**An external evaluative study of the**

# STATE HEALTH RESOURCE CENTRE (SHRC)

and the

# MITANIN PROGRAMME

A state-wide health sector reform initiative and
community health worker programme in
Chhattisgarh State, India

# Final Report

**December 2005**

**COMMUNITY HEALTH CELL**
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# FOREWORD

The Community Health Cell (CHC) of the Society for Community Health Awareness, Research and Action (SOCHARA), Bangalore has been privileged to co-ordinate and undertake the external evaluative study of the State Health Resource Centre (SHRC) and the Mitanin programme in Chhattisgarh state at the request of the Government of Chhattisgarh and Action Aid, India. We would specially like to thank all the study team members who came from different parts of India. They consented to participate in this exercise at very short notice due to the sense of urgency conveyed to us then. They made the time within their busy schedules to undertake the fieldwork and analysis. Their expertise and experience in community health, public health, community health worker training and in evaluation and research, along with their concern to improve health and access to health care have helped greatly in this study. Two study team members dropped out after having participated in the first planning meeting in Raipur. They had to be replaced during the study. We have faced dilemmas, strong opinions and varying field realities which needed to be faced with wisdom and honesty.

The bold initiative by the Chhattisgarh state government to improve public health and access to health care through a state - wide intervention started in 2001 and its continuation across change of governments and key persons is to be lauded. The ability shown to enthuse a number of stakeholders at different levels, ensuring and sustaining their participation through innovative and participatory methods including a variety of institutional mechanisms have been noteworthy. There is evidence of vision, leadership and commitment which needs recognition nationally. However the context within which this initiative was undertaken was not easy. The team from the Department of Health & Family Welfare, the SHRC team and civil society partners have worked with communities living in circumstances of poverty, with low levels of literacy and in difficult terrain. There have been several achievements made by the SHRC and the Mitanin programme. Organisational systems and institutional arrangements have been established for future evolution of the health initiative. Short

comings and gaps need to be viewed against the background mentioned earlier. The evaluation team has made recommendations based on the field realities and processes observed. It is early to expect, much less to assess outcomes. The methodology used has been reasonably robust for a rapid evaluative study. It has included fairly extensive travel, with use of semi-structured schedules, focus group discussions, in-depth interviews, group discussions and interactions, participation in events, reviews of documents and other material. We are confident that the report will be used constructively so that this important health intervention grows in strength and helps to realize the aspirations for better health of all people in the state, particularly those impoverished and excluded.

The team is grateful to the Department of Health and Family Welfare, Government of Chhattisgarh, Director and team of the State Health Resource Centre, national and regional office of Action Aid India in Raipur, for their confidence in us, for the support and logistical help, and most of all for sharing their insights and experience.

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# Section I

## The State Health Resource Centre (SHRC), Chhattisgarh Origin, Role, Review of Achievements

## 1. Introduction

This section deals with Objectives two and three of the Terms of Reference of the external evaluation namely to ***"Evaluate the SHRC role in strengthening key aspects of the public health system in Chhattisgarh***:

1.1. How far has SHRC been able to achieve its goals and objectives and to carry out the role defined for it as a part of the reform agenda, including the Sector Investment Programme (SIP) milestones?

*Study the SHRC impact as an additional technical capacity for the DHFW, GOC.*

*Review partnerships made and managed by SHRC with civil society initiatives in the context of the Mitanin programme and other policy initiatives.*

*Review SHRC contribution as an academic group through research activities, publications, and fellowship/internship programmes etc.*

*Review significance of the institutional arrangement of SHRC in the public health and health system context of Chhattisgarh.*

2. ***Evaluate SHRC as an institution and make recommendations for its future.***
   - *2.1. Review the following aspects and recommend steps to strengthen them further.*
     - *a) human resource management and development policies and procedures.*
     - *b) institutional structures, mechanisms and social arrangements.*
     - *c) governance and accountability systems.*
     - *d) financial systems.*
   - *2.2. Make overall recommendations for the SHRC" (Ref: Terms of Reference).*

## 2. Methodology

A sub-group of two members of the evaluation team focused on the SHRC component. Methods used included:

- A detailed document review – see Bibliography.
- Interviews and discussions were held individually with key participants from different stakeholders and in groups with some field coordinators.
- Seven districts were visited – Rajnandgaon; Durg; Raigarh; Bastar; Dantewada; Kanker; Dhamtari, seeing health institutions at different levels – district hospitals, CHCs, PHCs, health sub-centres. Discussions were held with health personnel, NGO team members; *prashikshaks* and Mitanins. We were accompanied by field coordinators. (See list for details and annexure for case-studies).
- There was close interaction with the subgroup of the evaluation team studying the Mitanin programme so that perspectives and findings were shared and integrated.
- There were two meetings of the whole evaluation team - in March 2005 in Raipur for planning and in end May 2005 in Bangalore to discuss findings.

## 3. Profile of Health and Health Care in Chhattisgarh

This brief profile developed from secondary sources is being given in order to contextualize the health interventions that evolved in the new state. Expectations, objectives and achievements from the SHRC, the *Mitanin* programme, and initiatives to strengthen the health system need to be viewed in this context.

### 3.1. Introduction

The health status of a population reflects the set of prevailing social, economic and political conditions. Health indicators that are used to describe the health status of populations draw particularly on mortality (death) and morbidity (sickness) data as the most gross indications of levels of wholeness and well being. Though they are limited in capturing many important aspects of health and life, particularly the qualitative aspects, they are often the only indicators available. Standardization and comparability across population groups are important features that help in assessing how far a society and its government have progressed in realizing citizens rights to health and health care. These rights and entitlements are enshrined in many national and international documents and agreements. Availability, validity and quality of data depend very much on the efforts and resources invested in developing health information systems. This section utilizes available standard secondary sources of information. It describes the administrative units within which public health services function; the health care services available; and the health status of people in Chhattisgarh with brief comments from a evaluative, recommendatory perspective.

### 3.2. Administrative Arrangements

The state through its administrative units and systems, including the department of health and family welfare has an important responsibility in initiating and sustaining measures to improve the health status of people and assure access to health care. While individual citizens also have responsibilities, in the context of widespread poverty and deprivation the role of the state administration becomes more important. Following statehood in end 2000 the political and administrative leadership in Chhattisgarh explicitly recognized the difficulties faced by people especially the high levels of ill health and under nutrition, and the challenges inherent in revitalizing the public health sector. The opportunities of new statehood were seized and measures to strengthen the health system were initiated in consultation with donor partners, civil society and NGOs. Several government health functionaries and people have mentioned that the smaller administrative units that resulted from creation of new districts, and the recent state level health and related initiatives have started or accelerated the pace of health sector strengthening. This includes building of infrastructure, roads, administrative mechanisms etc.

**Table 1: Administrative Profile of Chhattisgarh**

| Description | | Comments |
|---|---|---|
| Formation of State | 1st November 2000 | New opportunities, for health sector development were seized. |
| Geographical size | 9th largest state in the country | Hilly terrain, geographical access difficult,<br>Low population density. |
| Number of districts | 16 increased from 7, in 3 revenue divisions | Infrastructure and personnel needed for new districts.<br>Reduced distance between people and administration |
| Number of *tehsils* | 96 | Some states have *tehsil* / block health officers responsible for public health. |
| Number of blocks | 146 | Only 114 had CHCs, majority of which were not functional. First referral units technically weak. |
| Number of *gram panchayats (GP)* | 9129 | *Gram panchayats* role in governance of health sector to be operationalised through > 9000 dispersed units; requires inter-departmental collaboration; and capacity building of GP members. |
| Number of villages<br><br>Number of habitations *(para's)* | 19,720<br><br>54,000 | A mitanin (CHW) was planned for every *para* to reach out to the entire community.<br>This needs flexibility and funding. |
| Number of Muncipal Organizations<br>Other Municipal bodies | 6<br><br>69 | Health care for urban poor relatively neglected. |

### 3.3. Demographic Profile

While the over all *adivasi* population in the state is 32.46% there is a much higher proportion of *adivasis* in the southern, northern and north eastern districts. Dantewada has 79% *adivasis,* followed by Bastar (67%), Jashpur (65%), Surguja (57%) and Kanker (56%). The languages spoken by these ethnic communities such as *Gondi, Halbi, Bhadri* and others are different from the major languages of the state namely *Hindi* and C*hhattisgarhi*. These factors need careful consideration in health planning. *Health personnel working in these regions should preferably belong to the local community or should learn the language and be sensitized to the cultural patterns of the communities. Training material and health educational/ health promotional material needs to be prepared in the local languages.* This is not yet taking place.

**Table 2: Chhattisgarh Demographic Profile (2001 census data)**

| Indicator | Absolute number | Comments |
|---|---|---|
| **Total Population**<br>Total Males<br>Total Females<br>gender ratio | 20.79 million<br>10.45 million<br>10.34 million<br>990 (India 933) | a) Decadal growth rate during 1991-2001 was 18.06% (2000) as against 21.34% in India (2003)<br>b) Gender ratio good, increased from 985 in 1991 census<br>c) Population density low 154 (India 324) |
| **Under 6 year population**<br>Males<br>Females<br>0-6 year gender ratio | 3.47 million<br>1.75 million<br>1.71 million<br>975 | % of 0-6 age group to total population 16.68%<br>This group needs to be reached by the ICDS and health services. |
| **Literacy levels**<br>Number of literates<br>Males<br>Females | 11.2 million (65.18%)<br>6.7 million (77.86%)<br>4.5 million (52.40%) | Literacy rate on par with national figures – inter district differences exist, need to introduce indicators of quality of education. |

Source: Office of the Registrar General, India, Provisional Population Totals, 2001

**Life Expectancy at Birth (LEB)** in Chhattisgarh is reportedly better than in the mother state of Madhya Pradesh (MP). In 1991 life expectancy in Chhattisgarh was 61.4 years, while it was 57.3 years for the entire undivided MP. Female life expectancy was higher (62 years) as compared to male LEB (60.9). Urban LEB was much higher (69.6) as compared to rural LEB (60.0) years.

**Table 3: Other Demographic Indicators of Chhattisgarh (1991) are:**

| Indicator | All | Male | Female | Rural | Urban |
|---|---|---|---|---|---|
| Mean age at Marriage | 25.4 | 25.5 | 25.3 | 25.4 | 25.3 |
| Total Fertility Rate | 4.3 | | | 4.3 | 4.2 |
| Under five Child Mortality | 129 | 134.0 | 124.0 | 141.0 | 79.0 |

Source: Census of India 1991, Registrar General of India, New Delhi.

#### 3.4. Access to basic amenities as in 1991 when this region was part of Madhya Pradesh

Safe drinking water, sanitation facilities and food are basic determinants of health. Lack of access to them results in a heavy burden of preventable diseases and conditions, which also lower the productivity of the population. The table below reveals a high degree of deprivation. *Greater health gains result from increasing access to basic determinants of health such as food, water and sanitation other than only providing medical care for the diseases and conditions that result from lack of access to the determinants.* It is with this understanding based on principles of public health and human rights that the conceptualization of the health intervention was made through the initial consultations. This requires shifts in resource allocations and power relations, with a longer term vision and perspective. The role of the Department of Health and of Community Health Workers (*Mitanins*) needs to be seen and developed within this context. Impact indicators for the DHFW and GOC after 5 – 10 years of health sector strengthening will need to see the progress made in terms of access to the above basic amenities, as well as provision of primary health care for conditions arising as a result of denial of access. *If the concepts are not adequately discussed, disseminated and communicated widely and regularly, they could easily get misinterpreted and distorted.*

***Table 4: Access to Basic Amenities***

| Basic Amenities | All | Rural | Urban |
|---|---|---|---|
| Access to Electricity | 31.8% | 25.4% | 61.2% |
| Access to Safe Drinking Water | 51.2% | 45.1% | 79.6% |
| Access to Toilets | 10.3% | 3.3% | 42.4% |
| Access to all three | 7.6% | 1.5% | 35.6% |
| Access to none of the three | 36.1% | 41.9% | 9.6% |

Source: Census of India 1991, Registrar General of India, New Delhi (as given in the website of Govt. of Chhattisgarh).

### 3.5. Poverty

There is a lot of expert debate, discussion and controversy about different poverty lines. Methods generally used measure purchasing capacity necessary for basic calorie requirements ie covering only food and not shelter, clothing, health and education. Given below are figures from the GOC website citing National

Sample Survey Organization data based on the NSS survey of 1993 – 94 (the official poverty line – PL) and another by an expert group (Expert PL).

***Table 5: Poverty Levels***

| | 1987-88 | | 1993-94 | |
|---|---|---|---|---|
| | **Official PL*** | **Expert PL** | **Official PL** | **Expert PL** |
| All | 55.35 | 45.27 | 38.91 | 28.64 |
| Rural | 58.47 | 46.72 | 38.21 | 25.74 |
| Urban | 35.38 | 35.99 | 42.21 | 42.21 |

*Poverty line as per Planning Commission

Source: http://chattisgarh.nic.in/development/development.htm.

From the above table as well as from other sources it is apparent that the levels of poverty, deprivation and exclusion in the state are very high. *Studies and experience show that this broader context adversely affects the health status of people, as well as the functioning of health services. Findings of the evaluation need to be seen in relation to this context.*

The Madhya Pradesh government was the first to publish the **State Human Development Index (HDI)** and Gender Related Development Index. Data from the original seven districts which now comprise Chhattisgarh state, along with literacy data were applied to the 16 new districts of GG state by the GOC. *In terms of the HDI in Chhattisgarh, Durg district is the best among the districts followed by Dhamtari, Raipur, Bilaspur and Korba. At the bottom is Kawardha district. Other districts at the bottom are the northern and southern tribal districts of Surguja, Dantewada, Bastar, Raigarh and Koriya.* While the HDI for India is 45, Chhattisgarh is 39.

### 3.6. Social Development in the Districts

A deep understanding of the context of the process of social development of the entire population of the state would help to shape the contours of a statewide health intervention initiated by the government in partnership with a range of stakeholders and actors. Such a process was infact initiated by the state leadership which catalysed and held together groups and individuals coming from diverse backgrounds. The social realities that they dealt with based on 1998 date are indicated in the table below

## Table 6: Gender related Development Index in Districts of Chhattisgarh, 1998

| District | EDUCATION | | | | HEALTH | | | | INCOME | | | GENDER RELATED DEVELOPMENT INDEX |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Literacy Rate | | Child Enrolment | | Education | Expectancy of Life | | Health | Per Capita Income | | Income Index | |
| | Male | Female | Male | Female | Index | Male | Female | Index | Male | Female | | |
| Surguja | 30.0% | 15.2% | 72.2% | 43.7% | 0.333 | 63.4 | 63.8 | 0.642 | 6068 | 2852 | 0.635 | 0.536 |
| Koriya | 51.8% | 24.5% | 72.2% | 43.7% | 0.410 | 63.4 | 63.8 | 0.643 | 6532 | 2279 | 0.605 | 0.552 |
| Bilaspur | 62.4% | 28.0% | 81.6% | 49.1% | 0.466 | 60.1 | 62.0 | 0.600 | 8613 | 4290 | 0.733 | 0.600 |
| Korba | 61.5% | 28.1% | 81.6% | 49.1% | 0.468 | 60.1 | 62.0 | 0.600 | 9168 | 3658 | 0.714 | 0.594 |
| Jangir Champa | 67.4% | 27.6% | 81.6% | 49.1% | 0.469 | 60.1 | 62.0 | 0.600 | 8567 | 4409 | 0.735 | 0.601 |
| Raigarh | 59.1% | 26.9% | 79.2% | 36.9% | 0.414 | 59.9 | 61.5 | 0.594 | 6760 | 2942 | 0.648 | 0.552 |
| Jashpur | 51.0% | 25.7% | 79.2% | 36.9% | 0.396 | 59.9 | 61.5 | 0.594 | 6377 | 3325 | 0.662 | 0.551 |
| Rajnandraon | 66.0% | 31.9% | 67.2% | 47.6% | 0.475 | 57.0 | 40.0 | 0.561 | 5518 | 3371 | 0.650 | 0.562 |
| Kawardha | 45.4% | 14.2% | 67.2% | 47.6% | 0.342 | 57.0 | 60.4 | 0.561 | 5580 | 3289 | 0.648 | 0.517 |
| Durg | 74.1% | 42.8% | 77.9% | 58.3% | 0.588 | 62.5 | 65.0 | 0.646 | 9659 | 4681 | 0.758 | 0.664 |
| Raipur | 65.5% | 31.6% | 85.6% | 58.5% | 0.521 | 60.4 | 59.8 | 0.582 | 7472 | 3717 | 0.696 | 0.599 |
| Dhamtari | 69.9% | 36.0% | 85.6% | 58.5% | 0.551 | 60.4 | 59.8 | 0.581 | 7062 | 4172 | 0.707 | 0.613 |
| Mahasamund | 60.2% | 25.8% | 85.6% | 58.5% | 0.478 | 60.4 | 59.8 | 0.581 | 7542 | 3707 | 0.695 | 0.585 |
| Bastar | 31.8% | 13.5% | 44.0% | 30.0% | 0.248 | 61.2 | 62.7 | 0.614 | 6523 | 3483 | 0.672 | 0.511 |
| Kanker | 53.3% | 25.0% | 44.0% | 30.0% | 0.348 | 61.2 | 62.7 | 0.614 | 6326 | 3684 | 0.677 | 0.547 |
| Dantewara | 22.9% | 10.1% | 44.0% | 30.0% | 0.214 | 61.2 | 62.7 | 0.614 | 6406 | 3614 | 0.675 | 0.501 |

*Source: Chhattisgarh – A State is Born, Sanket, Bhopal.*

The inter-district variations in literacy rate, particularly women's literacy, and in child enrollment are marked. This would impact particularly on strategies for community awareness regarding health and health programmes. While the use of kalajathas and radio programmes are a strategic option, *the data above would suggest the need for very intensive work in the local languages and idiom that would need to be repeated in various forms over time. Strengths of the local culture and tradition, which are perhaps reflected in the life expectancy and gender ratio, would also need to be respected and reinforced.*

### 3.7. Health Profile of Chhattisgarh – Recent Trends

The **Infant Mortality Rate (IMR),** which is the annual number of deaths of children below the age of one year per thousand live births, is a sensitive index of levels of child health, maternal health, access to quality health care, as well as standard of living.

Chhattisgarh has not yet achieved the National Health Policy goals for IMR reduction by 2000, though there are indications of some decline. Figures are also much higher than the national average.

**Table 7: Infant Mortality Rate (IMR)**

| IMR | Chhattisgarh | | India | |
|---|---|---|---|---|
| | 2000 | 2003 | 2000 | 2003 |
| IMR total | 79 | 76/73* | 68 | 64 |
| IMR rural | 95 | 85 | 74 | 69 |
| IMR urban | 49 | 51 | 44 | 40 |

* Different reports cite different figures.
*Source: Sample Registration Scheme (SRS) 2003*

The IMR is substantially higher in rural compared to urban areas. It is probable that the rates are higher in the hilly tribal districts where the reach of health services and health information systems are much less. The National Health Policy 2002 which for the first time gives IMR by social stratification shows a much higher IMR for scheduled tribes and scheduled castes. While we do not have specific figures for Chhattisgarh, it is important to keep this in mind **as 32.4% of the population are scheduled tribes, 12.2% scheduled castes (SC+ST=46%) and 50% are Other Backward Classes (OBC).** It is also important to keep in mind that in several major states of the country there has been stagnation or worsening of the IMR over the past decade. This has been attributed to the agrarian crisis, jobless growth with widespread unemployment/underemployment due to economic and trade factors; along with contraction or stagnation of the social sector. It remains to be seen whether sectoral interventions with inadequate budgetary support can make a difference. *The DHFW, SHRC and academic institutions should encourage studies and documentation of infant, child and maternal deaths as an integral part of the state's capacity building efforts. This will also help to measure impact of health sector and other macro interventions.*

## *Under five Mortality Rate*

Chhattisgarh has a high under five mortality rate of 122.7 as against the national average of 94.9.

## *Nutritional Status*

Hunger and hidden hunger is high in Chhattisgarh as is evident from available indicators of nutritional status (source NFHS 2).

a) **Anaemia** among women was prevalent in 68.7% of women. WHO standards consider population prevalence rates of anaemia above 10% as a public health emergency. Anaemia prevalence among adolescent girls was 67.5% (mild – 42.1%, moderate 24.5%, and severe 1.9%)

**b) BMI (Body Mass Index)**

A large proportion of women (48%) have a BMI below 18.5 and 44.9% of adolescent girls fall below this level.

### Maternal Mortality Rate (MMR)*

The MMR in Chhattisgarh is reportedly over 400 (Madhya Pradesh 498 in 1997). Figures for MMR in India are contested by different agencies with some reputed groups suggestions that the MMR is much higher. Maternal mortality rates in India range from 29 (Gujarat), 76 (Tamil Nadu), 195 (Kerala and Karnataka) to 451 (Bihar) (Govt. of India, Annual Report 1999- 2000). Anaemia is a leading cause of death (19%) as well as of complications of pregnancy.

The **RCH 2** project implementation plan (PIP) for Chhattisgarh has ambitious and unrealistic goals to -

a) reduce the IMR from 73 to 35 by 2007 / 8.
b) reduce MMR from about 400 to 150 by 2007.
c) increase CPR (Couple Protection Rate) to 65% by 2007.
d) reduce total fertility rate to 2.1 by 2010.
e) achieve a net reproduction rate of 1.0 by 2010.

*It is necessary for the state to adopt do-able strategic plans based on a realistic assessment of available human, financial and other resources*. If not it would lead to frustration, a low self esteem among health providers and a loss of confidence in the health sector by the community.

The second important factor is the dominance of a demographic focus in the goals, which would influence the functioning of the health system. While the strategies are more broad based, coherence between goals and strategies could be adopted. Response to community need, community involvement in planning and a comprehensive health approach are missing here though they are a part of the conceptual plan in the *mitanin* programme. Divergent policies and approaches may cause conflicts of interests and confusion. *Congruence in health strategies and a move away from vertical approaches as is being attempted by the National Rural Health Mission (NRHM) need to be adopted, with a focus on strengthening primary health care.*

### *Communicable Diseases*

Diarrhoea, malaria and tuberculosis are still major public health problems in Chhattisgarh. Inadequate access to safe water and sanitation lead to high transmission of water borne and water related diseases.

Malaria is endemic in the state and has been described in the region since over a hundred years. A state level workshop on 'Malaria operational research' held in

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**** MMR – Pregnancy related death of women during pregnancy or within 42 days of delivery / termination) pregnancy per 1,00,000 live births.***

January 2003 discussed the problem and developed recommendations. The Annual Parasite Index in Chhattisgarh was 10.84 in 1997, 19.88 in 2000, 12.89 in 2001 and 10.21 in 2002 with 50, 63.32 and 3 deaths reported through the public health system. The Pf (Plasmaduim falciparum) rate is 69.35%. Malaria cases are reported most from Bastar (16%), Jashpur (16%), Dantewada (14%), Ambikapur (12%) and Kanker (11%). However it is well known that there is a lot of under reporting from the health system. The cyclical epidemiological trend of the disease should also be kept in mind. It is reported that there were big shortfalls in supply of insecticides due inadequate budgets and management / logistic problems.

## 3.8. Profile of Public Sector Health Services

In 2001 Chhattisgarh state had poor health infrastructure, with only 9 District Hospitals, 114 community health centres, and big gaps at the level of PHCs and health subcentres (HSC) in relation to norms. There were large vacancies of doctors and paramedical staff. PHCs in remote tribal areas did not have doctors, and facilities were in a poor condition.

The study report titled "Strengthening Public Health Systems" and the Reproductive and Child Health Programme II (RCH 2) proposal has a detailed situation analysis of the health infrastructure. These reports facilitated by SHRC, with substantial inputs by them, lay the foundation for health sector planning for the state.

### Health Sub-centres (HSC)

There are 3818 sanctioned health subcenters covering 54,000 hamlets and 19,720 villages. Of these only **1458 had government buildings,** while the remaining are supposed to be run in panchayat or any other buildings. In 2004 -5, 875 subcentres were sanctioned by government and their location was reportedly decided based on need, using a Geographical Information System. Thus *currently only 25% of subcentres have facilities to conduct deliveries in the centre.*

### Primary Health Centres (PHC)

Out of the 748 sectors in Chhattisgarh, only 516 have sanctioned PHCs leaving a gap of 232. However out of the 516 PHCs only 327 have buildings. The quality of existing HSC and PHC buildings and the staff quarters along with availability of electricity, water supply and sanitation facilities also needs to be improved. The siting / location of the health centres is also critical as they have to be accessible to the community. This is not always so leading to non-utilization of services and wastage of resources.

### Community Health Centres (CHCs)

There are 116 CHCs out of which only 34 are 30 bedded institutions. The remaining 82 are run in PHCs or other buildings. The state should have at least

146 CHCs (one per block for 146 blocks) or 180 if population norms of one CHC per lakh rural population is used.

**It is thus very evident that the primary health care system rests on very weak foundations in terms of physical infrastructure and availability of health personnel. These gaps need to be filled with a sense of urgency.**

It is also reported that private practice among public sector health personnel is widespread and that the health sector in general is fairly privatized (Sen, 2005). There are also several ongoing decisions to accelerate the process of privatization, with public subsidy to the private sector (*ibid).* How this impacts on access to medical and health care for the majority poor needs to be studied in greater depth.

## Health Personnel

- There are only 3816 ANMs (Multi Purpose Worker – F) out of the sanctioned 4094 covering the 54,000 hamlets, each covering 10-15 hamlets over a 5 – 25 km distance, often with little supervision or encouragement and without transport facilities.
- There are 2905 MPW (Male) out of the 3557 that are sanctioned.
- Among supervisory staff there are 730 Lady Health Visitors (LHV) out of 814 sanctioned.
- There are 355 Laboratory Technicians out of the sanctioned 436, and 125 Block Extension Educators out of the sanctioned 149.

The short falls in health personnel are well known in many parts of the country. The state however under took a study in 2003 to look more closely at issues of workforce management and human resource development. They also embarked on reforming the health sector through a set of mutually agreed milestones. Progress in this regard will be discussed elsewhere.

Some indications of the reach of the services are given by data available regarding coverage of reproductive and child health care.

***Table 8: Coverage of RCH services***

| RCH Service Provision | Coverage |
|---|---|
| Antenatal care registration | 97% |
| Antenatal care checkup | 12.8% |
| Safe delivery | 42.03% |
| Institutional delivery | 21% |
| Postpartum Care | 20% |
| Total immunization | 57.58% |
| Couple Protection Rate | 39.9% |
| Percentage of women who had the first child in the 15-19 age group | 73.8% Median age 18.1 years |

***Source: NFHS, SRS 2002***

*The coverage of basic mother and child health care by the system is very sub-optimal. The quality of care is also said to be inadequate.*

### *District Hospitals*

There were 9 district hospitals, many of which were poorly equipped and in need of repair. The state government is building new district hospitals for the new districts. In Dantewada for instance the new hospital has been well sited and built and is being utilized by people. Older district hospitals are being renovated and strengthened.

#### Medical Colleges

There are two government run medical colleges in the state in Raipur and Bilaspur. Public private partnerships are underway in both these institutions.

### *Overall observations*

The Govt. of Chhattisgarh initiated a consultative process soon after state formation to strengthen the health system. Financial support was negotiated through donor partners such as a DANIDA supported Rupees15 crore Chhattisgarh Basic Health Services Improvement Programme, and Rupees 16 crore Sector Investment Programme supported by the European Commission through the Govt. of India. The global fund for malaria, TB and HIV/AIDS RCH I; UNICEF and EAG (Empowered Action Group) funds were also made available through the Govt. of India. The injection of funds was used for construction of new buildings and repairs to District Hospitals, CHCs and PHCs; purchase of equipment; training; production of material and the *mitanin* programme. Some of the changes are visible. The programmes and initiatives have continued despite political and bureaucratic changes. Findings of the evaluation team as of April 2005 are given and discussed in the respective sections, *keeping in mind that three years is a relatively short period in a statewide effort to strengthen the health system.*

## 3.9. Conclusion

The health situation that the political and administrative leadership faced was of a population of around 20.7 million suffering from the diseases of poverty, with high levels of under-nutrition or hunger, anaemia, water borne diseases and communicable diseases. There were also several gaps in the health system and its functioning. It is a cause of concern for citizens and professionals that such a situation prevails fifty eight years after Independence, at a time when there is so much access to knowledge and resources. The magnitude and scale of suffering due to preventable ill-health is large, pointing to gross inequities in health in the country and the state.

*It was therefore timely and appropriate that the GOC initiated steps to strengthen the health system and involve communities through the mitanin programme and panchayats. How serious they were would be indicated by budgetary allocations, expenditure patterns, and fund flow systems; by methods adopted or not adopted for workforce management; by selection of strategies and the quality of implementation and its supervision and monitoring in the field.*

## 4. Origins of the Health Initiative in a new State

The formation of the new State of Chhattisgarh in November 2000 provided a unique opportunity to strengthen measures to improve health and health care. The context for health sector initiatives, as outlined earlier was challenging. Social stratification and deprivation of some social groups were centuries old; geographical terrain and access were problematic; literacy rates particularly of women were low, in some districts touching 12%; health indicators (barring gender ratios) were at the lower end of the national range; hunger levels, were unacceptably high. Health sector resources including trained health personnel of all categories were inadequate in numbers, working in weak health institutions without adequate equipment or drugs. There was a maldistribution and mismatch of personnel and infrastructure with areas of greatest need left underserved. Low motivation, private practice by publically paid health personnel during office hours and corruption in the health sector were not unknown here, as in many other parts of the country and the world.

To dream dreams for better health and health care, especially for the poor and to work towards actualizing them, in this context of impoverishment required vision, courage and support from several sectors and actors. The state initiated processes to work towards this goal, backing it up with support. The mother state of Madhya Pradesh had already experimented with a *Jan Swasthya Rakshak* scheme and a *Swasthya Jeevan Guarantee Yojana* from the mid 1990s. Thus health was to an extent on the public and political agenda though in a muted way. The Peoples Health Movement (*Jan Swasthya Abhiyan* - JSA) was developing at the national level throughout 2000 with a large *Jan Swasthiya Sabha* in Kolkatta in December 2000, during which a Peoples Health Charter was adopted. This process of social mobilization for health had built on 2-3 decades of earlier work. Though the movement was weak in the State, there were individuals groups, and smaller social movements within Chhattisgarh who contributed to and supported the call for 'Health for All, Now!' and worked on determinants of health based on an understanding that health and universal access to health care is a basic human right.

