistakeable, and in a context of limited employment opportunity and an almost completely unregulated private sector, not surprising.

Equally important in the Mitanin programme design is the choice of trainers/ facilitators as women. Being aware that the higher order of capabilities and mobility needed in training roles may not be readily available in every area the programme starts with facilitators in the selection phase who can be of either gender. These are often men. Then when the programme after three to six months transits to the Mitanin training and support stage, the programme reselects the facilitators ,this time insisting on almost all trainers being women- with some flexibility to accommodate the most effective men of the earlier period. . The effect of the local leadership becoming feminized is a significant contribution towards the goal of the women's empowerment.

In Chhattisgarh the choice of term Mitanin made this policy change from the male dominated Jan Swasthya Rakshak programme easy. Mitanin in local tradition is a life long female friend chosen carefully and fortified by a ritual declaration that binds the two girls to help each other lifelong "in every happiness and sorrow." The most common day to day translation of such a powerful ritual bonding is the commitment to help the other when she is sick- an idiom that the chief minister first picked on and popularised. Subsequently it was popularised most effectively in the kalajathas by all the cultural artistes who played on this element of such traditional bonding to the full. The name carries with it such a strong feel good factor that it builds, in rural hearts, a welcome for this programme long before it is actually initiated.

The power of this idiom has proven a mixed blessing too. Now every department and every programme tries to ride this idiom and may soon negate the power it had- spoiling as many of our partners fear the essential goodness of this century old ritual for all time to come. Thus we have malaria mitanins, change agent - mitanins and viklang mitans(mitan is male equivalent of Mitanin) and krishi mitans and now Dantewada of all places - police dept organised Mitanins!! Were we right in opening the way for this appropriation of such an invaluable ritual?

> *Women perceive health care as a major priority for social action. Culturally the health of the children and the men in the household are the womens responsibility.*

2. The Selection Process

One of the key issues in Community Health Worker programmes has been the selection of the health worker. One general principle emerges that since the purpose of such a programme is to reach the unreached as effectively as possible, persons who are selected as community health workers must be sensitive and have empathy with the poorest and the most marginalized, if not be someone drawn from their own ranks. Such a person must be owned by the community as acting on its behalf- not at the behest of the government , much less a philanthrophic institution or funding agency. These principles flow from a perception of health worker as part of a social process for empowerment- for social and economic justice. There are philanthrophic initiatives which see health care as charity or benovelence for whom such criteria would not be necessary. But as the ActionAid motto goes: what is needed in the world is not charity it is justice. The best way of attaining

> *"The problem with such cultural orientation is often that too low a value is set on the woman's own health care needs.*

these values is when the facilitating organisation has a close tradition in working with the community for securing the rights of the poor. And the longer their presence and the deeper their work the more likely they are to make the right choice. Indeed Organisations like CEHAT would call for a prolonged contact on rights based work for over one to two years before the process of health worker selection is initiated. There is really no other certain way of knowing that a selection is correct.

The limitation of this understanding would be that the programmes can be expanded only to such areas where we have a rights based organisation deeply involved with the community and having the surplus energy, time and resources to allot to taking on health care - which would be a very small area indeed. To be precise in the state of Chattisgarh it would have been limited to about 13 blocks and within that about 40 villages to a 100 villages in each.- just about the area where the pilot programmes were launched. Expansion beyond it is not possible if such close community contact becomes a precondition.

When one addresses the larger question of the state taking responsibility and therefore a state run community health worker programme - the selection process becomes a choice between letting the peripheral health worker choose her assistants in the form of community health workers or leaving it to the panchayat sarpanch. Even where a sarpanch is motivated and represents weaker section, given the lack of any tradition of consultation and given the precedence of treating such appointments as patronage the sarpanch is likely to choose a family member or some one who he is obliged to. And this problem is much worse if there is any honararium or even a training stipend attached - however small the amount. Since in many villages the sarpanch is often part of a local privileged section, sometimes even hostile to weaker sections, their choice is even less likely to serve weaker sections.

When it is a multipurpose worker (MPW) making the choice she usually settles for whosoever she can persuade to take up the task, and the village may never really accept or cooperate with this. Often she herself belongs to the better off sections by caste and economic background and her ability to recruit is confined to these sections.The motivation and effectiveness of such a choice remains low. This in turn would only reiterate her poor opinion of community participation itself -which is the dominant view within the public heath sector.

The Mitanin programme tries to contend with this problem by three major innovations:

The trained facilitator

The village must make the choice. This is critical. And this must be made in a general body of the village or at least a meeting with good attendance. But for the village to make a correct choice it must be well informed about the programme and be able to clarify what is expected of the village and of the Mitanin. A trained facilitator undertakes this task. An even more important task of the facilitator is to ensure that all the sections(stakeholders in current parlance)in the village are informed and discussed with separately and that the views and needs of the weaker sections and the women are articulated and find place in the final decision. This requires that the facilitator can identify different points of view and negotiate between them with a partisanship for the poorer amongst them. A five or six day training programme has been devised specifically to impart the necessary understanding and skills. Further the choice of the facilitator itself becomes a one or two month process with a small process for constitution of the district group who would choose the facilitators. A guidebook for this training and detailed guidelines on the selection process and evolution of careful indices for monitoring these processes form part of the strategy.

Hamlet as unit of programme

Another specific innovation of the programme is the choice of the hamlet as the unit of the programme-in contrast to earlier programmes, which used the village as a unit. Different groups occupying different positions in the power relationships, especially those based on caste, tend to inhabit different hamlets and by providing for a Mitanin per hamlet we ensure that all these sections participate. Choosing a Mitanin per hamlet means also a lesser number of families for each Mitanin to cover - usually 30 to 50 families which makes the work feasible on a voluntary basis. Moreover since in this state most villages are made up of highly dispersed hamlets, sometimes over a few kilometres, it is not even possible for one Mitanin to cover the whole village. Finally the intensity of coverage is so high that the diffusion of health education messages and its penetration to the furthest habitations is almost guaranteed if over 54,000 Mitanins go through this intensive 50 day process. On the flip side the change from village to hamlet means that numbers multiply from under 20,000 to over 54,000 with the attendant increase in costs and problems of management involved in providing support and training to so many more.

Social Mobilisation

The process of selection is not going to be effective unless there are many women who volunteer to take up this task, from whom, based on criteria, the most suited is selected. Even those women not selected as Mitanins would be involved in the women's committees. The process of selection is also not going to be effective if the village does not enthusiastically take part in the selection process thereby owning the programme as its own. But for this to happen one needs not only knowledge and motivation but also a certain additional factor - the collective will to action. The process of generating this is what has been termed social mobilisation. A charismatic leader or very respected proactive individual may elicit this but such a person is not available in most villages. Often a successful local developmental initiative or peoples movement has created the enthusiasm and the readiness to embrace such initiatives. In many villages in Chhattisgarh, women's credit cooperatives have played this role. But even these are too few. Therefore in

addition to other dimensions a social mobilisation campaign centred on the kalajatha is built into the selection phase. This role of the kalajatha is a lesson learned from the mass literacy campaigns of the nineties, which was spearheaded by kalajathas largely initiated and organised by the Bharat Gyan Vigyan Samiti. The kalajatha, a travelling troupe of artistes uses a carefully constructed set of plays and songs prepared by the best of playwrights and musicians of this genre and it uses the local cultural idiom and art forms to convey the spirit of the programme and its objectives. In the rural context this is very effective - a way in which the message is easily internalised by its audience. Along with the meetings, the conventional forms of publicity and the group discussions before and after the kalajatha establish social mobilisation for this programme.

3. The role of curative care

Another important point of departure from most other earlier community care programmes is the "supplementary- not central" role given to first contact curative care.

Most earlier programmes run by NGOs believed, quite correctly, that though preventive care is more important than curative care, since curative care is a felt need and an urgent priority , intervention has to begin with curative care to win the support of the community. In practice the focus remained largely in providing prompt curative care. Interventions in preventive aspects have been moderate . These programmes were pathsetters in showing that with such first contact curative care delivered by CHWs considerable improvements in health indices, especially in infant mortality , could be demonstrated. This has been demonstrated now from all over the world- by a wide number of programmes. In India itself publicised papers from Jamkhed, the SEARCH programme of Ghadchiroli, the Mandwa Programme of FRCH , the RUHSA programme of Vellore and the SEWA rural programme of Bharuch -to name a few- have amply demonstrated this.

This same approach when extended to government run programme has led to a large generation of quackery. Not all see this as bad. There is considerable disquiet on whether this informal sector should be referred to derogatorily as quacks. After all, the argument goes, that for most of rural India this is the only accessible curative care. There is some speculation that this informal unqualified sector may have contributed to decline in childhood mortality.

However most would see the generation of such unqualified curative care practitioners like what became of the Jan Swasthya Rakshak as an extension of the problem, not as a part of the solution. Firstly this was never the stated objective of these programmes. The Jan Swasthya Rakshak was meant to help achieve public health goals. But in practice they play almost no role in public health programmes and provide no preventive service nor even a modicum of health education. What he practices in many a village is the worst forms of "pill for every ill" and "injection - saline bottle" approach to curative care. He may arguably have picked up a lot of this from the nearby qualified doctor with whom he may even have worked as an assistant. But without the systemic knowledge and with such inadequate training ,his practice is more dangerous and irrational than the person he imitates. Secondly because they cannot treat more serious illnesses they settle down into intensive therapy for self limiting disease- thereby becoming a major drain on the family income and a major cause of ill health in the community. If today in rural households healthcare has become the second largest expenditure item, we need to note that most of it drains away into useless and irrational medication prescribed by this quack.

In such a setting of low access to quality care initiating the programme with curative care is to ask for the entire selection process and the community perception of the programme to be vitiated by this culture of irrational curative care. Especially when recruited through government functionaries in areas of limited community mobilisation, and when monitoring and support is so weak, the effect of intiating with curative care would be like an honararium. The grant of the opportunity to establish oneself in this trade and thereby earn a livelihood becomes a privilege to be distributed as patronage. We must also keep in mind that there are in this state one year and three

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> "For the village to make a correct choice it must be well informed about the programme and be able to clarify what is expected of the village and of the Mitanin".

year courses in paramedicals and in alternative medicine playing this role of generating livelihoods in curative care and therefore such a misinterpretation of the Mitanin's role would be natural.

Moreover today in most villages this sort of curative care is already available and setting up one or two more will bring little cheer to anyone- even the patronage hungry.

The Mitanin programme does recognise the need for rational curative care but to surmount the above problems, it is so designed that all the preventive components are introduced and deployed before the curative care training is delivered. Thus the Mitanin is already established in an active preventive and promotive role in most villages as of today and curative care has not been introduced yet . This would not happen given the prevailing perception of health care if she began with a curative role. Designing a vibrant preventive role whose effects can be seen and demonstrated is also essential to this strategy and this has been achieved by the programme in the area of child health, womens health and in communicable disease control.

Another safeguard built into the programme is a strong training component of avoiding irrational care and encouraging the use of home remedies for trivial illness. This is sensitising them against irrational care and they learn to see such poor quality care as a problem. It is still too early to say whether this understanding would persist, but the results are gratifying and at least the Mitanin seem to understand the message very clearly. One Mitanin expressed it quite explicitly to the chief minister during an official interaction in reply to his enquiries " we have no keenness to become doctors (hamein doctor bannein kee koi shouk nahin)- we seek to promote health".

Another important dimension in the plan design to prevent any relapse to quackery, is that unlike the JSR programme the drugs are to be supplied through the health department and panchayats and the Mitanin is to be backed up by a well organised referral system.

Six to nine months down the line after training has begun and in the fifth round of training- in the twelfth day of camp based training curative care is introduced. After this training she is given a 21 item, 12 -drug village medical kit and a guide book for the same. Now she is much better prepared for her role in first contact curative care. In a Jamkhed like programme where there is the close guidance of a dedicated medical leadership to inspire the community health worker and train her to avoid falling into the trap of irrational care, this danger may be low. But when in a large state level programme, such dedicated supervision is not available the system needs to recognise and adapt for this. And this is how the Mitanin programme has tried to address this problem.

4. Honorarium – to give or not to give

Most community health worker programmes provide for an honararium. Most NGO led community health worker programmes upto the eighties always had a modest honararium for its CHWs. So had govt programmes. The original CHW programme planned for Rs 600 a year (in the late seventies) and the JSR programme gave a training stipend of about Rs 3000 for six months. Recent versions of the CHW programme run by NGOs propose that drugs can de provided to CHWs who can sell these with a small mark up to provide her with some compensation. The JSR programme on the other hand implicitly encouraged services provided to be charged fees to provide remuneration for their work. But as we described earlier in today's unregulated private sector and dominating culture of irrational medicine it led rapidly into the worst forms of quackery. Yet the question remains- Can a programme be run without compensating the Mitanin for her work? And close on its heels is another question- Is it fair to do so, even if we can do so?

Indeed the non-provision of a honorarium in the Mitanin programme is one of the most contentious issues of the whole programme design. The Mitanin programme does not provide for any honorarium whatsoever. After the first year there is an understanding that for each day of training a livelihood compensation loss of Rs 50 per day, or Rs 100 for two days of training every month shall be paid- but nothing beyond that. Her participation has to be sustained only by motivation and support.

The main reasons advanced in favour of payment are the need to compensate for loss of livelihood and the concern that one cannot secure participation of women without it. There is also the concern that even if we secure participation initially we cannot sustain participation without the monetary incentive and it is difficult to retrain every time there is a drop out. There is also the reasoning that when everyone else in the health system is paid it would be unfair and discriminatory not to pay this woman- the poorest in the chain- for her services.

The considerations behind the Mitanin programme design that does not provide for any honararium for the Mitanin are many.

Firstly the Mitanin should not have to face any loss of livelihood on account of her participation. Only that much work must be given as can be done without loss of livelihood. Her workload is estimated at about 8 to 10 hours weekly or about two to three hours per day for three to four days per week. In ten hours it is possible to visit everyone of 30 to 50 families weekly and hold one or two monthly hamlet level meetings. The temptation to increase her workload beyond this should be eschewed. However in the first year there are twenty days of training which receives no compensation and after the first year two days or training per month which receives at best a nominal compensation of about Rs 50 per day.

The greater concern and reason for not paying compensation is that while the amounts considered are too meagre to amount to a livelihood, the payment would make the entire burden of work solely her task and the community would fall back. From

an organiser of women and the community, from being seen as representative of community monitoring the health services on their behalf, -paying her would make her the lowest paid employee of the department - with all its attendant consequences. This perhaps accounts for the greatest disquiet within the health department about the non- payment. For very often the very persons most vocal within the department about non payment could be equally reluctant about parting with travelling allowance for the woman to come to the training camp, or spending the full amount provided in the budget for the food expenses, which on the other hand is very much provided for and her due.

Moreover, and there is a broad consensus on this - not paying her safeguards selection process from pressures that would otherwise be inevitable and most damaging.

What then motivates the Mitanin to undertake this task? The reasons are many. Some of the Mitanin have themselves young children and would see the opportunity as enhancing their own knowledge. Many are educated women not going to work but who seek an opportunity for using their skills and the social recognition that comes with it. But if one has really got to explain how so many women have volunteered today, one has to accept that in the village, especially the tribal village the sense of community is strong and can act as a motivating factor. Indeed the programme can be successfully implemented only be those who believe that a community spirit still prevails at least in a sufficient number of people - and caring for he community is a value in itself. To those already in such work believing this comes easy. But to those whose own life experience is focussed around personal monetary advancement, conviction would naturally be slower.

Sustaining participation however requires a high quality of support and this requires substantial monetary and effort investment- a point too often easily forgotten. In its absence even monetary compensation is never adequate.

Avenues of monetary compensation that the community generates within itself are however to be encouraged though currently they are only in the realm of theory. Concrete plans for it are yet to emerge though the programme is open to the possibility and would be working towards it.

5. Training and Support to the Mitanin

The most important lesson for any CHW programme from all the past examples of NGO success stories, a lesson somehow not adequately noticed by government programmes, is the need for continuous training and support. Even NGO advocacy of CHW programmes often fails to bring enough emphasis to bear on this most central message of their own experience. Every single NGO led community health action that has been successful has had a dedicated and motivated leadership constantly engaged in training and in regular contact and support of its workforce. The NGO programme leadership meets with the workers regularly, troubleshoots their problems ,

> *However, most would see the generation of such unqualified curative care practitioners like what became of Jan Swasthya Rakshak as an extension of the problem, not as a part of the solution.*

constantly updates their knowledge and keeps their motivation alive- making timely replacements with retraining, wherever gaps occur. It is axiomatic in the NGO world that if we are not having regular meeting of the health workers and not regularly visiting them the programme would fail- invariably.

A marked contrast to this was the JSR programmes where there was one long initial stretch of training and after that no retraining and no support and indeed hardly any planned contact with them afterwards. This pattern has also been seen in village level voluntary functionaries like depot holders who have no training at all or for link workers, who had sporadic training and no support. Even the early CHW and VHG programmes had no continuing programme of training or support. Further there is never any planned deployment on various tasks.

The Mitanin programme has learnt from these lessons. Its training strategy envisages 20 days of camp based training and 30 days of on-the-job training. Training is staggered over a year and the maximum training at any given time is 4 or 5 days- usually two or three days. This way one does not have to withdraw the Mitanin from the community or her family or her livelihood for any long period of time. In each round of training

> *"The Mitanin should not have to face any loss of livelihood on account of her participation".*

one aspect of health care is introduced. Then she starts working in her hamlet on that aspect. A trainer visits her and helps her initiate work on that aspect reinforcing training on the job and building up her confidence to do so. When she gains confidence in this aspect the next round of training occurs and she learns he next aspect and again she goes back and with on the job support masters that aspect and starts working on it.

In the first two rounds of training the Mitanin learns about child health and about public health facilities. Supporting her while she conveys knowledge of health care facilities to the village and as she visits every house identifying child health problems and counselling the family follow this. Then the third round introduces women's health. Which is followed by improving her access to antenatal services and health education activities and a focussed campaign on anemia in women. Then the book on control of malaria and gastro-enteritis is introduced followed by her drawing up a village level plan to combat these two epidemic diseases. And then curative care is introduced.

To facilitate this on-the-job training and support a cluster of twenty hamlets are linked to a trainer who lives in the same area and who visits them regularly. Thus every block has some twenty designated trainers and the training of such trainers, their support and deployment becomes crucial to the over all outcome. For each training camp the four or five neighbouring trainers form a team who train all the Mitanin's in their areas.

For how long is such training and support required. The Mitanin programme like every successful CHW programme understands that this training and support is a continuous process and the programme can be sustained only as long as it is continuing-until larger socio economic changes make it unnecessary. The programme also understands that if we need to see significant changes in the most important health indices due to this approach the minimum time for sustaining this process must be anywhere from three to five years. Almost 80% of the project budget goes to this training and support aspect alone.

6.Mitanin programme as health sector reform

There has also been considerable divergence between different community health programmes in their approach and relationships to the public health system.

Many NGO programmes here and world wide were based on the premise that as the public health system is not working , at least in so far as reaching the poor was concerned- a more effective way of reaching the poor was needed. No synergy with the public health system was considered - giving up the latter as a lost cause. And curiously there was often a considerable agreement on this between radical proponents of health rights approach and in those whose work was an extension of philanthropy. Often such CHW programmes had their own referral centre. Only a few amongst them sought synergy with the public health system. In the era of globalisation and an ideologically driven retreat of the state, this lessened role for the government in health care provision became even more attractive and public policy increasingly talked of handing over areas and programmes to the NGO sector- not as part of a planned way to increase effectiveness but as a shift in responsibility and as giving up on a more proactive government role. In particular the cost effectiveness of the CHW programmes as compared to conventional public health systems seemed to find favour with international funding agencies.

Government interventions for CHW were however usually argued in terms of an extension of the department- a low cost approach in a financially constrained situation. Thus terms like link workers, depot holders were readily acceptable. The Jan Swasthya Rakshaks programme used the public health system for the training process, but after the training stage the only planned role was as depot holders and some related extension services.