## 5. Evolving Institutional Mechanisms and Roles

The political and administrative leadership in the state drawing on their earlier experience with health programmes and the literacy campaign seized the opportunity of new statehood and decided to initiate steps towards the community basing of health services, along with restructuring and reforming the health

system. Whether the implications and requirements for this ambitious goal were fully realized is not clear. But important and significant first steps were made. The *Rajiv Jeevan Rekha* programme was launched on Ist November 2001, with the *Indira Swasthya Mitanin Programme* being developed by the Department of Health and Family Welfare as an important component. The core idea was to have a *mitanin* (trained community health worker) for every one of the 54,000 *majra tola's/para's* (hamlets) in the state. There was political commitment and pressure from the highest level, with the Chief Minister taking personal interest in its launch and progress.

The new state had a single health secretary unlike 3-4 in the mother state. Being a medical professional from the region with experience of health and literacy programmes was an asset[1]. The value of NGOs and civil society was recognized and a consultative process which was fairly unusual was initiated and sustained through frequent discussions both formal and informal for over a year starting in 2001.

The dialectical discussions of this group placed equity concerns, participatory approaches, flexibility, and the need for poverty and gender analysis on the agenda. This grouping was later formalized into the State Advisory Committee by a Government Order. Documentation of this early process was meticulous, outlining the thinking and planning processes that took place.

In the early phase the main focus of attention seemed to be on developing a community health worker (*Mitanin*) scheme. The approach adopted during the early phase is best understood in their own words,

"*Operational mechanisms need to be worked out for NGO involvement in the programme and addressing equity concerns" (Minutes, November 24th, 2001*). Critical issues of scale and phasing of the programme were discussed. "*The scheme is entirely demand driven, the phasing of the interventions and the scale that it would assume would entirely depend on the number of mitanins who come forward for the training, nominated by the communities that they hail from.* ***No targets have been set for the collector for identification of mitanins bearing in mind the spirit of the programme"(ibid). "****Health will need to be understood by the mitanins as a social phenomenon" (ibid).*

The following important steps were identified for the *Mitanin* Scheme:
*1."Community mobilization and campaigning on the scheme.*
*2.Selection of mitanins.*
*3.Listing of duties of the Mitanin.*
*4.Ongoing refresher trainings for the Mitanin.*
*5.Community financing mechanisms for the Mitanin.*
*6.Monitoring and evaluation of individual Mitanins.*
*7.Redressal mechanisms for the community.*

[1] He was an IAS officer, with a post graduation in Surgery with experience in health programmes in Madhya Pradesh, and a publication on approaches to improving health care in India.

*8. Community support systems*
*9. Interface with formal public health functionaries (PHC doctor, ANM)*
*10. Interface with other Government functionaries (Anganwadi Karyakarta's, Teachers etc)*
*11. Role of panchayats / village health communities" (ibid).*

Thus the state started leveraging a change process in the health sector through a dialogue with health and social activists, NGOs, donor partners and some DHFW staff. These groupings become a think tank which provided a conceptual framework to the evolving initiatives. The discussions based on study, documentation and learning from the rich experience and diverse perspectives of a mixed group threw up new approaches to a state run community health worker programme, built on to the earlier MP-JSR and 1978 national community health volunteer scheme. How much these approaches were internalized and implemented will be seen later. However it is important to flag the issues raised, as well as the process factors, as the learning from the Chhattisgarh experience will influence other states and the National Rural Health Mission.

By this time the small group had gelled. Action Aid – India and its regional unit head quartered in Raipur became an important institutional partner which played a catalytic role facilitating the process, helping develop a non-threatening interface between government, NGOs and donors through which process the overall perspective for the health initiative evolved. The European Commission Technical Assistance (ECTA) which was involved in supporting sector wide approaches (SWAP) in health sector reform in several states participated in key meetings. An important workshop in Raipur on **"Moving Towards Community Based Health Services** (January 16th – 18th 2002), raised the key issue of the **urgent need to strengthen the public health system, along with training community health workers**. The consensus of the group was that community health workers were not to be seen as a quick fix to improve health or as a low cost alternative to the health system. Participants, particularly the NGOs and professionals felt 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 "* (Ref. Patnaik B, Beginning of the Mitanin Programme, undated) Infact the *mitanin* was seen as a change agent who was to increase community awareness about health and available health services, to generate a demand and increase the social accountability of health and related services. All partners including the state and donors took the outcome of this meeting very seriously. ***Fifteen important issues were raised which became the milestones for operationalisation of the health sector reform process.*** The issues included: "*developing community based services; delegation and decentralization; strengthening health intelligence, surveillance, and epidemiology and planning; control of epidemics; addressing health problems of poor people; capacity building; rational drug use policy; improving internal systems of Dept. of Public Health; workforce management and transfer policy; drug distribution and logistics; uniform treatment clinical protocols; management information system; developing decentralized laboratory services; mainstreaming Indian systems of medicine especially tribal medicines into the state health system and drug resistance in*

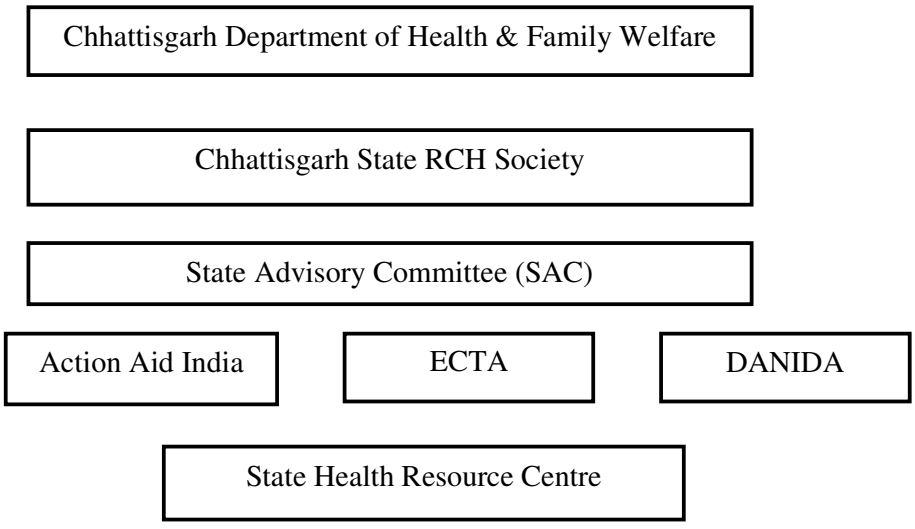
*malaria*." The timeframe for achievement of these far reaching changes was short, and expectations in the given context seem ambitious. While important issues were raised, the ability or capacity to operationalise these at a state or even district/block level were relatively limited in the entire health sector – public, voluntary and private. Prioritization of the 15 complex issues; with step by step planning; identifying or recruiting experienced, competent persons responsible for each component; using a management instrument such as the Logical Framework Analysis; could not be done fully in the given circumstances. However, it must be recognized that this was a decisive and defining moment, a window of opportunity to initiate measures to strengthen the health system and link it with a strong base in the community. An important and good beginning has been made.

While discussions, conceptualization and strategic planning was underway, there was a genuine need, as well as a strong political compulsion to get the programme off the ground with a greater sense of urgency. Thus work on the implementation aspects was initiated. For the *mitanin* programme it was decided to identify community based facilitators (*preraks)*, one or two for 10 -15 villages to enable the selection process by the community through the *gram sabhas*. The process of developing Hindi manuals for the facilitators and the *mitanins* was initiated early in 2002, by involving NGOs and individuals with experience of community based health work.

The group now felt the need for an additional body to provide technical and organizational support to this emerging initiative. Action Aid India was entrusted with the task of operationalising this component.

The formation of SHRC as a distinct entity emerged from the earlier loose formation which also got formalized as the state Advisory Committee (SAC). The state health secretariat through a pro-active process developed a new institutional innovation, the SHRC, out of a working network between the public sector, civil society and donors.

Key players at the state level were



The State Health Resource Centre (SHRC) was established as a product of a Memorandum of Understanding dated Ist March 2002 between the Reproductive and Child Health (RCH) Society, Govt. of Chhattisgarh and Action Aid - India (AA-I). The two parties agreed to facilitate *"the formulation, implementation and monitoring of reforms process in the health sector"* in Chhattisgarh. This was an imperceptible but significant shift from health sector strengthening envisaged in the February 2002 meeting to health sector reform which had a different history and meaning, which may not have been grasped by all partners.

The MOU was to "***make structural changes in state policy and practice, to make health services more accessible to people*** *who need them the most including very poor and marginalized groups, tribal people inhabiting remote hamlets, women and other people at risk****, mainly by strengthening community health , primary and district level health delivery systems; health surveillance, epidemic control and comprehensive reforms in policies, laws, programmes and institutions for realizing the vision of "Health for All".***

The SHRC was to be staffed by persons with vision and perspectives, combined with competence, organizational and technical skills, with an ability to work with governments, NGOs, civil society and communities. Interestingly recruitment processes included "head hunting" (the process of searching for a very specific sort of person through a number of formal and informal means – ref. -SHRC HR policies and procedures).

The SHRC had one staff member, as programme coordinator of the *Mitanin* programme from March to September 2002 who continued subsequently. At the end of September the Director, who was earlier involved in a couple of meetings and some discussions in the previous six months, joined SHRC. The first two months were spent by the new director in understanding the programme, visiting all the districts and beginning the recruitment process to staff and develop the SHRC.

In a relatively short period of time, by March 2005, that is in two and a half years, the SHRC has grown to a 33 member team and has initiated a significant amount of work related to the reform agenda as described in the MOU. During this period the SHRC adopted a "blistering pace" of work, operationalising many aspects of their mandate and driving the agenda that had evolved collectively. Though this has been critiqued by some, there was undoubtedly a need to take the Mitanin programme to a larger statewide scale. There are important lessons from this experience, especially as the ASHA initiative is being implemented in much larger states.

It was decided to pilot test the *Mitanin* programme at a block level by working through partner NGOs. Negotiations were held with some of the larger, more established NGOs in the state to join this process and the mitanin training programme was started in 14 blocks from May 2002. It was understood that further development of this initiative would take place one year later, based on the learning of this phase. Separate memorandums of understanding were signed between the

RCH Society, Action Aid India (AAI) and different NGOs. These were signed by the Director of Health Services and RCH Society for the GOC, the Regional Manager of AAI and the Director of the respective NGO. Without waiting for completion a year, the up scaling of the *Mitanin* programme started around November 2002, working through the District RCH Societies and through a variety of mechanisms and partnerships that evolved at block level. Some depended on ANMs for training, others in collaboration with local NGOs where they had a presence. Nodal officers, who ranged from medical officers, public health nurses etc, played a role, along with field coordinators and other SHRC staff to establish those arrangements, which used existing institutional bases and linked with civil society and others, demonstrating flexibility and creativity. There were differences of opinion in the SAC about the up scaling, and some saw this as a breach of trust.

While SAC was a 'high powered' advisory think-tank that had conceived of the idea, the SHRC became the executive arm. The potential for differences of opinion leading to some polarization of views and approaches became real and there was a distancing between the two bodies over time[*]. The SHRC became the dominant player, establishing close linkages with government and health department officials at state and national level over time.

The SHRC later registered as a Society, with a governing body. This shift of institutional arrangements reduced the role of the State Advisory Committee and some of the earlier partners, including civil society groups in Chhattisgarh. Methods of handling dissent; negotiating with several stakeholders at different levels; responding to varied reality sound bytes from the field; and handling shifting power relations are part of the complex tasks of the SHRC. How different groups that are involved handle these relationships influences the health initiative. *Given the important role the SHRC is playing, and the way it has positioned itself, it is important for the governance mechanisms to function well.*

## 6. Review of Achievements[2]

The SHRC was expected to facilitate the reform agenda of the State of Chhattisgarh (health sector reform was funded by the European Commission as part of its nation wide Sector Investment Programme). In this context, the following observations are made:

- Chhattisgarh is a newly established state and the health department is not fully functional. Large vacancies among Director and Deputy Director levels exist. Chhattisgarh does not yet have a State Institute of Health and Family Welfare (SIHFW), which in other states is expected to provide the Department with technical inputs and coordinate the ongoing training and

[*] This was articulated clearly through discussions with several respondents, as well as in print (ref. Binayak Sen, Myth of the Mitanin, June-July 2005, MFC Bulletin)

[2] This part of the report relates to both objectives two and three of the TOR.

continuing education of health personnel. Currently the function of the SIHFW is performed by the SHRC which acts and is acknowledged (by senior technocrats in the Department) as a think tank, and by the Danida Support Unit which manages training related functions. The SIFHW, Chhattisgarh is expected to be functional later this year 2005.

- The SHRC was established in March 2002. However it became fully functional around July 2002. Given the relatively short period of functioning- July 2002 to March 2005, **the SHRC has accomplished a significant amount of work related to the reform agenda as described in the MOU.**

- Several of SHRC's initiatives have informed national and state programmes- the *Mitanin* programme is reflected in the ASHA component of the National Rural Health Mission, several human resource and rationalization of service components are in the RCH II plans of other states. Several of the GOC and SHRC initiatives have served as models for the newly created states of Jharkhand and Uttaranchal.

- The SHRC has been engaged in four major programmatic areas:
  1. The *Mitanin* programme,
  2. Health Sector Policy Reform,
  3. Response to ongoing ad hoc requests from the department for data, reports, presentations and generally functioning as a think tank,
  4. Function as an arm of the Department in designing, negotiating new projects with GOI and external donors.

- **The SHRC with its limited staff has been able to contribute significantly to policy and programmatic reforms with in a relatively short time**. However acceptance and sustainability of these reforms remains questionable. Unless they are pursued and commitments from bureaucratic and political powers are obtained, the likelihood of continuation remains limited. Health sector reform is a long haul process that takes place over an extended time frame. Implementation takes place in an environment of vested interests, constantly changing profile of actors, and is infused with politics, where technical analysis and policy prescriptions are first starting steps. In Chhattisgarh like in several of the Empowered Action Group (EAG) states, several challenges to health sector reform exist. Thus SHRC achievements need to be seen in a larger context of lack of decentralization, low capacity, low morale, and limited support for reform process at various levels of the hierarchy.

- **The flagship programme of the SHRC is the *Mitanin* Programme.** It is this that has given them visibility and the other achievements- in terms of policy support, technical assistance to the Department really pale in comparison to this politically high profile programme. It is to the credit of the SHRC that they have been able to ensure commitment and ownership through political and bureaucratic changes. SHRC has weathered these

changes, partly because of its efficacy in enabling a programme of this scale and the recognition from political and bureaucratic leadership that this task could not have been handled within the government establishment. Several lacunae exist, many of them remediable, nonetheless the SHRC is to be commended on the scope and scale of the programme which deserves continued and sustained support. From a community perspective however the *Mitanin* programme needs a lot of strengthening. A detailed analysis with recommendations are given in the second section of the report.

- The sector reforms package was intended to ensure that health systems performed efficiently and equitably to be able to meet the expectation generated by the community based *Mitanin* programme. However in a newly created state which literally had to begin establishment of a range of systems, deal with manpower issues, and ensure effective management, the absorption of reforms by poorly motivated staff is bound to be slow paced.

- Also it cannot be expected that SHRC developed policies can transform organizational or political processes that affect actual implementation. The workforce study, for example, is a masterpiece of explicit analysis of the situation, clear policy directives and clear statements of intended outcomes. Nevertheless this could not by itself affect significant change.

- An important "missed opportunity" to trigger and sustain health sector reform has been due to lacunae in the *Mitanin* programme. The *Mitanin* component offered SHRC and the GOC the opportunity to transform the system because the demands generated by the community (based on the *Mitanin's* work) should have enabled greater responsiveness by the system and thus both policy makers and direct implementers at the district and local level in health and health related sectors (Public Distribution System, *anganwadis,* etc) would have been forced to act. However because the *Mitanin* programme was greatly accelerated, compromising selection, training quality and supervisory support, the micro processes that lead to intensive community engagement have not yet occurred.

- **Human Resource Development (HRD) and Training Policy**: Over the last two and a half years, SHRC has worked on a human resource development policy for the Directorate of Health Services, and provided inputs to the training strategy, design, development of training material, and training of trainers for a range of providers including *dais,* multipurpose workers (health assistants), and medical officers. The formal training/HRD policy was developed by SHRC and sent to the Dept. of Health and Family Welfare (DHRW) on 25$^{th}$ October 2004 and approved on 11$^{th}$ December 2004. The training policy has clear cut goals and objectives which if implemented will help improving access to quality health care. It outlines in detail the number of existing and proposed public sector training institutions to meet the training needs in the state. There has been a detailing of the content of training as well as requirements regarding the training of trainers. The proposed State Institute for Health and Family Welfare (SIHFW) has

been given a key role in providing the vision, direction and over-all guidance to the operationalization of the training policy.

- The goals of the training policy mention the need for '*requisite skills required for full capacity, utilization and effectiveness of health services*'. It is also necessary however for participants to develop an adequate knowledge base, good interpersonal skills / attitudes and an understanding of the social realities (including social stratification) within which they need to function The actual training, follow up and supervision was managed by the Danida Support Unit and the Directorate. Both acknowledge the high quality input provided by SHRC to the training component. Most of the medical officers in the field were for the most part, appreciative of the standard treatment guidelines. In conjunction with the Essential Drug List (EDL), many perceived the training to be useful in their daily work.

- **Workforce Development Study**- Health Sector Reforms- SHRC worked with national consultants to conduct a detailed study of rationalization of services, workforce management, and human resource development in the public health sector. The recommendations of the study were shared with all stakeholders on the GOC and civil society and the discussions and consensus resulted in policy formulation on-

- Human resource development, especially in-service training and multiskilling of all cadres,
- Policy on cadre restructuring and promotions,
- Policy on service conditions of health workforce
- Contribution to drug policies

- Of these policies the component on human resource development is being implemented. (For multiskilling, please see section on EQUIP). Part of the Drug Policy has been accepted and implemented, but its future remains tenuous given the power of the drug lobby and the munificence of the carrots dangled before the political and senior decision makers.

- The other two policy recommendations on cadre restructuring promotions and service conditions have not yet been implemented although they constitute important components of the reform process. Action on this critical component will be one of the measures to build up the morale of the health personnel and develop a high quality cadre. Currently, besides the large number of vacancies, a large number of even senior officials are only "in-charge" or holding temporary charge of their positions. Interest is therefore low adversely affecting work. Supportive supervision of staff in the periphery is also affected and needs to improve.

- **The Enhancing Quality of Primary Health Care (EQUIP) programme** is based on the recommendations of the Workforce Management study on rationalization of services using a block level approach. The original intention of EQUIP was to use a participatory process to enable Block Medical Officers (BMOs) to assess gaps in infrastructure, human resources, and equipment.

Based on this individual assessment, the Directorate would provide funding to ensure that each of the facilities received sufficient resources to close the gaps and ensure coordination between skills, equipment and physical infrastructure. Although envisaged for primary health care, the goals of EQUIP at block level were narrowed down to provision of Emergency Obstetric Services and round the clock institutional delivery.

- EQUIP was initiated in 2003 in 32 blocks (out of the total of 146 blocks) with the purpose of ensuring that each of the 16 districts would have two institutions at block level (CHC- Community Health Centres) to offer comprehensive care for obstetric emergencies. Planning involved the Block Medical Officers, oriented to conduct needs assessment and develop specific plans. SHRC facilitated the multiskilling training process, conducted in three teaching medical institutions. A good relationship has been built by SHRC with the three institutions, ensuring a good quality training with provision of teaching material. Teaching staff suggest a longer duration training programme so that participants get enough experience and confidence to conduct the surgical or anesthetic procedures on their own. Review of the records shows that, to date, 27 of 32 First Referral Units have the physical infrastructure; all of them have an anesthetist and obstetrician (trained through the four month multiskilling process). Available data indicates however that only 19 Caesarian sections have been conducted so far. The team visited a few CHCs. Findings from some CHCs are tabled below.

Table 9 – Implementation of EQUIP in some CHCs

| Name of CHC | FRU- Physical Status | MO trained in Anesthesia | MO trained in Obstetrics | Obstetric load | Comments |
|---|---|---|---|---|---|
| Dondergaon | Equipment in place, Theatre repaired<br>-No blood storage facility | BMO is a trained anesthetist | Lady MO just completed four month multiskilling course | Sixty deliveries per annum, no MTP services (04-05) | However the medical officer trained obstetrician is unsure of ability to actually handle obstetric emergencies, concerned about lack of indemnity and issue of what cover to expect in case of problems, and has not independently handled any CS during her training. |
| Balot | Equipment delivered one year ago-Boyle's apparatus has one cylinder missing<br>-No blood storage facility | MO trained in short course anaesthesia- in place since October 2004 | Two gynecologists- in CHC for several years | About 75 deliveries /annum, (04-05), 38 referred to district, 10 MTP per year | Interpersonal problems between gynaecologists and the anesthetist, thus they do not want to work together jointly, averse to taking risks, easier to refer to Durg district hospital |
| Dharamjayagadh | Equipment delivered, theater fixed, no leakages, | Anesthetist returned from training early | Gynaecologist in place, but not sent for training, | 69 deliveries /annum, 24 MTP | Boyle's apparatus, can't be used- complained several |

| | | | | | |
|---|---|---|---|---|---|
| | AC installed, -no blood storage | April 2005 | MO trained in short course obstetrics, but refuses to conduct deliveries | | times over past year to CMO, no response |

- Discussions with doctors who have undergone the training and visits to the other CHCs (see list) revealed that for a variety of reasons (lack of equipment, inadequacies in operation theatres, staff mismatch) a large majority could not put their new knowledge and skills into practice. However all of them appreciated the quality of the training, the materials given and follow-up during the course.

- Thus it appears that meeting the gaps alone is insufficient in ensuring improved obstetric care. Another factor that is at play here is perhaps the relatively high number of deliveries being conducted by ANMs and LHVs in the periphery. Delivery loads were higher in the PHCs and SHCs visited. They were being conducted by the multipurpose worker (female) in the center/or in women's own homes. This is an encouraging sign that more women are accessing "skilled attendants". However, the ability of the First Referral Unit (FRU) to perform is at the heart of resolving the maternal mortality issue. There are also many parts of the state where PHCs and SHCs lack buildings, staff and supplies, where deliveries cannot be conducted.

- SHRC staff are closely involved with the design, and supervision of the multiskilling training. Detailed progress reports on each of the medical officers trained are prepared and they are followed up rigorously during the training period. SHRC staff monitor the inputs and outcomes at the EQUIP blocks, and have evolved systematic processes to do so, but beyond bringing lacunae to the attention of the Directorate officials there is little direct action. Few field visits have been made until now in connection with EQUIP monitoring. Some transfers have been stayed to ensure that the team is not disturbed. Much more work with active follow-up in the field is required to make this functional and to expand to the remaining blocks within a realistic time frame.

- **Primary medical care needs of communities:** The response by the DHFW, SHRC and the DANIDA – support unit to the above need, by enhancing knowledge and skills through provision of training and supplies to auxiliary nurse midwives (ANMs), multipurpose workers (MPWs) and trained birth attendants (TBAs), is a rational and good approach. This approach strengthens existing health assistants who already have a basic knowledge and are a part of the health system. However despite these good efforts the gap in access to primary medical care still exists at community level, and needs to be addressed by the state as a priority. As mentioned in Section II the Mitanins could play a role in this, but after longer and better hands – on training, assessments and with systems in place that ensure supportive supervision and supplies. This approach may need to be implemented in a phased manner, in places where experienced trainers are available. The financial and operational aspects need careful

consideration, including integration with the primary health care and referral system.

- **Documentation and writing** are one of SHRC's core activities. This is another area of impressive progress. Both in quality and magnitude of subjects, SHRC has contributed to the literature and has pioneered several publications. The Essential Drug List, Drug Formulary, Standard Treatment Guidelines have reached the peripheral health facilities in Chhattisgarh and have been appropriated for use by Jharkhand. The SHRC publications (listed in the bibliography) both in English and Hindi are of good quality technically and in terms of presentation. The number of publications is large, for the short time in which they were produced. While SHRC's publications have acceptance within senior policy makers in the state and elsewhere, there is however little to suggest that other officials of the Directorate and medical officers at district and below appreciate or indeed are aware of these documents.

- The SHRC has accepted a number of **young professionals** from different parts of the country into their midst **to do their fellowship / internship and to work on dissertations**. The mentorship has been motivating and good. The team has provided a learning environment with a lot of openness and time for discussion.

- The **overall academic approach** used within the SHRC team enabling their professional personal and team growth; and through workshops for government and other staff; and the research work initiated through internal evaluations and studies has established a sound base for further development of the concerned health personnel, which can potentially positively impact on the health interventions. SHRC so far has been a learning organization, generating a tremendous amount of energy. A research based academic approach has generally not been used by the DHFW. This is a very welcome and useful introduction into the state health services by the SHRC.

- However there is a danger of the SHRC leadership and team taking on too much, with possible burnout, and loss of quality.

- SHRC has certainly provided **additional technical support** to the Dept. of Health and Family Welfare, GOC. However one has to consider whether a dependency has been created on it or whether there has also been a growth in technical and operational capacity within the department. It can be very convenient for the DHFW to have competent and willing workers on whom responsibilities can be offloaded. But this will not strengthen the department, though it could potentially undermine and even fragment it. It could also set a precedence to rely on sources outside the department; on consultants who may not have long term interests in the state. Alienation of health department staff may occur, resulting in a further reduction of their involvement. Capacity building in public health, wihin the Department is still a major gap.

- One area of concern is the **rapidity of scaling up processes**. This is clear in the *Mitanin* programme. In the EQUIP programme too, the state plans to expand

the process to an additional 50 blocks, beginning April 05. SHRC has been unable to halt this rapid expansion. There is little evidence that there is effort in doing so

- A second area of concern is the **limited involvement of civil society partners in the process of sector reform.** Over the past few months, discussions and document reviews show that increasingly the dialogue is between the government and SHRC. This is in a sense negates the idea of the MOU, and invalidates the role of the State Advisory Committee (SAC). The SAC expected to be a sounding board for the SHRC, has not met for several months and some of its members appear removed from and critical of SHRC functioning. It is likely that the caution constantly advocated by SAC members on too rapid up - scaling, on inclusion of organizations of integrity, to steer clear of political interests, actually impeded the SHRC from gaining legitimacy in the politico-bureaucratic arena. SHRC perceived that the exercise of such caution would reduce their image of efficiency with the system in Chhattisgarh and at national levels. SHRC somehow failed to achieve a balance between these two constituencies.

- **Several partnerships have been developed with NGOs/civil society for the Mitanin programme** at different levels (state, district and block level). Several of them are working well for instance in Manendragarh, Raigarh,Ambikapur, Bastar, Dantewada and Dhamtari. This involvement has helped the programme to perform better; the NGOs to enhance their capacity and increase the scope of their work; and the community to get greater space for participation as well as to get better services. Some partnerships with NGOs / civil society have not worked that well. One hears that the capacity of NGOs are varied. It is reported that new NGOs have emerged as the programme grew in importance and visibility, some with diverse interests and capacities. Partnerships need to be managed and fostered keeping community interest as priority. This is a new experience for block level staff of the DHFW. The over-extended SHRC team have played a pro-active role in this regard.

- A **community perspective** that emerges from the *Mitanin* evaluation and from several civil society members indicates that despite a lot of efforts there is still an ***implementation*** gap. The public health system is still not seen as performing adequately, making access to health care difficult. The *Mitanins* are in place, but need more capacity building, supplies and support from the health system.

- **Buy in and Ownership**: The Directorate appreciates SHRC's role and support. However, since SHRC as an entity does not belong within the system, it is not incumbent on the Directorate or bureaucrats to accept SHRC's recommendations. This applies to the harder to swallow areas of health sector reform.

- **Quality of implementation, supervision and functioning of the public health system**: How much can SHRC actually influence this? The challenge is to draw the line between supporting the department and actually undertaking the

department's work. While implementation and follow-up in the field is strictly not the role of the SHRC, the intent, goal and role of the SHRC in strengthening key aspects of the public health system get limited if major improvements do not take place in the functioning of the health system. Experience of field visits for the SHRC evaluation and feedback from the Mitanin evaluation suggest that there is still a long way to go in strengthening the public health system. This is an indicative and not a definitive statement. Though the time period from launch of the initiative in 2002 was short to achieve significant change, the momentum of strengthening the health system needs to be much stronger. In some institutions visited it was evident that infrastructure and staffing had improved and there was a fair degree of utilization of services. But we were possibly taken to the better institutions. Even so, there were health centres that appeared non-functional. The SHRC also had to develop its own team during this period and shoulder too many responsibilities. There was however a greater focus on the *Mitanin* programme than on health sector strengthening. *A greater balance may need to be achieved in future, with adequate number of staff and resources allocated from SHRC for the latter component.*
*The DHFW too needs to take greater, if not the prime responsibility for health sector strengthening.*

- **Institutional Arrangements**- The establishment of the SHRC through an MOU between an NGO donor agency (Action Aid India) and the Government of Chhattisgarh is a unique arrangement and really has no precedence in any other state in the health sector. Action Aid India staff were closely associated with SHRC and involved in key decision making processes during the first two – three years. There is some evidence of discomfort of late with the shift of SHRC closer to the system and their perception that compromises are being made in the micro processes of reform - such as community engagement, fostering activism, expanding the scope too quickly, and "choosing a route of political negotiation rather than staying with bureaucratic processes". However the support in the early period was critical in getting SHRC functional and a combination of leadership within the SHRC, AAI, and the GOC set in pace the entire agenda and ensured buy in from all stakeholders.

- It appears that SHRC will need to make a choice between continuing to stay within the system's sphere of influence and ensure that they are part of larger macro processes and in the forefront of policy at state, regional and national levels, or be content with a technical support and capacity building role. SHRC's future choice is closely linked to the direction the *Mitanin* programme takes.

- **Support from GOI:** The Govt. of India has recognized the health initiatives in Chhattisgarh and have involved state government and SHRC representatives actively in deliberations concerning EAG states; the National Rural Health Mission; the RCH II planning process etc. The GOI has backed the support from various donor agencies and programmes. The SHRC has been instrumental to a large extent in taking the Chhattisgarh experience to the

national level and participating actively in the health planning process at the national level.

- **Sustainability:** As mentioned elsewhere the different health interventions have been sustained over changes in government and changes of key government personnel. There seems to be recognition by many at central and state levels that health sector issues cannot be further neglected. However there are a variety of competing interests that intersect, including those interested in strengthening processes of privatization and commercialization of the health sector; to others for strengthening the public health system; increasing the role of AYUSH etc. *It is important for the SHRC and a wider core group to keep their focus and be proactive in taking measures and monitoring the strengthening of the public (government) health system. This was one of their key mandates.* The temptation to get involved in a variety of initiatives at state, national and other levels may divert their attention and energies. And sooner or later the window of opportunity to leverage change may close.

- **Donor support:** SHRC has been part of the negotiation team along with GOC officials in negotiating with donors such as the ECTA of the European Commission, DANIDA, RCH and others. The SHRC team have provided timely and professional help with preparation of project proposals and reports besides participating in discussions. Their technical assistance has been valued by GOC. The participation and support of Action Aid India has been invaluable not just as a donor, but as a partner in equitable development.

## Institutional aspects of SHRC

- **Human Resources in SHRC:** In terms of expertise, skill, and capacity, the SHRC team is comprised of individuals with a composite of skills that enables it to play the role it does. Currently it has a small team with a reasonable skill mix. However there is need for more people with expertise and experience in community health, public health, including health worker training[3]. At the Raipur office the SHRC is headed by the Director with three programme coordinators. While each of the Programme Coordinator (PC) has a specific job description, they are aware of the entire programme, although not in depth. The PC in charge of the *Mitanin* programme is almost a deputy to the Director and has far more in depth understanding of the *Mitanin* and health sector reform agenda issues.

- All the staff of the SHRC display a high level of organizational and professional commitment, a substantial majority is also very enthusiastic, motivated and competent, in a learning mode, and dedicated to the vision of the organization. These traits are reinforced by the leadership of the Director who leads by example.

[3] It is not easy to find such people, willing to relocate in Chhattisgarh.

- Overall there is an environment of openness within the SHRC team which has contributed to the early and rapid growth phase. However communication is mutually strained at an institutional level with some groups as indicated earlier.

- There are an inadequate number of experienced staff who can work on health sector reform/strengthening.

- The structure is bottom heavy with almost all field staff focused on the *Mitanin* programme. Their participation in the health sector strengthening process, apart from monitoring referrals and satisfied users is limited. There are 25 field coordinators, of whom ten are female; seven belong to SC/ST and six to OBC.

- However all the staff are stretched for time and are constantly working under time constraints and do feel pressured. For the programme coordinators, the task of dealing with the system is not stress free, although the Director is the key contact point. Day to day implementation requires constant interaction with several officials in the department and at the district levels and they are not always cooperative. The SHRC staff has two sets of tasks- one to attend to their day to day responsibilities and second to respond to ad hoc requests. Together the two constitute a substantial work load. It is perhaps only a matter of time before the burn out begins to show.

- There are no intermediate structures between Raipur and the district, particularly for monitoring the health sector reform agenda. The field coordinators are hugely overworked. Each covers five blocks and given the topography spends most of their time in the field traversing vast distances.

- SHRC has well established systems for work review through regional and state level staff meetings. At Raipur staff meet on an ad hoc, but at all times staff appear to have a broad understanding of current status. Morale is high and the work culture is conducive to good performance.

- The **financial systems** within SHRC are well established and function well. There has been an under utilization of budgeted and available funds. Printed annual reports of the SHRC could give the audited statement of accounts.

- **Fund flow delays** are common and this is reflected down to the block levels. This has been a major constraint as will be seen in the *Mitanin* evaluation. There are delays in payments to field staff (BRPs/*Prashikshaks)* and in drug supplies. These delays can seriously hamper the initiatives.

- SHRC has developed its own **institutional policies and procedures** and sometimes adopted Action Aid policies. It has an HR Policy and Procedures Manual, Accounting Manuals, and an Operations Manual which are open to staff. The HR policy is sensitive to women's needs and supportive of additional capacity building for those who opt to continue their education further

## 7. Overall Recommendations for the SHRC

- With greater autonomy of SHRC as it institutionalizes more and more the **governance systems** through the governing body etc needs to be stronger, with members giving it more quality time and efforts to ensure social accountability. There is need for brainstorming about SHRC's longer term role in relation to its mandate, and its linkages and positioning vis a vis the DHFW and other bodies such as the State Advisory Committee, the State Institute of Health and Family Welfare (SIHFW), the State RCH Society etc. The goal as mandated is to strengthen the public health system. The timeframe and boundaries of SHRC functioning could also be discussed.

- Undoubtedly the success of **the *Mitanin* programme** with a focus on increased community awareness and empowerment will drive the health sector reform / strengthening process. Recommendations regarding the *Mitanin* programme are given in the second section of the report. The role of the SHRC is as technical support group in giving direction; providing content; developing educational material for different levels; training of trainers, facilitating ongoing assessments and evaluations. SHRC could further develop these areas, and be a group to make sure that community processes are strong and the programme works at the field level.

- Finally however **policy implementation remains firmly within the arena of the health department at all levels**. SHRC should find policy champions, constantly engage in constituency building, (strategies- bargaining, negotiating, marketing, and building strategic alliances). Enable civil society partnership and participation- over a period of time this pushes for transparency and accountability, set up monitoring and evaluation systems that include public sector functioning, civil society action and community perspectives.

- Acceptance of sector reforms and strengthening the public health system is contingent on a host of politico-bureaucratic and other motivations over which the SHRC can really have no control. However if one envisages this as the first phase of familiarizing the system and the second phase of ensuring that at least the technical components get ingrained into the system- key among them being the EQUIP programme to strengthen primary health care, the referral linkages between the *Mitanin* and the system (strengthening the *Mitanin* is key to create pressure on the system), and implementation of the Drug Policy and the Workforce study recommendations.

- **Training Policy:** SHRC could have a stronger nodal group of 2 – 3 experienced community health trainers to facilitate the further implementation of the training policy in close collaboration with the DHFW, SIHFW and the DANIDA support unit. Focus could be on:
- A variety of interactive, participatory, learner centered teaching learning methodologies could be used to help participants develop the necessary knowledge, skills and attitudes. Use of relevant role-plays, simulation games, exposure visits etc could be evolved.

- It is very necessary to have a focus on primary health care and the new public health as a common theme for all levels of training. This requires conceptual clarity as well as good communication.

    - The financial requirements of the training programmes that are being proposed need to be outlined in greater detail on a annual and longer term basis. Reviews of training programmes also need to be built into the planning. Mechanisms to follow-up trainees in the field, to provide supportive supervision, and to ensure that the new skills are being applied in the field is most critical. Earlier training reviews at the national level have shown that despite large expenditures on training the outcomes and impact was poor.

    - Doctors trained in Obstetrics and Anesthesia under the EQUIP programme in Chhattisgarh have not been able to practice their skills at the time of this evaluation in April 2005 for a variety of infrastructural and management reasons and also due to lack of confidence by some to undertake the surgeries / procedures independently. Newly acquired skills get lost fairly soon if they are not practiced, leading to frustration among the professionals. Follow-up is required to ensure operationalisation at field level, with mechanisms set up to get feedback from doctors and health personnel so that necessary action can be taken. The newly trained doctors could work in their district hospitals for a few days a week, to get the necessary hands-on experience with help.

    - An integrated approach to training in keeping with the approach of the National Rural Health Mission will need to be evolved, as against the previous programme and donor driven fragmented approach, be it RCH, RNTCP, HIV-AIDS or Malaria training programmes.

- **Linkages with the SIHFW:** The role of SHRC and its relationship to the State Institute of Health and Family Welfare (SIHFW) will also need to be clarified to avoid duplication and confusion.

    - The SIHFW is a long term institutional mechanism to conduct higher level training programmes at state level for a variety of health personnel which should function as an autonomous institution. It could also possibly undertake operational and action research or facilitate this through other academic institutions in the state. The necessary infrastructure will need to be built up and maintained in keeping with its role.

    - Linkages with District Training Centres and Anganwadi Worker Training Centres and possibly with a University could enable the SIHFW to grow into the nodal public sector training and human resource development centre for the state.

- Careful staff selection as teaching faculty of the SIHFW will need to be done in keeping with its envisaged role. Post training follow-up and reviews to solve performance related problems in the field will require to be planned.

- **Publication of training material** will need to be continued and newsletters can be considered, with inbuilt feedback mechanisms for responses by departmental staff and other participating groups.

- This is a good moment for **SHRC to re-define its targets and goals**, making them more realistic. This could be done in a collective manner with the different stakeholders.

- **Financial requirements for different components** have been outlined in various reports, using this base and adding components that may be left out a higher financial planning process for the DHFW needs to be undertaken for the next 10 years with potential sources of funding from state, central and other sources.

- **Health promotion** could be given a separate budget. Money from tobacco taxation could be considered a source. A health promotion unit could also be developed.

- As part of **human resource development,** young DHFW staff could be sent for post-graduate studies in a range of disciplines under the broad umbrella of public health. A pool of clinical specialists (anesthesia, psychiatry etc) also needs to be built up, along with allied health professionals (public health nurses, counselors, health promoters etc).

- **District training teams** for both arms – health sector strengthening and trainers for the Mitanin Programme could be developed.

- **Career pathways and incentives for heath department staff** could be built up.

- Creative use of **mass communication methods and folk media** could be continued with adequate financial and organizational support as an ongoing mechanism for health awareness among the community.

- **Report cards on health institutions** by the local public done at judicious intervals would provide public feedback to the institutions.

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**ANNEXURE 'I'**

## DISTRICTS AND INSTITUTIONS VISITED FOR SHRC EVALUATION

**I. RAJNANDGAON DISTRICT**

a) Rajnandgaon District Hospital
   i) Dr. Moti Ramani, Civil Surgeon
b) Dondergaon CHC
   i) Dr.Devdas, BMO
   ii) Dr. Manisha Kesar
   iii) Mrs. Pushpa Veera, BEE, also DRP
c) Kappa PHC
   i) Dr. Pradeep Kundu, MO/IC
d) Kujji Sub Centre
   i) Mrs. Kiran Yadav, ANM

**II. DURG DISTRICT**

a) Balot CHC
   i) Dr. Claudius, MO/IC
   ii) Dr. Padmavathi
   iii) Dr. Gore
b) Sankra PHC
   (PHC shut – no staff available)

**III. RAIGARH DISTRICT**

a) Dharamjayagadh, CHC
   i) Dr. Bhagat
b) Seesringa PHC
   i) Mrs. Malathi Ratiya
c) Gersa Sub Centre
   i) Mrs. Suhani Ikka, ANM
d) Gersa Village
   i) Mitanin Discussion

**IV. BASTAR DISTRICT**

a) Nodal officer –Ms. Shalini Raj, District Public Health Nurse
b) Field Coordinator – Mr. Ram Jaj Gond
c) District Resource Person (DRP) - Ku. Mamta Sikdar
d) Maharani District Hospital, Jagdalpur
e) Bakaawan CHC/FRU
f) Chiyoor Subcentre
g) Makdi CHC /FRU, Dr.S.Soni
h) Shampur PHC

**V. DANTEWADA DISTRICT**

a) Mr. Om Prakash Burman, Field Coordinator
b) Dantewada District Hospital
   i) Dr. Chetan Dahariya from Geedam CHC, also block nodal officer
   ii) Dr. Alka Soni
c) Pratibha Vanvasi Chetna Ashram (Partner NGO)
   i) Sri Himanshu Kumar and Smt. Veena and team
   ii) Ms. Bhuwaneshwari, DRP
   iii) Ms. Ambati Yadav – Prashikshak
   iv) Ms. Sangeeta Bagha – Prashikshak
d) Bhairamgarh CHC
e) Tamnan PHC
f) Durparas Sub-Centre

**VI. KANKER DISTRICT**

a) Kanker District Hospital

**VII. Dhamtari District**

a) Shri. K. R. Bhosale, DRP
b) Dr. Thakur, Medical Officer (TB and Leprosy)
c) Dr. Shandilya, CMHO
d) Dr. A. D. Purena
e) Dr. Y. K. Singh
f) Ms. Satyavati Gajendra, BRP
g) Shri. J. Kalihari, DRP
h) S.R. Tandon, Trainer

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## ANNEXURE 'II'

## LIST OF PERSONS MET FOR SHRC EVALUATION

1. Mr. B. L. Agarwal, IAS, Secretary Health & Family Welfare, Govt. of Chhattisgarh (GoC)
2. Mr. Sunil Kujur, IAS, Secretary, Women & Child Development, GoC.
3. Dr. A. K. Sen, Director Health & Family Welfare Services, GoC.
4. Dr. Atre, Joint Director, GoC.
5. Dr. Pramod Singh, Joint Director, RCH, GoC.
6. Dr.Subhash Pandey, Deputy Director, RCH, GoC.
7. Dr. Madangopal, Danida Support Unit, Raipur.
8. Mr. Harsh Mander, Chairperson, SHRC Society, Delhi (previously Director, Action Aid –India when the process started).
9. Prof. Babu Mathew, Director, Action Aid, India, Delhi.
10. Mr. J.P. Mishra, European Commission Technical Assistance (ECTA), Delhi.
11. Mr. A. B. Singh, Externally Assisted Projects, Ministry of Health and Family Welfare, GoI, New Delhi.
12. Dr. T. Sundararaman, Director, SHRC.
13. Mr. Biraj Patnaik, Regional Manager – Action Aid India, Raipur Offie.
14. Dr. Binayak Sen, PUCL and National Alliance of Peoples Movements, Raipur, Member, State Advisory Committee (SAC).
15. Dr. Yogesh Jain, Jan Swasthya Sahyog, Member Governing Body, SHRC.
16. Mr. D. N. Sharma, Member Governing Body, SHRC.
17. Mr. Lakhan Singh, Member Governing Body, SHRC.
18. Mr. V. R. Raman, Program Coordinator, SHRC.
19. Dr. Premanjali Deepti Singh, Program Coordinator, SHRC.
20. Dr. Kamlesh Jain, Program coordinator, SHRC.
21. Mr. Komal Devangan, Accounts Officer, SHRC.
22. A number of field coordinators of SHRC in two group sessions and individually.
23. Mr. Jayant Bagh and Ms. Pratibha, Research team; SHRC.
24. Some NGO partners -
    - Mr. Himanshu Kumar, Pratibha Vanvasi Chetna Ashram.
    - Mr. Iqbal and Mrs. Kalavathy, Adivasi Harijan Kalyan Samiti,
    - Sameer and Sulakshana from Manendragarh district (very briefly)
25. Two groups of doctors from CHCs in different districts undergoing 4 month training in Anaesthesia and Obstetrics at Raipur Medical College and Sector IX Hospital.
26. Group meeting organized in June 205 by SHRC with NGOs from different parts of the state. (/this was for discussion on he draft report).

**ANNEXURE 'III'**

# NARRATIVE REPORT REGARDING MITANIN TRAINING PROGRAMME IN DANTEWADA AND BASTAR DISTRICT*

(by Dr. Thelma Narayan)

**Visit to Dantervada district, 1st April 2005**

**I.** **Meeting with** 40 mitanins, 7 prashikshaks, 2 DRPs, the field coordinator and NGO leader from Pratibha Vanvasi Chetna Ashram at Kutru Village,Dantevada block. We met for about 2 hours under a large tree.

**Background:** Kutru is 110 km from the district headquarters at Dantewada . Dantewada is one of the largest blocks in Dantewada district about 150 km across. People are mainly adivasis, speaking *gondi* and *halbi.* It is predominantly a forested area with widely dispersed villages, within which *paras (*hamlets) are spread 2 -3 km apart. It is largely a forest based subsistence economy. Bullock carts are not yet used in this region. People transport goods tied to bamboo sticks which are carried on the shoulder while they walk long distances to the weekly market. Some including the prashikshaks cycle. Buses ply on the main roads only. Seriously ill patients have to be carried. Levels of education and literacy particularly of women is low. This is an area reportedly with a strong presence of naxalites, who incidentally extended support to the mitanin programme after a study of the manuals and a discussion with the field coordinator.

Six blocks of Dantewada district mentioned below were covered under Phase I of the mitanin programme. In five blocks the programme worked in partnership with NGOs (mentioned below), through the district RCH society.

a) Pratibha Vanvasi Chetna Ashram covers 2 blocks (Dantewada and Bhairamgarh). This NGO under the leadership of Sir Himanshu Kumar has been in Dantewada since 13 years. They work in watershed development, rural sanitation, education of children, and health is inspired by Gandhian philosophy and by Sri Vinobha Bhave.

b) Prajya Seva Ashram covers Kuakonda block.

c) Adivasi Harijan Kalyan Samiti covers Chindgarh block.

d) Ramkrishna Sadar Seva Ashram covers Katekalyu block.

e) Geedam Block programme is run directly by the Govt. Block Medical Officer (BMO).

In the second phase five blocks was covered, namely Bijapur, Sukma, Usur, Konta, Bhogatpatnam.

**Observations from the meeting**

There were differences in the knowledge and social skills in the group which was a mix of mitanins and their trainers. The DRPs and prashikshaks though younger were more educated (some were doing their post graduation through correspondence courses). In this case they were identified by and work through the NGO and their payments are ensured even if there are delays in fund flows from the district level. They traveled to work on cycles. Mitanin training programmes are conducted in the NGO training centre. They have leadership abilities, self confidence, social mobilization and group skills. Their knowledge and skills in health work could be deepened. The 40 mitanins were all women in the age range of 20 – 45 years. They were mainly the daughter- in -laws of the village. In these remote areas it is an achievement and effort for women to come out of their homes for a social purpose. They seem to enjoy this. Some who were longer in the programme were more empowered and confident to speak. They narrated experiences in an authentic manner. Two examples of collective action taken by the mitanin groups, mentioned below were confirmed by the others.

a) The village primary school teacher was a heavy consumer of alcohol and often came late or not at all; slept in class and did not do much teaching. The mitanins discussed this in their meetings and decided to take action. They complained to the concerned authorities and after the issue was looked into the teacher was changed. They are happy with the new teacher who is diligent.

b) The ANM was not doing her work properly. After discussions with her and recognizing the difficulties that she faced, the mitanins began assisting her by collecting children for immunization and bringing mothers for antenatal care etc. They are now satisfied with her work.

On independently talking to an ANM in the nearby Kutru PHC she also said that the mitanins are very helpful.

The mitanins present had undergone different rounds of training and varied greatly in their knowledge of health issues eg. ORS, Malaria presumptive treatment, recognition of TB etc. A few had understood the concepts to an extent and appeared to have a little experience of actually handling cases. A larger number knew a little bit but did not seem to put it into practice. Others had very little recall. They had not received the drug kits and this could be one of the reasons. They were more enthusiastic and experienced in using local herbal remedies. They all warmed up and participated in singing health and mitanin songs in different languages. They complained that the local PHC doctors asked people to come to his house in the evening and charged them for services that were to be free. They felt his treatment was not good. This was based on their own personal experience. At the end a few raised the issue of need for an honorarium.

On visiting the PHC which was visible very close by we were accosted by armed men with revolvers in civilian clothes who said they were from the CRPF. They questioned us in some detail about who we were, what the meeting was about who organized and ran the meeting etc. They had apparently been keeping an eye on us throughout to check if we were naxals. We hear that there are more CRPF units than PHCs in the area.

**II. Meeting with seven mitanins in Medse village, Geedam block, Dantewada district** Ist April 2005

We met the group in a small remote village hamlet when it was already dark. They were older, more confident and knowledgeable about pregnancy, TB, diarrhoea. The Geedam block mitanin programme is run by the BMO. Three of them had undergone a ten day dai training programme after becoming mitanins and had conducted 4 -5 deliveries each. They refer patients and often accompany them to Geedam CHC which reportedly functions well. This was confirmed by the field coordinator. They know and use a variety of herbal remedies which they described. One was elected as a member of the Gram panchayat and another was a GP Sarpanch. They had a good set of songs and participated in singing very tunefully. They reportedly have weekly mitanin meetings and less frequent Mahila Swasthya Samiti (MSS) meetings. In the SHRC field coordinator's experience where the MSS are strong the mitanins work is better. While mitanins initially experienced a little resistance from their husbands, this had changed over time to active support; we saw some of the husbands waiting to take their wives back on their cycles.

**III. Met two mitanins at Dantewada district hospital**

The NGO, Pratibha Vanvasi Chetana Asheram has taken the initiative to have two mitanins to base in the new district hospital inaugurated in January 2005 at Dantewada as a 'help desk'. They talk to patients who come from distant villages and help them with registration, direction to the concerned department/doctor etc.

**IV. Action by Prashikshaks**

A rapid nutritional assessment survey measuring weight for age of under five children was carried out in November 2004 by the Prashikshaks supported by the field coordinator. Out of a total sample of 10,852 children the findings were as follows:

Normal : 3675
Grade I : 3281
Grade II : 2467
Grade III : 934
Grade IV : 495

This report was handed over and discussed with the District Collector for follow up action as 25% of Bhairamgarh block does not have anganwadis.

**B**

**Field Visit in Bastar district 3rd April 2004 –Dr.TN**

The district nodal officer for Bastar district is a graduate (B.Sc) Public Health Nurse, having joined the MP Govt. Health Service in 1977. She is the only nodal officer who is a nurse, the others being doctors, sub collectors, ICDS officers etc. She had a fairly good knowledge about the scheme, but did not know the CHC and subcentre visited. She has good communication and training skills as witnessed. Nodal officers are part of the support structure for the mitanin programme at district level. They help to coordinate, take responsibility for fund flows and occasionally trouble shoot. She said that meetings of all district nodal officers at state level were held earlier, but not since the past year. Partnerships have been developed with the following four NGOs in Bastar district for the mitanin programme: (i) Participatory Action for Rural Development Society (PARDS), (II) Institution for Management of Participatory Action for Community Development, (IMPACT) (iii) Social Education and Basic Awareness (SEBA), (IV) TRIVE – A society for the development of tribal and rural people, with a focus on women and education.

I. **Visited Bakaawan Community Health Centre (FRU) in Jagdalpur district 30 km** away from the Bastar district headquarters at Jagdalpur. Met the DRP Ku.Mamta Sikdar who was a very bright, lively and confident young person who had earlier work experience with the NGO Participatory Action for Rural development Society (PARDS). Met 20 prashikshaks from different villages some as far as 70 km away. In the remote areas there were male prashikshaks (3 in this group). They had a very good set of songs in the local adivasi language. They also spoke Hindi well. They had a good knowledge of common medical problems, TB, malaria and the expected functioning of the PHCs and CHC. They were very enthusiastic and spontaneous. Many were graduates. It is reported that deaths due to gastro enteritis have been minimized in the past year. Malaria slides are taken and sent to the health centres. Getting results from the health centre is often delayed. Bastar is a thickly forested adivasi area endemic for falciparum malaria. Prashikshaks do not have experience of working in health eg in being able to diagnose common ailments, in managing patients with dehydration, using herbal remedies etc. Hence their training on these issues is theoretical. Their knowledge regarding health and disease is just a few steps ahead of the mitanins. They are also not conversant about pedagogical methods for teaching in health.

**II. Brief interaction with 40 mitanins at Primary Health Centre Village**

These mitanins were gathered for the second round of training in the second phase blocks. They had completed only 3 days of training in the first round. A senior health assistant from the government PHC and prashikshaks were conducting the session. The male dresser from the PHC who was present was obviously drunk. It was a one day training. Women come by bus and arrive around 10.30 – 11 am. The actual hours of training are very short. This group was much quieter, very shy and did not know much. They however all sang together very well. Some of them raised the issue of smaller payment during the second round as compared to the first round. The lunch for all was organized at the Anganwadi Workers house. Here too the complaint was that the amount given was less than the previous time. Adequate reasons had not been communicated to the participants and local organizers.

The **overall impression** is there is an evident gradation in levels of self-confidence, social skills and health knowledge if one compares mitanins from Phase I and II. There are the beginnings of empowerment of women at individual and group level. There is reportedly a relatively low drop-out / turnover rate among mitanins (reportedly around 5%) according to the field coordinator. However some are not actually functional in the field. There are long gaps between training rounds. For instance in Bastar district the training rounds for mitanins were as follows:

**I Phase**

Ist round – April 2003
2nd round - May 2003
3rd round – November 2003
4th round – July, August 2004
5th round – November 2004
6th round planned in May 2005
ie only five rounds of training ( 12- 15 Days) were completed so far.

**IId Phase**

Ist round – July / August 2004
2nd round – March / April 2005

From July 2004 work has been slow. When there is no training, the momentum of the programme reduces, and subsequently contact and work in the field declines.

Attrition of knowledge and poor recall would occur especially when what is taught is not put into practice. The dropouts among prashikshaks is said to be higher at about 10%. We were unable to get data about dropout rates.

**Issues concerning mitanin programme arising from discussions in the field.**

1. **Fund flows:**
   - The mitanin programme was initially planned and budgeted for 18 months. Because of some savings they were able to continue though at a slow pace till March 2005. Conceptually and in practice health worker programmes need to have a long term perspective of 5 – 7 years and ideally 10 years. Even 3 years is too short to achieve results. Provision of insufficient funds is a sure way of disabling a programme. When such large state wise programmes are initiated through public policies the planning, budgeting and fund flow monitoring need to be done with a great sense of responsibility.

   - Monitoring of fund flows and taking prompt corrective action has been lacking. Cash flow problems have been a major bottleneck in the implementation of the programmes. The field coordinators are paid by cheque from SHRC. DRPs (Rs. 2,500 paid per month plus some transport costs), BRPs / Prashikshaks (paid Rs. 1000/- per month) are paid in cash by the Nodal officer and DRPs respectively. BRPs pay the mitanin training costs. Bastar district has been put in a special category and receives adequate funds. There has reportedly been no problem in disbursements of funds from SHRC. However there are delays at the level of the district RCH society and below. The full amount is also often not paid.

   - Uncertainty about continuation of the programme causes anxiety and could lead to lack of interest and loss of faith.

   - When community health worker programmes are not followed up and supported in the field most of the gains get lost resulting in a huge wastage of effort, time and money. Government policy makers, planners and donors would surely consider the public health ethics dimensions of their decisions. Accountability to the thousands of health workers, trainers and the community must be given the highest priority.

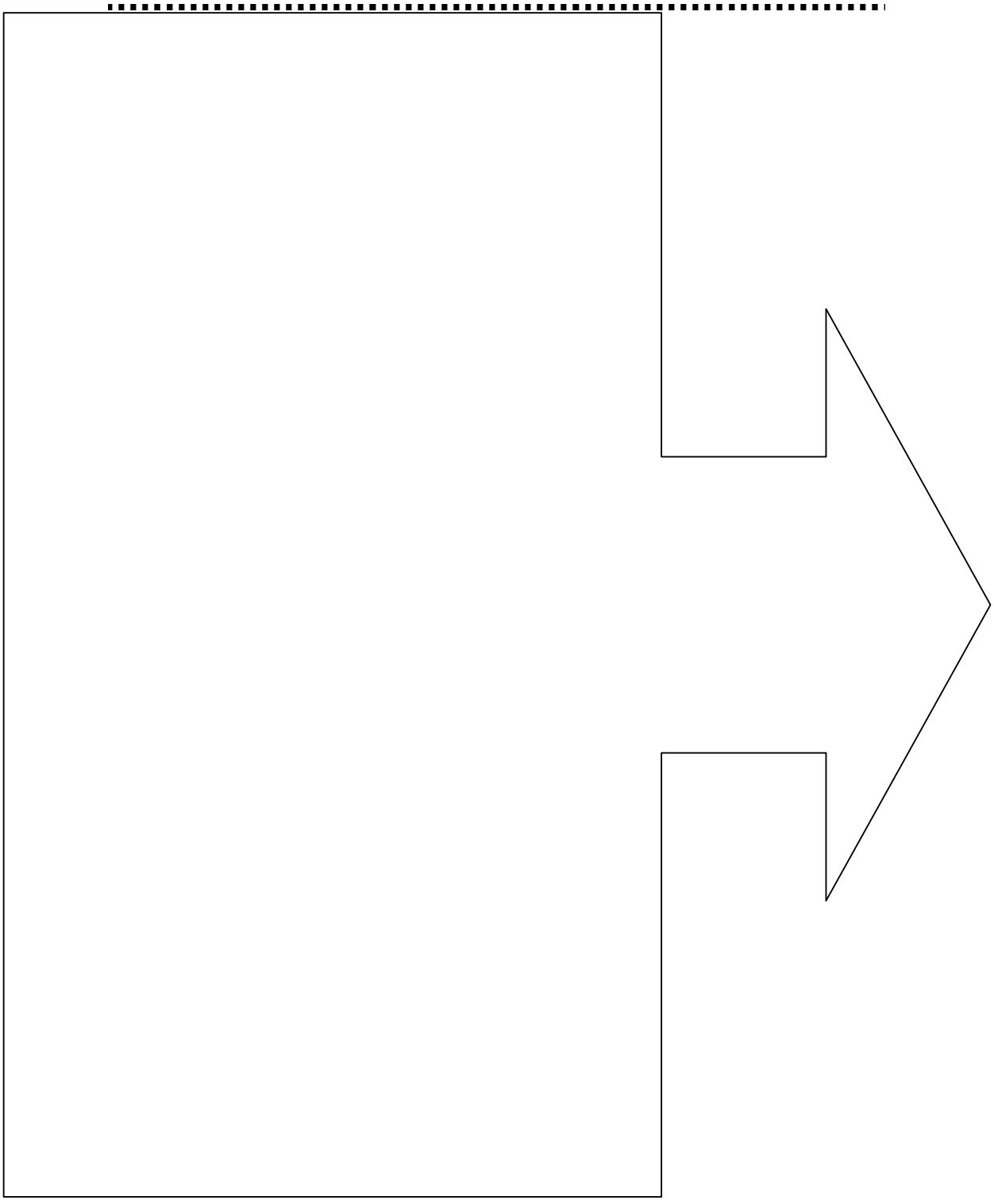
2. **Kalajatha's** on health issues were prepared and conducted in Phase I Blocks (66), through preparatory workshops and sessions with local artistes from Chhattisgarh. They involved a large number (about 3000) of young people from colleges etc participating in street plays in different villages to create community awareness about health issues and about the mitanin programme. A book of health and mitanin related songs has been published. The evaluation team has heard a large number of the songs sung by field coordinators, mitanins and prashikshaks. We have seen photographs of the kalajathas. This was a very important medium of communication and dialogue on social issues underlying health and should continue to be supported financially and organizationally. To save on costs Kalajathas were reduced in Phase II. Some were conducted through the IEC programme of DANIDA. There has been less outreach to communities in Phase II and efforts are reportedly less effective. Recall of messages from a single educational / kalajatha session is small. For a good impact health education sessions are sometimes repeated twelve times.

3. There is a major **language problem** in training and community involvement. SHRC staff, field coordinators and DHFW staff are not conversant with all languages such as gondi, halbi, bhadri and oriya which are spoken in just one block Bakaawan in Bastar district for instance. The major languages in the state are Hindi and Chattisgarh. Prashikshaks who are all educated usually know the local languages and dialects as well as Hindi. They are a bridge for communicating with mitanins and the people. DHFW staff have found prashikshaks and to a smaller extent mitanins very helpful in overcoming the language divide between the health system and the people.