The Mitanin programme learns from these but it also learns from a newer and more emerging approach within the NGO sector—a late nineties - twenties approach. Example of this approach are three programmes, relatively small and tentative, but nevertheless important pioneers : the CEHAT supported initiatives in Maharashtra, the PRAYAS work in Rajasthan and the larger more diverse of these- the various health activists programmes of the BGVS in the states of Tamilnadu, Bihar , Uttaranchal and Uttar Pradesh.

In these programmes the community health worker is seen more as health activist, someone who mobilises the community for a more effective and accountable public health system. And this is supplemented by providing health education and organising the community for self help- equally important goals in themselves. This community health worker, or should we say activist, far from being independent or parallel to the public health system is an intrinsic part of it . This increased utilisation comes from securing community participation for health programmes. This not only involves increasing knowledge of government health programmes and facilitation to its employees but actually redesigning these programmes to let the community in. Local area planning in health, involving the panchayats in the process, is one of the interim outcomes of the programme and is major tool of such restructuring to make health systems more responsive to local priorities and specificities.

While one is convinced that by health education inputs and first contact curative care substantial improvements in health status can be gained, the Mitanin programme recognises that considerable areas of intervention depend on the availability and accessibility of good quality health services, that cannot be substituted for by community action. Not to make this distinction would be only an unethical attempt to use community health worker programmes to transfer the blame of ill-health back on to the community. In contrast access to such

public health services, in an affordable way for the poor, is a basic human right. The health worker programme must move towards such a goal and not become a substitute for such movement.

Even within the logic of CHW as mere extension worker, a poor quality of public health system dooms the programme. Thus the health workers are persuaded to make blood smears and send them . If they stop, it is usually not for want of payment or skills, but because they never get back any reports in time. Similarly antenatal check ups can be improved. But if there is nowhere to send a complicated case to for a Cesarean section, then the motivation to detect high risk cases early becomes that much weaker. Of all the likely causes of programme failure the one least explored in discussions and yet most likely to be the cause is the failure of the public health system to provide a back-up.

The Mitanin and the women's health committee contributes to this goal of strengthening public health systems by her work in creating awareness on health services, by organising and empowering women and by sensitising panchayats to health care needs and health services available. Her work in facilitating village level services of the government employees is a more effective and Gandhian way of ensuring accountability in a hardened system, than mere complaints and protests.

However the Mitanin programme goes beyond the work of the Mitanin. It goes even beyond community basing of health programmes. It spells out the parallel measures needed to improve public health care systems and how this component of health sector reform- strengthening the public health system- has to be linked to the Mitanin's work so that both aspects mutually reinforce one other.

7. State – Civil society partnership

We have noted earlier the limitation in NGO programmes in area of coverage. There have been some attempts to attribute it only to fund constraints and hand over very large programmes to NGOs. When this is done the experience is that they too then become bureaucratised. The small scale NGO provides a motivated personalized leadership, which is missing in their large systems. One needs to correctly assess the capacity of a particular NGO to expand without losing this leadership level. Pushing them beyond this is doing them and the programme disfavour.

On the other hand government programmes are slow to innovate, and have very uneven quality of motivation in functionaries. Also given the nature of this programme and its link to health system reform, it is unrealistic to find within the system itself adequate motivation to make itself more accountable.

Also one must note that the government system is considerably understaffed and unable to fulfil even allotted tasks. To burden it with another set of tasks associated with this programme, even if eventually it would make them easier, would not only be impractical- it tends to get quietly rejected at the cutting edge level- where the MPW has to extend support to the Mitanin.

> The Mitanin programme like every successful CHW programme understands that this training and support is a continuous process and the programme can be sustained only as long as it is continuing

There is a need therefore to bring in more players- those who can bring in more woman power and motivation as well.

The Mitanin programme addresses this complex of issues by making state civil society partnership at all levels the cornerstone of its strategy. Such partnership is difficult to construct and sustain but is more effective.

In the Mitanin programme leadership at the state level is provided by a statutory State Advisory Committee made of all the NGOs who were active in areas of community health or health education as well as senior department officials and funding agency representatives. It was this group that shaped the major parameters of the programme.

Coordinating day-to-day implementation and developing the tools and tactics as well a s carrying forward the advocacy for the programme is the State Health Resource Center - a

> Of all the likely causes of programme failure the one least explored in discussions and yet most likely to be the cause is the failure of the public health system to provide a back-up.

functionally autonomous institution established as a joint initiative of ActionAid the main development partner and the government of Chhattisgarh based on an MOU signed between them. The SHRC is officially designated as additional technical capacity to the government of Chhattisgarh and has the flexibility to draw in the sort of expertise needed for the programme from both government employees and from active advocates and practitioners of community action in civil society. The SHRC in turn is able to monitor the programme and constantly facilitate and negotiate for more motivated persons both within and outside government to emerge in leadership roles at various levels.

Then in the pilot phase 7 NGO partners were chosen to build the model and the tools required based on which the programme could be expanded to 80 blocks.

At the district level, making the district RCH society the nodal agency has achieved one level of broadbasing. This RCH society has the district collector as chairperson and Chief Medical Officer as its secretary. Further a district team is constituted of all those who are playing an active role in the programme and in due course this must get formalised as part of a district advisory committee.

At the block level the partnership meant involving NGOs and local community based organisations which in most blocks have been formalised as part of block coordination committee. Today the majority of block level coordinators and trainers are drawn from this section with a small section of government employees supporting them and working with them.

This partnership - like in the literacy campaigns - is the key to the success and its lack a guarantee of failure. In the early part of the literacy campaigns when such partnership was well established the campaigns did well. But once the NGOs were edged out and a feeling emerged that we can go it alone the programmes slid back rapidly. Sometimes the difficulties of building a working relationship are so high that there are voices raised to just hand it over to the NGOs. But this is not the same as working in partnership and would equally fail, except for a very small number of NGOs in a very limited number of villages.

The seven conditions for success

These seven cardinal principles- women as CHWs, a well planned selection process, adequate continued training and support, no honorarium at least in the first year, supplementary and not central role for curative care, linkage to health sector reform and state civil society partnership at all levels, are the principles , that in our view govern success and failure in this programme. They cannot be compromised without seriously affecting programme outcomes.

Related reading and references:

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HEALTH AND HUMAN RIGHTS

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Human rights are those minimum rights that the individual needs to have against the state or other public authority by virtue of their being members of the human family irrespective of any other consideration. The concept of human rights is founded on the ancient doctrine of natural rights based on natural law. Ever since the beginning of civilised life in a political society, the shortcomings and tyranny of ruling powers have led people to seek higher laws. The concept of higher law binding human authorities was evolved and it came to be asserted that there were certain rights anterior to society. These were superior to rights created by human authorities, were universally applicable to people of all ages in all regions and are believed to have existed prior to the development of political societies.

The major factors causing disease in modern societies are social, economic and political in nature. Famine, pestilence, and war, the traditional sources of human ill being, are the result of public policy, almost always mediated by state power.

The codification and statutory recognition of human rights in the decades after the second world war represent a major advance for the working people of the world, and for the cause of equitable humanism.

"Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food clothing, housing and medical care….".

Subsequently in the International Covenant on Economic, Social and Cultural Rights which India has signed, article 12 (1) states: "The States Parties to the present Covenant recognise the right to everyone to the enjoyment of the highest attainable standard of physical and mental health."

However in the same year, 1948 in which the universal declaration was signed, George Kennan, a major formulator of the US Foreign Policy, stated: " We have 50% of the worlds wealth, but only 6.3% of its population. In this situation our real job in the coming period us to devise a pattern of relationships which permit us to maintain this position of disparity. To do so, we have to dispense with all sentimentality…we should cease thinking about human rights, the raising of living standards

The Programme for training and deployment of community health workers in Chhattisgarh, laudable as it is, cannot be seen as an extension of government health care services in to the community. Instead, it must be seen as the beginning of a campaign to establish human rights in the health care sector.....

and democratisation".

It is in the nexus between two bitterly contending forces that the current situation of working people of India needs to be located . In most cased the equations work out to their disadvantage. A few examples of the way in which state policy works are set out below:

Food

It is well known that about 40% of the Indian children under 5 years of age are malnutritioned by international weight-for age norms. This has been demonstrated repeated by credible survey data. What is not well known is 35% of all Indian men and women are malnutritioned by their Body Mass Index (BMI) which is under 18.5 (BMI= weight (kg)/ height (mtr) square). This is seen from the latest surveys conducted by the National Nutrition Monitoring Bureau (NNMB). These data cast a long scheduled on the future well being of our people. The tragedy is that this is happening at a time when our grain stocks are so large that storage has become a serious problem.

Water

This year Raipur had a major outbreak of Gastroenteritis with the onset of monsoons. Raipur is the capital of Chhattisgarh, but it is no surprise that a similar situation exists in Delhi also. There is a complete absence of municipal responsibility for supply of safe and potable water in adequate quantities to poorer areas of the city. At the same time with the privatisation of the sheonath river near Durg the future water supply of that large and growing urban centre has been heavily compromised.

Medical Care

Both in the Bhore committee and in Alma Ata, the Indian People promised themselves proper and well functioning primary health care systems. With the exception of family planning and immunisation programmes primary health care in Chhattisgarh is for all practical purposes non-existent. Laboratory services to prepare malaria slides do not exist. ANMs do not have stocks of sterile disposable lancets to collect slides and are reusing lanclets without boiling. So much for AIDS prevention! Meanwhile in the tuberculosis programme patients are being treated irregularly and with inadequate doses of drugs. An epidemic of anti-drug resistant tuberculosis is looming over our heads. Primary health care services have been heavily compromised by levying user fee and the prevalence of private medical practice by doctors and paramedics.

The programme for training and deployment of community health workers in Chhattisgarh, laudable as it is, cannot be seen as the extension of government health care services into the community. Instead, it must be seen as the beginning of a campaign to establish human rights in the health care sector. The programme for structural change in the health care system will need to create the capacity to correspond to this campaign. The Standard Treatment Protocols will be critical documents on the basis of which this response will be articulated and evaluated. The extension of the Panchayati raj to scheduled areas (PESA) act along with an effective financial devolution will provide the legal and administrative bases for communities to access and control the restructured primary health care system. The slogan "Swasthya Hamar Adhikar Hawe" is not a new one but is well established in the human rights documents to which India is a signatory. However this slogan now needs to be realised in the terrain of working peoples struggle for a healthy and dignified life for themselves and their children.

Reference: Nirmal, CJ(edited): Human Rights in India, Oxford Univeristy Press, 2000.

""The States Parties to the present Covenant recognise the right to everyone to the enjoyment of the highest attainable standard of physical and mental health""

article 12 (1) of the International Covenant on Economic, Social and Cultural Rights

STATE CIVIL SOCIETY PARTNERSHIP

Dr T. Sundararaman,
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State–Civil Society Partnership *is the bedrock on which this programme is erected. Its strength will decide whether the programme stands or sinks.....*

Introduction

Different persons use this term in different shades of meaning. Let us define what is the way we are using it. The state is for all practical purposes- the government of the day, and the administrative apparatus through which it rules. In theory ,it should mean more than that, but at the level of policymaking we are discussing ,it is very much dependent on just these two factors.

Civil society we use in the sense of associations of people other than those in government In practice this often refers to registered societies and trusts involved in health and developmental work and peoples movements representing the interests of one or more sections. However the term also includes professional associations, the press, and local community based organisations like youth clubs, which are not formally registered. There are two important exclusions in this usage. One is the panchayats. These are bodies of local governance and to be seen as part of the government. Due to their lack of powers and resources they may acquire activities and characteristics similar to a voluntary organisation- but indeed they should not be so confused. They just need more powers. The other important exclusion is private companies working for profit. There is an important role for them and a need for partnership in certain areas which we may discuss under public private parternships, but to prevent confusion we keep that section outside the way we are using the term civil society.

Reasons for civil society parternship At the grassroots

In the Mitanin programme at the grassroots levels the compulsions for having civil society partnerships - especially voluntary organisations or some social activists of good standing are :

a. These are *voluntary* coalitions of persons who come together for a specific purpose and they have contacts and credibility with the community. *When a government servant who is getting*

a regular salary and may be earning through private practice as well and is known to earn by other means appeals for voluntary contribution no one will respond to such a call. It is needed to recruit persons who have a local credibility and whose call to voluntarism would be respected.

We note that in times of scarce employment, some NGOs have even come together solely as a means of livelihood. These NGOs may lack two essential traits - of a strong motivation to rural development and an identity distinct from the government. These NGOs may be willing to act as "contractors" for any government programme without having any priorities or perspectives of their own .But for such a programme which is not a top down deliver of services such contractors will not do. We need someone who see themselves as talking on behalf of the people.. Small associations which work at local levels and are often not even registered also called community based organisations(CBOs) are playing a big role and perhaps more persons working fulltime have come from this section rather than any other... The district team must make an effort to choose suitable NGOs with such characteristics as the partners

b. The NGO offers considerable flexibility in recruitment , training and deployment. Thus for example the main trait that is sought in a facilitator or trainer is the ability to communicate and mobilise people. Formal qualifications play little role. Often identification is through association in past work or even familiarity with the local scene, etc. In the current context such flexibility in recruitment is not possible in the government. An informal, non-hierarchical work atmosphere, encouragement to seek further qualifications in parallel, flexibility in grant of leave and work timings(while ensuring desired work output) are all essential features of deploying persons as part of an NGO— as distinct from a person in permanent government service. These too are much needed charecterstics fo rhe Mitanin programme.

c. The NGO acts as a special access to reaching the poorer and weaker sections of the community, to motivating them, to building their capabilities and negotiating on their behalf if needed and bringing them into more active decision making roles. A community is heterogenous and there is due to historical reasons an unequal distributions of asset , and of power. Only affirmative action and an NGO committed to such action as evidences by its track record can overcome or at least negotiate these relationships and secure some entitlements and a role in decisional making for weaker section.

Why partnership at the district and state level

However not all NGOs have these traits. Some are just comfortably placed in the power structure and see this as a means of making a livelihood using their previous influence. Others are there who do sincerely attempt to reach the poor but are not attuned to these needs and require support and guidance. Caution is needed that if an NGO is recruited without this understanding or is unable to function within such an understanding then all the problems that led to the decline of the earlier systems -including corruption- can affect an NGO also. Its being an NGO is by itself no guarantee of effectiveness.

Both in the selection and deployment of groups from civil society and for building in these same principles of equity and need to reach the poor we need the leadership of the programme at state and district levels to be similarly sensitised. In our social context feelings of male chauvinism, caste discrimination, contempt for illiterate and the poor are so internalised that even without being conscious of it so many new trainers or full time persons recruited could have these internalised prejudices. Selection of fulltime persons from women and weaker sections helps but cannot substitute planned inputs to develop a critical under standing of these issues. Then again the development of training material must reflect these concerns. For all these reasons civil society partnership is critical at the state and district levels also.

Another important consideration was that those most successful examples at Community health work had taken place in the NGO sector and one needed to bring in these learning and experience to enrich the programme.

The design of the programme

One problem with many attempts-usually failed attempts -at partnership, is that often the programme design is evolved to the last nut and bolt and then partners are invited to implement it. Which brings in a lot of social contractors - but no partners in the real sense of the term. The Mitanin programme did not make this error. The programme design was evolved through a process of active dialogue with many senior civil society partners who also undertook to do the pilot programmes on which the whole design was finalised. Indeed this provided the strength

> *Care was taken to bring in those NGOs who have the ability and past experience of working on policy and were not merely known for obediently delivering various services.*
> ••

Even within the government there was a major effort at consensus building. The whole programme is approved by the council of ministers after wide circulation and comments from most of the departments.

The construction of partnerships

At the state level a *State Advisory Committee* guides the Mitanin programme. Its composition includes representatives of active NGOs in the field of health, and in the field of social mobilisation who have had a presence in Chhattisgarh over a long time. It has brought in faith based NGOs, both associated with church groups and with Ramakrishna Mission. It includes persons from civil liberties groups who have worked on health rights. The state advisory

committee also has representatives from the main external funding agencies (EU and Danida) as well as from the government of India and the state government. Coordinating this is the lead development partner from this section ActionAid India with whom an MOU was signed to organise this. Thus this committee becomes , by its charter and its practice, a forum for policy formulation and discussion not only of the Mitanin programme but of the entire health sector reform process. Care was taken to bring in those NGOs who have the ability and past experience of working on policy and were not merely known for obediently delivering various services.

The second key innovation on which the programme was built was the *State Health Resource Center*. The Government of Chhattisgarh and ActionAid India initiated the State Health Resource Centre (SHRC) " for the implementation of the Community Health Worker Programme (Mitanin) and carrying forward the pro-poor reforms proposed under the Sector Investment Programme." This was done under a signed memorandum of understanding. The SHRC is envisaged as additional technical capacity to the Department of Health & Family Welfare in designing the reform agenda under the sector investment programme, developing operational guidelines for implementation of reform programme and arranging / providing on-going technical supporting to the District Health Administration and other programme managers in implementing this reform programme.

The SHRC has a core team of full-time experts and support staff that were to be recruited from the open market. The work allocation of the SHRC as stated in the MOU was :

Design, build capabilities, monitor and coordinate the Mitanin programme- a programme for building up a community health worker in every hamlet of the state..

- produce situational analysis as well as detailed studies on various aspects of the health sector,
- prepare policy change proposals for the consideration of GoC, based on the situational analysis undertaken and/ or specific studies undertaken by it or through individual experts / institutions including
- conduct workshops and meetings, as may be necessary, on behalf of the GOC for effective operationalisation of the reform process.
- Undertake or facilitate operational research and epidemiological enquiry into disease prevalence and determinants.
- Assist in programmes to build capabilities of various different levels of health department cadre

Designing and implementation of this reform process / programme may require a number of activities (e.g. specific studies) which may have be outsourced to individuals and/or institutions on a turn-key basis. In such cases, the SHRC will act as the main link between the GoC and the individuals and/or institutions.

With specifc reference to the Mitanin programme the MOU set down that the SHRC would be

- Assisiting in the finalisation of the community-based health programme of the GOC ('mitanin' scheme)
- Assisting in designing a social mobilisation campaign for popularising the idea of 'people's health in people's hands' and creating effective demand for the programme
- Assisting in designing the media and communications strategy and package for the programme
- Assisting in developing operationalisation details and implementation schedules for the mitanin programme
- Assisting in developing all training modules and pedagogy for the Mitanin programme (see annexure)
- Assisting in monitoring and evaluation of the programme
- Assisting in the co-ordination and logistics for the training programmes

The SHRC has since developed a team of 6 programme coordinators and 16 field- coordinators, headed by a director, to be able to deliver these commitments.

One of the key functions of this team has been to constantly interact at district and block levels and help those with adequate committemnt to become more effective , capable and visible at that level. This help is often appreciated by programme managers who find that they are able to use the SHRC field staff to identify within their own staff and in CBOs,the persons who are effective and those who are not .The composition of the team goes on evolving till it stabilises after a few months in a really sincere and effective team. If today in most districts and blocks interested persons have emerged this process oriented selection facilitated by SHRC has played a major role. (An index of this is the wide variety of persons serving as Mitanin district nodal officers. Two block medical officers, two senior public health nurses, one district education officer, one district ICDS officer, one assistant collector, one health supervisor , two health education officers, one specialist gynecologist and a media officer.).

This process needs to be continued forward in the coming months.

At the district Level

The key innovation at the district level has been to let the district RCH society play the lead role. The district society is an inter-sectoral para-statal committee with the district collector as the chair person: This helps at the district level to widen the participation beyond the health department and this has been crucial to save the programme in many districts where the health

department could not manage by itself. It however is stable in the face of frequent transfers in the district administration.

To allow space for the participation from civil society a district resource team has been constituted. This is made of those who volunteer to spend time in actively organising the programme and providing raining. From this we hope to move towards a district advisory committee like the state committee which involves all the partners from whom the district resource team has been made. By constituting this committee in stages one has been able to ensure that those who are willing, competent and share the programmes values are able to find place without creating unrealistic expectations in others.

At the block level a process similar to the district resource team leads to the formation of a block resource team and then a block coordination committee. This is now functional in many blocks.

Problems and Constraints

Forging such partnerships has not been easy, nor are the partnerships stable.