4. The 14 part **radio programme** aired on All India Radio every week at prime time is in Hindi and Chhattisgarhi. More than one round of transmission has been completed. It has received good feedback. Other language versions are being developed. The radio programme has been one of the medium of communication used to reach out statewide. A listener feedback review can be done and a larger range of health issues can be regularly covered.

5. More recently a **video programme** has been produced about the mitanin programme. Some of it was shot in Bastar district. This will perhaps be used for advocacy purposes. It seems to be promotional in nature highlighting understandably only the positive aspects.

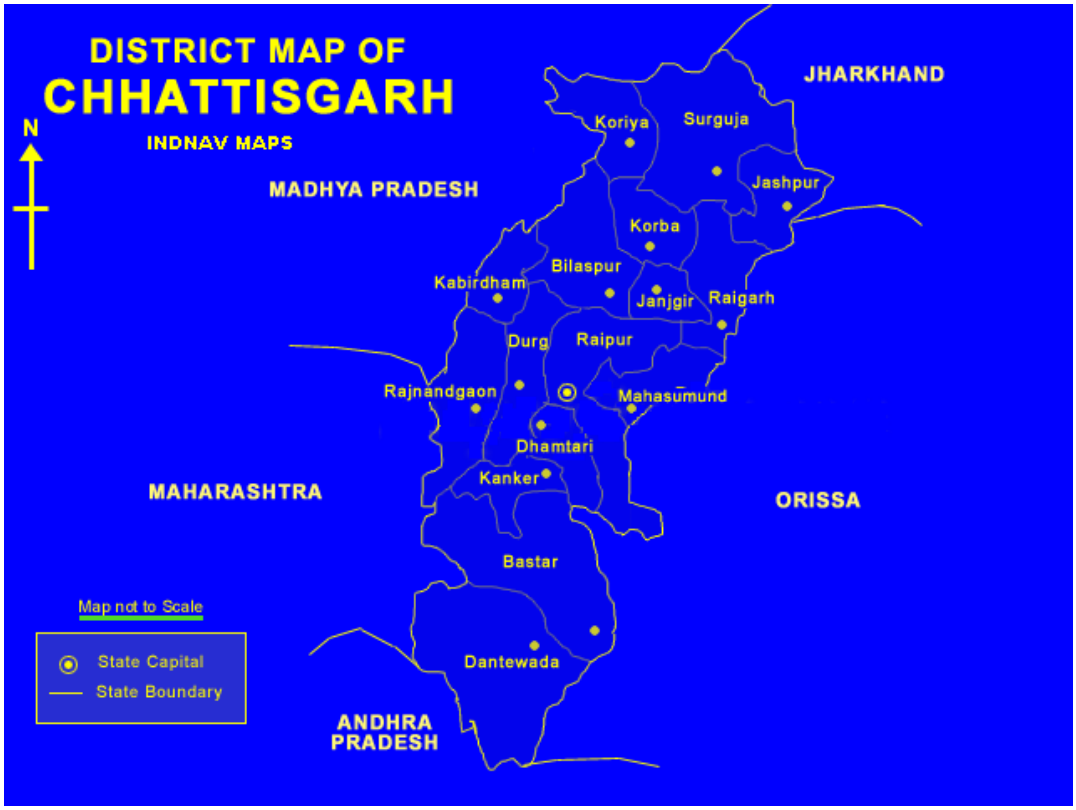
6. **Communication efforts to involve communities.** The SHRC team has been very proactive and creative in its use of songs; street plays, kalajatha programmes radio programmes and publications in Hindi produced in a fairly short period of time. The quality of productions has been good. The efforts though commendable have not been able to reach out to the entire community. Feedback from gramvasi's show that many people (60-70%) do not know about the programme at all or very minimally. Community processes and efforts towards increasing community awareness and involvement need to be strengthened and sustained.



# SECTION 2

# THE MITANIN REPORT

# 1. Map of Chhattisgarh



## 2. Abbreviations

| | | | |
|---|---|---|---|
| **ANC** | Antenatal Care | ***ICDS*** | Integrated Child Development Services |
| **ANM** | Auxiliary Nurse Midwife | **IDI** | In-Depth Interview |
| **ARI** | Acute Respiratory infection | **JSR** | Jan Swasthya Rakshak |
| **ASHA** | Accredited Social Health Activist | **JSS** | Jan Swasthya Sahayog (NGO) |
| **AWW** | Anganwadi Worker | **MPW** | Multipurpose Worker (Male) |
| **AYUSH** | Ayurveda, Yoga, Unani, Siddha, Homeopathy | **MTP** | Medical Termination of Pregnancy |
| **BMO** | Block Medical Officer | **MSS** | Mahila Swasthya Samiti |
| **BP** | Blood Pressure | **NHP** | National Health Programme |
| **BRP** | Block Resource Person | **NIOS** | National Institute of Open Schooling |
| **CHC** | Community Health Center | **NRHM** | National Rural Health Mission |
| **CHCB** | Community Health Cell-Bangalore | **NSV** | Non-Scalpel Vasectomy |
| **CHW** | Community Health Worker | **ORS** | Oral Rehydration Salt/Solution |
| **CME** | Continuing Medical Education | **PHC** | Primary Health Center |
| **DCH** | Dhamtari Christian Hospital | **PHN** | Public Health Nurse |
| **DRP** | District Resource Person | **PRI** | Panchayat Raj Institutions |
| **EDD** | Expected Date of Delivery | **RCH** | Reproductive and Child Health |
| **FC** | Field Coordinator | **RBA** | Rights Based Approach |
| **FGD** | Focus Group Discussion | **SC** | Sub-Center (Health) |
| **FHS** | Fetal Heart Sounds | **SHRC** | State Health Resource Center |
| **GOC** | Govt. of Chhattisgarh | **SSS** | Sugar Salt Solution |
| **GOI** | Government of India | **SWOT** | Strengths, Weaknesses, Opportunities, Threats |
| **GV** | Gentian Violet | **TOR** | Terms of Reference |
| **HDI** | Human Development Index | **TOT** | Training of Trainers |
| **HFA** | Health For All | **WCD** | Women and Child Development |

# 3. Executive Summary

## Context and Background

The Mitanin programme in Chhattisgarh is a major link between past experience at national and state levels with community health worker (CHW) programmes, and the future decades of ASHA (Accredited Social Health Activists), the programme espoused by the National Rural Health Mission. The ASHA programme undoubtedly owes some of its aspirations and proposed approaches to the Mitanin and Jan Swasthya Rakshak programmes and other critiques. It is therefore intrinsically linked to architectural changes in the health system. Essentially, community health worker programmes are responses to gaps in the larger Indian health system developed on the top-down model of hospital-doctor centric services based on the Bhore Committee recommendations that have not yet answered basic health care needs at the village - hamlet (*pada)* level. The paradigm shift came after NGO experiments, the Chinese nationwide system of barefoot doctors, and the Alma Ata primary health care approach. Yet CHW programmes (the generic name) are beset with problems all over the world and different nations have undertaken various experiments in this regard. The Mitanin initiative is a major large scale programme in this broader stream working towards improving health and access to health care.

Conceived in the new millennium, the programme was a product of wide ranging consultations, and study of earlier Indian experience. It was guided by a state advisory committee, and later the State Health Resource Centre (SHRC) took over as its mentor and manager. This was a special step in the state. The SHRC has clearly spelt out the approach to the programme in detail, and launched it in three phases. The first pilot phase (14 blocks), phase 1 (66 blocks) and phase 2 (66 blocks) by the end of 2004 covered the entire state at a rapid pace. This review by the Community Health Cell, Bangalore was requested by the government of Chhattisgarh (GOC), Action Aid - India and later endorsed by the Department of Health, Government of India (GOI). A team of eight researchers from different parts of the country undertook the study which was completed in three months starting from April 2005.

## The study

This rapid evaluative study adopted a mix of methodologies with qualitative approaches using semi-structured interviews, field observations, in-depth interviews (IDIs), focus group discussions (FGDs), review of documents and other material. A team of 9 researchers covered 14 blocks of 9 districts for in-depth data collection. Additional observations were made on the Mitanin programme by researchers traveling through districts for the SHRC evaluation, bringing the total of districts covered to 12. We formally met 96 Mitanins, 31ANMs and AWWs, and 19 *Prashikshaks* (trainers). 101 schedules were filled by discussions with individuals and groups of *Gramwasis* (totally over 495 villagers). However a much larger number of mitanins, *prashikshaks* and health department staff were met in groups during field visits. Validation was done through triangulation. The team found that the Mitanin programme has covered all areas, and there are Mitanins in almost all places. Supportive institutional mechanisms have been established at state level with the SHRC advisory committee, and at district and block level with district RCH Societies and a variety of arrangements. However the programme is struggling at the field level on several fronts including Mitanin's demand for drugs, remuneration, training, and referral support; non payment of BRP-DRPs for long periods; relative indifference of the health system, and lack of adequate meaningful community participation at several stages ( in selection, implementation). The knowledge level of Mitanins, their home visits, provision of primary medical care, referral, cooperation with ANM-AWW, Panchayat connection, gender-rights etc are presently at low levels. Their training, follow-up and support systems need considerable strengthening.

The document search suggests thoughtful planning with potential problems considered and options weighed. Due to several reasons spanning design, strategy and implementation, the programme is performing below expectations. Despite good efforts on some fronts like preparation of good training booklets, separate support system for Mitanins, picture – symbols on the tablet-packs, *kalajathas* to generate enthusiasm and community awareness and ensuring a Mitanin everywhere, the programme faces serious challenges. Continuing the process of learning by doing with technical, training, supervisory and referral support at block and district level, along with measures mentioned below could help to make the difference.

## Recommendations

a) Increase and sustain community participation through a variety of innovative means, with adequate financial and organizational support.

b) Undertake block to block feedback – interactive exercises with the community, panchayat members, Mitanins and health staff (also BRP-DRPs) to rejuvenate the programme and impart further need and situation based flexibility in the approaches.

c) Pruning of the programme can be considered by eliminating unwilling Mitanins, wives of general practitioners/RMPs and where there is already a village level health worker under some other programme etc. Selection and training of new Mitanins could be planned at places where there are gaps. The programme needs thinning, especially in view of the fact that there is some task-based payment in the offing.

d) Special inputs in Bastar, Dantewada and other backward areas that are sensitive to the local culture and language.

e) Improving programme design and management:

- Continued support for BRP-DRP teams for at least 3 to 5 more years, including their continued training and linking with health staff. Career and system planning with a longer term perspective also needs a health system and human resource development unit within the Department of Health.

- Financial discipline and management ensuring uninterrupted fund flows for the programme and employing formal channels like banks to be thought of.

- Inclusion of preventive – promotive health tasks, with necessary training and field support.

- Introduction of a system of simple clinical records and other work records that can be monitored easily by health staff and BRP-DRPs.

- Developing need-based evolving programme content.

- Introducing methods for assessment and performance appraisal for trainers at all levels and mitanins.

- Recognizing and respecting felt needs of first contact medical and health care of the community, and ensuring respect and remuneration for the Mitanins.

- Drug supply and replenishment through dual channels (Govt. and NGO).

- Task based payment, coupled with cost recovery of drugs on approved and displayed rates. Grievances redressal mechanisms at local levels using the exiting infrastructure and civil society participation.

f) Training: Implementing systematic re-training efforts with help of public health system staff, and NGOs using better teaching aids and methods. The training venue must be reconsidered with improved facilities for better training outcomes.

g) Reactivation and improving the performance of the public sector health system was an important component of the overall strategy. Much work still remains to

be done in this area. CHW s work optimally only within a supportive and effective health system.

In conclusion, the Mitanin programme is necessary for the health system in Chhattisgarh to strengthen its foundation in the community, but it needs modification building on the strengths and gains already achieved to increase its usefulness and role. In the absence of mid-course corrections, the programme may lose further ground notwithstanding the good efforts made so far. Most CHW programmes learn and grow organically from ground realities and experiences. This is already happening to varying extents in Chhattisgarh. We think this programme which is part of a broader process of making the health sector more responsive to peoples needs, could further grow from strength to strength.

# 4. Literature review regarding Community Health Worker (CHW) Programmes

### CHW: Paradigms, Concepts and Origins

The community health worker is a generic response which gained ground from the 1970s onwards to meet underserved community health needs everywhere, including in developed countries. CHWs exist as options in small or large programmes in several countries including the USA (Human Resource Development 1988, Mexico (Partners in Health – year not mentioned), Philippines (Council for Health and Development 2002), Pakistan (Agboatwala 1995), etc. The commonest hits to a web search on CHWs are the USA programmes for underserved communities. Many new health interventions like integrated management of childhood illnesses (IMCI) are being tried through CHWs (Bhattacharya) 2001). Obviously the tasks and responsibilities of CHWs vary from place to place.

It must be put on record that Mahatma Gandhi himself espoused the idea of a home and village doctor. On his suggestion, Dr. Dasgupta prepared a comprehensive book in English for would-be village medical practitioners. This book, first published in 1940 by Khadi Pratisthan, carried many chapters that are broadly the domains of health and health care even today: medical care, sanitation, hygiene, control of epidemics, Ayurveda and herbal medicines, women's health etc. Gandhi wrote a preface to this book and espoused educated people to study this book and go and practice in villages (Das Gupta 1940). The Sokhey subcommittee of the Indian National Congress in 1939 also recommended a health worker for every thousand population.

There was also a book on Ayurveda that Gandhi commissioned from a Pune based Vaidya in order that villagers could receive medical services at low cost. This author has brought out an important fact that the Mahatma tested the first students of the Vaidya and 'approved' them. Gandhi then wanted the Vaidya to start a training programme for 100 students (village doctors) at Wardha but the attempt was given up after Gandhi was tragically assassinated (Joshi 1932). Sixty years later we still talk of village health workers, though the semantics and roles have changed. The home 'doctor' is replaced by the terms community health guide, community health worker, community health volunteer and now social health activist.

The CHW owes its origin to the Chinese barefoot doctor in the fifties during the people's revolution in China, as is rightly acclaimed in the introduction to the WHO book for health workers (WHO 1987). The failure of health care models prevalent in various countries (India included), to meet the health needs of communities spurred the primary health care approach developed to meet the goals of Health for All at Alma Ata (1978). This included an important role for CHWs. The Srivastava Committee (1975) and the ICMR-ICSSR report on Health for All (1982) also suggested a community based approach with widespread training of

community health workers." The definition of CHWs adopted by the 1986 WHO Yaounde conference was that *they should be 'members of the communities where they work; should be selected by the communities; should be answerable to the communities for their activities; should be supported by the health system but not necessarily a part of its organization; and have a shorter training than professional workers*' (Frankel 1982).

The introductory note to the WHO publication for the community health worker (WHO 1987) stated that the notion of basic services advocated in the 1960s resulted in disappointments and failures. Then it became known that the health of the Chinese people had improved spectacularly as a result of what we now call the primary health care approach. One of it's guiding principles was the utilization of community health workers (CHWs) to: (a) extend health services to the places where people live and work (b) support communities in identifying their own health needs; and (c) help people to solve their own health problems. This new idea that communities should assume substantial responsibility for their own health brought a new dimension to the management of health care services and opened up for the members states of WHO an opportunity to expand their health services. At the Alma –Ata conference organized jointly by WHO and UNICEF in 1978, 134 states unanimously accepted the primary health care approach to achieve Health for All by 2000. This WHO publication outlines the profile of CHWs, conditions of work, their tasks, etc. In a table on page 12 the publication summarizes various country versions of CHW programmes with regard to their tasks. This table also describes the Indian version of the CHW (WHO 1987).

While PRC China had the only nationwide 'CHW' programme, several small NGO programmes came up in several countries as a response to underserved or unmet community health needs. In India these included the Comprehensive Rural Health Project in Jamkhed, the Mandwa project of the Foundation for Research in Community Health, the Mallur Health Cooperative of St. John's Medical College, the Link Worker Scheme of the United Planters Association of South India and St. John's Medical College among others. These have helped to evolve the model for CHWs and shaped national CHW programmes. In fact this groundswell led to the Health For All and Primary Health Care commitments to transform the conventional health system model. The now well known keywords of the new approach were: universal, accessible, affordable, essential and participatory healthcare. At least for developing countries one of the cornerstones of this approach was thought to be the CHW.

However the vivid image and description of the CHW came from David Werner's path breaking book "Where there is no doctor" (Werner 1977). This book, translated in 80 languages the world over has been the bible of community health worker programmes especially in the informal health sector. The later publication 'Helping Health Workers Learn' (Werner) is valuable in training trainers of CHWs.. Pedagogial issues have been influenced by Paulo Freire's methods as well as by another well known book 'Training for Transformation'.

Yet despite this long history and nearly global operation of the CHW programmes, there is on the whole relatively little published material available in English universally. There was no doubt a lot of research and reporting but that was, as a researcher puts it, in the 'gray domain or unpublished'. The website searches also yield very little on the classical CHW programmes in the world.

## Post – HFA CHW Programmes

Several countries evolved their own Community Health Worker programmes in the seventies. A very comprehensive publication 'The Community Health Worker' (Frankel *et al* 1992) deals with several country experiences on CHWs from Indonesia, China, Nepal, India, Tanzania, Zimbabwe, Nicaragua, and Honduras. This book provides a useful cross section of experiences across continents in the eighties when most of the CHW programmes were on the decline after operating for over a decade. The editor's overview starts with an able summary of CHW experiences. He says *"Community health workers have achieved much in many countries at different times but the frequent disappointment with the outcome of CHW programmes is often attributed to inadequacies in the CHW concept, or even laid at the door of the CHWs themselves. This debate is a sterile one. There is no longer any place for discussion of whether CHWs can be key actors in achieving adequate health care. The question is how to achieve their potential.(ibid)"*

The first chapter of this book is Frankel's editorial exploration of various factors, processes, trends and recurring issues in the country CHW programmes. This chapter deals with both the context and content of the CHW programmes. We recommend the whole text for reading so that policy makers and programme managers are aware of several pitfalls and experiences of CHW programmes.

Given below are some of the learning points:

### Frequent disappointment (p1)

When a success is expressed in terms of numbers of CHWs rather than quality of their performance. Health For All becomes CHWs for all….. and the PHC approach is robbed of its spirit and power (p3). Originally seen as stop gap……now recognized as permanent feature (p3).

The two basic strands in CHW advocacy/functions are their potential to provide basic health care needs in the context of vast unmet needs, and as basic agents for community participation in health (p4).

One can see these two roles along a continuum between two poles. The position of each country CHW programmes will depend upon development and health services penetration in each situation (p5).

Evidence shows CHWs no doubt can effect major changes in mortality and other indices of health status. They can also satisfy prominent felt needs (p5).

Reproducing successful small programmes on national scale remains a serious problem and over optimism about the role of CHWs undermines their potential role (5).

Resolution of CHWs' technical issues is a comparatively minor problem compared to the organizational issues at district level…. The critical obstacles are here …. (p6).

Relationship between CHW, doctor and nurse are a key factor for success…. doctors and nurses can oppose the dispensing of basic drugs by CHWs (p6).

The CHW is adrift in the choppy seas and without an anchoring in the formal health system, it is unlikely that his or her efforts will be directed effectively…(p8).

The sort of community alluded to in much of the literature about 'community participation' is at best an idealization and at worst a misleading myth (p8).

The ambiguous position of the CHW between community and the health sector may lead to conflict….. Their marginal role may be acceptable to neither the health sector nor the community (p9).

Case studies illustrate the misleading nature of the word 'community'…….. Genuine community participation cannot be built into a programme by any predictable way (p10).

This is the paradox of the centrally prompted community participation (p10).

There is a likelihood that communities' perceptions and need will not coincide with those of health personnel (p10)….. These issues must be acknowledged as inescapable facts of any CHW programme (p11).

The district health system is the framework….. without which the CHW programme may fail (p13).

(A community support group)…. is a fundamental requirement…. (of CHW programmes p16.

A special cadre of supervisors for CHWs….. is a basic investment in CHW programmes (p16). Employing experienced CHWs in this (supervisory) role (may be useful).

Joint supervisory responsibility….. The community supervision may concentrate on accountability while the health sector focuses upon more technical issues (p17).

(Continuous education)…… may not be receiving sufficient attention (p20).

The reporting system should have three minimum functions …. Continued record of care for each patient….. information on disease patterns…. To improve the practices of (CHWs) (p20 – 21).

(When physical distances are difficult for referral)…. The CHWs should be trained and equipped to manage a wider range of conditions (p23).

Problems in regular supply of drugs and general supplies to CHWs are widely reported (p24).

Securing adequate supply systems is a matter of critical importance for establishing effective CHW programmes (p25).

In addition to the integral value of treating major life threatening and discomforting ailments, effective curative services provide an entry point to wider elements of health care….. (p25).

It may be counterproductive to mobilize CHWs where basic supplies will subsequently be quite inadequate. The CHW in such situations is likely to be discouraged. (p25). It will be difficult to develop subsequent support for a programme that begins inauspiciously. This is an experience in many countries.

This broad remit (education, prevention of prevailing health problems, promoting food supply and proper nutrition, safe water and basic sanitation, maternal and child health care including family planning, immunization, prevention and control of locally endemic diseases, appropriate treatment of illnesses and injuries, and the provision of essential drugs…. (p28) essential to improving health status within communities is laid at the door of CHW…. is far too broad … (p28).

The WHO study group on CHWs (1987) considered it unreasonable and unrealistic to assign a wide range of functions routinely to CHWs (p29).

Many question the value of exclusively promotional or educational activities by CHWs, since only very small behavioural changes are possible within the target communities. However CHWs can be undoubtedly effective in preventive programmes(p30). However the bias towards preventive work—which characterizes the literature — is extremely rare in practice (p30).

A second reason for not denigrating curative activities (apart from the fact that simple and effective treatments are available for many diseases….. to improve health status) is a strongly felt need for such treatments within communities (p31). However the strongest justification for investment in curative services is that they

> may provide an important stage in the acceptance of the wider role of CHWs (p32). The question of client's response is very important…..(p32).
>
> People referred to them (the CHWs) as wall writers as they were expected to visits 30 houses everyday and sign up on the wall for benefit of supervisors…. as they carried no medicines…. (p32).
>
> Preventive and promotive activities present the greatest challenges to CHW programmes…. Unrealistically optimistic and unevaluated job descriptions have clearly no place in it (p33).

A fee for services for CHW is a backward step (in CHW programmes)….. (p34)

Volunteers…. The labour costs are borne by CHWs themselves (p35). Indonesia's efforts have violated most of the conventional wisdom on the feasibility and sustainability of mass voluntary action by CHWs…. But even voluntary based programmes require significant levels of spending (p35). The use of volunteers is associated…. with high attrition and low stability (p35). It is important to note that this model of altruistic CHW…. conformed to the reality….. only to a limited extent. (p36)…. Large numbers of them became dissatisfied and ceased working. (p37)….Nevertheless the Yaounde conference reached a broad consensus that the CHW should get some remuneration whether in cash or kind (p37).

Community funding …. The viability of such schemes largely depends upon the nature of the responsible local organization (p37). One means of community funding which can prove reliable is through drug sales…. This form of financing is widespread (p38).

Though the idea of minimal central funding is attractive…. Lack of central funding (for CHW remuneration) can jeopardize CHW programmes. (p39).

It is now proposed that CHWs should be female (p43)

Literacy is not an essential skill for CHWs, but in general it facilitates training…. Essential literacy can be incorporated in the training programmes (p44).

The working environment can be expected to influence practice more than a single training experience (p47).

Training programmes like job descriptions have been designed with little acknowledgement of the evidence that exists regarding current CHW performance (p47).

Interspersing training and work was advocated…. (p49)

Clinical skill (training)…. More recruits are concerned with…. and relates to the most common demand when CHWs start work (p 50).

Didactic training methods may be less effective than problem solving approach …. (p50).

…. Training to be conducted by the same individual who will supervise later….. (p50). Experienced CHWs potentially valuable as trainers (p50).

Career structure for CHWs…. In supervision and training (p52).

…. The evaluation literature (of CHWs)…. Talk about, rather than to the CHWs and idealize them rather than acknowledge the problems inherent in their mobilization.

…. So little monitoring and evaluation has been performed in the national programmes…. (p54).

… the achievement of wider benefits such as self-reliance cannot be captured by measurement of mortality patterns and immunization rates…. (54).

CHW programmes can have the greatest impact in areas where…. diseases of poverty are prevalent (p55).

The collection of vital statistics (by CHWs) is pointless unless it is supported by adequate facilities for processing and presenting the data for specific purposes (p56).

Both the potential value of CHWs and the sources of their failure stem from their unique position at the interface between the health sector and the community (p56).

Community health workers have not failed. It is the CHW programmes that have often floundered. (p61)

Overall the Frankel summary offers a very comprehensive summary of learnings from several country CHW programmes. It will be useful to read the study report in the light of this global experience.

The crucial question for any programme on a large country-like scale is: which basic architecture to choose so that the programme works in a meaningful manner. There is no single model to be recommended from the literature. Indeed the beauty of the CHW concept is in the flexibility it offers to the planners and managers of health. Community needs and resources available can shape the programme. However the major planks for programme planning and management are community involvement, training, remuneration, linkages and logistics. There is enough in the world literature about what works and what does not work.

## CHW: The Concept and Context

The present Indian health system has evolved from colonial health care systems established by the British. The district hospitals are testimony of this evolution. District hospitals are still the major part of our public health system. There were also large divisional hospitals in major cities. Municipal bodies also started their hospitals during the British period.

The second layer of public health services came thanks to the Joseph Bhore committee recommendations wherein primary health centers and sub-centers, and rural hospitals (now known as Community Health Centers – CHCs) were established in the post independence period. The PHCs and CHCs were increased in large numbers in the seventies and eighties.

However, even in the path-breaking Bhore Committee plan, there was no village level health facility (village level health committee was the only suggested structure). All the health programmes were to be administered through the CHC-PHC-SC and the village health committees. The committees remained paper – institutions. Thus villages had no direct health care at the local level, though it talked of good hospital support for all the population. The sub-center (3-5000 population) was the last bastion of health care for people in villages.

This peripatetic health care model through the sub-center auxiliary nurse created a health care gap for lakhs of villages and was never seen in this light till China's barefoot doctor experience became known. Despite its visionary health plan the Bhore committee approach was still a tax-based, top down, bottom thin, hospital centric, doctor-nurse oriented health services system, in contrast to China's decentralized, low cost, local resource based health system with a solid foundation in village health stations. In India despite many initiatives, five year plans, national health programmes, and community health worker programme of 1978) we still face fundamental gaps, distortions and contradictions.

The basic architecture of the Indian health care model is fundamentally inadequate to responding to village health care needs. The huge groundswell of private medical practitioners of every kind in the village bazaars is the tell tale sign of this need answered. The process of privatization actually started through this unfulfilled gap the Bhore model and later national plans left. We have historical evidence now that China solved their problem effectively and much earlier, at lower costs and with greater benefits and certainty than we can think of even now. Changes in China during the past decade however point to reversals of earlier gains due to policy changes that promote privatization.

In much of India, the gap at the village level still remains. The sub-centers with its Junior Health Assistant (ANM and MPW) have no doubt partially answered the need through health programmes, but they are severely limited mainly due to inadequate resources and lack of mobility. The health care deprivation and needs of villages have been also answered partially by private doctors staying at bazaar clusters but their means and ends have raised new and serious questions. A study in Nashik district of Maharashtra state reveals how the private sector has filled the vacuum especially since the mid - eighties when the CHW scheme was grounded (Ashtekar 2001). The sick in the village have to still travel distances on foot and wheels to get a semblance of healthcare. In 2005, that is still a reality in many parts of India even in so called advanced states.

Despite disappointments, many CHW programmes have continued and some new schemes were launched in the last decade. In India itself the *Jan Swasthya Rakshak* Scheme of Madhya Pradesh (1995) added to the list of experiences and disappointments (Narayan, 2001). The Mitanin initiatives of Chhattisgarh (2001 – 05) is a statewide scheme. It has built on the evaluation of the Madhya Pradesh – Jan Swasthya Rakshak Scheme. Maharashtra introduced it for tribal areas *(pada swaymsevak).* At the time of writing this report the national 'AHSA' (Accredited Social Health Activist) programme is launched in 18 states from 2005 as part of the National Rural Health Mission (NRHM).

There is perhaps no need to stress here that many health NGOs all over India still work with the help of 'village/community level functionaries' with mandates ranging from health care to functioning as counselors or multi-purpose resource persons. There are countless examples of NGO-CHW programmes in India. Partly because they existed in NGO islands, came the new Govt. of India ASHA initiative in the NRHM to be introduced in eighteen states. The other side of the coin is the varied approaches and arguments about every aspect of the AHSA programme – selection, money, drugs, linkages, tasks etc.

The Mitanin programme is probably the latest in the series of large scale CHW programmes in the world.

Yet the larger failure of the 1978 CHW programme is not adequately unraveled in Indian literature. The team is not aware of any GOI or State Govt. report on the closure of the CHW programme. There is no systematic study on why the scheme was withdrawn. There are some articles mainly in the form of viewpoints. Desai's article (Desai 1992) in the collection edited by Frankel (OUP 1992) blames lack of community action and the Gandhian movement for failure of the Indian CHW scheme. He sees CHWs as part of Gandhi's constructive workers who will look at all round development of villages and quotes programmes in Telangana in Andhra Pradesh as shining examples of the Gandhian dream. Somehow Desai overlooks the realities of a post-independence development administration era where a CHW like scheme is operated by the health department through a federal structure and a *panchayat raj* system where parties are jostling for power and common people are worried about the evening meals rather than national reconstruction. The CHW as a development worker is common to several small and big NGO projects in India and it is a laudable model indeed. But in an era of Govt. as the development engine with its many departments for developments efforts and programmes, such total development becomes an unmanageable dream through the small confines of a CHW programme. Mahatma Gandhi challenged the role of state as a development force and wanted village people to take over and restrict both Govt. and the market to minimum. Strangely the Gandhian idealism of village reconstruction dominates the idea and framework of CHW programmes even now. However, Gandhi himself suggested a simple idea of 'home and village doctor' who would render services and charge small fees, apart from endorsing many healthful practices like latrines. He appealed to freedom workers to learn and practice healing from modern and traditional healing systems (Joshi 1932). The 'seemingly simple' CHW model is in reality a very complex social- political construct as compared to Gandhi's model of home and village doctor. While the

Gandhian development model is the guiding dream for most CHW programmes, our programmes are state or NGO sponsored. Further, our CHW programmes have to posit themselves against the realities of a dominant, commercialized, sometime corporate, private sector medical care spreading even in rural areas. Desai's analysis ends up in a very simplistic analysis of the Indian CHW programme.