There was and is hesitation from both sides. In government circles, especially in district and block level health department leadership there was considerable lack of enthusiasm in including persons who were not under their control. Only when it emerged that there was inadequate response to their Mitanin selection and that the work was too much and needed partners did they relent. Sometimes the district administration had to actively intervene for that step to be made. Of course there were many districts where such partnerships were forged well. In state health department circles too the SHRC and its mandate causes discomfort which is sometime subdue , sometimes overt. Especially when such work extends beyond the Mitanin programme to other areas of health sector reform these problems are likely to exacerbate.

Similarly some of the best NGO partners remain sceptical about whether the government has a genuine long term commitment to both the Mitanin programme and the partnership or whether it is only a short term pre-electoral affair. The ability of the state to persist with such partnership when issues of public accountability get raised up would need o be tested in practice.

On the ground there are a lot of details in working together that need to be worked out. Fund flow in particular that causes considerable problems.

But what holds this partnership together has been that somehow despite constant differences trust has developed between partners at the state level and in most districts. Also that there is a commitment at the highest level to the Mitanin programme and that there is a realisation that this partnership is crucial to its success.

The support of the central and external agencies to securing this arrangement has also lent some stability to this process. This support would be critical when one enters areas of operational research, locally designed disease control programmes, health care financing and public accountability.

In conclusion

Speaking at a Peoples Health Movement International seminar at Geneva prior to the World Health Assembly this year , Dr Zafrullah Choudhury, one of the founder members of the Movement had this brief one line prescription to offer for strengthening public health systems in the face of the numerous constraints: “Let the civil society in”. In a small but significant way, the state of Chhattisgarh has made a start.

The most important threat to the continuation of the Mitanin programme and its successful outcomes is the real possibility of this partnership being undermined. This may occur from both sides - either for the state to say that we would go it alone, or for it to say- let us just contract it out to NGOs. Both will spell certain doom for the programme. State - Civil Society partnership is the bedrock *on which this whole programme is erected. Its strength will decide whether the programme stands or sinks.....*

THE BEGINNINGS OF THE MITANIN PROGRAMME

Biraj Patnaik,
Regional Manager, ActionAidIndia

On how the programme evolved and where the programme is as of today.....

The Initial launch..

The Rajiv Jeevan Rekha programme was launched by the Honourable Leader of the opposition Mrs. Sonia Gandhi on November 1st, 2001 in Chhattisgarh. The Department of Health & Family Welfare, GoC, planned to develop a massive community health programme called the Indira Swasthya Mitanin Programme as one of the main components of the Rajiv Jeevan Rakha programme. This aimed broadly to build select train and deploy a *mitanin* in every majra tola/ para (hamlet) in Chhattisgarh.

This high profile launch of this programme at such an early stage signified a high degree of political commitment for this programme. The honourable chief minister publicly and visibly associating himself with this programme and publicising this programme from many public platforms followed this launch. In a number of district collectors meetings he called upon the officials to treat this programme as a government priority and reach the goal of Mitanin in every hamlet as early as possible. The aim of having a trained woman in every single hamlet - all 54 000 of them- caught the imagination of the government leadership and managed to secure a very high degree of political commitment for this programme.

Consultation in programme design

For funding the government of Chhattisgarh made a policy decision to utilise the fund available under the European Commission supported sector investment programme. This required a process of consultation with the Commission's representatives. The state government also recognised its need for civil society partnership. The programme was large and new and with existing resources of the government being limited and already stretched thin such participation was essential.

The Department of Health & Family Welfare initiated a process of consultation with the leading health activists, NGOs and state officials. The regional office of ActionAid India was requested to facilitate bringing all the NGOs together and building up the dialogue to plan the Mitanin programme. This led to a three day workshop in January 2002 organised jointly

by the Government of Chhattisgarh and ActionAid which brought together leading health activists and NGOs from across Chhattisgarh as well as other parts of India and representatives from the European Commission.

At the workshop, there was consensus amongst participants, especially those from the leading NGOs of the state that the 'mitanin' programme was unlikely to succeed unless wide-ranging structural reforms were undertaken by the GoC to change the existing laws, policies, programmes and institutions of the state health delivery system. To achieve the vision of 'Health for All' there was need to make a transition from existing health services to community-based health services. The broad differences between the two approaches are given in the table below:

Table 1

Transition from existing health services and community-based health services

Existing Health Services	Community Based Health Services
Based on technical understanding of health care Minimal scope for peoples participation.	Emphasis on socio-economic and cultural aspects of health care People controlled / managed / governed.
Centred around curative care	Stress on preventive and promotive care
Emphasis on Secondary and Tertiary Care	More than equal emphasis on primary care
Managed vertical programmes	Managed through horizontal program.
Target-driven	Flexible and need-based
Not geared to make linkage between poverty and ill-health	Based on structural understanding of poverty issues
No recognition of Gender and health issues	Recognises gender and health linkages
Access and control with health bureaucracy	Access and control with people who need these services the most

The workshop therefore became not only a consultation on the Mitanin programme but an attempt to seek out ways to transform the existing health services in the state.

The Health Sector Reform Agenda

The January 2002 workshop identified a number of areas of the current health services provision which need structural changes in state policy and practice, in laws, in programmes and institutions. The focus was mainly on strengthening community health systems, primary and district level health delivery systems, health surveillance and epidemic control. The areas of reform, which would go along with the programme, were detailed as shown below.

Agreed reform agenda with role of civil society partners specified

1. ***Community Based Health Services***

- Assisiting in the finalisation of the community-based health programme of the GOC ('mitanin' scheme)
- Assisting in designing a social mobilisation campaign for popularising the idea of 'people's health in people's hands' and creating effective demand for the programme
- Assisting in designing the media and communications strategy and package for the programme
- Assisting in developing operationalisation details and implementation schedules for the mitanin programme
- Assisting in developing all training modules and pedagogy for the Mitanin programme (see annexure)
- Assisting in monitoring and evaluation of the programme
- Assisting in the co-ordination and logistics for the training programmes

2. ***Delegation and Decentralisation***

- Assist GOC in developing an autonomy package for (a) integrated District Health & Family Welfare Agency (DHA), (b) Hospitals, (c) programme managers at district and facility levels and (d) PRIs and ULBs.
- Planning of devolution of financial powers and other resources, specifically financial resources to PRIs and ULBs.
- Strengthening system of transperancy and the right to information and social audits.

3. ***Strengthening health intelligence, surveillance, epidemiology and planning***

- Review of current systems of health intelligence and surveillance, and proposing reforms in integrating the mitanin scheme.
- Developing systems of village and district health plans, with community participation.
- Improving the quality, reliability and analysis of health statistics.

4. ***Control of Epidemics***

- Improving community and primary health care systems for (a) prevention (b) early detection (c) early intervention (d) early prevention of morbidity and mortality because of epidemics

5. ***Health problems of poor people***

- Participatory studies of major health problems of rural and urban poor people
- Participatory plans at local, district and state levels to overcome these health problems of poor people.

6. ***Capacity building***

- Assisting in identifying capacity building needs and training packages for the DHA officials and Hospital managers to enable them to perform their new role effectively.
- Assisting identifying capacity building needs and designing training packages for the PRIs, starting from the Gram Sabha level as well ULBs to make devolution of powers to control government health institutions and services effective.
- Assisting in building capacities to utilise existing funds, draw budgets and plan interventions.
- Assisting in building capacities to develop accountable community mechanisms, like social audits to effectively manage and monitor the local health department.

7. ***Rational Drug Use Policy***

- Develop a rational drug use policy for the state
- Monitor the implementation of the rational drug use policy
- Establish transparent systems for community monitoring of the implementation of this rational drug use policy.

8. Improving internal systems of the Department of Public Health

- Identifying internal systems which need reform
- Proposing changes for identified areas of reform

9. Workforce management and transfer policy

- Assisting in the development of a workforce management policy which is clear and transparent.

10. Drug distribution and logistics

- Assisting in identifying bottlenecks in the distribution and supply of drugs
- Conduct a feasibility study to set up a parastatal organisation for the distribution and logistics of drug supply across the state
- Based on the recommendations of the study, suggest policy norms and guidelines to further extend the reach of the state drug distribution network
- Monitor the implementation of the new drug distribution norms.

11. Uniform Treatment Clinical Protocols

- Recommend standardised clinical protocols across the state at the primary, secondary and tertiary level.

12. Management Information System

- Assisting GOC in designing comprehensive computerised Management Information System for the Health Department from the mitanin upto the distrcit level
- Assisting GOC in the user need analysis as well define outputs expected from the MIS across all levels
- Assisting GOC in the process flow analysis of the Department
- Assisting GOC in feasibility of hardware platforms and software across all levels of users within the health department
- Assisting GOC in the development of atleast two web-sites - one for the mitanin programme and one for the health department of the GOC

13. Decentralised Laboratory Services

- Assisting in developing low cost diagnostic tools and systems for decentralising laboratory services to the primary care level
- Assisting in developing training packages for 'barefoot laboratory assistants' across the state

14. Mainstreaming of Indian Systems of Medicine esp. tribal medicines into the state health system

- Studying feasibility of integrating some aspects of traditionally practised tribal medicine in Chhattisgarh

15. Drug resistance in malaria

- Studying extent of drug resistance (to cholroquine) in selected areas of Chhattisgarh
- Focussing on the incidence and prevalence of forest-fringe malaria in Chhattisgarh and recommend comprehensive treatment protocols for malaria

Since then this reform agenda has become the main policy framework that defines the objectives of the state civil society partnership and on the basis of this agenda both the state advisory committee and the state health resource center were set up.

The Formation Of The State Advisory Committee

Taking on board these suggestions, the Department of Health & Family Welfare, Governemnt of Chhattisgarh decided to formally formulate a collaboration with the leading NGOs of the state who were involved in health action and who had been part of this process. These partners including Rupantar, Jan Swasthya Sahayog, Zilla Saksharta Samiti (Durg) and Bharat Gyan Vigyan Samithi, Raigarh and Ambikapur Health Society and Ramakrishna Mission. A high-powered State Advisory Committee was formed by a government order. This state advisory committee was constituted with representatives of these NGOs, of senior state health officials and of representatives of funding agencies contributing to health sector development to monitor the progress of the reform process as well as provide inputs for the community health worker programme. The committee is chaired by the health secretary and the member secretary was the regional manager of Actionaid India.

Simultaneously, the Department also sought support from these NGOs in designing and implementing the community health worker programme. The 'mitanin' programme was now designed in close consultation with NGOs and leading health activists. Their help was also taken for setting the objectives and detailing of training material. Fourteen Blocks in Chhattisgarh were identified for the first phase of the programme which was scheduled to start from May 2002.

Formation of the State Health Resource Center

To provide on-going support to the health sector reform and development process and to facilitate this massive community health worker programme ActionAid was requested to set up a State Health Resource Center (SHRC), fully supported by the Government of Chhattisgarh in order to make available high-quality human resource support for health services in Chhattisgarh. The terms of reference for this state health resource center was agreed upon and crystallised in the form of a Memorandum of Understanding signed between the country director Actionaid and the secretary health. It was decided to look for someone preferably with a medical background but necessarily with experience in health policy and in community health programmes and in social mobilisation to head this institution. After a careful search, Dr.Sundararaman (Professor, JIPMER, Pondicherry and Founder-Member of BGVS) will invited to take on this task and set up a team for this task at the SHRC.

The memorandum of understanding defines the State Health Resource Center as "*an additional technical capacity to the Department of Health & Family Welfare* in designing the reform agenda for the objectives outlined(see table above), developing operational guidelines for implementation of reform programme and arranging / providing on-going technical supporting to the District Health Administration and other programme managers in implementing this reform programme."

Getting the programme going

Even as the SHRC was being set up , work began in initiating the Mitanin programme.

The state advisory committee, to implement the pilot phase, identified fourteen blocks. Reputed and pioneering organisations of the concerned area were entrusted to implement the pilot phase. These were as follows:

- Nagari, Magarlor(Dhamtari)- by Rupantar
- Dondi Lohara, Gundar Dehi, (Durg) by ZSS, Durg
- Marwahi,(Bilaspur)&Podiuppoda (Korba) by BGVS
- Batauli(Sarguja)&Pharsabahar (Jashpur) by RAHA
- Kharasia, Pusaur (Raigarh) by Lok Shakthi
- Narainpur, Orchha(Bastar) by Ramakrishna Mission
- Ghumaka and Dongargaon (Rajnandgaon)by the district chief medical officers team.

The *Pilot Phase* of the programme was formally launched by the Hon'ble Chief Minister of Chhattisgarh, Mr Ajit Jogi, at Marwahi, Bilaspur on 25th of May 2002.

Not all pilot programmes proceeded at same pace. Approaches to training also differed. However by the middle of October enough experience had gathered and enough consensus had been reached to finalise the training material and training strategy and to reorient all pilot programmes to a common programme design. The State Health Resource Center was also in place by now.

It was then that in mid- November that the programme went into *the First Phase* when another 66 blocks were brought into the programme. Thus the entire process of start up from November 2001 to November 2002 took about a year- a year well spent in building up dialogue, and understanding and partnerships and institutional mechanisms before we forged ahead.

By July 2002 most of these 80 blocks had completed Mitanin selection and gone into training phase. By August 2002 the programme was ready to go into *Second phase* and reach out to all 146 blocks of the state.

The road ahead

Though so much has happened in the last year the programme is still in its preliminary stages. Even the pilot blocks have yet to complete their first six rounds of training. The first phase

blocks would have completed their six rounds only by end of October or early November. Selection would be ongoing in the other blocks. After this six rounds of training are over in all blocks, refresher training and support should continue for at least five years. Thus though a lot has happened in one year , not even 20 % of the programme can be said to have been completed. We have just made a beginning.

The Mitanin programme calendar of 'activities achieved' in brief

1	Mitanin Programme Announced as Priority programme of the state	November 2001
2	First Workshop to Envisaging and Finalise the Programme Details	January 2002
3	Setting up of State Advisory Committee	January 2002
4	Setting up of SHRC	March 2002
5	Finalisation of implementing Partners	Feb. - April 2002
6	Identification of Pilot Blocks	April 2002
7	Preparation of Facilitators Manual	April-May 2002
8	Identification of Facilitator- Trainers by Partners	May 2002
9	Initial Training of Facilitators	May 14-21, 2002
10	Production of Communication Material	May 2002
11	Launching of the Campaign	25 May 2002
12	State level Training of Trainers	June 2002
13	Identification & Training of Facilitators	June 2002
14	Social Mobilisation Campaign in pilot blocks begin	July 2002
15	Signing of MoU with partners and Transfer of Funds.	July 2002
16	SHRC fully functional with director in place	October 2002
17	First set of Mitanin training material printed Most pilot blocks into Mitanin training	November 2002
18	First Phase: Expansion of programme to 80 blocks	November 2002
19	Sensitisation of officials and Social mobilisation for 80 blocks begins	December 2002
20	Mitanin selection work begins in all 80 blocks	January - February 2003
20	Printing of all training material and training guidebooks for Mitanin training	
21	Training of trainers at state district and block level for first phase blocks	March - May 2003
22	Mitanin training first phase- first round- Mitanin training third round for pilot blocks	May - June- July 2003
23	Thirty Thousand Mitanins now functional in about 70 blocks of the state	July 2003
24	Programme ready for entering into second phase ie reaching out to all blocks in the state. Cash flow problems become main bottleneck to programme consolidation and expansion.	August 2003.

MITANIN PROGRAMME AND HEALTH SECTOR REFORM

Dr P. D. Singh,
Programme Co-ordinator
State Health Resource Centre

On how the Mitanin programme relates to measures to strengthen the public health system.....

The Mitanin Programme will no doubt generate a greater demand for health services, but would it be met with an improved supply of services by the existing public health system? This is one of the most frequently asked questions about the programme. The concern is that the programme would raise expectations, which the government may be unable to fulfil.

Recognising this problem the Mitanin programme is planned in parallel with a number of measures to strengthen the health system. Nor is this just a statement of intent alone. The Mitanin programme is funded by the Sector Investment Programme and the MOU signed between the government of Chhattisgarh and the Government of India specifies that each quarterly instalment is received only when certain milestones are attained- and the milestones state not only Mitanin milestones but also measures to make the public health system more functional. This is a commitment proposed and made by the state government, which recognises this linkage.

This article does not deal with all these measures. Only those which are directly linked to the Mitanin Programme and dependent on it are listed..

a. TBA (Traditional Birth Attendant) training programmes

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

b. Co-ordination with MPWs.

This is one of the key steps as much of the services outreach that the programme aims to improve are the services delivered

through the MPWs. The following steps are envisaged:

1. Regular block level meeting of MPWs with Mitanin trainers

2. An in-service training programme of MPWs on the Mitanin Programme and community basing of health programmes. A guidebook for this purpose has been prepared by SHRC . The aim is for all the MPWs to undergo this training.

3. Panchayat level meetings with all Mitanins and with MPWs so that a calendar of visits for the MPW is worked out. Mitanins would help by informing people and bringing those in need of services at the time of visit and MPWs would keep to their schedule. This calendar is discussed and finalized preferably in presence of panchayat leadership. The Mitanin would also have a village health register where she is able to track which service each family has got and not got. In a few months all identified gaps within the service provision area of both the MPW and anganwadi delivered services should thus be closed. Block leadership would have to mediate and negotiate between both streams(Mitanin and MPW) giving them equal respect and encouragement so that the gap is closed. The Health sector staff would have to learn that complaints of shortfalls and gaps brought in by Mitanins should be seen as an opportunity and not as a problem. Equally important the health sector and other staff are advised not to dump work on Mitanins. Any work allotted must be done so through an adequate consultative process.

Thus most ongoing health programmes would need substantial modification if they are to become community centred. Without this step the Mitanin programme would not be able to contribute much to disease control on national priorities.

4. The skills of the MPW to act as a referral to the Mitanins and to respond better to the perceived health needs of the community are being upgraded through a number of measures. An expanded list of drugs has been made available for them. Along with this is the introduction of a special Hindi Standard Treatment Guidelines and a training programme where they learn to expand their primary level curative care skills.

c. Improved disease control programmes though designing for community centred disease control approaches

1. In service training inputs for MPWs and health supervisors on community basing of health services, based on a guidebook, have been initiated.

2. The approach to malaria control has been community centred by making a participatory local plan for malaria control central to the exercise. This is planned as a joint exercise at panchayat level with Mitanins and their trainers and facilitators and the elected panchayats. Follow up with hamlet level meetings and then finalizing plan at another panchayat level meeting. Guidebooks are prepared and training of facilitators for this by SHRC is set to begin We need to train 20 facilitators per block.

3. A suggestion had been made to modify the approach to tuberculosis and leprosy control so that the community can understand the disease load it has and make a commitment to eradicate the disease from their panchayat . While this is readily compatible with the ongoing leprosy control programme the tuberculosis control programme design is so health-sector centred and rigid that a commonly agreeable approach has of yet not been possible to evolve. Eliciting community participation for health programmes is not to be seen as merely a matter of informing the community and asking them to carry out tasks assigned by the department. It must require participation in planning, in setting goals and in monitoring outcomes too. Thus most ongoing health programmes would need substantial modification if they are to become community centred. Without this step the Mitanin programme would not be able to contribute much to disease control on national priorities.

d. Strengthening referral services

This needs to be done from Mitanin upto CHC level with feedback mechanisms to Mitanin for identified categories of health problems. Work on this has yet to begin.

e. Strengthening Health information and disease surveillancetems

Linking data inputs from the community (through the Mitanin programme) with health information management systems and disease surveillance operated by the health department could benefit the community and assist health sector functioning. Care needs to be taken that this does not increase the workload of the Mitanin.

f. Streamlining drug procurement and distribution mechanisms

This is essential to ensure that drugs are regularly supplied to Mitanin and that its use is monitored.

g. Local Health Planning

Eventually the construction of a block level health plan integrating the panchayat level plan with the district health system and with inbuilt feedbacks from disease surveillance and health management and information systems should enable effective decentralization and planning of health services. Block level planning has now been initiated in all blocks and its integration with Mitanin Programme would be strengthened.

h. Strengthening panchayat role and public system accountability

In the process of undertaking all the above activities the people and their elected representatives in the local government get a much better understanding of what services are being provided and what others are needed. This promotes advocacy for services that are needed and builds in local accountability for services that are available.

Note: In parallel to the Mitanin programme some of the other measures being taken to strengthen the public health system include:

a. The adoption of an Essential Drug List, State Drug Formulary and Recommendations for Comprehensive State Drug Policy.

b. Standard Treatment Protocol and delineation of levels of care and training on the same.

c. Training of primary health sector staff— especially of Medical Officers & ANMs - both on STPs and on local planning on health. Building up of training infrastructure also.

d. A study has been undertaken to make recommendations on workforce management, on rationalisation of services, on human power development and on decentralisation of health sector planning and management.

e. Based on all the above inputs a plan is being drawn up to take up a number of Mitanin blocks for intensive motivational, planning and organisational inputs as well as resource inputs so as to actually be able to demonstrate an improvement of primary health care. This programme, "Enhancing Quality in Primary Health", is now at the conceptualisation stage.

FINANCING AND SUSTAINING THE MITANIN PROGRAMME

A seriously implemented Community Health Worker Programme is not a low cost option, though it is a highly cost effective one.....

The unit costs of the Mitanin Programme

The cost of the Mitanin Programme works out to roughly Rs 16.16 lakhs per block or approximately Rs 16 lakhs for 400 Mitanins.. For 146 blocks the cost of the programme is Rs 23.36 crores. That is about Rs 4000 per Mitanin per year: The cost of training books and materials comes from outside this budget and works out to another Rs 500 per Mitanin.

Let us look at what the Rs 4500 goes into :

Social Mobilisation :	Rs 150
Selection :	Rs 200
Training and support (20 days of camp based & 30 days on the job) :	Rs 3000
Administration :	Rs 350
State support and ditrict training:	Rs 300
Training material and medical kit	Rs 500

Of this Rs 3000 about Rs 1000 goes into monetary compensation for trainers and block coordinators for regular support visits in-between training camps and Rs 2000 goes into the expenses of twenty days of training camps. Most of the training material came from outside the budget and this amounts roughly to about Rs 350 to Rs 500 per Mitanin.(depending on quality of books and the medical kit bag we decide to give).

Further the cost excludes the cost of drugs dispensed by the Mitanin which comes from the state and central drug budget

The costs in perspective

This cost of Rs 25 crores - over 18 months may appear too costly unless put in perspective. The state health budget is Rs 300 crores .This itself is by recommended norms insubstantial and 25 crores would represent just 8. 3% of this.

The benefits even in a low outcomes scenario -where the 54,000 were given the requisite number of training days and

then did no work at all- would still mean such a wide and deep penetration of health messages that this in itself would justify the programme.

We may also build the case on another basis. There is a serious degree of under-utilisation of health care facilities today. Given the fact that the state spends 300 crores on a public health system of which over 250 crores goes to salaries alone- a further investment of 25 crores that would build the community participation and accountability needed to effect a better utilisation of these services is a big step forward in preventing wastage of scarce public resources. Given the gaps in immunisation coverage , the gaps in pregnancy care and family planning services, the low attendance in many public health facilities and the overcrowding of its district level facilities, such an investment is long overdue. Given the other many tasks that are on paper assigned to the multipurpose workers, but in practice as we saw in the opening chapter, never attainable under the current system- this programmes' cost benefit ratio, if it attains its process indicators-let alone outcome indicators- is beyond doubt.

When one sees the budget in detail one can see that it is a bare essentials budget- in some areas even sub-critical. When budgets are worked out with even less costs one should be concerned that it is not an attempt by the government to retreat on its commitments, while it shifts responsibility of the lack of health and health services onto the community. If there has to be a community health worker programme the rock bottom financial requirement is adequate provision for regular monthly training and support and in the long run some livelihood compensation for days lost in training.

The community's contribution, if costed, works out to more than the governments contribution. Thus if we pay a minimum honararium of Rs 500 per month per CHW it works out to Rs 6000 per year which is 50% higher than what the government's contribution. At the state level it would be Rs 32.4 crores annually. And this is not costing what the village women's committees does , or the cost of various activities organised collectively by the village, or the time spent by cultural artistes, or local leaders etc.

Sustaining the Mitanin Programme

To make a significant change any health programme needs an uninterrupted five years of intensive work. At least three years to make any visible impact. The current Mitanin programme has been able to locate funds for only an 18-month programme.

"The key to sustaining the programme is to sustain the state - civil society partnership, and to sustain the training and support on a monthly basis."

The plans for the follow up in the next three to five years, though informally agreed upon have yet to receive formal government sanction.

The most likely follow up plan is to continue at the current modest levels of expenditure. One would need to make a provision for the programme in the state budget and to also reach out to central government and bilateral international funding agencies for this purpose.

The key to sustaining the programme is to sustain the state - civil society partnership, and to sustain the training and support on a monthly basis. To keep this interaction interesting and useful one would have to diversify to include more intersectoral elements into local health planning

1. In such a scenario we can suggest a sum of Rs 200 per month per mitanin - Rs 100 for the cost of the training camp and Rs 100 for livelihood-loss compensation for her attending two days of review, training or mobilisation work (paid to her when she attends the meeting). This can be supplemented by some local related income generating activities largely in sales commissions for health related goods. (Rs 80,000 per month per block). Training camps can be funded through the health department or through the panchayats.

2. The 20 trainers can be paid Rs 600 per month livelihood compensation for the 12 days she spends on receiving and giving trained and support.. An alternative/supplement to this is that the trainer also gets support to set up enterprises or laboratory services as suits her capabilities. (Rs 12000 per month). This job of provision of training can be contracted out to a local NGO/CBO if there is one who available who has played a good role in the initial 18 months.

3. Drugs to the Mitanin are taken from the health department through the panchayats or through the ANM who enters it as part of the services provided by her. A minimum quota of drugs is fixed. All the other drug depot holder and the TB - DOTS providers are all converged on the Mitanins.

4. A two person block resource unit (Rs 6000 per month plus TA),of which at least one is from an NGO and a three person district unit can remain active to provide leadership. They conduct the training of trainers and monitoring functions. (Rs 12,000).

5. The cost of this works out about Rs 104,000 per month or Rs 12.48 lakhs per block per year which is a recurring cost of Rs 18 crore a year.

This above is a minimum set of options which the health department would have to implement. But there are more possibilities that the government should consider:

Strengthening panchayats

As an additionality to the above the government may give a fund as collective incentive to panchayats who are performing well. Thus any panchayat where the programme is viable and who has drawn up and are implementing a local health plan could have a budgetary allocation of 100,000 rupees every year.

We note that drawing up such a plan is part of the 18 month process and funds are already earmarked for panchayats -in the health department, in the panchayats department and in the department of tribal welfare which would be better utilised in the presence of the plan and the presence of the Mitanin programme.

Strengthening civil society networks

The situation created by the Mitanin programme should be used to strengthen civil society institutions and interventions. The intervention area should expand to include food security including grain banks;credit cooperatives; local water and other natural resource management, education etc.

This cannot and need not be done by and through the health department. But the civil society network put in place could undertake such programmes that can piggybank on the human resource and enthusiasm created by the Mitanin programme. Thus a sum of about Rs 1 to 5 lakhs per year to all the main NGOs/CBOs for related projects would achieve this synergy. It would also act as an incentive for these NGOs/CBOs to continue to support the Mitanin programme, which in itself provides too little overheads for a honest NGO to survive on. Most of these would not come from the health department budget but there are many NGO programmes like in HIV control, that can also be offered to these organisations.

Public -private partnerships: Another area of possible synergy is to use the networks set up to develop marketing outlets for insecticide impregnated bed nets and sanitation related domestic products which the NGOs can take up and run. Also some NGOs equipped to do the same can set up local level laboratory services at the market- centers which the sub-centers and even primary health centers can use, on a rate agreed upon and periodically revised. A quality check mechanism is also to be built in. This will help us to get blood smear examinations done on time, and to ensure that all pregnant women get checked for anaemia and some other related tests that are not happening. The funds for these are not shown as part of the Mitanin programme . This is only mentioned here to point out that there are many possibilies to build up a system where the trainers and organisations who are working full time on this can be provided with livelihoods in a way that it helps sustain the programme.

PIONEERS IN COMMUNITY HEALTH WORKER PROGRAMMES

V. R. Raman,
Programme coordinator,(Mitanin Programme) , SHRC

Community Health Programmes became well known in the mid seventies. Since then many organisations have replicated different forms of community health work across the world. India too has a rich experience of such programmes.

The central issues of these programmes have always been how far replicable they are - especially by the government. When they are small projects run by a dedicated capable voluntary leadership they tend to do well. On the other hand when they are large programmes integrated with the main system they tend to do poorly. However despite this major limitation one aspect that was established beyond any reasonable doubt by the pioneers of community health action was that substantial improvements in health status can be brought about a team of well trained and guided community health workers despite their having low literacy skills and educational levels.

Let us briefly look at some of these pioneering community health worker programmes in India.

Some of the major pioneer programmes that have defined this community health worker approach are :

"Indeed the Jamkhed Programme, was to influence the dialogue on community health workers ever since and in a modest way even the framing of the Alma Ata declaration."

●●

We travel
on the shoulders of
giants.....

	Venue/Name of the Project and Organisation and key resource person associated	Approximate project size
1	Comprehensive Rural Health Programme- Jamkhed, Aurangabad district , Maharashtra Dr. Mabelle and Dr.Rajnikant Arole.	100 villages
2	Comprehensive Rural Health Project Mandwa; Maharashtra Dr.NH. Antia, Foundation for Research in Community Health	30 villages
3.	SEWA- Rural, Bharuch, Gujarat Society for Education Welfare ad Action Rural. Dr Anil and Lata Desai; Dr Mira Chatterjee.	35,000 population
4.	RUHSA project, Vellore district, Tamilnadu Rural Unit for Health and Social affairs- (assoiated with CMC Vellore) Dr DS Mukherji, Dr.Rajarathinam Abel	84 hamlets; about 1 lakh population
5.	SEARCH project, Ghhadchiroli, Maharashtra Dr Rani Bang and Abhay Bang	58 villages 48,000 population
6.	KEM Rural Health Project Extension service of King Edward Memorial Hospital Dr BJ Koyaji	186,442 Population approximately one block
7.	Vivekananda Girijana Seva samithi, Billi Ranga hills, karnataka HS Sudarshan	Yelandur Taluk 70000 Population
8.	Comprehensive Labour welfare scheme and United Planters association of Southern India, Idukki (and Tata Tea planatations. Munnar) Dr V Rahmathullah,	2.5 lakhs- mainly tea garden workers
9	Raigarh Ambikapur Health Association Sr Georgina/ Sr Elizabeth	150 villages, 2.5 lakh population

Of the above list the first six are important because they have generated substantial data to show the improvements in health status and much of this has been published in internationally peer reviewed journals. The other projects listed have have important innovations or situations that are worth studying closely, though they have not focussed on such data.

(note there are many more projects eg CHDP, Pachod, the Banwasi sewa ashram the Deendayalu project in chittor, AWARE programme in Naydupeta of Andhra pradesh which are also significant- but we are constrained by lack of space and figures to discuss these.)

Let us look at some of these projects for relevant lessons.

Comprehensive Rural Health Project : Jamkhed : Dr Raj Arole and Mabelle Arole; Ahmedhagar dt – Jamkhed;

This programme is the most well known pioneer in this area. Indeed the Jamkhed Programme was to influence in the dialogue on community health workers ever since and in a modest way even the framing of the Alma Ata declaration. This programme was led by two doctors- a husband and wife pair of Dr Mabelle Arole and Dr Rajnikant Arole, both of whom had graduated together from medical college in 1959,worked for three years in villages and then moved to learn higher skills in the US , working at Cleveland Clninc and John Hopkins- two of the most renowned programmes before returning to India in 1970.

The Jamkhed programme started in 1970 with trying to build a programme around a health center, linked to weekly village visits by the doctors, supported by ANMs.This was much like what was then available in the government system- one woman for 5000 population. They started with six ANMs. But over the next two years they had to change their strategy.In his book on Jamkhed Dr. Arols writes, "The ANMs were to stay in a village and attend and provide services to about five villages each. However though trained and intensely supported by us the results were not encouraging. They were successful in curative care but had great difficulty in getting acceptance as midwives or in doing preventive and promotive work. Moreover they found it difficult to stay in villages. Nor was it possible to afford an ANM in each and every village". Analysing it they saw that when it came to preventive and promotive messages the cultural gap between themselves and the ANMs led the villagers to disregard their messages.(" the nurses are different, they dress

differently. Sometimes our women do not understand their language. They use big words and strange phrases that we have never heard before. They keep aloof, and do not like to meet our women in the field. They are not able to explain things to our women and not sensitive to our beliefs." Report of sarpanch to Raj Arole about why a very good ANM was being ineffective stated during an evaluation session - quoted in the book "Jamkhed.".) The team noted that in China too similar problems had been noted. It was decided therefore to limit the ANM to a weekly visit and instead create a cadre of the community health worker. With the withdrawal of the ANM to the health centre, as part of the medical team, they became not only more effective but more cheerful as well and in all their functions including support to the community health workers they were able to play an important role.

Faced with a very limited success in this ANM centred approach , largely because of her inability to reach to the hamlets regularly and becuase of the cultural and social gap between her and the population she has to serve, they decided to start by training village level volunteers- that too women.

From the very beginning the Jamkhed strategy was to be a multipurpose service and they chose to start farmers clubs too in all the villages. By 1975 they had built such farmers clubs in 30 villages. These clubs became to focal point of all the comprehensive health activities planned. The selection of the CHWs was also a farmers club function.

CHWs were selected to be women, usually married and who were resident in the village. Most of them had children but a home situation where they could be helped. Some were widowed and needed the small financial support that the programme provided. All were selected by the farmer's clubs-, which were active sensitised entities, which knew to act in consultation with the team.

Training consisted of an initial week long orientation followed by periodic weekend visits and reviews. The ANMs served to play a major role in training and even senior VHWs helped significantly. Training was participatory with a lot of group discussions and practical demonstrations. Considerable cultural adaptation of messages could take place.

The programme went on to form womens development groups as well.

By 1975 the programme had an impact in 30 villages. It was then decided to expand the programme . Over the next five years it did expand to 175 villages.

Meanwhile in 1977 the government partly influenced by this programme and also driven by its own compulsions launched a community health volunteer programme later known as the village health guide programme. The government approached the Jamkhed team to help them conduct the programme in the entire district. This was agreed to .Teams from the programme visited the villages explaining the programme , helping in selection and then later undertaking the training. Training was one week at the Jamkhed center, one week visiting and working with one of the established VHWs and another two weeks at Jamkhed. Further once every three months there was are training at the center with monthly one day sessions at the PHC.

This programme however did not have the desired impact.To quote Dr. Arole..." VHGs expected the same kind of support from the staff at their primary health centres as the village health workers enjoyed atJamkhed.But the government PHC staff are not trained or even inclined to provide support or consider VHGs as learners and competent equals. The government did not make provisions for ongoing refresher training of the VHGs and did not have facilties for overnight accommodation." To modify these problems twelve local NGOs were selected and trained to provide this support .This helped limit the problem by providing some quality of monitoring and training support. In this process women were also developed as trainers.

What were the health out comes of Jamkhed ? There is considerable data on this. The IMR fell over four years from 176 to 60 and then a slower fall over the years to about 18 to 20 by 1992.Birth weights increased by 0.75 kg. The crude birth rate fell from 40 to less than 20 over this twenty year period. And couple protection rates have reached desirable norms. Certain areas like a marked son preference affecting gender ratios below the age of 15 had not changed- but on the whole the programmes impact was unquestionable. The impact was most on child health and the major strides forward was in the first five-year period. Socio economic indicators, knowledge, attitudes and perceptions also showed positive changes.

(Note : Jamkhed also did not start in a vacuum . The architects studied in detail an yet earlier project known as the Narangwal project in Punjab .This project had been a very important component of defining the role and possibilities of the ANM.There is no single project which can ever be named to be the very first!)

"Some of the impressive results of the RUHSA programme was their work on child malnutrition- an aspect that the Mitanin programme has understood and incorporated."

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KEM rural health project 1987: 22 villages

This project was more like an extension programme of a large tertiary care center. - the King Edwards Medical college and hospital in Mumbai. This background made for a fairly rigorous data collection on impact of community health workers. They report that in the ten year period from 1978 to 1988 infant mortality fell from 118 per 1000 to 67 per 1000, primarily due to a fall in post neonatal mortality due to better child care services. Perinatal and neonatal mortality however did not change. The drop was steepest in the first five years - when it fell from118 to 80. Crude death rate declined from 10.4 to 7.3. Crude birth rate too declined though not as dramatically. Like in Jamkhed, this project too had it had its own referral center- a 30 bedded rural hospital with an operating theatre. The CHWs were community selected but the ANMs were from the government center. They were also seen as having a role in improving outreach of government provided services. The government contributed Rs 50 per month and the KEM contributed another Rs 75 per month towards a stipend for these workers.

Expansion of the programme to the whole block however met with innumerable problems, especially as the PHCs which were to be referral centers were not under project control and could not provide the same motivation and support as the base referral hospital. Also target oriented vertical programmes like the family planning programme would frequently interfere with the routine activites of the community programme and local priorities. The basic reason for synergy between NGO and government was expressed thus by Coyaji - one of the initiators of the programme: "Why are we there? Because we *want* to do it.The government is there because it *has* to do it."

Rural Unit for Health and Social Affairs (RUHSA– Vellore)

This is a creation of CMC Vellore- itself one of the premiere medical colleges in the country. This programme was set up in 1977 to integrate health care with socio economic development as part of the Reorganisation of Medical Education(ROME) effort. The structure of the programme had five family care volunteers each catering to about 200 families organised under a full time paid community organiser for every 1000 families. This is called a Peripheral service unit and was visited weekly once by a mobile medical team. There were 16 such PSUs and four such mobile teams operating out of two central services unit. These two central services units also acted as the first referral points of the programme. The family volunteers who were the main workforce received continuous training and support from the community organisers.

The strategy to link health and development was known as the TEAM approach - training, education , agriculture and animal husbandry and medicine. The target groups were women and children, educated unemployed youth and socio-economically weaker sections. The programme therefore involved setting up daily and sheep cooperatives and a weavers cooperative and broiler programmes. Kitchen gardens and water management was also integrated. Securing bank financing for such initiatives was also a major thrust.

At the level of organisation they developed village advisory committees, youth clubs, women's groups and young farmers clubs. Adult education and women's organisations were also major thrust programmes.

Some of the impressive results of the RUHSA programme was their work on child malnutrition- an aspect that the Mitanin programme has understood and incorporated. Severe malnutrition in their area fell from 26% in 1978 to less than 2.5 % in 1988. The birth rate fell form 36 to 23.3 but this was parallel with the rest of the state. The decline in infant mortality fell from 116 to 50.8, which was better than the state figure of 93.0 at that juncture. Service indicators including inpatient and outpatient figures in the referral centers, pregnancy registration and immunisation coverage all had remarkably improved. Like we saw in other models in almost all these figures the first five years shows the steepest improvement after which the slope flattens but continues to improve for the next five years. About 66 to 80% of the improvement is in the first five years.

Society for Education Welfare and Action– Rural (SEWA Rural);

SEWA -Rural an organisation inspired by Gandhian ideals committed itself to integrated development encompassing activites in the fields of health, agriculture, self employment and ablve all man making and character building education." The decision was taken to start the project with curative health services which the group believed should precede and form an integral part of preventive health services. They took over an NGO maternity home and converted it into a fully equipeed referral center with four full itme doctors and necessary Xray and laboratory facilties and an operation theatre. The response of the community to this was overhelming and from this they could move on to their community health mandate.

The programme was done in collaboration with the government but with SEWA rural having independent access to external funds for its components. Village level health care functionaries- community health volunteers, anganwadi workers and dais were placed under this projects command, thought heir honoraria was provided by the state government. The programme was particular that the NGO role was supportive and must not duplicate government's roles.

Initially acceptance was very difficult but with an outbreak of measles being effectively handled by the team SEWA was able to make a break into the community.