Meera Chatterjee (Chatterjee 1993) presents another analysis of the 'faltering steps' of the 1978 Indian CHW programme after nearly 15 years of its existence. She has blamed the 'inadequate support of the community and the health system' for the CHW. The 'medicalization' of the CHW was another 'faltering step' according to her, which earned the wrath of the medical community on these new 'quacks'. She rightly identifies the 'poor role definition' of the CHW by policy makers; the frequent change of names; CHWs being men rather than women; the small honorarium that failed to please the CHWs, as problems. The mistaken partial withdrawing of support by the Central Govt. and unwillingness to complement support by the states, pushed the scheme into the Family Welfare Dept which then drove the last nail in the coffin by making them agents for 'bringing cases'. Thus Chatterjee has mentioned the most commonly cited reasons for the failure of the CHW programmes and laments this missed opportunity to 'democratize the health system'.

In a recent article in MFC bulletin (Ashtekar 2005) the author presents the quintessential complexity of the CHW programmes – that it has at least three stake holders to satisfy – the people, the planners (system), and the CHWs themselves. A programme has to consciously try to match the aspirations and expectations of all these three perspectives. Another point in this article is the failure to recognize that there are not one but many models of CHWs including the rural medical practitioner. Every model on the continuum has its own requirements and limitations and strengths too. There is no place for political dogmatism or ideological saber rattling in the arena of CHW programnmes, and the model has to change itself like a kaleidoscopic arrangement when the needs, resources, and situations change. There is no one answer to suit all situations. And unfortunately, we cannot combine the best of everything into one model. The policy community has to consciously make choices and understand the frameworks, requirements and possibilities. The changing context in an era of globalization where decisions regarding determinants of health care made by corporate and international bodies sitting in board rooms far removed from people's realities also affect CHWs. Reversals in health gains point to the social impact of these decision making systems. Whether CHWs can or should bear the burden of this extra load of ill health and premature death due to complex causes such as environmental pollution and trade agreements is a question that could be asked. Can health workers also be trained as health activists or social health activists (GOI, 2005). If so, what would be different in terms of expectations, roles, responsibilities, training and support systems?

This literature review is presented with a purpose of bringing alive the complexities of CHW programmes, which are difficult to handle. The CHW-a seemingly simple solution for the long unmet needs of village people – quite often becomes unviable in large scale programmes. There are many attempts at revivals worldwide, and fewer survivals. We will need an expanded search for a programme and out of the box

thinking to make a programme in each situation, and a programme that will hold ground and survive to facilitate and deliver primary health care for decades to come.

## 5. The Mitanin Scheme - An Overview

The 'Mitanin' is the latest addition to the nomenclature of community health worker programmes in India. The Mitanin programme, conceptualized in 2001, started between May to November 2002 in Chhattisgarh through a process of governmental and bilateral consultations. The state of Chattisgarh was created in the year 2000 from Madhya Pradesh which had a JSR scheme. The JSR scheme suffered high attrition, however many JSRs are still present in the state of Chattisgarh. The birth of the Mitanin programme concept/ design can be traced to a meeting of the State Advisory Committee (SAC) in January 2002. The SAC consisted of representatives of state government, bilateral agencies and NGOs in the state and in India. It was decided that out of the 146 blocks in 16 districts 14 blocks had NGOs with substantial experience in health and development and therefore the pilot phase would be launched in these blocks.

### *Mitanin: The concept*

*Document 1: Compulsions behind the CHW programmes*

An SHRC document titled Compulsions behind the CHW programmes (Alok Shukla) describes why the Mitanin programme was conceived in the state given the background of failures of the previous two schemes: the CHW (Chatterjee 1993) and the JSR (Narayan 2001). The programme was conscious of the previous failures of CHW programmes and sought to overcome the difficulties and pitfalls.

This paper clearly recognizes the huge workload of ANMs in terms of tasks and coverage area. It also recognizes the limitations in expanding the MPW force the need to increase health education from within the community. It also stressed participation from the community, increasing the utilisation of health services, and the importance of linkages with panchayati raj institutions (local bodies). The paper states that "the challenge of the Mitanin programme is to look carefully at all the constraints in the past programmes and find a way of overcoming them. And to learn from the success stories of the past especially in the NGO Sector and adapt to our needs and build on them".

The Health Secretary was highly committed to this scheme and wrote an approach paper for the programme. The outline of the same is produced below.

A Mitanin has cultural roots in the fact that adivasi women through a traditional ritual befriend each other and call each other Mitanins. Mitanin is supposed to be a lifelong relationship. The use of this concept for a state run CHW programme has been critiqued by some (Sen 3, 2005).

The Mitanin scheme was an important component of health care initiatives in the new state. This was a community based scheme and government guaranteed some

of the support necessary for its functioning.. The panchayat should, it was decided, give publicity to the scheme, mobilize communities for health, identify one Mitatnin for each habitation and help the community in deciding a compensation package for the Mitanin.

On the other hand the government would guarantee training and retraining; integration of the Mitanins' work with Govt.services, and supply free medicines and material available from the various National Health Programmes.

Compensation to Mitanins, it was decided, should come from the community in cash or kind. This compensation could take any form including annual payment or user fees from the community. There is mention of a possibility of allocating five acres of land for Mitanins to cultivate and use the produce, till they works as Mitanins.

The State Health Resource Centre (SHRC) came into existence and one of it's important tasks was to support the Mitanin programme. A core team was drawn from NGOs and other institutions from all over the country. A majority of the team are form Chhattisgarh This team, especially the SHRC team prepared a training package for the trainers and for Mitanins. SHRC would also undertake the training of trainers, publicity, community mobilization, and training of panchayat raj representatives. The panchayats would then assist with community mobilization and identification of Mitanins.

The **role of the Mitanins** was outlined as follows*:*

- Health education

- Leadership of public health activities in the village for various health issues like cleanliness, safe drinking water, hand pump safety, soak pits and drainage, use of sanitary latrines, women and childcare, nutrition practices, child feeding practices, prevention of anemia, antenatal care, 100% registration of vital events and delivery in institutions, consultation on MTP services, family planning and reproductive and child health, and various problems including HIV AIDS, control of communicable diseases.

- Care of common illnesses and timely referral - for this she would be examined periodically and certified for proficiency.

**The Mitanin was to function in the following manner:**

The Mitanins would work in collaboration with the ANMs, other health staff and Anganwadi workers. The would help the ANM in several tasks and in turn the ANMs would also help the Mitanins.

The Mitanins would work in close association with Panchayati Raj Institutions (PRIs), and perform the functions of both civil society and a free press to sustain democracy in the village.

Mitanins were to be selected by the community of the habitation , to be later approved by the gramsabha. The selection process would involve orientation of the PRI members and key officials about the scheme. A team of trained facilitators was to sensitize the community of the habitation regarding selection of the Mitatin through several visits with night halts if required. The team would help build consensus for a formal choice. Then a formal meeting of the gramsabha would approve the choice in various habitations. The sarpanch would endorse the agreement and inform the block programme team to train the Mitanin. The community would be sensitized through wall writings, posters, meeting, cultural events etc. to build interest in the programme.

**Training of Mitanins:**

The Block Medical Officer (BMO) would organize the training programmes for Mitanins and the cost would be borne by government. The first stage of training would consist of six rounds and was expected to be institutional based. The second stage of training would be mainly refresher training at regular intervals and at cluster and panchayat level.

The first stage of training would include preparation, and building of certain basic attitudes, knowledge, and skills. She would be expected to perform the following tasks after training: blood smear preparation, anemia detection, antenatal care, weighing children, malnutrition detection and care, ARI (Acute Respiratory Infection) treatment, chloroquine treatment for fever, early detection and referral, treatment of dehydration, health education for specific groups.

## *Document 2: Building on the past*

In the paper titled '*Building on the Past'* by the Director of SHRC, the **seven conditions for success of community health worker programmes** have been consciously listed and explained:

- Selection of women as health workers,
- Ensuring proper selection processes (by a trained facilitator, with hamlet as unit of programme, and through social mobilization),
- The (limited and supplementary) role of curative care, to be introduced later,
- No regular honorarium but volunteerism,
- Proper training and support,
- Positing the statewide community health worker initiative, along with health sector reforms, and
- Building state and civil society partnerships.

**Document 3: Pioneers in community health**

The Mitanin programme was launched by the GOC and SHRC after visiting nine NGOs in various states in India. The paper recognized the success factors of NGO managed CHW schemes as follows - high quality leadership; women as CHWs; programme of 5-10 years duration; referral linkages with a support hospital .

The three papers mentioned above are evidence that the leadership of the Mitanin programme was fully aware of all the pros and cons of contentious issues like selection, payment and curative care that have dogged CHW programmes the world over. The Mitanin model of the Chhattisgarh CHW programme was a conscious and considered choice, much more than the previous Jan Swasthya Rakshak (JSR) scheme of Madhya Pradesh. The leadership was also conscious of the fact the great efforts were required to establish and run such a programme to ensure success.

**Summary outline of the Mitanin scheme**

| | | |
|---|---|---|
| 1. | Objectives | To create a women community health worker per habitation to ensure health information, utilization of health services, and some medical care. |
| 2. | Publicity | Radio, oral publicity through *preraks, kalajathas*. |
| 3. | Selection | All women, through panchayats or mahila samitis facilitatedby *preraks* before selection meetings. |
| 4. | Size of popultion per unit | One Mitanin per habitation, about 50-70 houses per Mitanin. |
| 5. | Formal criteria for selection of Mitanins | Women, ever-married (*bahu*), age, from the habitation, no educational qualification required. |
| 6. | Facilitator | Male, to be replaced by women at the stage of training. |
| 7. | Costs | Rs. 4000 per Mitanin per year, additional Rs. 500 for books etc. This is about Rs. 25 crore per year and is about 8% of the state health budget. |
| 8. | Support structure | Team of *preraks* / BRPs in each block (about 20 for 400 Mitanins). |
| 9. | Training | 20 days total training, broken in 6 rounds. To be held at nearby health institutions (sometimes held at *panchayat* clusters). |
| 10. | Books | Six training booklets in the first stage. |
| 11. | Tasks | Health education, community organization, stimulate health action, support national programmes and health cqare delivery by Government, demand health care, give first contact care. |
| 12. | Methods | Home visits, ANM clinics. |
| 13. | Income for Mitanins | No formal regular payment, at least at this stage. Later *panchayat* would decide how much and how to pay. Land award was not mentioned in any other document later. |
| 14. | Working hours | Estimated to be 2-3 hrs everyday for 2-3 days eachweek. Thus the working time on average was expected to be about 1-2 hrs. daily. |
| 15. | Linkages | With ANM and MPW (No formal statement about AWW). |
| 16. | Referrals | To PHC and CHC. |
| 17. | Records | Gramswasthya register (pictorial book with boxes for text).<br>One page per family. |
| 18. | Medicines | To be given in the fifth round of training titled davapeti (drug-box). Includes Paracetamol, Chloroquine, Albendazole, Gentian Violet paint, Cotrimoxazole. |

## The Phased Approach

The Mitanin programme was initially started in 14 blocks where established NGOs were present, in partnership with the government. This phase (2002) was to learn about the various processes involved and the difficulties that may surface. In the next phase (2003) the programme was started in 50% of the remaining blocks ie 66 blocks. The third phase (2004) covered the remaining 66 blocks.

The overall approach in programme implementation indicates some flexibility in the three phases. The NGOs had reasonable freedom to implement programmes within the framework of the objectives and fund availability.

An interim evaluation of Mitanins was done in 2004.

## The SHRC Annual report on Mitanins

The Mitanin programme work report released in April 2004 is an important document because it gives a full report of all the stages of the development of the programme and its evaluation at that stage. The salient points of this document are given below in brief.

The Mitanin programme design and its operationalisation was done by SHRC, although the concept and the broad framework were developed by a number of stakeholders in a workshop in January 2002.

The Mitanin programme was based on an understanding that health and access to health care is a fundamental universal human right. It involved only women, across the whole state, with no honorarium to the Mitanins.

Efforts to strengthen the public healh system were to be made simultaneously.

The chronology of programme implementation was as follows:

- In May 2002 the programme was launched in 14 pilot blocks.
- In July 2002 the training strategy, modules and basic contours were finalized.
- The first three training modules were available by September 2002.
- In November 2002 the programme actually took off in 14 blocks.
- The programme was expanded to an additional 66 blocks (total 80 blocks) in January 2003. At this time a programme command structure was formulated. Guidelines for selection, training and support for Mitanins were circulated. The general body of the State Health Society endorsed the details on 19$^{th}$ January 2003.
- In June 2003 the operational guidelines were published by SHRC.

- In March 2004 a participatory evaluation and mid term review of the Mitanin programme was done. Based on this a mid course correction was made.

Seven training modules were developed, mainly for use by trainers but also for the literate Mitanins. The eighth booklet on developing a village health plan was to be written later (now available).

The village health register was finalized and printed.

An illustrated picture book (Kahat he Mitanin) was developed to include all the key messages in the seven modules.

It was planned to print posters to be used at villages in 2002. Except for posters on malaria and other introductory posters, the SHRC could do not do the rest due to fund constraints.

The trainers hand book (in addition to modules mentioned above) was produced.

The district level health administration was appraised about the Mitanin programme at appropriate stages.

The district resource persons – DRPs (three per block) were trained. Two of the DRPs were from the voluntary sector and one from the public health system (usually a health supervisor). In January 2003 the DRPs were trained to train the Preraks for the selection of Mitanins. Thereafter they were also trained for the first three modules. Other training programmes followed for the village health register and for reinforcement.

DRPs would train the Mitanins.

For publicity and awareness about the programme various strategies were planned and used; these included posters; Kalajathas and a. radio programme (Kahat hai Mitanin) which was developed in 14 parts. This was mainly about women's health and the Mitanin. This programme, it has been said, has been useful in establishing women's groups in villages.

Kalajatha teams were trained through a cascading model of training creating 240 +264 trainers in the 146 blocks. These trainers would in turn train two Kalajatha teams in each block.

For monitoring and support of the programme, the SHRC has built a force of 25 field co-coordinators. These are full time persons and are highly motivated. They train and

support the DRPs and BRPs. They also take responsibility for administrative, organizational, and accounting matters for their respective areas.

A monitoring strategy was developed with indicators.

The SHRC conducts structured and unstructured field visits. Three studies have been done by research students for their postgraduate degrees. A participatory evaluation workshop was conducted by SHRC with Mitanins.

## *Findings of the Internal evaluation of the Mitanin programme*

On March 31st 2004 SHRC produced a work report which included the quality of the programme; expenditure status; accounting efficiency; block level reviews and monitoring quality. These work reports are available for all programme blocks graded into 4 categories A, B, C and D. The conclusions were as follows:

Mitanins were found to have a sense of ownership and understanding about their role. Concerns included: apprehension about the community wrongly believing that Mitanins are getting money from the Govt. or that they will be paid later.

Most women became Mitanins 'to serve the village community', and 'to step out of the four walls of the home'. Many of them thought it was good to learn about child birth and health to benefit at least her own family.

The perceived deficiencies of the programme included - no definite role for Mitanins in Grampanchayat activities; gaps in the health system at pada level; shortage of training time; inferior food in many training camps; no compensation even for training days; and supply side gaps like shortage of weighing machines, medicines etc.

The suggestions for improving the programme included – provision of identity cards, encouraging atmosphere for work from the Govt. doctors, material incentives etc. Financial incentives were demanded, but Mitanins understood that it was not part of the programme. Better support to resource persons was another demand. Other recommendations included rejuvenation of women's health committees; using films and posters to popularize the Mitanin programme; Dai training opportunity for Mitanins; ensuring better supply of health education material, weighing machines, delivery kits and most important adequate drug supply. Mitanins insisted that without these provisions they would not be effective. It was also felt that the role of Mitanins vis-à-vis the Anganwadi worker ( AWW), Auxiliary Nurse Midwife (ANM) and the Gram Panchayat should be clarified and defined.

The problems at work included - misunderstanding in the community about Mitanins getting money from Govt.; lack of community help; problems of the Anganwadi

system; inadequate referral back up at the hospital; and some other opposition faced. The ANM charges high fees from the community for delivery of children and this was another problem. Also mentioned were the difficulties in attending training programmes; and problems concerning food and short prior notice given for trainings etc.

A village committee was considered necessary (but more guidelines were sought by Mitanins).

Home visits helped the Mitanins work; as more services reached the people after the home visit started (but there was no information on whether home visits were taking place all over the state).

It was felt that some of the health advice was followed and some was not. For instance there was a reported change in breast feeding practices for the better after the programme. However advice to prevent early marriage was not followed. Advice about not going to priests and traditional mystics for medical problems was also not followed.

## *6. Study Objectives of the External Evaluation*

These were developed in March 2005 and are as follows:

**B. Evaluate Key Processes Regarding:**

- *Preparation, Selection, community processes, Training of Trainers (TOT), training, Follow-up and Panchayat involvement,*
- *Evaluate supportive systems as planned, in comparison to what was implemented, trying to understand variations and reasons for difference / change,*
- *Logistic supplies including training materials and drugs,*
- *Referral systems,*
- *Fund flows,*
- *Continuing education.*

**B. Study outcomes in terms of the following:**

- *Health education and improved public awareness of health related issues.*
- *Improved responsiveness and utilization of public health care services, with equity.*
- *Community action and participation for health and development.*
- *Access to immediate relief for common medical problems.*
- *Women's health empowerment and increase in women's access to primary health care.*
- *Linkages with gram panchayats and enhanced capacities of local panchayats for health planning and programme implementation.*

**C.** To study the different models used ot implement the programme using SWOT priniples, focusing on flexibility, participation, equity and effect on outcomes**.**

**D.** Gender analysis of various components of the programme**.**

**E.** Identify the programmatic challenges faced by the Mitanin programme**.**

**F.** Make recommendations for further strengthening of the programme**.**

**G.** Draw out lessons from the Mitanin programme that could feed into the proposed ASHA programme (Accredited Social Health Activists) of the National Rural Health Mission (NRHM) of Government of India**.**

## 7. Methods and study sample

### *Qualitative techniques*

Given the Terms of Reference (TOR), the very short notice for a team to be put together, and the time and resources available, the evaluation team decided to undertake a rapid evaluation study using qualitative approaches. It was decided that the evaluation would draw on perspectives of the 4 main groups in the program namely: a) the Mitanins', b) the community or Gramwasis, c) the support system—the public health system and the prashikshaks, d) the planners'—the SHRC.

To capture the first three perspectives it was decided to study what we termed the "Mitanin Unit". This consisted of a village – all the Mitanins of the village who were contactable; the people of the village; the Prashikshaks; and the Anganwadi worker and ANM (female health assistant) where possible. In each block we also met the PHC medical officers, and NGO staff team who ran the program (in case of an NGO run program). We thus tried meeting a cross section of persons in the village or 'Mitanin Unit' to get an indepth understanding of what was working or not working, rather than covering a particular percentage of Mitanins.

While it is important to quantify the achievements of the training in terms of knowledge and skills, we felt that we would rather look at the way the program was actually perceived by the various stakeholders to understand the ground reality of the programme. However even in this predominantly qualitative approach, we have tried to make the exercise representative by selecting the sample of Mitanin Units from various districts and phases of training, and doing the study with six plus two[1] researchers.

### *The sample*

Given the nature of the state, and the different phases the program was implemented in, as well as the different administrative arrangements found in different blocks, we chose a stratified random sample. The steps that we followed were :

**Chhattisgarh was divided into North, Central and South Zones, after discussions with SHRC staff, Government and NGOs working in the state.**
**The North comprised of the following districts – Koriya, Sarguja, Jashpur, Raigarh, Korba, Janjgir and Kawardha.**

The Central Zone districts were – Rajnandgaon, Durg, Raipur, Mahasamund, and Bilaspur.

[1] *The Mitanin study was primarily done by six researchers, while two other researchers who studied the SHRC also added their observations from districts visited by them.*

The Southern Zone districts included Dhamtari, Kanker, Bastar and Dantewada.

**In each region the blocks were classified into three groups, depending on the phase of implementation of the project.**

1. The pilot phase blocks.
2. The first expansion phase – Phase I.
3. The second expansion phase – Phase II.

Since the pilot phase was totally run by NGO's, and the second expansion phase was less than a year old in some places it was decided to give greater weight to blocks in the first expansion phase. Thus from each zone the selection of blocks was: One block from the pilot phase; two blocks from the first expansion; one block from the second expansion phase.

All blocks were being assigned numbers and the study blocks were chosen by using the table of random numbers from the eligible set of blocks after due stratification as described.

Totally 12 blocks were selected from the total sampling frame of 146 blocks.

***The 12 blocks in the study***

| | Pilot phase | First expansion (Phase I) | Second expansion (Phase II) |
|---|---|---|---|
| Blocks sampled / selected | Nagari<br>Nawagarh<br>Podioprada<br>Marwahi | Sarangarh<br>Lakhanpur<br>Churra<br>Dhamtari<br>Lohandiguda | Pandriya<br>Gurrur<br>Durgkondal |
| Blocks completed | Nagari<br>Nawagarh<br>Podioprada<br>Marwahi | Sarangarh<br>Lakhanpur<br>Churra<br>Dhamtari<br>Lohandiguda<br>Doundi | Pandriya<br>Balod<br>Gurrur (Partly) |

| | | | |
|---|---|---|---|
| | | Kurudh | |

During the study the blocks of Durgkondal and Gurrur were not completed. In their place Balod, Doundi and Kurudh were visited ie *14 blocks were covered*. These last minute changes in plans were made to offset the effect of any tutoring of the Mitanins preceding the interviews (as we discovered that our questionnaires had reached some selected blocks).

Once the team reached the chosen block / block head quarters the following procedures were broadly followed:

At the block level 2 PHCs were chosen based on accessibility (one inaccessible and one easily accessible).

At each PHC a list of villages was drawn up and at least two villages were randomly chosen (by chits). Sometimes villages on the way to chosen villages were also visited especially if the target of 3-5 Mitanins were not reached in the chosen villages.

In each village the following persons were met:

- Panchayat leaders / ex-panchayat leaders (as the program was started during their time)
- The Mitanin(s)
- *The Anganwadi worker / ANM if possible*
- Villagers gathered in some common place and through house to house visits, visiting houses both near and far from the Mitanin's house in the same Para.
- Members of the health committees or the women's committees as the case may be.
- *Prashikshak* (trainer).

At each village a questionnaire / checklist was used to collect information from the various stakeholders that we met.

## *Development of the questionnaire / checklist*

A questionnaire schedule for each stakeholder was developed and used mainly as a checklist to guide our discussions in trying to understand the various perspectives. The questionnaires were semi- structured (options provided) and partly open ended.

The questionnaire was developed in a step wise fashion after careful study of the internal evaluation just completed, the objectives of the program and the operational objectives as defined in the internal evaluation. Based on all these the broad domains were agreed upon. These included : Conceptual basis of the program; Selection of the Mitanin; Training; Support to the Mitanin; Interaction with the public health system ; and Outcomes such as health education, home visits, community level activity, gender empowerment etc.

For each of these domains we listed assumptions and then fashioned a question that would capture the essence of the information we wanted. Members of the team went on three pilot field visits to gain a feel for the program before actually making the questionnaire. These include a meeting with Mitanins at Gunderdehi, a two day visit to Manendragarh and interaction with Mitanins, NGO activists as well as Field coordinators, and observation of the field coordinators meeting and training. The finalized questionnaire was field tested in the village of Baital in Doundilohara block of Durg.

## *The CHC-Banglore team*

The CHCB team consisted of the following members: Thelma Narayan, Shyam Ashtekar, Sunil Kaul, Deepti Chirmulay, Shashikant Ahankari, Rajani Ved, Rakhal Gaitonde, Amulya Nidhi, (and two assistants Vinay Vishwanatha and Naveen Thomas). All except Amulya Nidhi and Naveen are doctors. All the team is experienced in the area of public health, and community health including training of community health, workers. Brief biodatas of the investigators are given in an appendix. The SHRC study team consisted of Dr. Thelma Narayan and Dr. Rajani Ved assisted by Mr. Naveen Thomas. Other members made the Mitanin team, coordinated by Dr. Shyam Ashtekar. The SHRC study team also met mitanins in groups, as also prashikshaks, DRPs etc but did not use the questionnaire.

## *The Final Sample*

By the end of the field investigation the Mitanin team study interviewed :

- 96 Mitanins
- 495 villagers (Gramwasi)
- 19 Prashikshaks
- 31 AWWs /ANMs
- 8 Doctors

Apart from this the whole team met nearly 300 Mitanins in groups, besides trainers and almost all the field coordinators in groups. While these group meetings did not lead to questionnaires being filled they contributed richly to the narrative and case-study data that the team built up.

The mitanin study team finally traveled to 14 blocks in 9 districts. In all we visited 60 villages.

## *Secondary data sources*

Documents listed in the bibliography have been used as secondary sources of information along with newspaper clippings and photographs given by SHRC. A film

made by SHRC on the Mitanin programme was also viewed by the teams. All the training material (seven books) was perused.

## Analysis

Data analysis was quantitative and qualitative.

## *Quantitative*

The questionnaire-responses were subjected to the following analysis:

The primary data entry was done on Excel spreadsheets. These were sent to one of the evaluators who merged the various tables, and after running logic checks, proceeded to analyze the data using the software package EPI INFO 2002 (CDC Atlanta).

The data was initially presented as cross tables on the entire data and then stratified by Phase of implementation and the administrative arrangement. These stratifications were done to see the emerging trends in the data due to the phases and the administrative arrangements.

## Qualitative

The qualitative data was analyzed at two levels,

- At first evaluators wrote out narratives of their experience and reports of meetings, focus group discussions, quotes and case-histories.

- Subsequently the evaluators arranged the questionnaires of different stakeholders according to the blocks, studied the emerging trends and wrote block wise reports.

The emerging trends and results of the qualitative as well as the quantitative data analysis were discussed at a meeting in Bangalore 30$^{th}$ and 31$^{st}$ May 2005. where most of the evaluators met and shared their individual assessments. This helped a lot to make sense of both the qualitative as well as the quantitative data.

## General comments on methods

While collecting the data we have contacted and gathered perspectives of all the stakeholders of the programme – the planners, the support structure / implementers, the key functionary – Mitanins, the beneficiaries – Gramwasis and other village level

functionaries. We have asked each about their assessment of the programme, the work by the Mitanins and any suggestions for improvements.

We have tried to answer the study objectives through this enquiry and from review of secondary data sources. Subsequently we have summarized the findings against the objectives.

We have juxtaposed analysis and comments in this presentation to help make convenient reading.

Using a quantitative mind set the study deals with a relatively small sample of 96 Mitanins (out of 54000), and when split in three phases, each category becomes smaller still. The number of respondents in other groups (support staff) is even smaller. However, the study adopted an indepth qualitative approach. We rely on geographical spread of the study, depth of the enquiry and eight different researchers bringing in almost similar findings as our corroboration. We have therefore felt comparatively safe in concusions made regarding the programme as per the study objectives.

The overall insights about the Mitanin programme (and health sector strengthening in section II) derive from our collective understanding based on all aspects of our involvement in the evaluation - discussions with a very wide variety of people, field visits, observations of events and processes, and reading a large number of documents and reports.

# *8. Findings and Comments*

## The study sample characteristics

### Area and population covered

**Table 1** shows the blocks studied in various zones of the state. On an average 7 Mitanins were interviewed in each block.

60 villages in the 14 blocks were covered and 495 villagers were interviewed (228 women and 267 men). Some of these interviews were in groups (68) for which a single Gramwasi schedule was filled. Hence, the Gramwasi prapatra filled were only 101. The analysis was also done on the basis of 101 entries.

The Mitanin programme is administered somewhat differently in different districts. Four types of administrative set-ups were encountered based on which agency runs the programme. All types were covered in the study:

- District RCH society running the programme - 1 block , 11 Mitanins
- Run by Govt. alone - 6 blocks, 23 Mitanins
- Government with NGO /through NGO - 2 blocks, 13 Mitanins
- Entirely NGO run - 5 blocks, 49 Mitanins
- The study sample had 3, 8, 3 blocks from pilot phase, phase I, and phase II respectively.

## Blocks and VILLAGES studied

### 3. Sample and Respondent profile

| | Pilot phase | First expansion (Phase I) | Second expansion (Phase II) | Total |
|---|---|---|---|---|
| Blocks visited | Nagari<br>Nawagarh<br>Podioprada<br>Marwahi | Sarangarh<br>Lakhanpur<br>Churra<br>Dhamtari<br>Lohandiguda<br>Doundi<br>Kurudh | Pandriya<br>Balod<br>Gurrur (Partly) | 14 |
| Mitanin | 39 | 47 | 10 | 96 |
| Gramwasi | 39 | 52 | 10 | 101<br>68 group interviews, 33 individuals (total 495) |

| | |
|---|---|
| SHRC Officials and FCs | 2+ |
| DRP | 1+ |
| BRP / Prerak / Prashikshak | 19 |
| NGO representatives | 1+ |
| Doctors | 8 |
| AWW / ANM | 31 |
| Others | 1 MP<br>Action Aid |

The SHRC study team met many more respondents.

## Key proceses and inputs in the Mitanin programme

### Govt and public health system support

Through the interactions and interviews with state level government officials and SHRC officials we could see that the planners are very positive about the programme.

They narrate several successes as well as bottlenecks and their efforts to solve problems. They are also very aware about issues and realities at the ground level, but believe that these can be resolved.

At the **senior government officials** level there was more or less uniform satisfaction expressed. Department of H &FW staff found Prashikshaks and to a smaller extent Mitanins very helpful in overcoming the language and other divides between the health system and the people.

**State Health Resource Centre (SHRC)**

A special support unit—the SHRC—for the programme was established as an innovative institutional mechanism almost from the beginning of the programme, alongside the formal public health system. It functioned with a fair degree of autonomy. The SHRC was expected to give special training and programmatic inputs. The SHRC, with its dedicated team of programme and field coordinators working at state and the district level was found to be an asset for this pogramme. It not only gave inputs but also provided leadership and energy for the entire programmes, generating new ideas, ways, mechanisms etc. If the programme is seen performing sub-optimally today, it is not mainly because of shortcomings in the SHRC but because of a failure to match funds and administrative efforts by the Dept. of Health in relation to the programme needs.

**The Field Coordinators** (FC) employed by the SHRC, were also reasonably well grounded in the subject. We found them highly motivated and they seemed to have worked tirelessly for the programme. Discussions with FCs brought out some weak points that adversely affected implementation such as corrupt and insensitive practices by the health system at places making financial supervision difficult, delays in and slip-shod arrangements for training in Government managed programme, difficulty in convincing Prashikshaks in the face of limited funds and payment delays etc.

FCs thought this cadre of 'BRPs' to be essential for running the programme. As one of the FC put it, 'the programme can not run with only Government support, this team (of Prashikshaks) is necessary.'