Then the project was upscaled from 10 villages to 40 villages and later to 400 villages with 45,000 population(tribal area)in the district of Bharuch in Gujarat. Maternal and child health and mobile dispensary care was intensified. Supervisory power was extended to include the MPWs. A choice was given to MPWs- they could opt to work with the project or choose to get

"Sustainability of the project depends on how long such financial support is forthcoming though some of the health gains, especially secondary to increased knowledge and better practices, should be irreversible."

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transferred out. The sub centers were also placed under SEWA rural care with 100% financing from the government. The ICDS programme was also given to them. This was perhaps the first major example of state civil society partnership of this sort in the area of health care. The details of the problems that arose and the irritants and constraints in such partnership are worth learning from for they would be inevitable in any such partnership.

The programme improved skills of dais, and of the CHVs and provided them a high quality of training and on the job support as well as referral back up.

At all levels there was an effort made to introduce collective decision-making and participative management.

Review of programme impact shows a predictable dramatic improvement in access to services. Even in basic health indices like IMR there was a fall from 164 in 1981 to 61 in 1985 and there was a decline in severe malnutrition from 15 to 10. However in the next five year period some of these gains could not be sustained.

Some other innovations

SEARCH Ghadchiroli founded in 1985,has also generated rich figures of improvement in infant mortality. Since in most CHW programmes all elements of infant mortality and child mortality showed improvement except neonatal mortality the Ghadchiroli group addressed this problem in some detail and established that with the right inputs and two visits in the post-partum period even neo natal mortality could decline with effective community health worker experience.The Gadchiroli programme covered villages of two health centres, using a CHW called Arogya Doots IMR declined in their area from 12 to 79.7 and neonatal mortality from 17.48 to 4.84.

The RAHA programme needs to be noted not only because of the difficulty of terrain where they have worked but also because in such terrain where both government and private sector penetration was minimal they set up a health insurance system that generated substantial funds and participation from the community. Of course the funds generated were only a small part of the over all expenditure but it did ensure a good quality of care to all its participants..

NGO experience in Community Health – an overview

We see from the above examples three types of motives for initiating community health worker programmes. One is a set of doctors, often doctor couple who want to put their programme to use in he service of the poor. Another are institutions that are trying to establish a model- which involve scientific demonstration of the validity of the approach and the development of tools to replicate them. Yet another variety not discussed here are the experiments with plantation workers whose prime motivation is cost effective quality care for the workers.(This could be relevant to Chhattisgarh's mines.) Whatever the motivations, whatever the starting points, whatever the routes taken eventually there seems to be a residuum of absolute non-negotiables in the success of any CHW programme.

These could be enumerated as follows:

1. Referral linkages, usually in the form of a ten to 30 bedded rural hospital, where higher degree of illness is handled adequately.
2. Duration of project at least five to ten years
3. High quality leadership providing active support and training throughout the programme - no end point at all to this process.
4. Women as healthcare providers, especially at the community level.

When Mitanin programme attempts to replicate these programmes on a gigantic scale across the entire state, many aspects may change but eventually success or failure would depend on ensuring that these four lessons are not compromised with.

The limitations of the above programmes are also clearly that they cover only a miniscule part of the population and beyond their establishing the approach and its tools- cannot over all affect the health situation. Also we note that none of them recover more that a fraction of the costs -even where this has been tried - and therefore are dependent on continued government support or external aid with all the limitations and insecurities of such funding. Sustainability of the project depends on how long such financial support is forthcoming, though some of the health gains, especially secondary to increased knowledge and better practices, should be irreversible.

A BRIEF PROFILE OF PARTNER ORGANISATIONS

Partners implementing or assisting Mitanin Programme and Health Sector Reforms in Chhattisgarh....

ActionAid India Society, Chhattisgarh Region

Initiated in 2001, the envisaged imperatives of the AAI Region office in Chhattisgarh include capitalising on the policy opportunities and programmatic challenges that the creation of a new state entailed. As of now, it works on a number of issues like Urban Development (Asha Abhiyan in Bilaspur), Tribal rights and self governance (The Koriya Initiative), Girls and Boys in Difficult Circumstances (Balsakha Programme-Bilaspur, Raipur, Bhilai and Raigarh), Right to Food and Work (Lok Adhikar Yojana), Custodial Justice, issues related to land and natural resources (especially water) and State Disability Resource Centre. Many of these initiatives are taken up directly by the regional office and the rest through identified implementing partners to whom it provides funding and programmatic support. It also played a key role with other organisations in organising the Bio-diversity Security Forum, the Chhattisgarh platform under World Social Forum, and so on. It has been able to mobilise and provide expertise to a number of departments in the state government also, on various issues related to social welfare.

As far as the health sector is concerned, it was able to deliver in a major way , by playing the instrumental role in building up the policy framework and in initiating systems for the Chhattisgarh State Health Sector Reforms Programme. The regional manager of ActionAid India has been appointed as Member secretary by the state government, of the statutory State Advisory Committee constituted to formulate the recommendations for forming the guiding principles of Health Sector Reforms. It has been given the role of nodal organisation too, to assist the state government in Implementing Mitanin Programme. Also for realising the various components of Health Sector Reforms and securing civil society partnership for it, the state government has joined hands with ActionAid India through a Memorandum of Understanding. The State Health Resource Centre is a major outcome of this MoU, which is an institution founded jointly by ActionAid and GoC as an additional technical capacity to Department of Health and Family Welfare, GoC, to assist various processes of the Health Sector Reforms and the Mitanin Programme.

BGVS (Bharat Gyan Vigyan Samiti)

Has been formed by the All India Peoples Science Network jointly with National Literacy Mission in 1989. BGVS is primarily known for the countrywide motivational environment and massive social mobilisation it has created for the Total Literacy Campaign. It was instrumental in the evolution and widespread use of the Kalajatha concept, as not only a tool for social mobilisation but a mass education media. It has conducted a number of national events on different social issues varying from literacy, elementary education, gender equality, reading and library movements, Science popularisation, campaigns for national integrity, sovereignty and self-reliance, etc, through which it was able to build up a large organisational network with massive outreach in 21 states. It is also running community health programmes in a number of states, of which the design and approach has won international recognition . It is a frontier organisation in the Peoples Health Campaign also, formed as the India Chapter of International Peoples Health Movement,which was formed after Peoples Health Assembly. BGVS Chhattisgarh has a good activist base. At present, the BGVS has been given responsibility of District Level Monitoring of development programmes in 3 districts by Government of India, and Women empowerment Programme in one district by Govt of Chhattisgarh other than its own initiatives in many of the districts. In the Mitanin pilot phase, BGVS is implementing the programme in 3 blocks- Marwahi (Bilaspur dist), Podi Uproda (Korba district) and Raigarh (Raigarh district). The major contribution anticipated from BGVS is in the front of social mobilisation and in creating a mass movement around the programme.

Jan Swasthya Sahayog, Ganiyari, Bilaspur

An organisation built up by a number of committed doctors from All India Institute of Medical Sciences, New Delhi, JSS has been working on appropriate technology development for rural medical services, with support of Institutions like AIIMS and other supporting agencies. The hospital set up by JSS in Ganyari village of Bilaspur is the largest health service provider for the poor in the area, and could set as a model for how secondary health care should be. The JSS is doing a large chunk of public health research also. They are also in the area of community health initiatives, with experimentation on an innovation designed by their own team. The JSS is playing an active role in State Advisory Committee, as well as providing timely inputs on various aspects of Health Sector Reforms. In a number of areas of health sector reforms like health problems of the poor, addressing drug resistance in malaria, drug policy, rural laboratory services, the JSS inputs will be vital.

LOKSHAKTI Samiti, Raigarh

An offshoot of Total Literacy Campaign in then Raigarh district, (which has now been divided into Raigarh, Jashpur and Koriya districts) the Lokshakti Samiti, which was formed in 1996, got a reach up to the grassroots level in both these districts. It has a number of committed activists and is running a series of development initiatives in the area, with and even without external support, in different sectors including health.Their democratic organisational structure and good coverage and outreach in the rural areas has encouraged many organisations like UNDP (Pilot Programme in Peoples Empowerment), CAPART (Tribal Area Watershed Development Programme), and Department of Tribal Development (Primitive Tribal Development in Bishor tribes) to enter into collaboration with Lokshakti to run their pilot efforts. In Mitanin Pilot Programme, they have been entrusted 2 pilot blocks in Raigarh District- Pussaur and Kharsia. It is expected that the strength of Lokshakti in organising at the grass roots will add to the strength of programme.

RAHA (Raigarh Ambikapur Health Association):

A member of Catholic Health Associations of India, RAHA is one of the pioneering organisations for Community Health in Chhattisgarh, working in the field since 1969. They cover 4 districts of the state- Sarguja, Jashpur, Raigarh, and Koriya- where they provide both primary and secondary health services to the poor as well as are running community health programmes . The community based health insurance scheme is a significant innovation that RAHA is organizing. Many other programmes like a Technology Resource Centre working for the agricultural development of the area, and a Centre for Disabled at Pathalgaon are doing well. They have a well-trained core team of staff also, to look after the wide spectrum of initiatives. Recognising its wider outreach in the remote areas, The ICDS programme, which is usually run by the government, is handed over to RAHA in Lundra Block of Sarguja. In Mitanin Pilot Phase, RAHA is initiating the programme in Batauli(Sarguja dist) and Pharsabahar(Jashpur dist). It is expected that the wider experience of RAHA in community health initiatives and their skills in material production and health care services would enrich the programme .

RK Mission Ashram, Narainpur

Member of the nationwide Shri Rama Krishna Mission networkwith headquarters at , Kolkata, the RK Mission Ashram in Narainpur, Bastar has been established in 1985. It is having a deeper reach to the tribal areas in Narainpur and Orchha blocks of Bastar, which are known for Abujmaria tribes. The Ashram in Narainpur is providing social support to the locality in primary and secondary health care, educational institutions, fair price shops, Agricultural Training Centre for tribes, Tribal Training Institutes and so on. The state and central government,and the Ratan Tata Trust also have entrusted them with a number of programmes. They have been entrusted the sole responsibility of ICDS programme , in Orchha Block. In Mitanin Programme, They are implementing the programme in 2 pilot blocks, Narainpur and Orchha. RK Mission's pilot programme is expected to guide the tribal interface of the programme.

RUPANTAR

Rupantar, Raipur, is a charitable trust. Though it got

registered in 1992, it has a long radical and progressive tradition, as its founders were part of the peoples liberation movements in Chhattisgarh, long before the inception of the trust. Rupantar is mainly working for alternative paradigms of development and its various human rights interfaces. It works on issues like Gender Rights, Education, Health, Bio-diversity Conservation and Right to Food , in the districts of Raipur, Dhamtari and Rajnandgaon. It is also the coordinating group within the state, for the countrywide Peoples Union for Civil Liberties (PUCL). Rupantar is a pioneer organisation in the state as regards community health. Also, It is one of the leading groups among the members of Chhattisgarh Voluntary Health Association. In the Mitanin Programme Pilot Phase, Rupantar is implementing the programme in Nagari and Magarlod Blocks of district Dhamtari, where a major output is expected on rights based health education- especially in popularisation of the understanding that health services and health care entitlements are health related human rights.

Zila Saksharata Samiti Durg

This para-statal body headed by the district collector for implementing Total Literacy Campaign (TLC), was formed in 1990 in district Durg. This is the only remaining ZSS of its kind in Central India, which, after the TLC phase is fulfilling the wider social roles envisaged for the ZSS during the inception of ZSS based approach for TLC. The Samiti effectively runs the literacy campaign in Durg, which is now in the Continuing Education Phase. Other than its envisaged roles related to literacy and continuing education. Didi Bank programme is a well acclaimed programme, through which the ZSS was able to organise and empower village women, by providing them a regular activity platform set up through thrift and savings groups. It also runs 'Jan Shala' primary education programmes, Watershed Development Programme and regular social awareness campaigns on various issues through the Kalajatha caravans. For this wide range of activities, it is being supported by Govt. of Chhattisgarh, Govt of India and various UN agencies. In the field of health, the ZSS have carried out effective IEC and training programmes for Reproductive and Child Health Programme, and they have organised a programme 'Nannhi Muskan' on childhood health management. Nowadays, the ZSS also focuses on disability sector with a set of programmes supported by its own resources, and is soon going to launch an awareness campaign on reproductive health and issues related to AIDS, for adolescents, especially among college and high school students. As a partner of the Mitanin Pilot phase, ZSS has given responsibility of programme implementation in 2 blocks of Durg, -Gundar Dehi and Dondi Lohara- where the strengths of ZSS in social mobilisation and training is expected as the prime contribution to the entire programme.

Other than the organisations named above , persistent interaction is maintained with *Chhattisgarh Voluntary Health Association,* member groups of *Catholic Health Association, Care Chhattisgarh, Indian Medical Association, Shaheed Hospital Dalli Rajhara* and Faculty members of *JNM Medical College Raipur,* whose creative contributions and suggestions are providing major inputs to the programme. *Red Cross Society Chhattisgarh* has also recently extended their partnering hands to the programme and discussions are on with them about identifying the area of partnership. We also note that the most of the partner organisation named above were active participants in the Peoples Health Assembly held in Dhaka in the year 2000 and are also connected with the network called the Jan Swasthya Abhiyan that coordinates advocacy for strengthening Public health systems in India.

2

MITANIN PROGRAMME

Operational Guidelines

PROGRAMME OBJECTIVES, OUTCOMES AND ACTION PLAN

These Operational Guidelines form the training material for officers at the district and state level.....

Context and the Background of Mitanin Programme

Chhattisgarh's health status , though it has shown improvement over the years, continues to be below the national average and a matter of serious concern.Particularly worrying is the persisting and high levels of maternal mortality and infant mortality. The latest surveys show an IMR of 84/1000 with a rural index of over 95 per thousand IMR. Major communicable diseases like tuberculosis and malaria continue to be high though the state has been able to make considerable headway in the control of leprosy.

This poor record is despite a relatively large network of government run public health facilities at the primary secondary and tertiary level. One major reason for this is the geographical dispersion with so many remote villages that employees find it difficult to go there and villagers find it difficult to come to the nearest health center There are 20379 villages in the state and approximately 54,000 hamlets. But there are only 3818 subcenters. Most habitations are not connected by roads and often are unapproachable in monsoon months. This physical inability to ensure outreach gets compounded by the public sector's focus on a selective sub-critical set of concerns. As a result there is often a a mismatch between peoples perceptions of needs and what is delivered and in the absence of community participation and planning in health programmes there is a serious under-utilisation of existing infrastructure and resources. There is also a mismatch between infrastructure and the workforce and between institutional growth and their utilisation.

Though one needs to explore all possibilities of private public partnership the heart of state health policy needs to be around strengthening the public health system. In a state where poverty figures remain considerable, where safety nets to mitigate the effects of economic changes are weak and where much of the population is indigenous and still in a non-monetary economy - a weakened public sector would only lead to exclusion of major part of the population from any effective medical care.

The urgent need is therefore to strengthen basic primary health

care services, to improve the outreach of all existing health care services and to improve their quality. In parallel we need to strengthen and expand efforts to improve health awareness and community's capacity to plan for and cater to its own basic needs. The current under-utilisation of existing services as a serious wastage of scarce resources for a developing state.

It is in this context that the government of Chhattisgarh has planned and announced the Mitanin Programme in the November of 2001 and formally launched the pilot phase in May 2002.

It is not facts that the kalajatha conveys but a dialogue on attitudes and beliefs that they have been acquired unconsciously - as part of their culture.

Operational Guidelines –An Overview

The Mitanin Programme has been launched with a number of objectives.

Four critical components for achieving these objectives-

1. Mitanin selection;
2. Mitanin training;
3. Support to the Mitanin in her tasks; and,
4. Making health system improvements that enable the system to respond to the demand for services that her work brings about.

This manual attempts to explain the Mitanin selection,training and support components We begin with an understanding of the objectives of the programme and the expected programme outcomes.

Objectives of the Mitanin programme

The main objectives of the Mitanin Programme are to

- Improve health education and health awareness.
- Improve utilisation of existing public health care services
- Promote community initiatives for communicable disease control
- Provide a measure of immediate relief to health problems through the provision of first contact curative care at the hamlet level and help the community avoid needless, expensive, often hazardous care .
- Organise community, especially women and weaker sections on health care issues
- Sensitise panchayats and build up its capabilities.

Operational objectives

The operational objectives of the Mitanin programme are to:

- Select, train and deploy a "Mitanin" in every habitation in the state.
- Ensure effectiveness of the Mitanin by supporting her internally in the habitation by a women's health committee, the village health committee and the elected panchayats as well as support the Mitanin externally by a cadre of trainers, and the local government employees.
- Ensure effectiveness of the Mitanin by providing her with at least 20 days of camp -based and 30 days of on the job village level training.

Programme Outcomes

At the end of 18 months we aim to have

- Mitanin available in every habitation .
- A working support system for every Mitanin the key to which is the trainer- and facilitator.
- Increased health knowledge of every family as measured on a list of questions
- Improved utilisation of health services-

  i. Higher immunisation coverage, utilisation of vitamin A, paediatric iron tablets, de-worming tablets and use of ORS in diarrhoea

  ii. Antenatal check ups, improved FFA, TT coverage, number of births with trained assistance.

  iii. Malaria local planning, efforts complementing state efforts at malaria control.

  iv. TB, leprosy case detection and retention levels,(where this is a part of the campaign) improve. There is an availability of first contact care and treatment for minor illness at every habitation level.
- There is an increased organisation and empowerment of women.
- Increased knowledge and capabilities of panchayats as regards health programmes and health needs.
- Local panchayat level plan on health emerges by end of 18 months which guides action for next 18 months at the least.

All the above outcomes are expected to be achieved after 18 months of initiating the programme in a given block. Further, these outcomes are to be sustained for a further 18 months at least for ensuring that the programme objectives are attained. The programme must continue for at least a three year period. For achieving significant measurable changes in health indices the programme must be sustained for two more years,i.e. five years on the whole.

Some Health Indices for impact evaluation after the three year and the five year period

- Child malnutrition prevalence
- Anaemia in women
- Birth weight of babies
- Also IMR and MMR
- Tuberculosis/ Leprosy prevalence

- Malaria incidence

Parallel Infrastructure and system improvements needed

- Strengthening sub-centre and primary health centre level capabilities and performance- so that increased demands can be responded to.
- More inputs on TBA (Traditional Birth Attendant) training.
- Streamlining drug and consumable distribution mechanisms up to PHC, sub-centre and Mitanin.
- Setting up of referral systems especially the first referral unit and linkages up to Mitanin.
- Strengthening Secondary care capabilities in public health sector
- Disease surveillance
- Decentralisation of health care based on capability building and local planning
- Research inputs - epidemiological, operational, social - in select areas.

Action Plan

The unit of planning and implementation shall be the block level by the block Mitanin programme committee. The programme shall be coordinated, monitored and supervised at the district level by the district health society. At the state level the State Health Resource Centre shall provide technical assistance as well as coordinate, and monitor the programme.

The Action Plan has the following three phases:

1.	Pilot Phase - 14 blocks	- run by different NGOs on varying time schedules	initiated in May 02.
2.	First Phase - 66 blocks	-	initiated in Dec 02
3.	Second Phase - 66 blocks	-	to be initiated.

The Action Plan in each block shall have seven components- largely initiated in sequence- all components are in place by 18 months .These seven sequential components are:

1. Select Mitanin, Build understanding of the programme

The health department and district administration along with leading NGOs should build a campaign to convey the Mitanin programme to the villages. As part of this a team of facilitators visit the villages and interact with local communities, NGOs, peoples organisations etc to help the community identify and select a woman in each hamlet who is willing to be trained and function as the Mitanin on a voluntary basis. We may also identify a group of active women who would support her. Special emphasis is laid to involving the panchayat and its health committee in this task.

2. Train Mitanins on Existing Primary Health Care facilities and Child Health programmes so that they can :

a. Ensure that child health components of the ANM and ICDS programme reach the children (done in coordination with the health dept and the ICDS programme)

b. Identify children (below five years at risk) by weight for age measurements as well as all children in the first year and counsel and support mothers of such children to prevent infections and optimise feeding practices.

The first round of training also helps the Mitanin understand the objectives and organisational strategy of the programme. It also informs her about existing public health care facilities and how to go about educating community on this.

3. Train and deploy Mitanins on Women's health issues to:

a. Help women especially adolescent girls understand the causes and determinants of women's health problems .

b. Ensure that government programmes to train dais, to provide care in pregnancy are effective and accessible to the public.

c. Ensure that there is a capacity to identify common womens health problems and provide relief for them.

4. Train and deploy Mitanins to organise community initiatives for the control of Communicable disease in coordination with the health department.Special focus initially on three diseases - malaria, tuberculosis and Leprosy where existing government programmes would be modified to utilise these initiatives and made more effective. A special programme on building local response to micro- epidemics of water-borne disease, so as to prevent major epidemics -would be undertaken also.

5. Train Mitanins to maintain and use a simple medical kit, supplemented by home and herbal remedies, to provide care for minor illness and first aid.

6. Train Mitanins to help the local women health committee maintain a basic village health register that acts as an instrument for programme monitoring and local health planning. Also link up with other women's local organisational activities like self help groups for mutually reinforcing both programmes.

7. Build a local village level plan with the leadership of a panchayat whose capability has been built up - This capability combined with tools like the data from the village health register and processes like the collaboration with the health department would help in the identification of local health priorities and the drawing up of local health plans.

The Facilitation Process – Selecting the Mitanins and Building the teams.

What are the facilitator tasks ?

The tasks of the facilitator are as follows:

1. Dialogue with local leaders and people and explain the

programme.

2. Hold local meetings to explain the programme.
3. Arrange to host a kalajatha or other event that arouses public interest in the programme, creates a peoples character the programme and thereby generates voluntary interest in it.
4. Draw up a ray diagram to define distribution of hamlets and population.
5. Dialogue again with the local leaders and women's groups and help them select a Mitanin.
6. Identify one or two women who would be willing to play the role of trainer.
7. Continue to provide support to the programme in the coming months . The facilitators leadership is needed for Mitanin, for her trainer and for the panchayat and village committees and local women's committees that are formed.

No one likes propaganda even if it comes in local culture. Kalajathas are about social reform.
••

How is the facilitator selected ?

The members of the district training team make the selection. This team as we know it is composed of both specifically identified government employees as well as NGO partners. The facilitator is selected for his or her attitudes and capabilities. They have to have a strong sense of social justice and a desire to help the weaker sections. They must be disturbed about the current state of health and health services and must be charged with the motivation to do something about it. They must be people who by nature have a lot of contacts and knowledge about people in that locality. They must be willing to go to every hamlet in their locality within the next three months and quickly achieve their tasks. Such a person may be difficult to find if there has been no past NGO work in that area. However there are always some persons who are well connected locally.If we find a person with the correct values and motivation they can make use of such "contact persons". We also intend to train the facilitators rigorously so as to build up motivation and understanding of the programme.

How is the facilitator trained?

The district team does the training. The district team is itself trained in a regional training camp . The facilitator training is scheduled . It is a five day training based on the facilitators manual. Like all training camps this would be monitored for quality and effectiveness.The trainers are the dt team assisted by the stste team.

What is the kalajatha? How is it made effective as social mobilisation?

The Kalajatha is an invaluable approach to initiating a programme or strengthening an on going one:

Half the effect of the kalajatha is in arranging for it. Whenever an NGO organises a kalajatha to initiate a programme and expand to new areas, the organisers begin by drawing up a calendar. On which day and what time would the kalajatha reach a village. Then they go to the village where hitherto they may have never even known anyone and explain that a kalajatha is coming to their village and could they make local arrangements for the programme. They explain why a kalajatha is coming - with what messages and the importance of that. Either a formal reception committee or at least a group of youth are formed. This group arranges to make the stage arrangements, and print a pamphlet or put up posters or go around and announce the programme. They also undertake to provide a meal for the kalajatha participants and perhaps put them up for the night. All this may require some donations in cash or kind, which they raise locally.

During the programme the sarpanch and other persons who matter are invited and they participate. Between the skits and plays, clear messages are given on what is the coming programme. If the health programme is ongoing the local activists are also introduced and felicitated.

After the kalajatha is over the local team/committee is reconvened and an appeal made for forming a committee that will oversee the programme itself. Since by now we have a good understanding of who is an effective mobilizer, of who all in the village are supportive and interested -a much better committee forms. The response of the people to the kalajatha has demonstrated to the group that many people feel the same way and such issues can be publicly raised. In other words it creates a favourable environment for the committee and the Mitanin to start or continue functioning.

Some posters going up just before the kalajatha remain as constant reminders of the programme. This is the main role that posters play. Try to make the poster message brief and "sticky." It must be catchy- stay in ones mind.

The kalajatha content

Ideally a kalajatha should not be used as a substitute to a speech. "People do not listen if it is speeches. But they do if it is a kalajatha" - is an inadequate logic.

Good kalajatha programme raises critical questions on answers people already have in their minds. It raises to discussion attitudes and practices that people have always taken for granted. It is not facts that the kalajatha conveys but a dialogue on attitudes and beliefs that they have been acquired unconsciously - as part of their culture. They never consciously learnt it. And therefore a cultural form becomes especially appropriate to questioning it.

Thus it is important that the kalajatha is in the local dialect and uses local art forms-adapting it to ensure that the message does not get drowned out in the art. The message itself uses local idioms and proverbs - sometimes approvingly, sometimes

critically- even raising them to ridicule. For example there are many sayings about women in any culture that should be ridiculed. But in ridiculing also one can use idioms from within the same culture, which have an opposite direction or quotes from famous poets or social reformers , or by creating powerful poetry.

An example - A play on malaria by JSS raises the issue that the village has never seen it fit to take collective action against malaria. If a tiger attacks and kills one person the whole village rises up. But malaria has killed eight in the last year and no one has bothered. One can add what all they need to do - but that is not critical to a good kalajatha -it is questioning the attitudes that are critical. One can give the facts in short well planned talks or with banners in-between plays and songs- not try to give all the facts in the play and lose the audiences interest and heart. No one likes propaganda even if it comes in local culture. Kalajathas are about social reform.

Perhaps the failure to understand this is why in some hands kalajathas work like magic whereas in others it has little impact.

Creating a kalajatha team

The process starts with identifying a group of youth (about 8 to 14 in number) that are interested in this work. At least a few women should be part of this group. They should be willing to be trained - one week - plus go on tour - three to four weeks. So when they come it should be for a one month process. At least two or three should have had past experience in acting and at least one of them should be able to lead the team.

One or two directors are then recruited with the help of the state Mitanin team. The directors will conduct a seven day camp when they would train the team. Subsequently the team would be ready to leave.

If they have a van to go about in it ,makes work much better and coverage much more.

Every district needs to identify one kalajatha organiser from its district team and he would be briefed more rigorously on the organisational aspects.

How many teams ?

Ideally the team must give on one day - three performances in every panchayat. That is quite a bit. In practice we may achieve much less. Plan for about 70 performance distributed over three weeks over the block. At any rate at least one team per block. Ideally three teams - but that is too difficult to manage. And it needs locally mobilised funds.!!

What are the other social mobilisation events needed ?

Village and panchayat or cluster level meetings are also most useful and must be emphasised. At least some of them must involve elected representatives, and senior district administrators and social reformers/leaders.

Other forms like rallies, poster exhibitions are also welcome.

Mitanin Programme FAQs:

the "Identification- Training- Deployment - Support" Process-

1. How is the Mitanin selected?

The selection of the Mitanin is by a dialogue between the projects facilitator and the local community. The local community should be told that the mitanin is their representative who would monitor the public health services to ensure that these reach the people properly. She would work as an organiser for community initiatives in health care. And she would have a medical kit to help with minor illness and for first contact care in more serious illness.

The Mitanin should be a woman. Preferably a woman who is married and who would be supported by the family in this work. Since motivation is important any woman who has been the past associated with voluntary work for the betterment of the village would be a good choice . This is something we have to enquire about .If no such woman is there we need to ask whether there is a young woman who is willing to come forward for voluntary work. We should mention that we are looking for a woman who would be able to develop as a leader, as an organiser.

The Mitanins educational level is not a criterion. However a good level of literacy would be most desirable.

Recognising that the community is heterogeneous the facilitator must dialogue with different sections especially the poorer sections. The Mitanin must be someone who would be comfortable and welcome in visiting their houses. If in addition the more influential sections of the village accept her role that would be ideal. The community must own the choice of the Mitanin as their choice.

2. How much time and work is expected of the Mitanin?

The most important guiding principle is that a Mitanin should be able to continue with their livelihood .So being a Mitanin is a part time task. About three hours in the evening after she returns from her work for about four days per week should be adequate. Moreover once in two weeks she should be able to come outside the village to the block headquarters town or a nearby town for training and meeting with other Mitanins.

The Mitanin would also have to come to the training centre for a first round of training where she would have to stay outside for three or four days alongwith other Mitanins. After three months and then at about the seventh or eigth month this residential training would be repeated.

3. How is the Mitanin's work supported at the village level?

The Mitanin must be supported in her work by the elected panchayat. Elected panchayats have a subcommittee to take care of health issues. Where this is functional they should be fully involved. If such a committee is not functional we would try and make it so.

The Mitanin would also help create and sustain a village women's health committee or health team. This may be made of women drawn from different areas of the village. It should meet at least once a month. In this meeting there would be a short talk on health to educate this group. This group would also undertake to maintain the village health register- just to enter in vital events like births, deaths , marriages and pregnancies as well as disease outbreaks. Most important these women would help the Mitanin in her various tasks and feel themselves as part of the local organising team for the Mitanin programme.

There are some events like the campaign against tuberculosis or malaria that require the help of such a team. The goal is that this team should become capable of assessing local health priorities and planning for local health action.

Another source of support to the Mitanin should be the ANM and the local primary health center. By giving special attention to cases referred by her, by encouraging her work, by explaining the importance of her work to local leaders she would be honoured and supported in her work.

Finally and most important the persons who trained her would visit her village once or twice a month and work with her for some hours so as to provide her with inservice training and confidence.

The Mitanin should be a woman. Preferably a woman who is married and who would be supported by the family in this work. Since motivation is important any woman who has been the past associated with voluntary work for the betterment of the village would be a good

We must remember that the success of the Mitanin is not just due to her motivation and ability. It depends to a very large extent to the quality of support given to her by all four of the approaches outlined above.

4. How are the Mitanin trained ?

Trainers: The Mitanin are trained by specially trained and motivated trainers. These trainers are drawn from the ANMs or from NGOs or from other motivated individuals identified by them. Often they would be those identified by the facilitators. It is essential to select the trainers with a proper geographical distribution - one per cluster of gram panchayats. .The reason for insisting on this distribution is that in service , on the job training is an essential part of Mitanin training. **Given the low literacy levels and lack of previous exposure to such work it is unrealistic to expect most Mitanins to grasp adequately from camp based teaching. Unless the trainer goes to her village and goes house to house with her and helps her with meetings etc once or twice a month - they would find it very difficult to pick up. For this reason it is preferable to have women trainers.**

Training of trainers : The trainers are trained by the state training team along with the block resource team (three persons per block).Roughly after the facilitation phase w should have determined both the distributed trainers and the block resource team.

The training programme has two components- the training camps and the in-service training.

A.The training camps for each Mitanin would be at least 20 days spread out over the year.

The training content of the camps would be as follows

1. First round of training - Three days - residential- would cover training manuals 1, 2 & 3. In this the Mitanin would have an introduction to the programme and its approach .They would also learn about existing public health services and how to improve their utilisation. Finally they would have a full 6 hour session with another three hours of field trip to lean child health.

2. Second round of training -two days- preferably residential-would reinforce child health training and all issues of the first round.

3.Third round of training would reinforce earlier inputs plus cover womens health in detail(Training manual 4).

4. Fourth round of training - which may be two days non residential or three days would over one or two communicable health disease(from training manual 5A &5B).This round may be repeated to cover more communicable diseases -if these diseases are a local health priority.

5. Fifth round of training- should be at least four days residential- would introduce the village medical kit and first contact curative care aspects.

6. Sixth round of training -Another three day training - the fifth round may reinforces the curative care aspects(training manual 6)

7. Final -Towards the end of the programme a three day residential training programme would discuss how to sustain the programme and how to assess local health status and draw up a local health plan.

B. The in-service training would consist of the trainer visiting the villages and working with the Mitanin for one or two day every month. Each trainer would have to thus provide training and support for about twenty Mitanins. On occasion the trainers may ask Mitanins of nearby hamlets of a village to come together so that he can provide in service training to a small group rather than individually. This would also boost their morale for it is difficult to work alone for change . The regular meetings once in two weeks in the nearby market town (kasba: habitation) would also serve the purpose of in-service training. *That is why we suggest that the Mitanins be grouped according to hamlets pertaining to a market town or kasba* .There will always be some work for which they would have to come to the market and they can combine that work with meeting their trainers or

the other way around. Later on when we go into other dimensions of the programme such a distribution of trainer and such a grouping of Mitanins would have other uses too.

5. How can we expect the Mitanin to work without any monetary compensation?

The Mitanin's work is part time. It should not affect her existing livelihood seriously. It is therefore possible to do her work voluntarily. (On the other hand some of the trainers and full time staff would be required to work fulltime .When one has to work fulltime for a number of months one can no longer earn in parallel and monetary compensation becomes essential).

The Mitanin is not a government employee. She is NOT "under" the ANM. She is a community's representative to monitor and facilitate government provided health services and to help the community organise self help measures. This work may be seen as community service. Her area of work is limited to about 50 to 100 households- a size that is small enough for her to be able to cover voluntarily and part time.

A number of other women in the local women's committee or team are also working voluntarily. For a number of activities the whole village has to chip in. Once we pay the Mitanin the entire task will become "her job" and he others will be less motivated to participate. And one can't pay so many persons.

Also we know - the moment we introduce payment- there will be a lot of less motivated persons who will also come forward. Often panchayats heads and local employees may recommend such persons whom they are obliged to or whom they want to favour. In turn the persons so choses will have to return the favour. The right woman cannot emerge.

After 18 months the village would have a better understanding of the programme and the role of the Mitanin. They would be able to see what work she has. At this stage some monetary incentive or financial benefit for her to continue with this work or as a reward for her work in the past year may be welcome. But it should be given by or through the local panchayat- so that unlike the government employee they are accountable locally. And given only after her voluntarism and her work are well established. If she has meanwhile emerged as a local leader , especially as a women's leader that would be more satisfactory to her than any incentive we may be able to give. In many places such women have got elected as panchayat members or even in one or two villages as the pradhan!! Our aim is to create local leaders not local employees.

6. Why do we not start with curative care ? Why are we delaying six to eight months before we introduce that training?

We want the Mitanin to develop a good understanding of health and disease before she is trained for curative care. This she will gain in the first six months of her work. Otherwise the prevailing culture of seeing all health as taking tablets or injections for this or that disease will trap her also. Also the public would insistently demand for her to give these drugs given to her by the government rather than listen to all that she has to say.

In the first six months the Mitanin undertakes a number of work that is of preventive and promotive nature and involves the village in this. Some of this work also involves pointing out to the people how much they waster in needless dugs and on preventable disease. Thus a better understanding of health is created.

The Mitanin is trained not to promote victim blaming. That is blaming the victim for her suffering. The message is not that you are diseased because you are ignorant and dirty When often we say that the cause of ill health is not solved by taking drugs or if we say we are going to do health education the public understands that we are going to only berate them for their ills. Once we break away from such victim blaming the public accepts our messages on health education readily and even welcomes it.

The Mitanin also promotes the public health system. She is not conceived as an alternative to it. Not even as an apology or stop gap measure to cover its failures -like the failure of the doctor to come to the PHC. No,She is active part of improving all existing public healthcare services.

TRAINING STRATEGY

The objectives of the training strategy

Our objectives are to:

- Train about 400 Mitanins per block..
- Have each Mitanin receive at least 20 days of in-service training over 18 months and 30 days of on the job field level training .

The trainers: The suggestion is that each block builds up over the course of the programme a good team of about 20 to 25 trainers..

The trainers would be *initially* drawn from two sources.

One source is the government employees working in reproductive and child health areas- the ANMs, the LHVs and sister tutors. To recruit trainers from them we should plan for a one or two day orientation programme for them and then seek volunteers from them for this task. If they volunteer they should be invited to the training of trainers programme. At present in a block there are about 35 to 50 persons in this group. We should get at least a few of them to volunteer to help in this task *in addition* to their regular work- though some of them can be provided permission to attend to this task.

The second source from which they are *initially* drawn are from names nominated by NGOs who have joined this programme by the district resource persons team or from the preraks they trained. The Prerak, who helped in the Mitanin selection, may especially if they are women, become trainers themselves.

The trainer must be a suitable literate woman who stays in that cluster of villages and can visit the Mitanins in her area frequently on her own and is available to work almost full time on this task. Trainers must be fluently literate in Hindi and able to speak the local dialect very well .

As the programme proceeds into the second and third round of training we find that some of the trainers are not effective or not able to find the time for this task. Then we need to be able to make changes in the list . The programme must have the flexibility to make these changes .Often at this stage , we identify some

women, who were selected to be Mitanin, who are so enthusiastic and qualified that we can take them on as trainers. Since they were already trained as Mitanin they would not need much training as trainers.

Over time the trainers who provide the best follow up and in-service support would emerge as a team that provides local leadership to the programme. They would be both from employees and local volunteers.

Training Trainers

A district training team should be constituted. It is to be made up of three trainers per block. A total of about 210 district trainers would thus need to be trained. This would be done in 7 training camps of about 30 persons each to be organised by the SHRC's state training team.

On going back after the state level training the district training team would train 25 trainers per block. The 25 block level trainers receive a four day initial training and then, further training every month as per schedule.

Training Mitanins

After these 25 are trained they would split into groups of five each, forming five teams. So even if there is some redundancy we still should have two to three good trainers per group. Each of these teams trains two batches of Mitanins of 40 women per batch. Three days of training (or four days if possible) per batch. Thus, in a block, there would be 10 training camps to cover 400 Mitanins held as 5 parallel camps in first round and then 5 more parallel camps the next week. This has to be repeated every 4-6 weeks as per schedule.

Trainers time requirements and In-Service training

After the first training camp each pair of trainers in the next month commits to visiting eight villages twice so as to help the Mitanin get started and provide some in service training. That's 27 days of trainer time (4 days in getting trained, 6 days in training, one day in post training review, and 16 days in village visits) That's what minimum quality training takes. And please remember that the logistics of training, poor attendance, unfamiliarity of trainers with the classroom setting and the lower competence of trainers all make it unlikely that too much will happen in the camp alone. Working with them on the job however will really make them capable, the camp having provided the motivation and introduction. Learning is much better in the concrete situation. Also the Mitanin needs to be supported, to be visited. And one needs to collect the feedback from her especially about service delivery.

In the next month the trainers are retrained over three days and they give two days of training to two batches and again 16 days of village visits each. That is 23 days and it is likely to remain at this level for the next 18 months for a really good Mitanin programme.

At about eighth month when some of the processes and activities have been completed, then we go in for a four days training where we introduce curative aspects and give them a kit.

We continue intensive in service support and monitoring for at least 18 months after which the programme transits to the maintenance phase.

Training venue

Mitanin trainings will be conducted at the block level. This will cut costs, create easier logistics and make for a more familiar and comfortable learning environment. Identifying and booking training venues requires attention from the district administration.

Time requirement and compensation

Because of the intensity and commitment required, we believe that a training fee or honararium (not exceeding Rs 1000 per month) including local travel should be provided for the 20 women trainers who are not ANMs. The primary reason for this compensation paid as a training fee is that if we require them to do 20 to 27 days of full time work in a month they would be deprived of attending to any other means of livelihood. This is unlike the situation for Mitanin of whom we are asking only 2 to 3 hours per day for 3 to 4 days a week plus 2 to 3 days per month in training. This training fee comes to about Rs.20,000 per month for 20 trainers or 3.6 lakhs for 18 months. This financial investment could pose a problem in terms of logistics and for the different pressures it would generate. These are discussed in chapter 6. Although we would like to pay the ANMs as well, long-term implications and constraints rule this out. Any volunteer trainers would also help. NGO groups would have the option of adding this honorarium on to their current employees remuneration for this additional work..