**District Resource Persons** (DRP) too had a good understanding about the programme. A DRP in Bastar says, '…the major outcome of the Mitanin programme is that women have come out in open in large numbers everywhere, and this has helped the health programme. However,the health staff is feeling uneasy about these new observers of their performance…'

The **Block Resource Persons** (BRP) however did not seem to have the larger picture. They were neither consulted nor informed about management decisions. There was a general discontent and distress due to the fact that many had not received any honorarium for several months. Only a third of the 19 Prashikshaks (BRP) interviewed

formally had received their salary regularly. In yet another block visited, a group of BRPs were holding a meeting to discuss this very issue and to decide on a course of action.

BRP's travel costs in relation to what they were paid were excessive, so much so that continuing with the work was becoming difficult for many. However, they were pulling on in the hope of receiving their dues and a 'salary raise' later in the day. BRPs were also not aware of the transient nature of their occupation.

BRPs' collective opinion on the programme was that it was a great step forward. The strengths they felt were partnerships between NGOs and Government; women getting a chance to come out; and Mitanins being able to relate to their community and bring about increased awareness. Their main concerns were the high drop out rate among Mitanins; illiteracy making selection difficult; very short duration, irregular and infrequent training.

'*Swasthya-karamchari upekshit bhavanase Mitanin karyakram ko dekhte hai. Yeh bahut nirashajanak hai. Hamara insult karte hai'* [ the health department staff look down on this Mitanin programme, this is very depressing. They insult us] – they told us. Their plea was for the doctors (in the PHCs) to take a greater interest in the programme (and support them).

In another group discussion in Raigarh where about 35 Prashikshaks from three adjoining districts had gathered, there was relative satisfaction among the BRPs. Several of the BRPs here were Government functionaries (receiving the BRP allowance as additional to their salary).

**NGOs**, as the implementing agencies, had tried to cope with the financial constraints through raising alternate resources. However, they too were finding it difficult to continue without funds. The NGO workers did not seem to know that "by design" the programme would come to an end after three years of implementation. Many were of the opinion that for a lasting impact the programme should run for at least five years with pace and inputs similar to the early phase. They had also made adjustments and modifications to the programme structure to fit into their existing work and suit their needs such as making payments through alternate sources; increasing the number of functionaries; starting a help desk at a district hospital / CHC etc.

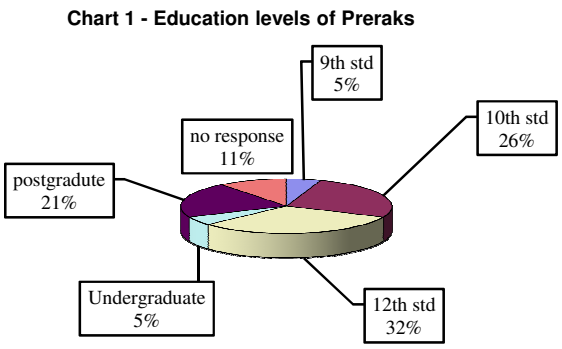
Only a few Government officials in their capacity as nodal officers or trainers / facilitators seemed to be fully 'involved' in the programme. Misappropriation of training funds was reported and noted at a few places. At one place the Medical Officer (also a DRP) had good insights and suggestions for the programme.

## Comments

The SHRC and the BRP-DRP system is a unique experiment in India wherein a parastatal body was created as an additional technical capacity to help the health dept. On the whole, this is a welcome step since the Departments of Health in government may be neither fully equipped nor enthusiatic about such a vast new involvement. There are also time constraints for training and monitoring. If we point out weaknesses in the Mitanin programme, it is largely despite SHRC rather than because of SHRC. This is not to say that the research team agrees with SHRC policies and plans in toto.

Another point to consider is how well are the SHRC, and the BRP teams integrated with the public health system.

### The BRPs - Link between Mitanins and SHRC




Preraks (initial motivators)/ Prashikshaks (trainers)/ BRPs are the key resource persons in this programme. Several of them are educated up to school higher secondary level and above. Many have experience of having worked with the literacy mission and are engaged in social action through SHGs (self help groups) and other local committees. Many had some one else in the household working as an allied health professional.

We interviewed 19 trainers in the field study (and met more). Only 5% had education levels below 10$^{th}$ standard. (See Chart 1– above) We found this cadre to be a very enthusiastic and hardworking group.

However the evaluation team found that the BRPs' motivation had started faltering over the issue of non-payment, and low payments. We had the occasion to interact with 16 Prashikshaks along with their supervisor DRPs gathered on their own initiative for discussing this very issue in Durg district. Some of them were very distressed emotionally as well as financially. They had invested a lot in working for this programme. To begin with they were promised a low honorarium (lower than the minimum wage considering that they have to spend good part of the day in visiting Mitanins in the villages) out of which they were to spend for transport too. Not even this was however received in full. Some had borrowed money to pay for expenses in the interim period, hoping to receive compensation some time later.

Over half of the BRPs expressed that the salaries are irregular. Only a third of the 19 Prashikshaks (BRP) interviewed formally had received their salary regularly. Many of them received the payments after three months. This story was echoed in the districts visited by the SHRC evaluation team.

One NGO coordinator commented - 'trainers are the pillars of the whole programme, if they are withdrawn the whole structure of the Mitanin programme will collapse.' He also said that the programme had brought about a 'sea-change' in the attitude of people towards health issues. However, the chief concerns were fund flows and weak training. He also believed in having a larger number of trainers and supervisors. Mitanins in this NGO area were paid an honorarium for some other work they were engaged in.

One more disappointment was in regard with the way Prashikshaks have been handled. Admittedly, the most important person in the entire programme, these Prashikshaks had to be smart enough to get trained on health related information in a few days of did actic training; and be able to train others by the same method; besides moving around in the villages motivating the Mitanins; building their confidence and helping them get credibility in their work.

Yet, most Mitanins never saw them as anything more than messengers who would inform them about their next training. At the lowest end of the paid-worker tier, their payments have been left to the mercy of the government authorities at the PHC or CHC level. No wonder that at some places we found that they had received only 3500 rupees in a 'year and a half' of work – in Raipur, the capital district - when they should have been getting a thousand rupees every month for their workie Rs. 18,000=00 for 18 months. One could speculate as to where the remaining allocated money had gone.

Almost all Prashikshaks told us how they had to borrow money to pay for their transportation, and how they had to wait for months before they would get some money or a gift like a saree in return!

The experience and dilemmas of Prashikshaks are best expressed in their own words :

*'Aas main kar rahain hain, bhagwan ke atuut astha par tika hain, kuch din karenge, aakhiri mahina hain.' [Prashikshak in Marwahi who has not received money since November 2004 – am working on hope, continued due to belief in God, will work for some more days – this is the last month (of waiting for the payment)]*

*'Woh hamare TA par bhi vishwas nahi karte, kat ke dete hai.' [Prashikshak, Balod – They (DRP) do not believe in our travel claims, give less] (the BRP felt this to be very insulting)*

*'Mahilaon ko jyada joda jayaen, prashikshak purush mil raha hain, upar bhi cluster prabhari purush hai to khulkar kaise batayen'. [Prashikshak, Marwahi – more women should be employed. They are getting more (and more) male Prashikshaks, on top too the cluster in-charges are men, how can women talk freely in such situation?]*

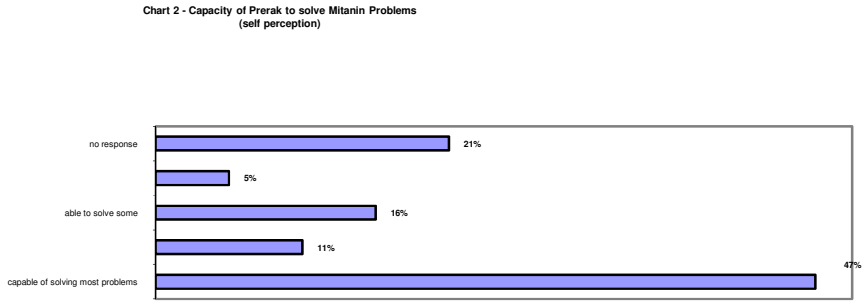
It was difficult to get a Mitanin as there was no money. [Trainer, Podiuprada].

*'Mitanin ko paisa milna chahiye, protsahan rasi milta to interest hota.' [Prashikshak, Marwahi – Mitanin should get money, they would be interested if there were incentives]*

*'Jo thodi bhi samjdar hain woh to samaj rahi hain ki milega, jo nahin samajthi, woh kahti hain, kuchu to nahin mili ka bar kareen, tohe to mile tu kar'. [Prashikshak, Marwahi – Some who have capacity understand that they would get money (in future), those who do not, say 'I don't get anything, why should I work, you get (money) you work'].*

## Capacity of Preraks/ Prashikshaks to solve Problems faced by Mitanins

Regarding capacity for problem solving for Mitanins, half of the Prashikshaks felt that they were capable enough. About a fifth said that they were capable of solving some problems. While another fifth felt deficient. One fifth of Prashikshaks did not respond.




Most Prashikshaks said they were capable of training, helping and nurturing the Mitanins. However, half said that they need more training to be able to do so.

### *Comment*

A well 'structured' management system exists as of today. However, communication from top to bottom seems to be weak or breaking down when it comes to the lowest rungs. Where Government is managing the programme, due to the known limitations of the government system, the issues get exaggerated. There is lack of clarity about how to deal with the age-old issue of a corrupt system and refractive Government officials – which would be the inevitable ground reality in most states of India. The Mitanins alone can not be expected to deal with the system.

The remuneration structure relies heavily on 'voluntarism' and 'high motivation'. To achieve this though, consistent inputs for orientation regarding the vision / goal is essential. There does not seem to be a design or strategy to achieve this, especially where the field staff and Mitanins are concerned. In face of this the discontent at grass-roots is not unexpected.

Plans for sustained support for the programme and for Mitanins on the ground were not evident to us.

There was little evidence of planning for human resource management in the Mitanin programme itself: there were unanswered questions such as – what happens to the large cadre of BRPs? What about attrition? What about retraining, and training of new entrants?

Training of Trainers for a week or 10 days or more, with differently designed modules for conducting training during the different phases, using audio visual methods, seems necessary.

Payment to Prashikshaks should be made directly by the SHRC; and regularity needs to be ensured. With a fewer number of Mitanins, smaller training teams may do. Prashikshaks as they are today, may not be suitable as primary trainers, but as field facilitators. Prashikshaks need more inputs and hands on experience to develop knowledge, attitudes and skills in health work, so that they can guide the mitanins and gain their confidence to be more fast than messengers. They also need supportive supervision from community health practitioners.

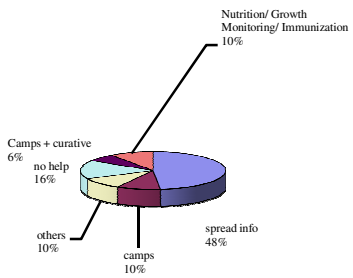
## Role of Mitanins as perceived by preraks and peripheral health functionaries

### Preraks on role of mitanins

The 19 Preraks were asked about the most important functions of the Mitanins. Information about medicines was mentioned by 16%; information and community organization had a similar response; information, medicine and organization (3 tasks together) had another 16% . Indeed information as a task figures in almost all responses or combinations. Thus it is a dominant task perception by all the Prashikshaks (84%).

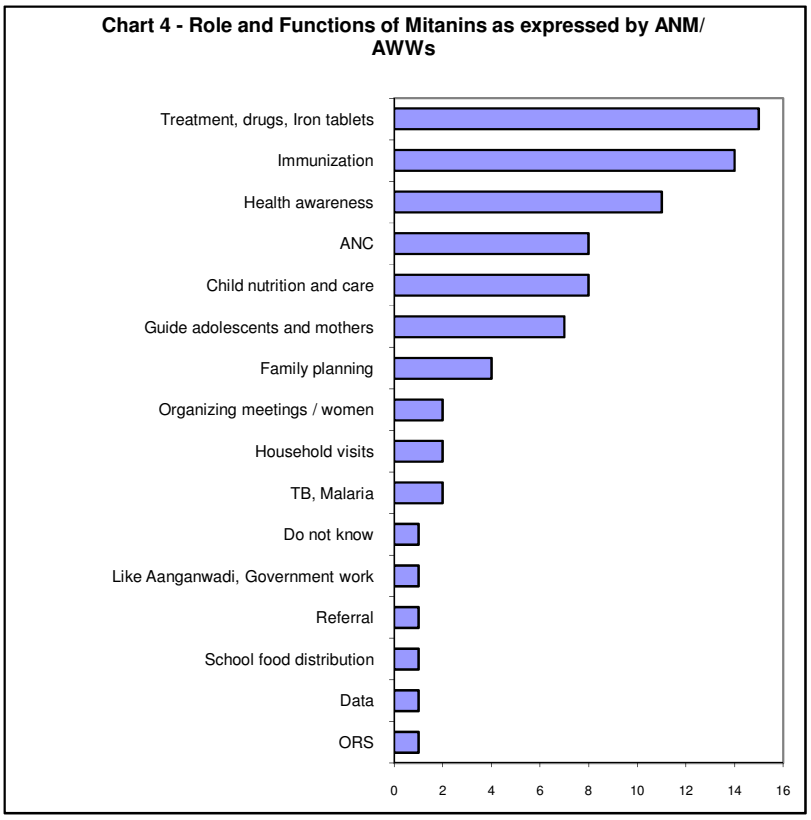
Medical treatment figures as the second most cited tasks (over 62% responses). About 45% responses included community organization as a task of Mitanins.

**Chart 3 - Participation of Mitanins in National Health Programmes**



### *AWW/ ANM on role of mitanins*

The AWW /ANMs (31) perceive the major role of Mitanins as creating community awareness by spreading information and mobilizing the community for camps, immunization and other services etc. (48%). About 16% respondents talk of 'no help' expected. Apart from these, the team also explored ANM /AWW's expectation about Mitanins' participation in the National Health Programmes.




### ***Gramwasis'* on role of Mitanins**

*Gramwasis*' perceptions about the role of Mitanins were derived from their comments and responses to the question about the work by Mitanins in the villages and their observations of the programme.

Some of the quotes of *Gramwasis'* are telling:

*Bas sun raha hun, Mitanin – Mitanin – kya kam, kya chaltaa kuch pata nahi' [*villager in Baster - I have only heard about it, but have no idea what the Mitanin does]

*'Suru suru mein ek bar suna, aur ab sun raha hun!'* [Had heard about it in the beginning, and since then only now!]

*'Jab unko bhi pata nahin ki unka kya kaam aur adhikar hain woh kya karenge?*' [Said a villager in Kosaga, Lakhanpur – When they themselves do not know about their own work and authority, what can they do?].

Gramwasis' almost uniformly expected that Mitanins should have a stock of medicines and give these free to people. They complained that the mitanin herself does not have anything, hence they can not give anything to us!

*'Kuch kam nahi karti! Kya kar sakti, use to khud kuch nahi mila'* [village woman in Durg – she does not do any work, what can she do, she herself has got nothing]

**Programme Awareness in the community**

Mitanins have a long way to go to be evaluated on the basis of awareness, going by what we saw in most villages.

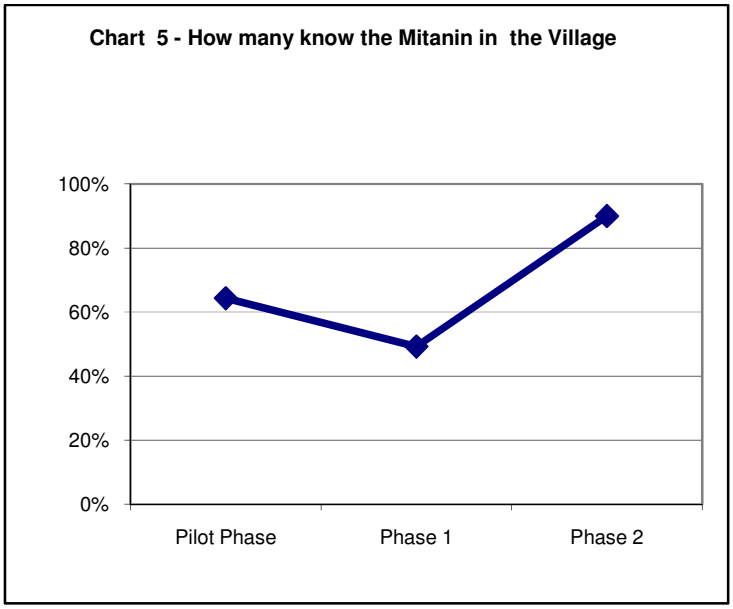
Though many people we interviewed have 'heard' about mitanins, not many people seemed to know about the content of, or the existence of different initiatives at village level expected from the Mitanin programme. After enquiring with several people, one would find an AWW who would know about the Mitanin in the village / locality. At best some women would know about the Mitanin and say that she goes for some training and meetings. In other cases they said she does not do anything! Men who knew about it thought about it as 'Government programme' and through it expected to receive medicines free.

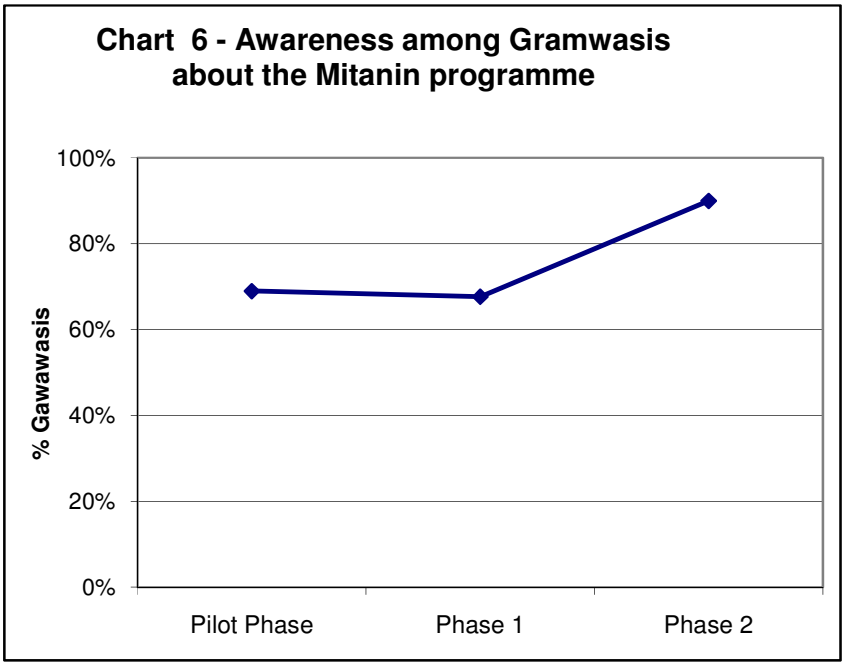
**Panchayat meeting in Marwahi**

In a panchayat meeting that team members attended, it took some time before anyone could understand what we were talking about when we told them that we had come to look at the Mitanin programme. No one except the Panchayat Secretary knew about the Mitanins – and there must have been about 10 or more Mitanins in the Panchayat area which belonged to Marwahi block, the first block where the erstwhile Chief Minister, Ajit Jogi launched the programme. Three years of programme, and of the 30 odd men – admitted that women had gone by the time we reached there – no one had heard about such women who had been trained or were expe cted to be doing some work. Even if the planning training has not been conducted there and were to be done shortly, one would reckon that they wouldn't trust such a person to lead them into planning the health future of the area.

The evaluation exercise included interactions with over 495 Gramwasis' (101 schedules or gramwasi groups). This included not only semi-structured interviews, but also collecting of specific responses to key aspects. The analysis is presented below.

*Nearly 70% Gramwasis have heard about the Mitanin programme which is an encouraging response*. The phase-wise analysis indicates positive change (awareness about the programme) from around 70% (68%) to 90% Gramwasis. (however from Phase II only 10 schedules of Gramwasis interview were filled, making it difficult to be sure of the trend).




*When asked to name the Mitanin about 57% responses were positive. Another 8% knew the person but not the name.* The response is on the whole favorable as regards name of the Mitanin - in Pilot phase (65.8%), phase I (45%) and phase II (90%).

## Kalajatha's

The medium used to create awareness about health messages was one of the discussion points with Gramwasis'. The interactions brought forth interesting information. Of the total 101 Gramwasi groups, *44% have got a health education message through some medium.*

Kalajatha's were the leading medium (26%) through which health information was received. About 56% either do not know/ have not heard about and others did not

respond. Home visits seem to contribute very little as a medium of learning health messages (11%). The situation is slightly better in the pilot phase because 'negatives' are only 35% and 65% have received health messages through some media. In Phase I the percentage of positive responses drops to 34%.

*In several interviews and questionnaire responses the Kalajatha was mentioned. It is possible that Kalajathas were held in many places in every district*. This is presumably the major input for pre selection sensitization of village communities about the programme and the selection process.

In the total study sample 24% recall having a Kalajatha in the village. The others did not know or did not respond. The situation remains nearly the same in the pilot phase and Phase I.

The planners expressed their inability to use other means like posters, etc. to raise programme awareness due to financial limitations. Kalajatha's thus remain an important medium for communication. Wall paintings were found in some areas.

Levels of awareness regarding programme content and purpose was low in general. This finding was not expected in a programme designed as a participatory one, with emphasis on community support and activism from the Mitanins. Communication – continuous and consistent in the message it gives - with all stakeholders, was thus found to be weak. Ongoing need further support, along with strengthening innovation, professionalism and feedback systems.

**Selection of Mitanins**

Selection of Mitanins is the most crucial of the design components. Selection was to be done through an iterative process of engaging with the community in a dialogue about health needs and the requirement of a suitable local person. This was expected to result in volunteering by service-minded women, followed by choice of the most appropriate person and acceptance by most people in the community. Gram panchayats and gram sabhas were to be involved in the process.

The internal evaluation had shown that 'in as many as 38.73% cases, the process of Mitanin selection had been inadequate.'

"The most common error that could occur is that the Prerak decides on behalf of the village, usually in consultation with the Panchayat or Government employees like the ANM/AWW. In 44.43% of cases, we find that the Preraks have made the decision."

In keeping with the internal evaluation finding, the most common description of the selection process that we came across was – '*The Prerak came to the village / to the anganwadi worker and asked who could be the Mitanin. He/ she would then visit the*

*prospective Mitanin and try to convince her. Sarpanch would be informed and his / her approval taken for finalizing the name*.'

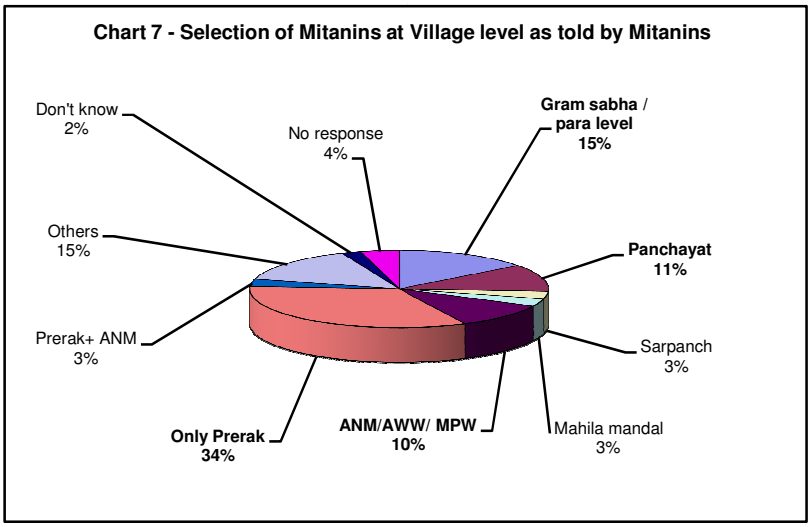



Chart 7 shows the various means through which Mitanins were selected, as reported by Mitanins. It appears that the facilitator dominated the selection process of Mitanins.

Adding the agency of ANM/ AWW/ MPW about 47% mitanins were selected by non-panchayat agencies. With addition of 'others', non -responding Mitanins, and those answering don't know, the non-people non-panchayat process of selection accounts for 69% of the study sample. *About 32% were selected by either Grampanchayat or Gramsabha or Mahila Mandal or their combinations*.

The phase-wise analysis of the selection process shows more or less the same picture. In the pilot phase the panchayat - people selected 32% Mitanins, 31.3% in the phase I and 10% in phase II. Thus the process of panchayat selection weakened further beyond the pilot phase. It needs to be noted that almost 60% in phase II were selected by "Only Prerak". However phase II is a small sample of ten Mitanins, thus we have not looked at the statistical significance of these trends. Mahila Mandals accounts for less than 4% of Mitanin selections in all the phases.

### Influence on selection of Mitanins as expressed by AWW/ANMs

Less than a fourth (25%) ANM/AWWs confirmed their individual role in selection of the Mitanins, next only to the Preraks. The women's group, Gramsabha, and Sarpanch accounted for about 18% selection according to these respondents. The respondents also talk of 16% 'others' who played a role in selection.

Many ANMs in their interviews told the evaluation team members that they were not involved in selection. Had they been asked, they would have suggested a more appropriate woman for this work. On the other hand several AWWs were asked for their opinion during the Mitanin selection.

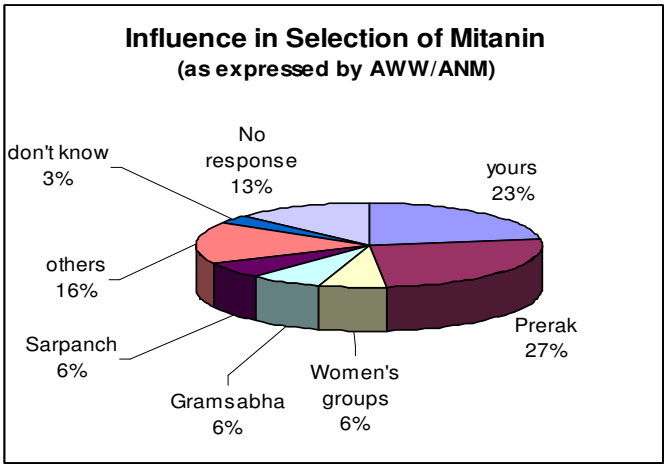
## Influence on Selection of Mitanins as expressed by *Prashikshaks*

Of the 19 *Prashikshak*, four stated that they played the main role in selecting the Mitanins. According to them the *Gramsabha* had a major role (one third responses). However, a sizable number (8) did not know because they may not have been *Prashikshaks* when the Mitanins were selected.

## Mitanins' selection as expressed by *Gramwasis*'

**of Mitanin**
**M)**

About the selection of Mitanin there is no unanimous opinion by the village community. Only 16% of the aggregate called it the best choice. In the pilot phase 17.9% said they were the best choice, but the same falls to 9.6% in phase I, and improves again in Phase II to 4 out of 10 responses.




In the pilot phase many people have reconciled with the selection of the Mitanin – 'have to put up with the one selected' - (23%), and this figures in the aggregate as 15%. One out of 10 in phase II suggest that the selection was a mistaken choice. However, the 'don't know' and 'did not know about the programme' categories make the most of responses in aggregate as well as in the pilot phase and phase I. In general there is small support (about one third respondents) to the selection of the present Mitanins.

The Gramwasis' (41.6% of the aggregate sample) favored a woman as a Mitanin. The pilot phase has 43.6% positive responses; the proportion is 38.5% slightly less in Phase I. This may perhaps be influenced by the local culture within the blocks selected in various phases.

## Approval of selection by the Sarpanch

The expected endorsement by the *Panchayat* is not the major trend.

In Marwahi block, a programme for *Sarpanchs* to 'tie a rakhee to the Mitanins' in a ceremony to formalize their role in the *Panchayats* had been planned and supported by a special fund allocated for the block. We couldn't confirm this special feature in Marwahi block - not one Mitanin or *Panch* member or NGO personnel had heard of such a programme.

At many places, we did come to know that one or the other *Panch* had been consulted by the *Prerak/ Prashikshak* to select the Mitanin, but there was no institutional engagement as had been planned in the programme design.

The data shows that less than 30% of the Mitanins mention approval of the *Sarpanch* for the selection. About 36% deny approval and about 35% either do not know or do not respond. The same situation prevails in the break up of phase wise selection figures. However the *Sarpanch* might have approved the selections eventually at appropriate stages or after reminders by the *Zilla Parishad*. Some researchers asked the Mitanins whether they received a letter from the *Grampanchayat* or *Sarpanch* approving their selection. Such certificates were reported occasionally only in Raigarh district (it was seen in no other area). We learnt later that the Department for Panchayati Raj had not been involved in this exercise from the beginning. They were infact critical of the setting up of village health committee by passing the panchyat health sub-committee (*sthayee samiti*) Letters of endorsement by *Grampancayats* were summoned at a later stage of the programme.

We consider selection by the Gramsabha, Grampanchayat, Sarpanch or Panchayat as part of the same broad category. Though there are different processe involved, for people in villages and *paras* the differences are barely seen. From the Mitanins' responses, about a third have been selected in this manner, while ANM/AWW interviews suggest even a smaller role played by PRIs.

When some Mitanins were asked in detail about the actual event or process, often the Gramsabha turned out to be just a few people meeting including the Preraks and Mitanin candidates, instead of village community gatherings as was intended. This could be different in tribal and non tribal areas. Generally it is easier to hold a Gramsabha in tribal villages. The intensive, participatory selection process envisaged in the design seems to have been circumvented. However, a beginning has been made.

## Constraints in the selection process

The preraks / prashikshaks expressed that problems occurred in the selection process due to:

- Very short time given for selection,
- Women not coming together,
- Difficulty in getting literate women to work as mitanins,
- Difficulty in convincing the women to work as volunteers,
- Less educated women being less 'intelligent' (lower grasping capacity),
- Difficulty in reaching villages due to lack of roads,
- Difficulty in organizing Gramsabhas or women's meetings,
- Some trainers had joined the programme after the selection process was over.

In the hope of receiving future payment, several influential people like the Sarpanch, MPW, local doctor have tried to get their relatives nominated.

**Selection of Mitanins - some case studies**

*'Ek sal ho gaya anganwadi ne kaha Mitanin ban gaya, gaon mein dekhbhal karegi. Gaonwale nahi bana sakte, sarkar ka aadesh nahi hai to bana nahi sakte hai' [FGD in Podioparda – Aanganwadi worker told us one year ago that the Mitanin has been selected and would work for the village. Villagers can not make any one else a Mitanin since there is no Government order for the same]*

*A Mitanin in Paraskol, Sarangarh said, 'Nobody was willing to become the Mitanin in the village, so the trainer (who knew her husband) asked her to become the Mitanin.'*

*'Padhai likhai ka adhaar nahi hota to doosri ko bhi Mitanin bana sakte, gaon ki purani mahilaon ko jo jachki vaghera karate hain.' [Gramvasi in Bhalupani, Sarangarh – If it were not for the condition of literacy, we would have chosen some one else like the Dai/ TBA]. {this village was proud that no delivery had occurred outside the village for the past 34 years, they had great faith in their Dais}*

*'Janaki Nirala ka naam tha, sarpanch ke bhai ki gharwali thi, anpad hai isliye nahi jati hain'. [Mitanin in Hirri, Sarangarh – Janki Nirala was selected (as Mitanin too) as she is wife of Sarpanch's brother, but since she is illiterate, she does not go (for training)].*

*Anganwadi worker chose this woman as she was poor and very talkative. [Gramwasi in Kosaga, Lakhanpur].*

In the villages there exist several health related workers like former Jan Swasthya Rakshaks (JSR), malaria depot holders, AWW assistants (supported by CARE), Kishori Mandals helping AWW (adolescent girls' groups). Now with addition of a Mitanin through selection 'as per instructions' without considering the 'actual situation' these villages can have one more worker. This has led to a situation of having several Mitanins in main villages. With some adjustments and better implementation, villages / hamlets with sparse populations and those in difficult terrains could have got more mitanins ensuring a more equitable distribution.

Village level health functionaries in Bital

One person enumerated the following 11 health functionaries at the village level:

Malaria Mitanin, *Sangwari* or CARE Mitanin per *mohalla, Swasthya* Mitanin per *mohalla,* Malaria Link worker, Ex- *Jana Swasthya Rakshak*, Depot holder, Anganwadi worker & her *Sahayika,* ANM, Malaria worker (Multipurpose Male Health worker), Health Committee, *Vikalang* Mitanin.

## *Comments*

The evaluation team felt that the programme could have taken stock of existing local health workers and brought them under the Mitanin fold as per the community's willingness. Not building on ground reality has led to a situation where many health functionaries (including the AWW) are doing overlapping work in the village and the Mitanin is one more addition to the same. First, such duplication is a wasteful application of resources and secondly it injects a feeling of lack of purpose among the competing cadres. For instance eighing of babies is an AWW job, why should the Mitanin be doing it, is the question—to countercheck? or to replace AWW tasks? Ways of meaningful collaboration have not been worked out.

However, at this moment having completed the selection process,it is advisable to organise programmes where the Mitanin is formally introduced to the Panchayat and the village clarifying her role, and the fact that she is a voluntary worker. Steps to enhance her status may be taken, such as by equipping Mitanins with a BP (blood pressure) apparatus (generic aneroid machine costs Rs 140.00 in Delhi) and a thermometer as developed by the Jan Swasthya Sahayog (JSS), Bilaspur. A special arm band identity card, or board for the Mitanin's house can be given as a marker of her position and social role'.

## Mitanin Training

In this programme the BRP is the trainer, though ANMs also participated as resource persons for some lessons. Views from mitanins, BRPs, ANMs and others have contributed to our understanding on the mitanin training component of this programme.

We met several Trainers (Prashikshaks) during the study, but structured questionnaires were used for only 19 of them. Others have contributed through FGDs or in open ended in-depth interviews. We are aware that the number (19) is rather small to draw conclusions regarding a large scale programme.

## Training venue and Physical facilities

There was no structured question on this. Most training camps were held at clusters of village Panchayats. This could be the Panchayat Bhavan or a health sub-center building. Seating places for participants was the only facility in such situations, not even black boards were available. There are no teaching aide available. This is very inadequate and does not help the learning process.

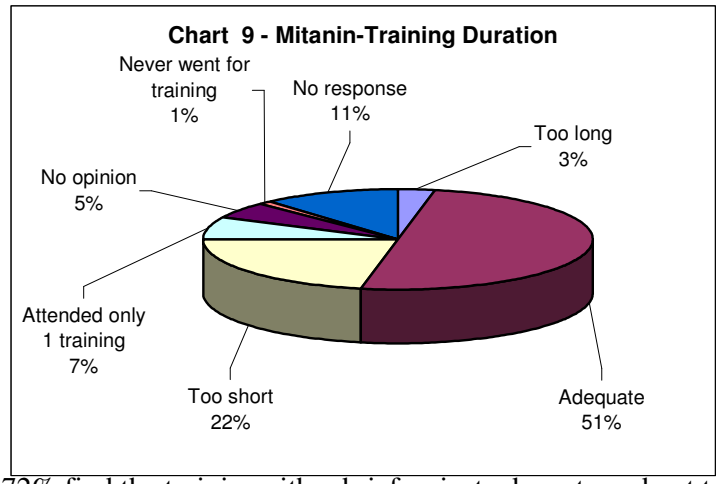
## Batch strength

The usual batch strength as stated in interviews is about 30-40, which covers about 4-5 villages and their hamlets /paras.

## Hours of training

The usual hours of training camps were between 10 am to 5 p.m., and most Mitanins traveled from the villages on foot, by bus or some vehicle. Training was generally not residential. At times some Mitanins have stayed overnight depending upon distance and arrangements. The village cluster approach made the commuting easy.

## Training duration




The interviews with Mitanins revealed that about half of the Mitanins found the training period to be adequate. Only 3% said it was too long. About 22% felt that it was too short. 7.7% have attended a single training and 1% never attended training. Mitanins giving no opinions and non-respondents are about 17%. On the whole about 72% find the training either brief or just adequate and not too long.

About 42.1% of the Pilot Phase respondents find it adequate and 26.3% felt it was too short. In phase I about 58.3% find it adequate and 14.6% find it too short. The phase II training has just begun and so we do not attach importance to phase II responses.

However, from the narratives it emerged that except in the 14 pilot phase blocks, the training pace was slow. Infrequent training inputs, problems in attending sessions due to lack of transport for Mitanins were common problems. Some cases of corruption leading to reduced payments for travel reimbursements and for food arrangements have been reported.

## Travel and food support for training

Mitanins said that they had received only a small amount of money for travel and were given only tea or snacks during training in several places. Field Coordinators also corroborated this by saying that they were given '*panch rupaye ki roti-sabji*' while claims' vouchers were for full amounts.

The question on duration and other aspects of training is based on recall and is rather remote for the phase I Mitanins. It does not matter to them if it is either long or short and therefore it would be safer to say it was adequate. In general the short training programmes conducted at walkable distances in the vicinity of their homes (clusters) were found convenient by most Mitanins.

The same question was posed to the Prashikshaks. Over half of them felt (56%) that training duration was adequate for training Mitanins. To a question on whether the duration for Mitanin training was suitable for women; 42% Prashikshaks felt the duration was acceptable, and 37% thought it was not. Another 21% have not responded.

## Period between trainings

The question on *the ideal 'gap' between training sessions for Mitanins threw up 'one month' as the most favorable option*. A camp of 15 days or two months evoked less support. About 23% had no opinion or did not respond.

The pilot phase Mitanin respondents largely favored (47.4%) the one month gap. In phase I, however only 39.6% of the Mitanin respondents thought a one month gap was good. About 14.6% of the phase I Mitanin respondents have suggested a two months gap. 30% Mitanin respondents had either no opinion or did not respond. Half of the phase II Mitanin respondents favored a one month gap.

This is consistent with experience in most CHW programmes where a month is found to be a convenient interim period for performance review and additional inputs.

## Methods of training

The usual method was didactic-lecture and questions—the oral '*kirtan*' tradition (discourse). Often there were no black boards, no flip charts, no models, or use of information technology. However the Hindi manuals were available and these are good training materials with pictures.

On the job training by the prashikshaks was found lacking. The prashikshaks themselves were trained just a little earlier and lacked first hand experience of health work, which is necessary in order to train confident and well.

The other method of training was by prashikshaks visiting Mitanins and giving them lessons. In fact this has been grudged by some prashikshaks.

## Quality of training

Responses to enquiries relating to quality of training also followed somewhat similar patterns. *Nearly 46% Mitanins thought it was very good*. Some 24% thought it could be better. About 3% opined that there were lots of problems. Others attended a single training or no training or had no opinion or did not respond.

The Mitanin respondents in the pilot phase were equivocal about 'goodness' of the training with 28.9% terming it very good, and 28.9% thinking it could be better. In phase I the tally on 'very good opinion' is about 58.3%. A proportion (18.8%) expressed that it could be better. In corroboration with qualitative data where most respondents have asked for more training, this is a point that could be followed up.

The next question was about whether the Mitanins found the training easy or not. In general close to half respondents found it very easy and about 31% had only some difficulty. In the pilot phase 31.6% found it very easy and about 36.8% equal numbers had some difficulty. In phase I this proportion changes with 54.2% saying it was very easy, 31.3% had some difficulty. In phase II only two training programmes had taken place and nearly 8 out of 10 have found it very easy.

### Training and Learning Materials

A review of the learning material is given in the annexure. Due probably to the wide variation in the literacy/schooling level of Mitanins and the new or inexperienced trainers employed, the SHRC document terms the material as being meant for trainers, from which the trainers will train the Mitanins. The same booklets are however also in the hands of Mitanins. This material contains the final 'content' of the programme. There is a Training of Trainers (TOT) book too, however we found that the ToT book was not much used for the actual training events at the level of Mitanins. Given below are some points from the interviews:

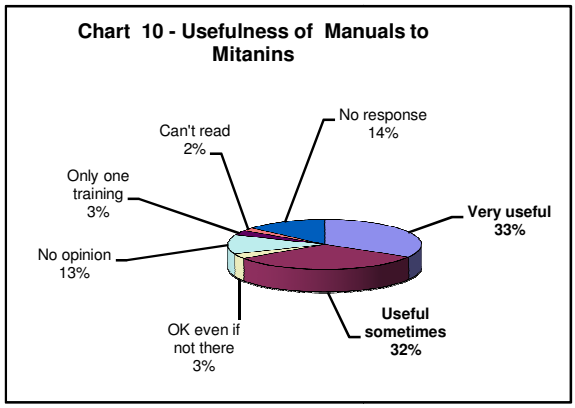
*Most prashikshaks felt (63%) that the training material was adequate* and that programme information regarding treatment of women's illnesses was sufficient. Most (63%) also felt that the written material was sufficient.

The availability of other teaching aids like flash cards etc. was perceived to be adequate or very good by about 67% prashikshaks. Others feel that it was inadequate. Although SHRC or GOC has not provided other teaching material, we included the question because some NGOs have also participated in the programme and may have used other media and methods.

A question on understanding the training manuals (learning manuals for the Mitanins) throws up 'easy' as the most chosen response. About 51% of the study sample, 45% of

pilot phase, and 50% of phase I, find it easy. 22% of Mitanins said that the training was 'little difficult' (18.4% in pilot phase and 27.1% in phase I).

**Usefulness of manuals**




To a question on usefulness of the manuals, about 33% of the mitanins found them very useful, and about the same proportion found them useful 'sometimes'. 2% of the Mitanins can not read manuals, about 13% respondents have no opinion and another 13% did not respond. 34.2% of the pilot phase Mitanins find them very useful and about 21.1% 'useful sometimes'. In phase I the percentages are 33.3% and 39.6% respectively.

## Frequency of reading the manual in the last month

The question on how many times the Mitanin respondent used the manual during the past month evoked somewhat different patterns. Of the study sample *8.3% had used it more than 10 times and 6.3% between 5-10 times. 45% have used it 1-5 times. 'Never used' category counted 25%.*

In the pilot phase about 47.4% had used the manual more than once during the preceding month, but 34.2% had never used it in the last month and 13.2% did not respond. *Thus close to half had not used the manual in the last month*. In phase I close to 64.6% had used it more than once in the last month. In phase II where Mitanins had undergone recent training, eight out of 10 had used it more than once in the last month.

These questions were backed by subsequent queries by the team members about what topics were read from *the manual in the last month. Many Mitanins could not even tell which of the booklets were used in the last one month. The manuals to us looked very fresh and clean and seldom appeared as 'oft handled books'*.

## *4. Frequency of use of manual by Mitanins*

| | Total Study | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Manual Use | Sample | | Pilot Phase | | Phase 1 | | Phase 2 | |
| Frequency of use | N | Percent (%) | N | Percent (%) | N | Percent (%) | N | Percent (%) |
| More than 10 times | 8 | 8.30 | 5 | 13.2 | 2 | 4.2 | 1 | 10 |
| 5-10 times | 6 | 6.30 | 2 | 5.3 | 4 | 8.3 | 0 | 0 |
| 1-5 times | 43 | 44.80 | 11 | 28.9 | 25 | 52.1 | 7 | 70 |
| Never | 24 | 25.00 | 13 | 34.2 | 10 | 20.8 | 1 | 10 |
| Only one training | 3 | 3.10 | 2 | 5.3 | 0 | 0 | 1 | 10 |
| Whenever time | 4 | 4.20 | 0 | 0 | 4 | 8.3 | 0 | 0 |
| No response | 8 | 8.30 | 5 | 13.2 | 3 | 6.3 | 0 | 0 |
| TOTAL | 96 | 100 | 38 | 100 | 48 | 100 | 10 | 100 |

### Problems experienced by Mitanins during training

The question on problems encountered during training evoked somewhat similar responses. In general 48% Mitanins had no problems and 23% only few problems. Thus about 71% have no serious problems during the training. About 7% faced lots of problems and 3% said it was difficult to attend because of rains.

The picture remains similar in the pilot phase and to some extent in phase I. This underlines the importance of the consideration of convenience to participants, that has been followed in the training programmes.

## *Comments on training*

Training and retraining is a major part of any CHW programme. The vast scale and rapid speed of operations planned by SHRC for training seemed to have affected the quality of training.

a. The DRP-BRPs do not have any first hand knowledge of health issues. They receive rather short training through didactic sessions, which they passed on to Mitanins. They have little understanding of training and communication processes and methods. They have themselves never handled health problems.

b. The health system was only marginally involved. The original idea of the main training events to be held in a health institution (PHC-CHC) seem to be sometimes given up in favor of cluster training at a nearby village where no training facility existed. Health institutions also offered meagre facilities. Health staff may not know the roles and skills expected of mitanins. This affected the training and compromised on quality, field follow-up and linkages.

c. There was some ambiguity on whether the training material was for Mitanins or trainers. The same material was given to both. The trainers require more maternal with more content, along with methods of training. Books such as "Helping Health Workers Learn" by David Werner, and "Training for Transformation" are useful in this regard. . The non-literate Mitanins were not into training really as the books were not designed for them.

d. The training of Mitanins seemed to have become somewhat a ritual, rather than an empowering process as designed. The Prashikshaks themselves require more empowerment so as to enthuse or empower their trainees.

e. The capacity of the trainers is a serious concern. Normally the teacher is expected to have deep, comprehensive knowledge and command over a subject. Often such qualities come only through experience of community health work over a period of years..

f. Iterative training and more frequent training of Mitanins is necessary. Almost every Mitanin repeated another lesson learnt from all successful CHW programmes, however small in size – that unless training sessions were conducted every month or so, they were likely to forget what they learnt, as they got busy with their household chores once they reached home. There seemed to be less emphasis on this aspect of training, even though the frequent blockages of funds also pushed trainings apart and created repeated uncertainties in the minds of the project staff and the Mitanins.

g. There is a need to use a larger variety of training material and methods including games, role plays, field work etc.. CDs on ARIs/ dehydration etc can be made and used for near-live demonstration training of what can be done in a rural setting in Chhattisgarh, to be used where VCD players are available on hire.

h. One of the major problems of training systems in primary care is the lack of evaluation. Often the trainer and evaluator are the same. There was no pre/post concurrent evaluation of students mitanins during the entire training. A certain level of knowledge and proficiency needs to be achieved before a person can function as a community health worker.

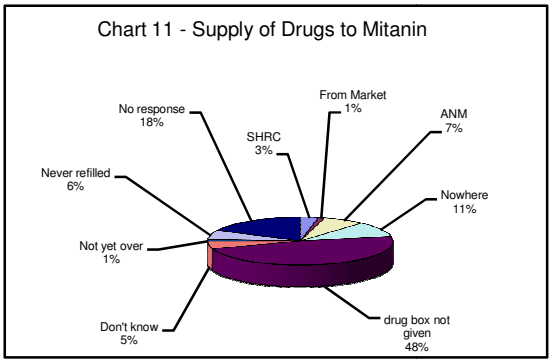
There are examples of involvement of academic institutions in training of grassroots workers. Cehat Saathi in Pune has recently involved SNDT University, Mumbai for their Pada Health Worker (PHW) programme in Thane district (Cehat). Similarly, the Foundation for Research in Community Health ( FRCH) Pune has involved the National Institute for Open Schools ( NIOS) for its programme in western Maharashtra. In Maharashtra the YCM Open University, Nasik, has been approached by the government of Maharashtra for its larger PHW programme in tribal areas. The advantages of such arrangements are evident. First there is a pedagogic involvement in the programme from professional educational

institutes which can raise the level of training-learning. Secondly, the very prospect of an end test or evaluation raises the involvement and quality of both trainers and learners. Thirdly, the arrangement can mainstream the CHW programme which is otherwise sidelined as a non-academic non-formal programme of no consequence meant only for poor village women. Fourthly, this will challenge and invite the academic community of the country to engage directly with grassroots problems. This possibility is still open for the Mitanin programme.

i. The training-retraining component of the Mitanin programme is not a finished product; it can be further developed with need based, problem-oriented, adult learner-centric pedagogical methods and support systems that are rooted in the public health system rather than outside it. SHRC and the public health system must do this together in a more flexible and continuous manner. The staff of the Department of Health at all levels will also need orientation and inputs about methods for training and supporting community health workers.The funds and resources if spent well on this will be rewarded by outcomes and impact for decades to come. Hasty decisions and action, rapid fire responses and lack of attention to community processes, quality and details will be couner productive.

## Drugs

The programme envisaged support to Mitanins in the form of an initial supply of medicines as a '*Davapeti*' following a special module of training on its use, and then expected that the drugs would be replenished by the Government machinery. However, we observed several problems regarding this assumption.




**Davapeti** - Some of the pictorial representations on the medicine containers like an iron hammer to indicate Iron tablets, or a wriggly snake to depict the deworming' medicine - Albendazole are brilliant for illiterates and neo-literates to use. However peoples perceptions about their meaning and interpretations would be useful. Some argue for more medicines to be introduced in a graded manner for Mitanin use, as unless people know that she has cures or knowledge for most illnesses, they are unlikely to access her services.

Supplying more drugs on the other hand may not be possible with this type of minimal training, as persons with half-baked knowledge trying to give medicine may be harmful. Better and longer duration training,along with assessments, supervision and support in the field and a functional referral system need to be developed.

**Drug supply** - The evaluation team's attempt to understand the system for drug supplies and replenishments to the Mitanins brought a lot of insights relating to gaps in 'support systems planned' and 'actual field implementation'. To a question about where they get the refill of the *davapeti*, about 89% Mitanins gave varied 'negatives' as responses - no where, no *davapeti*, don't know, never refilled and no response.

About 6% of the above group had the *davapeti* but had no refill anytime. Thus only about 11% had a davapeti and refill too. In this category the ANM was the most frequent source for refills. When analyzed for phases the proportion of positives and negatives remains nearly the same. However in the pilot phase 23% did not get the *davapeti* and in phase I 54% did not receive them 10% in the pilot phase and 5% in phase I got *davapeti* once but not the refill. Since in phase II the training is incomplete, the *davapeti* has not been given yet.

Overall, the responsibility for drugs supply and periodic replenishments is not well defined. The frontline staff of the Departments of Health and of Women Child Development did not seem to be responsible. The result is 39% ANM-AWW have never been associated with supply of drugs, while about 13% ANMs attempted to supply the same occasionally. Out of the 31 AWW-ANM interviewed, only 2 were successful in replenishing the drugs 4-5 times.

Enquires with the prashikshaks, showed that most (53%) feel that the drug box has adequate medicines for Mitanins. A fourth of them opined that Mitanins should be given more drugs. Drug procurement processes were non-transparent, reportedly with corruption at even top levels. Drug distribution processes were uneven across districts and at the lower levels.

## *Comments on drug supply*

The unmet need for medical treatment and care in the villages is large, as most Mitanins who had got drug boxes confirmed – their medicines ran out within days of receiving them. The refills never came. In a few PHCs, some doctors are allowing a refill, but this is not universal. "There simply aren't so many medicines as can satisfy the demands of all the village people," we were told.

A CHW programme without drugs supply and proper logistical arrangements can be defunct as primary medical care is a concrete community need and is an expectation from any health programme. In case of Mitanins, there was a conscious decision to give drugs and curatives at a later date. This has its positive aspects—of not pinning the programme into a pill for ill every scheme and providing for a build up of basic knowledge and skills which is still very inadequate. The phasing also created a space for other important health interventions. However the two year delay was on nobody's agenda. That was a trying time for the system, for Mitanins and for SHRC. The *davapeti* has now arrived. However the challenge of sustaining supply and for

economical utilization by Mitanins is greater still. With a free-drug supply approach, this is going to be difficult indeed.

There may be some ideological reasons why drugs are offered free in the Mitanin programme, and the Rights based approach could be an intellectual position for this. Launching a populist scheme could be another reason, with little planning or follow-up. But practically, this will lead to several known problems—rapid utilization, irresistible and ceaseless demand on Mitanins' drug resources, If she does not comply with the demand, a backlash is possible.

The AYUSH component is not very prominent in the Mitanin programme. Otherwise the Mitanins could have started growing and using selected medicinal herbs. It is still possible and highly recommended that AYUSH be given its proper position in the programme. It can offer several advantages. First it will integrate AYUSH at the foundation of the health system, preserving traditional knowledge and practice. Second, it will reduce dependence on drug supply and carry the day in times of short supply. It will also reduce programme costs. Non drug remedies or low-cost homeopathic remedies could also be considered for inclusion.

If the government can't afford continuous drug refills, it could look at the alternative of allowing small village level pharmacies that provide medicines for common illnesses, selling generic medicines at break-even prices. To give a drug box and not provide for refills, suggests poor design and implementation as it potentially tarnishes the credibility of the person involved.

The need for 'access to medicines and medical care by the hamlet residents' seems to have been underestimated. There has to be a realistic assessment of the needs for medicines per unit population. The drug supply chain has also to be strengthened*.

Since the programme is identified with the government, there would be some difficulty in convincing the people to pay for the medicines available with the Mitanin. There is no reason however, why the GoC will not be able to pay for the costs of medicine if the drug procurement storage and distribution system is improved, like that of Tamil Nadu or Delhi.

We also feel that people would be ready to pay for realistic generic medicine costs if made available through a village pharmacy. It is to be noted that the Chinese barefoot doctors collected drug costs in the communes.

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*The initiative to enhance the training and drug supply to ANMs, and to increase the number of ANMs to two per sub-centre will help to meet the need for primary medical care. The training and skill development of TBAs (*dai's*) is also a welcome step. The implementation of these initiatives at field level has not been studied.

***Compensation / Remuneration***

This was the issue topmost in the minds of almost all Mitanins, their families, the BRPs and DRPS and other programme managers. They put forth all types of reasons as to why they should be paid. These included: just compensation for time and effort; livelihood issues; status in the family and community; and parity with other programme staff like BRPs. Several convincing arguments were put forth.

As against this, a tiny minority was happy with the decision 'not to pay' for work. According to a pulic health nurse who is also a district nodal officer '…there are about 10% drop outs in the programme, mainly due to lack of payments. But introduction of payment would kill the programme. Daily work for one hour is no big deal and the amount of work per Mitanin is too small to pay for.'

Some quotes given below reflect the popular mood in the Mitanin community:

'*Kuch milegi to bano, nahi to nahi'*. [Mitanin / jatga / podiuprada – become a Mitanin if you get something, not otherwise]. {on being asked about criteria for recommending others to become a Mitanin.}

*'I have come in the times of difficulty for the government, then why not government pays us.'* [Mitanin / Khodri / Korba].

'*Haman kaam kare nikaley to haman kuch bhi nahi mile. Taman jaise aye sahab khana kharcha deho tohab tabhi to aaye ho'*. [Mitanin / Sandhara / Podiuprada – when we go out to work we don't get anything. Officers like you come only when you get food, reimbursements and money].

***Paise nahi milega aane jaane ka to lamba kaam nahi karenge*** **.[Mitanin / / sandhara / Podiuprada. If we do not get paid, we will not do a lot of work].**

*Without compensation she won't travel much*. [Malaria link worker, husband of Mitanin /Ghosara/ Podiuprada].

'*Nurse ko paisa milti hai, isliye ghoomti hai, yeh bina paise ke ghoomti hai'*. .[FGD / Veersa/ Podiuprada – the nurse gets money, so she moves around. The Mitanin moves around without money].

'*Vetan bani to ayegi. Abhi hum kahengey to kahegi milat nahi to kahe ke jao*'. .[FGD / / Veersa/ Podiuprada – she / they will come only if they get salary. If we ask they would say we will not get paid so why go?].

'*Gaon ke bahar theen km binjara, ane jaane ka bhada nahi mila, kaam chod ke jayi to pucho*'. [Mitanin / Martarai/ Podiuprada – Banjara stay 3 km outside the village. We do not get money for travel, I went leaving my own work, (so what is the use?)]

*In the training it was communicated that you will get Rs.500, but we are not getting anything*. [Mitanin / / Hirri /Sarangarh].

'*Gaon main jangal kantenge lakdi kategi roti chaval kahan se ayegaa. Ek din a mazdoori jata hain woh milna chahiye. Nyuntam mazdoori 45-50 rupaya hain utna milna chahiye*.' [Doctor / / Sarangarh CHC – If they were to stay back they would cut wood and earn.They should get at least a days wage. Minimum wage is 45 – 50 rupees. They should get that much].

'*Malli wali ko hazar rupay mil rahe hain, asha hai ki hamain bhi aage milega, swasthy vibhag sarangarh ne kaha hain, sambhav hai 500 rupaya milega*'. [Mitanin / / Ochha Bitti/ Sarangarh - Malli woman is getting Rs. 1000. I hope we too would get paid in the future. The health department has said that there is a possibility of getting 500 rupees].

'*Sarkari kaam kar rahi hoon jaldi hi sarkar degi.* {Her prashikshak has told her that slowly she will be absorbed in the government service and will be remunerated} [Mitanin / /Singarpur/Sarangarh – I am doing work for Government, soon Govt. will pay me for it].

'*Sabhi Mitanin ka math hain, ki aane jaane ka tho milna chahiye*'. [Mitanin / pushpalatha / kumhari / marwahi – all Mitanins think that at least to and fro travel fare should be paid].

'*Raigharh se jo theka liye hain, unke paas kaha ki paisa milna chahiye, aane jaane ka nahi mila, sirf ek baar mila hain, avedan diya hain, raigarh wale ko denge bola par dayt nahin*'.

[Mitanin and husband / / Uchha Bitti/ Sarangarh – we have told those who have contracted the programme from Raigarh that we should get paid. I received travel expense only once, I have given an application. They said they would give it to Raigarh officers, but they not given us the money yet].

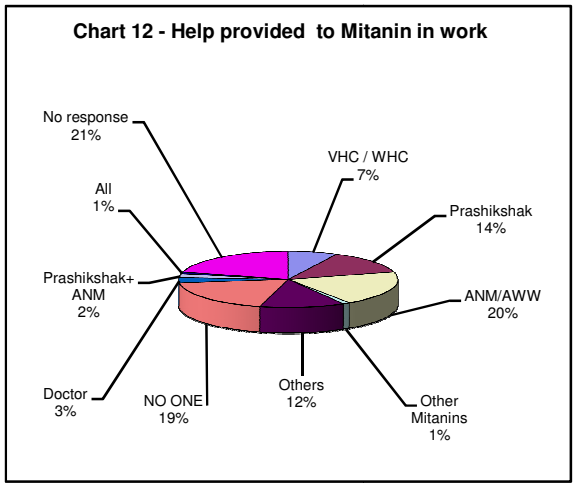
## *Comments*

The issue of volunteerism by Mitanins must be handled by the programme early on, or at least now. It is noteworthy that even the Chinese barefoot doctor received payments from the commune and people also paid for medicines. In a comprehensive article on primary health care systems in China and Vietnam, Gerald Bloom, a long time China health watcher, mentions this fact. He also notes that the barefoot doctors were part of the multi-tier health care system. The idea of CHWs and Alma Ata sprang from the decades of experiences in East Asia. It was part of their health services and there was an economic component to it. The Mitanin programme takes a strange and possibly unviable break from this robust model of CHWs in espousing volunteerism. There is really no ground to experiment in the area of volunteerism versus paid work. The unfair

gender dimension of expecting unpaid work by poor women also needs consideration. It is another matter that Bloom points to the aberrations in the China-Vietnam systems due to linking health care to market models.

The SHRC position seems to be now rightfully shifting towards payment for tasks. The NRHM also supports this approach. Incentive-based support have been tried in many country projects which utilse CHW services for specific tasks like childhood illnesses (Bhattacharya).

***Support to Mitanins in day to day work***




When asked about whom they go to for help while working in the village, about 20% of Mitanins mentioned the ANM and AWW. The prashikshak was approached by about 14% of Mitanin respondents. 7% went to the village health committee and about 13% mentioned 'others'. Some talked about doctors, other Mitanins etc. About 40% either did not mention anybody or did not respond.

On asking Mitanins about the contribution of the prashikshak in her work, the major response was 'no help' (38%) and no response (25%). Others mentioned about increasing information (14%), problem solving 3%, home visits 13%, and getting information about meetings 8%. On separating the pilot phase and phase I, the 'no help' category stays about the same (39.5% and 39.6%). About 26.3% and 25% of Mitanins have not responded to this question.

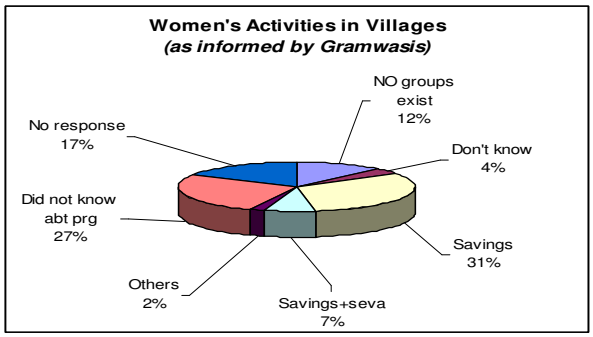
However in the pilot phase, the predominant help from the BRP is in 'house to house visits' while that in phase I is about 'giving information'. In phase II 'no help' response is from 20% Mitanins and increasing knowledge is mentioned by 20%. In this category the major form of help (30%) is 'being informed about the meeting'.

The enquiries relating to willingness to help the Mitanin showed that *gramwasis* would co-operate in encouraging the work of Mitanins. About half of the respondents agreed to provide help. In the phase-wise analysis, the proportion of *gramwasi* responses regarding 'help' is 61% in the pilot phase, falling in phase I to 50%. However, the enthusiastic response 'definitely help' was rather rare – only 15%.