Compensation

A training fee or honorarium of about Rs50/day (not exceeding Rs. 1000 per month) including local travel may be essential for the 20 women trainers who are not ANMs. Any volunteer trainers would also help. It would have been good if it were possible to pay ANMs also some extra compensation for this additional work but other constraints and longer term implications rule this out.

Preventing transmission loss

A central problem with such "training pyramids" is what is known as "transmission losses." As information is handed from state resource person to district resource person to block trainers to Mitanin much of the information gets lost or distorted. The information that finally percolates to Mitanin is sub critical and loaded with subjective and often unscientific messages that crept in during this process.

Past experience with such training pyramids, show three effective measures of preventing transmission losses

a) Better the quality at the top , the better the delivery below-most transmission losses were not really lost on transmission but lost in the first level where one has a lot of "senior" resource persons .These senior persons believe they know all that is needed and are not in a learning frame of mind. However even if

they do know a lot it is often inappropriate or not as effective. When they do to the next level they violate the syllabus and methods planned and with complete confidence give their individual understanding of what needs to be stated. By the time they and the programme planners realise the gaps - it is too late and too costly to correct. MOST FAILURES OCCUR AT THIS LEVEL. Surprisingly relatively very little is lost between the trainer and the Mitanin.

b) Insist on following the training material. Better to go for an approach where the training material can be read out (either in small groups or by the trainer) and then discussed and explained by the trainer. Of course, other than mere reading which can be very boring, one must have presentations, good work, group discussions, role plays etc- but never fail to have reading sessions also. Training material is so built that it can be read out and ticked as and when each message is covered.

c) Introduce in built training evaluation - there are a set of questions circulated separately. These questions act as revision for the trainees. Knowing that there is an evaluation at the end, especially if it is being done by trainers - but in the presence of others -it would give some seriousness to the training process and prevents its degeneration into a string of speeches. Remember that we are talking of about 10 training programmes per block every month and there is no way we can ensure all the training teams will maintain sufficient quality without such a tool. The evaluation is known to participants and trainers and is part of the training material and is announced- so there is no suspense - just a baseline being set on knowledge elements.(this is detailed in the chapter 7 on training evaluation).

Other Challenges

There are other challenges that are uncontrollable. They come as a result of us merely being human. For example, Mitanins drop out because they become disinterested or the commitment is too much, trainers fail to turn up for training, rains wash out a training programme, the food was not ready and the trainees were so angry that no one would listen, the organiser himself sabotaged the programme for he felt slighted. This could go on.

Our approach to this is to make sure that We have the space to redo everything and allow for one round of turnover at every level before the final team settles. In practice we would require another round of training programmes for new mitanins and those who missed the first round in almost every block.

TRAINING COMPETENCIES

A training differs from other group activities like meetings, seminars, workshops etc in that it builds specific competencies in the trainee. We need to identify these competencies in terms of knowledge and skills.

Competencies required of the Mitanin:

- Knowledge
- Skills
- Attitudes

Knowledge

Round One

Sl. No. Competencies

1 Learn the definition of health Learn the major determinants of good health and ill health Learn that the perception of health as "doctors-drugs- diseases" is wrong

2. Learn the answers for the following questions: Why persons often do not seek health care in time? Why persons often don't listen to good health advice? Why persons demand injections and drugs? How the system tries to blame the victim for his disease? How superstitious practices relate to health seeking behaviour

3 Understand the objectives of the Mitanin Programme Understand the main activities through which these objectives would be attained.

4. Understand that health services are entitlements or rights Learn about the main local public health institutions and the services they are built to provide

5. Understanding why child malnutrition is made a focus of our campaign Understanding the multidimensional causes of child malnutrition *Know the six main messages on child nutrition(exclusive prompt breast feeding; supplementary feeding from six months, five or six feeds per day, fats and oils, greens and reds, feeding during and after illness)* Know the common illness that cause and contribute to malnutrition. Know the family contexts of malnutrition- age of mother, health of mother, time

available from mother for child care, space between children, support available from other members and poverty. Know which health services the child should receive from anganwadi and from ANM Know the common wasteful expenditures that such families incur on nutrition management and the cheap and appropriate foods available locally that could have been used. Understand why children need to be weighed and what grades of malnutrition means

9. Know the causes of diarrhoea *Know how to prevent recurrent diarrhoea in children- hand washing; protecting food from flies; safe water; Knowing how to manage diarrhoea at the village level.- making and giving oral dehydration ; recognizing dehydration, knowing when to refer .*
10. Understanding the Management of ordinary coughs and colds Preventing Pneumonia. Early recognition and referral and first contact care in Pneumonia.
11 Immunization - how and why
12 Understand relationship of patriarchy with ill-health - especially the ill-health of women Brief introduction to the elements of ill-health thin women at will be introduced later in the programme.
13 Learning the answers of the 12 most commonly asked questions about the programme- to be able to organize the programme locally Having other doubts about the programme cleared

Round Two

1. Learn objectives of maintaining a local register-(identify families at risk to prioritise for counselling/referral, ensure that all families have got desired services, tool of local planning later)

Round Three

1. Learn relationship between ill-health and patriarchy Learn relationship between women's health and women's rights
2. Learn some major health issues in adolescence- *nutrition; anaemia, knowledge of menstruation and managing it,* feeling of adequacy about bodily functions, control over ones one self
3. Learn major causes of maternal mortality and morbidity *Know high risk cases to be referred for institutional delivery Know what are the elements of good antenatal care* Know dangers signs of pregnancy Know about public health services for pregnancy and child birth .
4. *Know the elements of what constitutes good , desirable and harmful practices at child birth Immediate post partum care for mother and child*
5 Violence and women
6. Reproductive tract infections

Round Four (and a Later rounds)

1 Know how malaria is caused and how it spreads
2. Understand the need for early and correct treatment and making a blood smear
3. Know how to administer chloroquine tablets and maintain depot
4. Know the use of individual prophylactics- mosquito nets, long sleeved clothes, oils and creams, repellents.
5. Know all elements of vector control
6. *Know to build all the above elements into a local village level plan.*

OR

1. Know how tuberculosis is caused and how it spreads
2. Know the need for early and complete treatment.
3. Know to detect cases likely to be tuberculosis on basis of symptoms
4. *Know how a diagnosis is established*
5. *Learn how to monitor treatment*
6. *Learn how to construct a village level initiative (with health sector support)to ensure complete case detection*

OR

1. Learn how to construct village level systems to ensure complete compliance
2. Learn all the common causes of cough and how to manage them at symptomatic level and when to refer them.
3. Learn common skin diseases and how to manage them
4. *Know to identify leprosy*
5. Know what is leprosy, how it spreads and what are its manifestations
6. Learn how to construct a village level initiative (with health sector support) to ensure complete case detection.
7. Learn to monitor treatment and how to build village level systems to do so.

AND

1. Know when to suspect an early waterborne disease outbreak(or any other diseases)
2. Know whom to notify and how
3. Know how to suspect source of outbreak
4. Know how to disinfected a suspected source
   - Know how to notify families at risk
   - Know to promote individual and family level measures to avoid getting affected
   - Know first contact management of diarrhoea, dysentery, jaundice

3.1.5 Round Five and Six (detailed separately)- 7 days

1. Understand how disease is caused
2. Understand how drugs work and precautions on its use
3. Understand how body parts are placed
4. *Learn symptomatic care for eight common symptoms- pain, fever, cough, diarrhoea, constipation worms, itch, and anaemia and when to refer*
5. Learn the management of acute severe malnutrition
6. Learn to manage simple wounds
7. Learn the use of herbal and home remedies in colds, simple coughs, small wounds and some other common symptoms
8. Learn first aid in poisonous snake bites and stings and in major injuries, in fits and in loss of consciousness
9. Learn how to transport an unconscious or very sick person.

Skills

These can be taught both in camp and during in-service training between the corresponding rounds of training camps.

Round one and two

Skills of establishing rapport with a family

Learning Dos and Don'ts of how to approach and address a family on this topic at their doorstep

Learning how to counsel a family with newborn child on breast-feeding

Learning to counsel a family with a six month to one year old normal child on nutrition- the six key messages;

Learning to analyse and understand the causes of malnutrition in a specific child between six months and five years and counsel accordingly

Learning how to construct local enquiries on availability of health services and how to increase public awareness and utilisation of these services.

Conducting a village level meeting of women; of children, of all Maintaining a basic health and health services register Weighing a child and reading a weight chart to find grade of malnutrition. Conveying the level of malnutrition(as seen in weighing) to the mother.

Looking for anaemia

Identifying severe malnutrition that needs referral.

Making an ORS solution

Identifying dehydration

Measuring respiratory rate(difficult)

Recognizing signs of pneumonia- as different from symptoms(difficult)

Skills - round three

Learn to look for anaemia.

Interpreting an anaemia blood test report to know whether it is mild , moderate or severe.

Identifying high risk cases for recommending institutional child birth.

Making a clean sanitary napkin at low cost.

Skills - round four

Look for spleen.

Estimating fever- manually

Make a blood smear for malarial examination.

Knowing how to bring fev*er down by tepid sponging.*

Learning to look for jaundice

Know how to make a mosquito repellent oil.

Identify a mosquito larva

Know to identify and map places of mosquito breeding locally

Be able to draw up a local plan involving all elements.

Identify the difference between saliva and sputum.

Identify common respiratory infections

Identifying a person with high likelihood for tuberculosis

Identify the lesions of leprosy

Know how to test for loss or decrease of sensations in a skin patch

Know how to test for thickening of nerves.

Identify common skin diseases

Know how to disinfect water in a pot with chlorine tablets or stock of bleaching powder

Know how to use bleaching powder to disinfect a well or water storage device

Skills -round five and six

Know how to decide on appropriate diagnosis in an individual case

Know to identify all drugs in her kit

Know to use the drugs appropriately

SESSION - BY- SESSION PLAN FOR TRAINING CAMPS - AN EXAMPLE

Only the plan for the first training camp is given - as an example to show how it has been constructed. The session by session plan for the entire training camps is readily available on request.

First Training Camp

Session I

TOPIC: Inaugural

OBJECTIVE: To introduce the Trainees to the Mitanin Programme, and the Training Camp at large

MATERIALS NEEDED: Pad of paper, pen

ACTIVITY:

1. Let a senior organizer open the session with a brief introduction to the Programme. Make sure to emphasize the Training Camp objectives:

To understand the Mitanin programme and its objectives

To share the programme's perspective on health

To learn what public health services are available; and, how to create awareness about them

To learn about child health and what the Mitanin's role is in this area.

2. Try to involve at least one official from the local government/ health department, and some panchayat leaders. Let them give a BRIEF talk on the importance of the Programme

Do NOT exceed time limits, especially if all Trainees have arrived. It will be a bad way to start out the session.

Session 2

TOPIC: What is health?

OBJECTIVES:

To learn:

The definition of health

The major determinants of good and ill health

The perception of health vis-à-vis doctors, drugs and diseases

MATERIALS NEEDED: Book 1, Chapter 1, Poster boards, color pens,

SKILLS LEARNED: Teamwork, Presentation skills

ACTIVITY:

1. Begin with a quick presentation by the Trainer.

2. The trainees are divided into groups of 5-10. One or more Trainees participate in reading the chapter out aloud. This will be followed by a quick discussion with the group.

3. Then each group must design and put up two posters - one on the causes of good health, the other on ill health.

4. Each group will make a presentation on their posters. If there is not enough time each group to make a presentation then the Trainer must visit each group and ensure that the participants have understood the objectives of this session.

Session 3

TOPIC: Ice breakers/Introductions

OBJECTIVES: To create a relaxed, fun, group atmosphere

SKILLS LEARNED: Teamwork

MATERIALS NEEDED: Fun group-game ideas, any materials that go with it

ACTIVITY:

The purpose is to get participants more comfortable with each other. Any fun game ideas will work. Remember to keep the session short and FUN.

Possible ideas: *(please choose one based on time constraints)*

- The name chain: All participants sit in a circle. The person sitting next to the moderator begins by telling her name. The person sitting next to her should say all names before her, followed by her own name. The moderator should go last.
- Passing the ball: A ball is thrown from participant to participant. The one who gets the ball has to tell the name of the person who threw it. One should not throw it to the same person twice.

Session 4

TOPIC: Perception of Health and Health Care

OBJECTIVES:

- To learn:
- Why persons often do not seek health care in time?
- Why persons often don't listen to good health advice?
- Why persons demand injections and drugs?
- How the system tries to blame the victim for his disease?
- How superstitious practices relate to health seeking behaviour

MATERIALS NEEDED: Blackboard, book 1 chapter 3

ACTIVITY:

1. Divide participants into groups of 5-10.

2. Read out ONE of the questions specified in the book. Write it up on the board.

3. Let the groups discuss amongst themselves for a specified period of time. Each group must come to a consensus, which is presented to the class. The Trainer summarises the answers to the question.

4.The Trainer then reads out the answers from the book, emphasizing necessary points.

5. The Trainer then moves to the next question and repeats steps 2,3 and 4.

Note: Complete one question before proceeding to the next.

It is important the Trainer understands correctly what each group is saying before summarizing. Also she needs to make sure that the group understands the correct answer.

Session 5

TOPIC: Objectives of Mitanin Programme

OBJECTIVES:

- Understand the objectives of the Mitanin Programme
- Understand the activities through which these objectives are attained

MATERIALS NEEDED: chart paper, color pens, book 1 chapter4

ACTIVITY:

1. Ask Trainees what they think are the objectives of this programme. Write them down, and arrange on the board.

2. Discuss how each listed objective can be achieved. Record the correct responses on the board.

3. Read out from the book.

4. Divide Trainees into groups of 5-10. Ask them to write on a chart how they would explain the objectives to

a) govt officer or doctor

b) panchayat officer

c) women in the village.

5. Put the charts up on the wall. *(Trainer should check them before display.)* Encourage different ways of expression, not different objectives. Trainers must take special care not to agree with statements of objectives that cannot be achieved within this programme.

Session 6

TOPIC: Public Health Care entitlements – what they are and how to secure them

OBJECTIVES:

- Understand the moral and legal basis for calling these services as entitlements or rights
- Learn about the local public health institutions and the services they offer
- Learn how to construct local enquiries and activities around book 2.

MATERIALS NEEDED: Book 2

ACTIVITY:

i. Introduce and emphasise the following - any state anywhere in the world is required by law to provide basic public health care. Explicitly explain how this contract came to be- the entire process of independence and negotiation of the nature of rule.

ii. The next point to make is that literacy and assertiveness play a HUGE role in how services are rendered. In countries and states where citizens are more literate and assertive, health is a matter of public debate and discussion. The services consequently, are of better quality and more funded. This is why knowledge of available facilities is very important

iii. Ask a Trainee to read out the introduction in book 2.

iv. Divide into groups . Have Trainees read aloud the rest of the chapters. (Stop once you reach the child health sections. These will be covered in the next Training Camp.) Make necessary clarifications and emphasis along the way. Keep explaining it in local dialect. At the end of each page - pose two questions and have a discussion. Let them note down the consensus.

a. How/who can give out this information in the village?

b. What action should be taken with this information?

Note: The first four pages require little action. Following that there is considerable action that ensures a considerable increase in utilization of services.

Session 7

TOPIC: Recapitulation/Songs/Introduction

OBJECTIVES:

- Refresh Sessions 1-6
- Reinforce a sense of togetherness

SKILLS LEARNED: Songs, making a summary ,learning to present to a group.

MATERIALS NEEDED: None

ACTIVITY:

1. Select three persons (who had taken notes) to summarise previous day's key points.
2. Arrange for a light game or some songs to enliven the atmosphere.

Session 8

TOPIC: Child Health – *Malnutrition*

OBJECTIVES:

- Understand why child malnutrition is the focus of our campaign
- Understand the multidimensional causes of child malnutrition
- Learn the main messages on child malnutrition

MATERIALS NEEDED: Book 3

ACTIVITY:

1. Begin with a presentation covering the 6 main points that make Child Malnutrition the focus of our campaign.

2. Divide the Trainees up into smaller groups. Have the groups read and discuss the text and analyze the questions following the chapters 2 of book 3

3. Visit the groups, making sure Trainees have correctly understood the answers.

Session 9

TOPIC: Child Health – *Diarrhoea*

OBJECTIVES:

- Understand the causes of diarrhoea
- Understand how to prevent recurrent diarrhoea in children
- Understand how to manage diarrhoea at the village level

SKILLS LEARNED: Drama

MATERIALS NEEDED: Book 3 chapter 3

ACTIVITY:

1. Choose 4-5 persons to do the characters in the Play. A Resource Person or talented Trainee should play the role of the doctor. The Play is read out like a radio-drama. If there are suitable resource persons in the trainees they can prepare earlier and do it as a role play also.

2. Interrupt to emphasise points, especially important ones that were overlooked during the reading.

3. Attend to the questions at the end of the section. Read each question out and call for a Trainee to answer. Emphasise the correct answer.

Session 10

TOPIC: Child Health – *Coughs and Colds*

OBJECTIVES:

- Management of ordinary coughs and colds
- Preventing Pneumonia
- Early recognition and primary care for Pneumonia.

MATERIALS NEEDED: Book 3 chapter 2, posters,pens

ACTIVITY:

1. Divide the Trainees into smaller groups.

2. Have them read out, discuss, and write the answers to questions at the end of the section.

3. Read out the questions to the class, and have each group give the correct answer.

4. Let each group write out the signs of pneumonia and the doses of drug to start treatment where referral is delayed.

Session 11

TOPIC: Child health – *Counselling a family*

OBJECTIVES:

- Learn the Do's and Don'ts of family counselling
- Learn how to find the causes of ill health in a child and counsel the family appropriately

SKILLS LEARNED: analysis and counselling

MATERIALS NEEDED: Book 3,

ACTIVITY:

1. Start with a presentation.

2. Divide the Trainees into groups, and have them read it amongst themselves. *No need for a discussion now, as this will happen in the next session*

Session 12

TOPIC:–Child Health–*Field Visit*

OBJECTIVES:

- Develop skills to establish rapport with a family
- Find out the causes of ill health in individual children within that family
- Counsel them appropriately

SKILLS LEARNED: , situational analysis, Counselling, Confidence

MATERIALS NEEDED: notebooks and pen

ACTIVITY:

(*This is the most important session of the entire programme. The notes given below are only to jog your memory. Actual leaning can take place only if you have gone through the process given below under guidance.)*

1. Choose a nearby village, preferably from a poorer area where we have good contacts. The village should NOT be more than 10-30 minutes away.

2. Take the Trainees in groups of 10-15. Each group should be accompanied by TWO Trainers.

3. Take the group to visit 1-2 families, with children below the age of five.

4. Proceed to build up a rapport and talk to the family about their child(ren).

5. Complete the four-fold inquiry. Then present the group with a summary of the child's health and nutrition issues. (this teaches situational analysis).

6.Proceed to counsel the family. Do it in as ideal a way as possible.

7. Break up the groups into pairs. Have each pair visit at least two families with children below the age of 5.

8. Have them come back and present their summaries to you. The let them counsel the family under your supervision. ENSURE that they have gone through every element of the process.

Special care must be taken to see that

- the Three Don'ts are observed
- they do NOT begin counselling until the complete four-fold understanding is achieved(that is before situational analysis is complete).
- they begin the counselling with praise
- they place their questions as suggestions, and use discussion to get the family to state their beliefs
- they explain why some practices are "wrong"
- they see different aspects of what has been learnt-children in first six months, severely malnourished children, normal children, grade 1 malnourished, children with diarrhoea, pneumonia, etc

9. If possible visit the anganwadi and talk to the workers there. Take a look at the register. Compare it to what people in the village have told you -

- Are weights taken?
- What is the malnutrition situation?
- Have the drugs been received? And distributed?
- Does it match what people said?...etc.

10. Debrief the group upon your return to the camp. Allow them to state what they have learnt.

Session 13

TOPIC: Child Health – *Immunization*

OBJECTIVES: To learn about immunization - the how and why?

MATERIALS NEEDED: book 3 chapter 5

ACTIVITY:

1. Begin with a brief presentation. Emphasise why some people do not welcome immunization. Make sure Trainees understand immunization as a way of preventing FIVE diseases effectively-not ALL diseases.

2. Divide the Trainees into small groups. Read the material aloud, and answer the questions at the end.. Promote a discussion based on this

Session 14

TOPIC: Women's Health and Rights

OBJECTIVES: To Introduce the relationship between patriarchy and ill-health, particularly the ill-health of women Briefly introduce the elements of ill-health

MATERIALS NEEDED: book 1 chapter 6

ACTIVITY:

1. Begin with a brief presentation on women's health and its relationship to patriarchy. Close with a description of how the Mitanin campaign will address this issue. Make the presentation emotive, one that makes the women think and reflect.

2. Consider inviting a women's leader from a women's organization to make this presentation, if needed.

Session 15

TOPIC: FAQs on Organization

OBJECTIVES:

- Learn the answers to FAQs about the programme
- Learn how to organize the Programme locally
- Clear doubts about the Mitanin Programme

MATERIALS NEEDED: book 1 chapter 5

ACTIVITY:

1. List the Programmes 12 most commonly asked questions. Then ask if there are other questions from the group.

2. Briefly present the answers to the questions, or read out the answers from the guidebook.

3. Divide the class into smaller groups, this time cluster-wise (those with nearby villages together), and discuss the above questions once more.

4. Have them discuss how they will organize campaigns in their areas.

5. These strategies are presented to the class and summed up.

Session 16

TOPIC: Organization & Action Plan

OBJECTIVES:

- Discuss the main organizational dimensions of the programme
- Draw up an action plan for the next two months

ACTIVITY:

Group work - planning the exact day to day schedule

Session 17

TOPIC: Valedictory

OBJECTIVES:

- Closing the Training Session in a positive mood.

Note: Trainers have one additional day of Training , which teaches them participatory methods as well as number of games and activities which can provide relaxation as well as make it more informal and participatory.

ON-THE-JOB TRAINING AND SUPPORT FOR MITANINS

The Importance of support and on the job training

Support and added training are absolutely essential for the success of the Mitanin program. It is unrealistic to expect the Mitanin to be able to initiate and do her work on her own - without support and further training inputs. The nature of the support envisaged comes from two levels:

A. Support within the village

a) Womens Health Committee: This support comes largely from the hamlet level Womens Health Committee (WHC). This Committee is formed by the Mitanin, soon after she is selected. All the women in the village are encouraged to join. Ordinarily, the WHC comprises one representative for every 5-10 houses. In small hamlets, aim for one per house. About 7-15 members makes a good-sized Committee, though this number is not fixed.

The WHC supports the Mitanin in the following manner. After every Training she attends, the Mitanin must share the information she has procured with the WHC. Thereafter, all designated Mitanin Program tasks should be supplemented with Committee Support. For example, her house-to-house visits can be carried out with the corresponding woman of that block of houses in tow.

In a sense the Mitanin should be seen as the convenor of the WHC(which does the work), rather than a solitary worker. The only individual action required of her is regular house visits.

b) Panchayat: Support from the Panchayat and its health committee is also critical. We expect that in many panchayats interest will be lacking even after about 3 months of work. To maintain their interest, Block-level meetings of panchayat leaders attended by the collector, with specific requests, should be periodically organised. Specific requests include :

1. Ensuring coordination of anganwadi, ANM and Mitanin
2. Local level planning for malaria control
3. Anti-TB and leprosy campaigns
4. other motivational or programmatic campaigns.

Do not ask for Panchayat financial support until outcomes are more visible, at about the 18th month.

Do not ask for Panchayat financial support until outcomes are more visible, at the 18th month.

c. Other Mitanins: Regular meetings with other Mitanins is very useful. These meetings can be held at the panchayat or cluster levels. The Mitanins should understand that they are an organised force- a peoples movement for change.

B. Support from outside the village:

Trainers/Prasiksaks: These provide the most important support. They visit the Mitanins regularly - at least twice every month. During these visits they help them with house-visits, meetings, and train them as needed, inspiring them to be better. Of all the different forms of support - this is the most important in deciding a positive programme outcome.

ANMs/Anganwadis/MPWs: These form the other major support system for the Mitanins. They meet them regulary to coordinate work with them. In this process though, Great care must be taken to maintain a democratic, not top-down relationship. Whenever the help of Mitanins is sought for example in pulse polio- there must be a meeting where the programme is explained to them and their help is requested . The Mitanins must also be convinced that the ANMs are not seeking to pass off their responsibility but seeking their cooperation to do it better.

Medical Officers: The medical officers help by providing referral services, making occasional visits to the village (at the request of the Mitanin), and by encouraging them. Programmes where there is some fee provided (for example in tuberculosis drugs provision) may also be allotted to Mitanins .Only if they are unwilling should others be drawn for these services.

District Administration: The district adminstration and other government employees help them through encouragment, ensuring that the Mitanins are always consulted whenr a village level programme occurs..

5.2 Prasikshaks: Leaders of the Mitanin Movement.

A Prasikshak is a Trainer of Mitanins. .But over and above this they are expected to emerge as the local leaders of the Mitanin Programme. They need to be specially trained and motivated to play this role. The trainers are in turn supported by 2-3 Block level full time project coordinators who may be government employees, or NGO members.

Every month a Prasikshak will spend 3-6 days receiving training, 6 giving training, and 8 -12 visiting with her Mitanins. Thus, 20-25 days of a Prasikshak's month will be occupied. Because of the intensity of their jobs, Prasikshaks will receive training compensation/fees at a rate of Rs 50 per day or about Rs 1000 per month. Although there may be a problem because this comes to be viewed as an employment opportunity, it is unavoidable. We can try to reduce this problem by ensuring that the trainers are not selected by appointment from above but emerge from the best preraks and Mitanins and assisting NGOs(elaborated below).

Getting our Prasikshaks

Most prasikshaks would be women. Currently we see the following as sources for Prasikshaks:

1. Preraks: Currently, Prasikshaks emerge from the Preraks. However, in our experience, most Preraks do not make good Prasikshaks. The programme, therefore, should have the space to reorder once we start recruiting from our Mitanins.

2. Mitanins: Often, there are good, well-educated, enthusiastic Mitanins who view this programme as an opportunity for advancement. To encourage and foster this enthusiasm, we can "promote" them to Prasikshaks (they must continue to attend to their Mitanin roles until a suitable replacement can be found).

3. ANMs: Although this will be a very suitable role for ANMs, it will be unreasonable to expect too many to join. Heavy workloads, and high vacancy rates make them unavailable.

4. NGOs; Many NGOs would be able to provide some persons to play the role as trainer in a given locality. Though they would not get funds from doing so, their influence and work in this area would improve and for many serious NGOs this is a worthwhile gain.

The heart of sustaining the Prasikshak in this work lies in developing their identities as part of a peoples movement or district level NGO. Regular meetings of prasikshaks will enhance their understanding of society, and build upon their desire for social improvement. Simultaneously they should understand how an NGO or peoples movement is to be built and sustained.

After some months we need to also counsel those who need the salary to support themselves as to how they should plan a future career for themselves.One option that is being considered is to "hybridise" the two jobs. For example to train them to play an earning role in the provision of some services - data collection, blood examination, peripheral laboratory services, social marketing etc.

5.3 What is expected of a trainer

The trainer visits each Mitanin at least twice a month. During these visits three aspects have to be covered

a) How Family visits should be conducted. -This process has been outlined in session 12 of the first round of training. Initially the Mitanins house visits focus on counselling on child health especially the malnourished child. Over time her counselling during house visits extends from child health to cover womens health, control of communicable disease and eventually first level curative care as well. At every step of her learning and doing the trainer must be there to assist her initiate it

b) How to conduct meetings: It is the Mitanin's responsibility to conduct the Womens Health Committee, and Village level meetings for health education. Prasikshaks must train/support the Mitanin to hold such meetings. Panchayat level meetings and activites in contrast to hamlet level or even village meetings would require the trainer to initiate and facilitate. .

c) Data Collection: Compile the data that the Mitanin has gathered about utilization of services/ state of health in her register. This will be the key to monitoring and supporting the increased utilisation of public health services. Note that the programme dynamic requires that the Mitanin should never be asked to fill up and submit forms or data of any sort. Any data needed from her register is to be collected from persons providing her support..

TRAINING EVALUATION AND IMPROVING TRAINING OUTCOMES

Importance

Training evaluation is the key to ensuring quality and effectiveness of training Evaluation will give a feedback on the training process. It will be used to correct and reinforce subsequent rounds of training. Regular evaluation and feedbacks on all training programmes is one of the best ways of monitoring the programme as well.

Note that all evaluation is of the training and not of the trainees.

Approach:

Evaluation is based on a questionnaire , which is asked orally to small groups of trainees. Written answers especially multiple choice questions are actively discouraged.

The questions are framed in a setting compatible with the context in which they use the knowledge. They are simple, unambiguous and relate to key messages only. Usually they are never asked questions where they have to list four or five or more items. If such questions ar epresent any two or three answers would be considered adequate

Evaluation is preferably done in small groups with questions rotated to various Mitanins and others answering if one does not answer. At all times the evaluator must tell the correct answer gently if they have not got it.

The evaluator has to be very encouraging. Evaluation should be non- threatening and should be welcomed by trainers and trainees.

There should be no element of surprise. The questions and answers should be with trainers before the training camp and should be asked to trainees at the outset of the training programme.

When persons, even VIPs, go to monitor the programme they should have a questionnaire and should expect answers only within this list.

The evaluation questions add up after each round of training.

Evaluation questions after first two rounds of training:

(note the training evaluation for other training rounds are also available on request)

Knowledge:

1. What in your view is most important for being healthy - name two or three factors What in your view is most important for disease? - name two or three factors.

2. Learn the answers for the following questions: Why do persons often not listen to good health advice ?

3. What are the major objectives of the Mitanin Programme - name two or three - What do you understand by the statement "Swasthya sevaian milna Hamara Adhikar hai".

4. Where is your PHC? Where is your CHC?

5. (a) We visit the house where a mother has given birth to a normal child by a normal childbirth just three hours ago? What will you enquire? What advice would you give mother and child?

   (b) The husband has come to take the wife and child home when the child is six months? What advise is most important regarding feeding for child?

   (c) What advise is most important that needs to be talked to mother and father or at least to the mother?

   (d) The mother of a one year old child tells us that she gives a small cup of rice and dal in the morning and another cup of rice and dal or rori at night . In between the child gets breast milk. She says that she the child is not eating more than that ? What is your advice?

   (e) Other than poverty what family level factors can lead to malnutrition?

   (f) Mother says there is no ghee or makkhan in the house? Why is more oil in a child's diet needed? What is your advice to this mother?

   (g) What locally available non commercial food based preparation can make a snack for a child between meals?

   (h) A child goes to an anganwadi and gets her daily quota of sooji./dalia. What else should she get there? What other test should be performed there?

   (i) A mother has spent over Rs 100 on the local village doctor to treat colds and a mild diarrhoea in the previous month? What is you advice?

   (j) At the anganwadi the child is found to be grade I/II/III- how do you explain the meaning of this to the family.

   (k) What are *the six main messages on child nutrition (exclusive prompt breast feeding; supplementary feeding from six months, five or six feeds per day, fats and oils, greens and reds, feeding during and after illness)*

6. (a) How do the germs that cause diarrhea get into your food or water?

   (b) The child has developed diarrhea. What would you advise the mother to give the child as treatment? What in the way of feeding?

   (c) How would the mother know that enough ORS solution is being given?

   (d) When will you insist that the child is taken to the ANM or doctor?

   (e) A child has recurrent diarrhea- name two or three precautions that the mother can take to prevent its recurrence? What in you view is usually the most important and practical precaution?

10. A child has a cold with a mild cough -

   (a) what advise would you give for treatement? Regarding feeds.

   (b) When will you ask them to take a child with cough to the doctor?

   (c) You are suspecting pneumonia and there is no doctor within twelve-hour journey. What drug may you start till they reach a doctor or in case they are unable to go?

11. A child has received three injections along with drops in the second third and fourth months. Now it is eight months old. The mother wants to know whether any more immunization injections are needed and if so when? What would you say?

12. In what ways do the inequality of women affect the health of children and the family? In what ways do the inequality of women affect their health ?

13. Who supports the Mitanin inside the village in these tasks.Who supports the Mitanin from outside the village in her tasks. How many days of training are planned for her? Why is there no payment for the Mitanin?

ROUND TWO- Evaluation

1. All the questions of the earlier round need to be re-asked?

2. What is the need to maintain such a register ? Name two or three objectives? Learn objectives of maintaining a local register-(identify families at risk to prioritise for counseling/referral, ensure that all families have got desired services, tool of local planning later)

SKILLS- to be tested on field:

Go with Mitanin to the house of a child with malnutrition Grade II; one house of a child with recurrent diarrhea and one house of a normal child of six to nine months age ? Ask the Mitanin to make an understanding the health problems in that house and state it to you - step I: Then to counsel the family in your presence.

Evaluate for the following :

1. Does she have rapport with the family -2

2. Did she make a comprehensive assessment or just stopped with one or two issues.-4

3. Did she make any gratuitous(donts) statements- like keep the child clean, take care of the child well, give child nutritious food etc?(- 2 for each)

4. Did she start by praising and supporting mother or by criticizing and finding faults?(4)

5. Were her messages " prescribed in a one - way manner" or queried and discussed with family ?(3)

6. Were her messages appropriate and tailored to specific context or stereotypes and general in nature?(15)

7. Were explanations given for what were pointed out as problems?(2)

8. Ask her to call a small group meeting of women on problems of diarrhoea? Evaluate for her confidence in doing so and appropriateness of messages: 10

9. Weighing a child- 5

10. Making an ORS solution- 5

Total Marks- 50:

IMPROVING PROGRAMME OUTCOMES AND PROGRAMME IMPACT

Programme Outcomes are outcomes directly related to the effectiveness of the activites we undertake as part of our programme. These are irrespective of socio-economic changes. For example, the number of Mitanins trained, or the increase in immunization levels, or better utilization of chloroquine for fever, are all program outcomes.

Programme Impact involves societal level change. For example, a change in child malnutrition level depends not only on our programme but also on socio economic changes which are out of our control. Thus one can have good programme outcomes and poor impact. However it is important to measure what changes we are able to create at the societal level - at the level of health indicators.

Programme Outcomes and Impact: a discussion

(For a list of the programme outcomes and health changes, please refer to the first chapter.)

Programme Outcomes in the Mitanin programme depend on

a) How well we have selected, trained and supported the Mitanin.

b) How well we have been able to make systemic changes in the health system so that it can respond to the increased outreach and awareness and demand generated by the Mitanin programme.

Programme Impact of the Mitanin programme on health indicators depend on

1. How far we achieve programme outcomes.

2. How well we are able to sustain the Mitanin programme for three to five years at least.

3. How far inter sectoral areas are able to also work in coordination at the village level.

We have already discussed how to improve Mitanin training outcomes. Let us look at systemic changes in the health system and how these could be linked to the health programme.Then we would see how we can sustain the programme for three to five years.

Inter-sectoral coordination would be addressed in a later book.

Systemic Changes in Health Sector

The State Advisory Committee(which is the state - civil society partnership that set down the basic parameters of the Mitanin programme)had identified a set of systemic changes that are needed in parallel . They are

Community basing of health care services with special focus on improving outreach and participation of weaker sections of society

Capability Building at all levels

Workforce management policy revisions

Humanpower development Policy

Internal Reforms leading to rationalization of health services and referrals

Decentralisation of health system

Essential Drug policy and rational drug use - including drug procurement and distribution

Graded Standard Treatment Guidelines

Health Manangement Information Systems;

Disease Surveillance and Epidemic Control

Peripheral Laboratory Services

Mainstreaming of Indian Systems of Medicine

Research and Development (example: drug resistance in malaria.)

Work on many of the above areas are proceeding in parallel to the Mitanin programme and their outcomes must be awaited. However some areas of systemic improvement are to proceed in complete synergy with the Mitanin programme and these are listed below

i. TBA Training Programmes

ii. Coordination with ANMs.

-Block level meeting with ANMs and Mitanin trainers

-In service training of ANMs on Mitanin Programme and community basing of health programmes.(guidebook prepared.)

-Panchayat level meetings with all mitanins and with ANMs so that a calendar of visits for the ANM is worked out.

iii. Improved design of disease control programmes:

iv. Strengthening referral services upto CHC level with feedback mechanisms to Mitanin for identified categories of health problems.

v. Linking data inputs from the community (through the Mitanin programme) with health information management systems and disease surveillance operated by the health department..

vi. Streamlining drug procurement and distribution mechanisms so that drugs are regularly supplied to Mitanin and so that its use is monitored.

vii. Eventually the construction of a block level health plan integrating the panchayat level plan with the district health system and with inbuilt feedbacks from disease surveillance and health management and information systems should enable effective decentralization and planning of health services.

The approach to other reforms are being planned under the aegis of the sector ivestment programme and are not discussed here. They are to be undertaken by the department of health with technical and planning advisory support by the State Health Resource center.

Sustainability and Impact

The Mitanin programme' programme outcomes has to be sustained for at least five years to show significant improvements in health indicators. Theoretically if this is done ,there can be a significant , even dramatic improvement in the health situation given the fact that many of our health indicators are poorer than what is possible for this level of per capita income.

Sustaining the Mitanin programme would need

A) Sustaining the Mitanin- Partly this is by meeting her expenses and costs in regular training and review, and by encouraging panchayats to support her . It would also need her to identify herself as a part of a larger social reform movement for change.

B) Sustaining the training team. : They could be networked into an organization and supported through this and/and/or capability building with related income generating opportunities which can be channelised preferentially to them.

C) Strengthening the role of panchayats :Panchayats would after formulating the plan at 18 months take over more of its implementation and should receive the funds and support to do this - all the time being monitored by a block level support group to ensure quality of the programme.

D) Effective strengthening of the health sector as envisaged under the sector investment plan…

E) Maintaining the political will to keep up such a programme, by building on its strengths and overcoming its shortcomings, instead of impulsively and arbitrarily switching to newer and more transient options of the day.

List of Mitanin Programme Training Modules

1.Janta ka swasthya, Janta ke haath.
(Introductory book on health and Mitanin Programme.)

2. Hamara Hak, Hamari Hakikat.
(Introduction to public health services and facilities.)

3.Hamare Bache, Unki Sehat.
(Basics of child health action.)

4.Mitanin Tor Mor Got.
(Basics of womens health action)

5. Chalbo Mitanin Sang.
(Local planning for malaria and gasteroenteritis control)

6. Mitanin Ke Dawa Peti .
(An introduction to first contact curative care.)

7. Kahat Hai Mitanin
(A pictorial book with key Messages that Mitanins can use for local communication)

Modules on
Control of Chronic Communicable Diseases,
Local health Planning,
Herbal & Household Remedies
and Disabilities
are also planned.

Modules prepared for Trainers and Programme Officers.

1. Prerak Prashikshan Sandarshika
(for training the facilitators to guide Mitanin Selection)

2. Mitanin Prasikshan Pustika.
(A handbook for Mitanin trainers and programme officers)

Publications for Strengthening Public Health System

(Authored by SHRC and Published by Chhattisgarh Basic Health Services Project)

1. Dai Training Module
(for traditional birth attendants training)

2. Swasthya ki Bath Sabki Saath
(for MPW's in service training on community participation in health programmes)

3. Essential Drug List.
(Chhattisgarh Graded Essential Drug List-2003)

4.Manak Chikitsa- Bahu Uddesyiya Karyakarta Sandarshika
(Standard Treatment Guideliness for MPWs)

5. Standard Treatment Guidelines for Medical Officers (in print)

7. Chhattisgarh State Drug Formulary (in print)

SHRC Working papers

1. Malaria- Operational Research
(Proceedings of malaria operational research workshop, Korba)

2. Mitanin programme: Conceptual Issues and Operational Guidelines

Next in series:
3. Strengthening Public Health Systems
(Issues of workforce management , rationalisation of services and human resource development in the public health system)