**Presence of *Mahila Swsathya Samiti* (MSS – Women health committees) in the villages**

In the aggregate sample, 35% Gramwasis' said there is no MSS in the village and 49% did not respond; with only about 16% saying yes to this question. In the pilot phase and phase I, the positive response is 36.8% and 31.3%. There is (thus a small potentially significant) presence in the villages studied or it so appears in the sample.

***Chart 13 – Women's group activities***




Savings remain the most dominant response by Gramwasis' to this question (30% to 40%) on (activities of women's groups in the village) in all samples. Some respondents talk of savings + other services (ranging from 5% to 14%).

In 12% villages of the total study sample no community groups existed and many people did not know about the same. Community support expected to emerge for the Mitanin was found to be nearly non-existent. Nor was there any systematic effort to building support, barring in one NGO administered programme area.

## *Comments*

This is an eternal problem for CHW programmes. Community involvement and women's support for CHWs is where most programmes are expected to start. Yet most programmes begin without waiting for such support. Programme managers assume that the programme itself will generate the support groups on the way. It is indeed a mythical part of CHW programmes—it is there and it is not there. However, if community/women involvement was expected to be the precondition for the Mitanin programme, the precondition has not been met in most of the Mitanin villages we saw and this may be the case in general. What were the peculiar compulsions to spread the programme to all blocks and villages without waiting for community processes and women's groups to be available for support is unclear. Political compulsions before assembly elections could be a driving force. However there is no need to deny that politics and elections are a force in democracy to foster change.

The larger question now is how to generate meaningful community support and women's group support for a Mitanin programme that has so far bypassed it. This calls for special programme and PRI inputs; building capabilities in the Mitanin cadre; and offering SHGs/WSS etc some leverage in the Mitanin programme. It may mean re-selection of Mitanins at places.

### *Monitoring by Prerak /Prashikshaks*

The Mitanin programme is monitored by the district level field coordinators, who fill a grading sheet every month on BRP-DRPs' activities such as monitoring quality, training

status, programme quality, expenditure status, accounting efficiency and block level reviews.

In our field investigation we observed that several Mitanins had partially filled Registers, and many said that the *prashikshak* had taken it for compiling reports. They had note-books with some notes and answers to list of standard questions / learning messages written down. This was incomplete in several cases.

The research team could not assess the processes and criteria involved in the grading exercise. The parameters used to monitor the Mitanins' work were also unclear. When asked to point out some indicators to evaluate the Mitanin programme, many of the district and block resource persons suggested evaluation on the basis of the village health plans made at the *panchayat* level. Others asked for the evaluation of the health services provided, or primary education, hygiene and sanitation, or Mitanin registers.

The Mitanins are supposed to fill up the *gram swasthya* register, but in many places it was the BRP who did this for the Mitanin either because of non-literate Mitanins or due to the dilemma about whether Mitanins should be told to do 'work' when they are unpaid. The quality of recording in the gram swasthya registers that we saw was not satisfactory. The *gram swasthya* register itself is a static record, not very much up-gradable in itself. Patient records - so vital to medical care – are not maintained.

Recording of output, outcome and impact data apart from descriptive documentation of cases is essential for programme monitoring and evaluation. Gram Swasthya Registers were very weak. Summary reports by BRPs / DRPs are useful but subjective recordings of Mitanins' performance of activities, but can not provide adequate hard data for evaluation.

FGD of Mitanins in Amera Tikla viilage of Marwahi block

**In this village, although most people still hadn't heard of the Mitanin programme, we did manage to meet one who led us to the other 4 Mitanins. We held an impromptu focus group discussion. We discovered that only 1 of them was literate while 1 more could be considered semiliterate. Consequently we were told that not all of them were provided medicines. There was too much of a fuss about getting us something from the shop to eat and for us to drink lemon juice etc. – later they admitted that their *prashikshak* had come the previous day and told them that the programme and their future of salaries etc would be determined by our visit and hence they better look after us. What was more shocking was that when only one of them tried to dominate the answers and we stopped her, we discovered that she was the only one who could match the medicines with the disease – the others failed to match even a single one. They maintained that they were working very hard and that their *prashikshak* was coming every week – while our enquiries earlier had told us that no one in the village knew about their work and that it was impossible for their *prashikshak* to come once a week to their village, we had to confront them to speak the truth as it would help everyone.**

**They finally admitted that they had been systematically coached the previous day about each answer to each question that we were asking them with a 'paper like yours.' They also admitted that the *prashikshak* rarely came and the previous day she had come and given them a new book, *Chalbo Mitanin Sang* Part 2 to read something about TB as we were likely to ask them about TB although the training had not yet been carried out!**

## Programme outputs and outcomes

One of the major outputs of the programme are the number of Mitanins - 54000 of them in the entire state. This is a sizeable human resource for the health programme. If working and sustained, it can become another major force like the ICDS system. Let us look at the Mitanins.

### Observations and comments on Mitanins

The study included 96 Mitanins who answered the questionnaire, while we met several hundred others in groups whose feedback is integrated in the narrative part of this study.

The mean age of Mitanins (information available for 79 out of 96) is 30 years and the median and mode for age is 25 years. The youngest was 18 years and the oldest was 65 years age. Half the Mitanins were between 22 to 35 years.

The education level of Mitanins (information available for 88 out of 96) ranges from non literate to $12^{th}$ standard school education. Of the 88 Mitanins, 14 were non literate (16%). The mean is 6 years of education, the median 7 years, and the mode 8 years. 50% Mitanins had reached the $4^{th}$ to $8^{th}$ standard of school education.

For most parts the Mitanins fit the general prescription – a married, daughter-in-law in the village, educated and willing to work as a volunteer. However, volunteering time meant loss of wages and hardship for many. There was also a hope among many that at the end of the training they would either get a salary / stipend or opportunity to charge a fee for services. In some cases though the Mitanin herself had no idea why she was chosen.

Mitanins in some areas had some one in the family engaged in the health related field or they themselves were doing some other health related job. -Some Mitanins have undergone TBA (Dai or trained birth attendant) training after starting work as Mitanins.

It has been reported that during the recent gram panchayat elections, a fairly large numbers of Mitanins have been elected. In those areas this is a recognition of the leadership and social role of the Mitanins.

#### *Mitanins' capacity/capabilities*

The evaluation team during its various interactions aimed at understanding the knowledge absorbed by the Mitanins. The Mitanins were asked to list signs of dehydration as given in the Mitanin book. About half the Mitanins could not answer it correctly, while others gave one or two correct answers or acceptable answers.

**5. Response to question on Diarrhea treatment by Mitanins**

| | Total study sample | | Pilot Phase | | Phase 1 | | Phase 2 | |
|---|---|---|---|---|---|---|---|---|
| Diarrhea treatment | N | Percent (%) | N | Percent (%) | N | Percent (%) | N | Percent (%) |
| ORS | 55 | 57.30 | 14 | 36.8 | 32 | 66.7 | 9 | 90.00 |
| ORS + acceptable | 3 | 3.10 | 1 | 2.6 | 2 | 4.2 | 0 | 0.00 |
| ORS + wrong | 8 | 8.30 | 7 | 18.4 | 1 | 2.1 | 0 | 0.00 |
| Only wrong | 12 | 12.50 | 6 | 15.8 | 6 | 12.5 | 0 | 0.00 |
| ORS wrong dose | 3 | 3.10 | 2 | 5.3 | 1 | 2.1 | 0 | 0.00 |
| Not ORS but ok | 2 | 2.10 | 0 | 0.00 | 2 | 4.2 | 0 | 0.00 |
| No response | 13 | 13.50 | 8 | 21.1 | 4 | 8.3 | 1 | 10.00 |
| TOTAL | 96 | 100.00 | 38 | 100.00 | 48 | 100.00 | 10 | 100.00 |

No response to the simple question in itself is a finding highlighting the need for repeated skill based training for Mitanins. During group discussions it appeared that while they may know about ORS a large majority had never used it.

***Diagnosis of fever and malaria***

Even though we encountered Mitanins who had been coached with answers to our possible questions a day or two before our visit, rarely could we find a Mitanin who could mention the dosage of Chloroquine correctly, or even say the name of the medicine. Malaria being a focus, one wonders how effective the training and the manuals have been. Only half of the Mitanins could get the ratios correct for sugar and salt in the sugar - salt solution, and except the odd one, the signs of dehydration drew a blank repeatedly. It appeared that they were not using this knowledge or practising these simple health interventions. To blame the Mitanins would be wrong.

***ANM perception about knowledge of the Mitanin regarding the drugs***

The AWW & ANMs have mixed opinions about the knowledge of Mitanins regarding drugs. Right at the outset, it is important to note that in 12 out of 31 AWW/ ANMs interviewed, the Mitanins of the area had not received any drugs. Eight had no specific information and thus do not express their opinion, and two did not respond. Four AWW/ ANMs indicated that mitanins had good knowledge whereas equal numbers expressed that Mitanins have very little knowledge.

### *Peoples's perceptions*

Though several people interviewed had 'heard' about the mitanin programme, not many seemed to know about the details or working of the programme. After enquiring with several people, one would find an AWW who would know about the Mitanin in the village / locality. At best some women would know about the Mitanin and say that she goes for some training and meetings. In other cases they said she does not do anything! Men who knew about it thought it was a 'Government programme' and through it, expected to receive medicines free.

Some quotes by the people interviewed are telling:

'*Mitanin (programme) chala raha tha, abhi to bandh hai! Hame to pata nahi ki abhi woh kam karte ki nahi*.' [Mitanin's neighbour in Lakhanpur block said - The Mitanin was doing something earlier but now the programme has stopped. We do not know whether she is working any more]

'*(the scheme) Sarkari ho sakti hai jao. 500 rupaya milnewala hai*.' [Said by ex-Sarpanch & Mitanin's husband in Sarangarh – The programme is likely to become Government's programme – 500 rupees will be given (every month)]

One of the investigators had a chance meeting with a Member of Parliament from Chattisgarh. He was not happy about the fact that there was no communication with people's representatives about the programme or its progress. The sarpanch and other elected members in the area too were not very well informed about the work of Mitanins.

Issues that emerge are – lack of adeauate communication with people and problems of ownership of the programme by the people – the very essence on which the programme bases itself.

### *Perceptions of the health support system*

The ANM, the lowest rung in the health system considered mitanins as an extra pair of hands and extension of herself for improving the performance of her duties. The Mitanin was expected to inform and motivate women to avail of exisiting services. In the context of several other functionaries like 'malaria depot holders', 'Condom & Pill depot holders' and old JSR and CHWs, the ANM was often unsure of the exact role of one more worker at the level of 'first contact care'. In case of a very active Mitanin in Khadgora block, her work had brought her in direct confrontation with the ANM over the issue of which of them would be entitled to the'incentive money'.

An ANM, in Gersa, Raigarh perceives the 'Mitanins' utility in mobilising women, to improve her outreach. She relies on them for motivating women'. She reported increase in sub-centre deliveries. (Investigator noted that the supervisor had to

constantly nudge the ANM to provide the right responses! It was also observed that several Gentamycin and Cephalosporin vials were stored in the room ostensibly for use by doctor)

Male MPWs however, do not seem to have much contact with Mitanins nor a clear idea about how they should function.

'Chal raha hai, par dava goli bat nahi pa rahe hai. Ya to log nahi pahuch pas rahe hai, ya nahi jante hai.' [MPW, Bhareeda, Marwahi – (it's) going on, but they are not getting medicines. Either it is not being supplied or they do not know]

**The Prerak's / prashikshak Analysis about the programme:**

Their collective opinion was that the programme was a great step forward. The strengths identified by them were of partnerships between NGOs and Government, women getting a chance to come out of their homes, and of the Mitanin being able to relate to her community and bring about increased awareness. Their main concerns were: high drop out rates among Mitanins; widespread illiteracy making selection difficult; and very short, irregular and infrequent training.

***6. Prerak / Prashikshaks' analysis of strengths and weaknesses***

| Programme strengths | Weaknesses & difficulties |
|---|---|
| Women working together, coming forward,becoming aware, and thinking about their health | Delayed and incomplete training |
| Will reduce burden of disease | No regular replenishment of drugs, not receiving drug-kits |
| Revitalization of *Panchayats*, involvement of people, | No attention by officers, no coordination with Government |
| Home visits, people listen to Mitanins | Cash flow problems, late / non-payments |
| *Sangathan* formation and coordination | No honorarium to Mitanins |
| IEC and improved hygiene in the villages | Contempt by the community |
| | Men trainers – difficulty in communication with Mitanins |

Poor referral support was de-motivating Mitanins. In their opinion '*We give big talks, but empty promises' – 'unless the refilling process is finalized, do not give drug kit' they cautioned.*

In-depth interviews of 16 trainers were conducted, eliciting the key strengths and weaknesses or difficulties (see table).

According to the trainers the First Referral Units (FRUs) were not functioning properly, causing problems in referrals. The FRUs needed some more equipment too.

Interview with Dhamtari District Facilitator (DF)

**Smt. Shakuntala is the DF/ FC for district Dhamtari. She feels that her work in Dhamtari is good because:**

- **She has good contacts in the district,**
- **She attends all Mitanin meetings,**
- **She visits all DRPs,**
- **Training in this district is good,**
- **Education level of Mitanins is good, there are only 3% non-literate Mitanins.**

**[In this district, the *davapeti* was given much earlier than others, because of Dhamtari Mission Hospital (DMH). On the other hand RCH Societies could not give it early.]**

**The support team for 400 Mitanins consists of 24 persons—BRPs, DRPs, Dist. Facilitator+ Nodal officer. The Mitanin scheme can not run with only Govt. support, this team is necessary. Dropouts are 15 out of 400 Mitanins (4-5%)**

**Mitanin trainers in this district are 'A' quality, very good. Some variation is observed. 18 months phase was good. '*Now the seventh round of training is going to start, we will do good work. Mitanin trainers are overworked, but they have increasing will to work. Only one has dropped out'*.**

**Suggestions about training: There should be no delays, diagnosis must be taught, cluster approach in training is good, residential training is necessary, today it is mixed. Anganwadi or Subcentre is a good venue. Practical training is necessary, not just classroom teaching.**

**The Mitanin tasks she reports are: Coordinatation with people for health, prevention of childhood illnesses, women's empowerment, and social action (like closing liquor shops). She says that 20-30 villages have closed their liquor-shops.**

**About 5% Mitanins in Dhamtari district are engaged in social tasks. Other 95% can also do it. In one village Mitanins have lodged complaints against a corrupt sarpanch. In this village *soram, satta* (lottery /betting) has been effectively stopped. The press supported it well.**

**All 18 blocks have received *davapetis*. We need to train Mitanins *on dava peti* use, and use it sparingly. 75% Mitanins do not demand money for work; but they will demand it later. Money (for Mitanin) is not necessary at this stage.**

**On the Mitanin programme's relations with Health departmental staff: *"ANM is Ok, birth – weighing is Ok – but THEY FORCE WOMEN TO DELIVER AT HOME. AWW weighs children, Daliya supply is Ok. Mitanins should be able to work against or raise questions about these staff and this is changing the situation".***

Feedback from Doctors on the Mitanin Programme

**The evaluation team interacted with several doctors during the overall exercise. Some of these were the PHC medical officers, as well as private doctors. It is interesting to note that the PHC doctors realize the utility of Mitanins to increase outreach and provide more services. However, no concrete linkages seem to be established as part of the programme. This has led to a person based or individualised support to or utilization of Mitanins in some areas.**

Doctors' opinions

**A Government Doctor (PHC Medical Officer) in Korba said – The '*Mitanin programme is not an additional burden on the public health system. Instead it is a great boon for the public health system...*' A MO said good things about it early in an interview but off the record had several reservations. '*The programme is no different from the earlier CHW programme...*' – he said.**

**Another MO in Raigarh officially said that it was excellent, and thought that the programme helped them implement the National Health Programmes. But he was not in a position to comment about the competence of the Mitanins. Yet another MO had no idea about the programme design despite the fact that her mother a Block Medical Officer (BMO) – was the nodal officer for the same in the block.**

**BMO Katghora, Korba has his views on the Mitanin as a health activist: "*Hamare Mitanin neta bhi ban gaye hain, per discipleen main rahte hai.*" [Our Mitanins have even become leaders but still stay disciplined!]**

**A medical superintendent of a CHC in Bastar feels 'left out' in this programme. He accedes to some positive effect on immunization and family welfare but not on utilization of other services. In the last year only 10 to 12 referrals to his hospital were through Mitanins.**

**Private doctors in block or district head quarters for most part had not heard about the programme, nor had they experienced any referrals from Mitanins. In the villages however, a former *Jan Swasthya Rakshak* (JSR) now engaged in private practice (Singharpur, Lakhanpur) said, '*for any serious case she refers to me. The timing of referral is very good. She is a better agent of change than ANM or AWW*'.**

**Mitanins perceptions**

For Mitanins it was an avenue for self development – to know more and be able to prescribe medicines and thus earn respect. They expected to earn a living out of the work done – either in the form of honoraria or rarely as fees for service. Although no commitments had been made the informal understanding was that some day in the near future, Government would start paying an honorarium. Of the 96 Mitanins interviewed, only half have commented on the effects of the programme on themselves and their own life:

**7. Comments by Mitanins on the usefulness of the programme**

| **Perceived benefits** | 55 | **Perceived loss** | 47 |
|---|---|---|---|
| Increased knowledge | 25 | Loss of money – wages, travel | 7 |
| Increased confidence, self-worth, public contact, opportunity to go out | 14 | Loss of time | 4 |
| Useful for own family | 9 | | |
| Opportunity to work for people, share in others' sorrow & happiness | 7 | | |
| No particular use | 12 | No loss | 38 |

*Note: multiple responses were given for both questions*

A couple of responses – *'it's the first time that I have joined something!'; 'this way I get relief from work at home'* – reflect gender issues and women's social status, than on the programme itself!

Two Mitanins mentioned how useful it was for them to know about ORS. They have used it for children in their own family and thus saved a lot of money (which they would have spent on consulting a private practitioner and buying medicines).

***The Mitanin and her family***

We could gather from the interviews with Mitanins and their family members that '*she was never asked about what she would like to do*!' During the selection process they were probably told (by the preraks) that she would work for the village and would be able to treat illnesses.

The Mitanins' own concept of their role is solely based on the information that they have gathered through training and contact with *preraks/ prashikshaks*. Despite the book about Mitanins' role, they did not generally see themselves as change agents. Instead they thought their role was of service providers to the community, and kept telling us about the need for medicines and other logistic support so that they could go to people.

The basic concept of the Mitanin's role as a 'volunteer' / 'activist'* has either not been understood or is not accepted by them as can be seen from some of their quotes –

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*There are some areas, particularly in NGO run programmes, where Mitanins have played a role as health activists, eg in Koriya (Nandi. S, 2005), Gundardehi, Dhamtari etc. The training and support approach, as well as expectations are different in these cases.

*'Meeting mein jana aur pustak bharna'* [Mitanin, Parsada chota, Sarangarh – Going to meetings and filling registers (is the programme work)]

'*Ghar ghar jana sambhav nahi hai, ghar me karenge*' [Mitanin, uchala bitti, Sarangarh – It is not possible to go house to house – I will work from home]

'*Hamare paisa hamhi kharchakarke goli layab to hamhi xxxx!! Hamh kahan ki du du rupaiya deehan khun janchke ta log kahe ki tohar ham thodi bhejat hin goli lelela, sarkar tora dehat hain….*' [Illiterate Mitanin from Podioparda – I am (a fool) to spend my own money and get pills. I asked villagers to pay two rupees for blood test, and they said we have not asked you to fetch the pills, government is giving you…]

'*Pahali sochi thi ki phayada hoga, jankari hogi, kamse kam gharke bare mein. Par khuch phayada nahi hua. Mitanin ki ane-jane ki kharcha dete to karte*.' [Mitanin, kumhari, Marwahi – I thought initially that this would be beneficial, I will learn at least something useful for the household. But it was of no use. If they had given money for travel –transport then I would have done work]

'*Bolte hai ki programme bandh ho gaya*' [Mitanin, Marwahi – (people) say the programme is over]

As one Mitanin's husband who himself is a Malaria link worker put it – '*Mitanin ka kya kam – Dawa goli batna – salaide bantana – PHC se dava lane jana*' [what is a Mitanin's work – distribute tablets and slides and get medicines from PHC]

Another Mitanin's husband in Martarai, Podiuparada said, '*Phukat math ghoom, akela nahi jayi sake, jabardasti naam likhawe*'. [She should not go (work) for free, she can not go alone, her name was written (as willing to join) by force]

One more Mitanin's husband in Karra, Podiuparada feels that his wife would become a Government functionary in the long run. He does not mind his wife continuing work without compensation. He was very enthusiastic as he had observed qualitative improvement in his own family after she attended the training. He complimented the effort of Government in operationalizing the Mitanin programme.

It appears that the systems – both the programme support and government (PHC) – mainly expected the Mitanins to be of assistance to the PHC activities. However, the expectations of people are quite different and the need for first contact care is uppermost in their mind. Mitanins, too, mirror this village reality and see themselves as being of use to people by dispensing drugs.

**The Mitanin's and activism**

The expected characteristic 'popularity' or 'ability to convince others' was not very evident in many of our field observations. Most Mitanins we met were little more than ordinary village women. They were just beginning to get exposed to the larger world and get some opportunity for self development.

There definitely exists an opportunity but this has to be systematically realized through consistent inputs and support to Mitanins. Indeed their immediate supervisors – the

*prashikshaks* – exhibited tremendous latent potential which should also be systematically harnessed, not only for the programme but for a larger social mobilization for health.

Some very positive cases of social mobilization by Mitanins were quoted in the focus group discussions and interviews with planners / implementers.

*Some case studies on the mitanins social role are given below*

- Mitanin – Ms. Ramabai from Rokda hamlet seems to be extraordinary in her capabilities. She has organized women and managed to reform an erring school teacher and monitor school activities, to oppose a corrupt ration shop owner to get rightful ration for people, She also made it possible for village women to participate in the village affairs.

- A highly motivated Mitanin – Ms. Sukhwanti in Manendargarh block kept working till full term pregnancy and delivered her baby boy on her field visit. The boy is fondly referred to as '*Sangathan Ka Beta*'. (An article written by an NGO coordinator quotes this and several other incidents of social actions initiated by Mitanins from Manendargarh block.)

- A Mitanin – Ms. Chaba in Balod, Durg is a 'self selected' Mitanin. On a routine visit to PHC she came across a training session and joined it. Despite no support from her husband she is very keen to learn more and work for health. She has not received more than 6 days of inputs but could talk about DOTs by just listening to advertisements on TV.

- Mitanins in Dantewada and Bastar districts were very vocal, confident and knew what they were taught reasonably well. In one case they have helped the ANM to overcome her problems and thereby to improve services.

- Mitanins in an NGO supported block in Raigarh district too were very confident and enthusiastic. Their knowledge regarding diarrhea and malaria was satisfactory.

### *Village Planning*

The evaluation team wanted to know if the Mitanins had done any village level planning as part of their work. Of the study sample about 94% had not made any village plan or had no training for doing so or had no response to give. In Dhamtari block there was some village level action against liquor shops, but this was not designed as a village plan or in the questionnaire. The questionnaire only included a query on planning for malaria and diarrhea and cleanliness. About 4% had made some plan about these issues.

When analyzed for phases, about 7.9% Mitanins from the pilot phase had prepared village-plans on these issues. In phase I the percentages dropped to below 2.1%. We

did not expect any positive response from phase II respondents as they had not received the relevant training as yet.

### *Village meetings by Mitanins*

Village or *Para* level meetings, functioning Village Health Committees or village plans were seldom found during the field visits. Here is a response in an NGO run project:

"There is no health committee and no visit of any NGO [*sachiv* secretary of Panchayat in Sasin, Podiuprada]. {This is a block run by the BGVS}."

### *Gramwasis' feedback on meetings*

A proportion of Gramwasis' (10%) said that they 'learnt something' from the meeting. All other responses were negatives (waste of time, never went, no information, did not know, no meeting, no response.) In the pilot phase, about 28% responded favorably but the percentage dropped to 0 in phase I.

### *Health messages given by the Mitanins*

About a third of the AWW / ANM respondents feel that the health related message by Mitanins is always correct; and an equal proportion opines that Mitanins make some mistakes. Others (23%) do not know or do not respond. About 13% respondents say that the Mitanins do not do health education and another 3% feel Mitanins most often makes mistakes.

### *Home Visits by Mitanins*

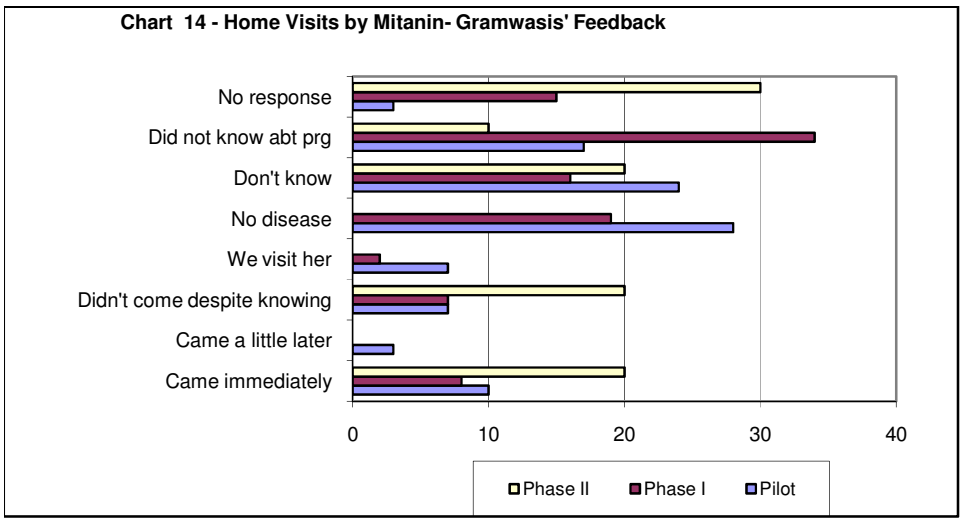
In the aggregate sample about 66% Mitanins reported no home visits for new born care or diarrhea or cough. Another 13% did not respond. The rest (21%) have visited homes for various reasons - for new born care (1%), diarrhea (3%), cough (1%), fever (5%), for any-two causes (6%), only for giving information (3%). One Mitanin said that she went for home visits only when there were drugs. Thus of the 21% respondents who went on home visits the major reason was for curative care.

The phase wise analysis shows about 24% respondents doing home visits in the pilot phase and phase I. In phase II the home visits (30%) are mainly for diarrhea; 50% do not undertake home visits and 20% did not respond.

Thus, in general about 80% Mitanins did not go for home visits. In the remaining 20% the major reason was for curative care.

**Gramwasis' *feedback on home visits***

About 16% of the *Gramwasis'* responded that the Mitanin comes often for health education. About 7% remember she had come once. Another 4% have seen her in some other house regarding health education. The remaining 73% had either never heard about it, or did not know or did not respond. In the pilot phase, the situation was slightly better (30.8% confirming visit) but in phase I it shows a decline with only about 23.1% confirming home visits for health education.




Enquiries relating to the timeliness of Mitanin's home visits showed that only in 10% of cases the Mitanin came immediately for treatment of illness. About 8% said she did not come despite knowledge of illness occuring in some families. All others (80%) reported that they do not feel concerned with this issue, as either there was no disease or they did not know or the team did not receive any response. A small proportion (3%) said that they go to the Mitanin instead of her coming home. The situation is the same across the Phases.

Experience of referrals by Mitanins

The actual patient related work done by the Mitanins was an unclear area.With very little training, the absence of 'Davapeti' or of refills with medicines, the Mitanins found it very difficult to face the villagers or do household visits. Most mentioned lack of medicines as the main reason for not doing any work – as people expect to get free medicines and do not listen to the advice or health education given by them.

The drugs in their kits (for those who received it) were exhausted within a week to fortnight of supply. With no drugs to treat, there was no question of treating or referring any patients. And the experience of referrals was on the whole not very encouraging too.

*'…she referred a patient with a kidney problem, but didn't get a good response (from the government doctor). She took ten patients for an eye camp; they were promised compensation but were not given any as they came from 3 km only. She took a leprosy patient, ANM did not follow up and she was unhappy. So they lose credibility and people don't believe them anymore.'*

In the study sample, 65% of Mitanins have never sent any patient to a hospital, and another 12% did not respond to the question on referral. Thus about 23% have sent one or more patients to hospital. Of the 23% respondents 6% have had a 'bad experience' after referral. In the interviews the Mitanins spoke of indifferent or callous treatment in the referral centers.

The phase-wise analysis shows, that in the pilot phase, 60.5% had never referred a patient and 15.8% did not respond. Of the 21% who have referred patients, 13.2% had a bad experience. In phase I, 64.6% Mitanins did not refer and 10.4% have not responded. Of the 25% who referred, 6.3% had a bad experience. In phase II, only one has referred someone and reports a good experience.

**8. Referral experience of Mitanins**

| | Total study sample | | Pilot Phase | | Phase 1 | | Phase 2 | |
|---|---|---|---|---|---|---|---|---|
| REF-EXPERIENCE | N | Percent (%) | N | Percent (%) | N | Percent (%) | N | Percent (%) |
| Good | 15 | 16 | 5 | 13.2 | 9 | 18.8 | 1 | 10 |
| Bad | 6 | 6 | 3 | 7.9 | 3 | 6.3 | 0 | 0 |
| Never sent a pt. | 62 | 65 | 23 | 60.5 | 31 | 64.6 | 8 | 80 |
| Mission hosp. | 1 | 1 | 1 | 2.6 | 0 | 0 | 0 | 0 |
| No response | 12 | 13 | 6 | 15.8 | 5 | 10.4 | 1 | 10 |
| TOTAL | 96 | | 38 | | 48 | | 10 | |

***Recent recall on referrals***

Another question was about referrals in the week preceding the study. 78% had not referred anyone, 17% did not respond, while 5% of Mitanins referred some cases to hospitals in the preceding week.

When stratified for phases non referrals remain in the range of 73 - 90% In the pilot phase, about 8% have referred one patient in the last week; with very few referrals came in the last week in phase I and II blocks.

### *Cooperation with AWW / ANM*

Work with the AWW / ANM was mentioned by the ANM and AWW as well as by Mitanins. This was in the form of assisting them to extend maternal and child care services, such as weighing of children.

The evaluation team interacted with 23 AWWS and 6 ANMs. The AWW helper also participated in the discussion. This is the group which is supposed to cooperate and guide the Mitanins in the village. During the interactions 65% of these members agreed that Mitanins help them in their work. The primary role played by Mitanins is directed towards mobilizing community members for MCH clinics and immunization.

### *Programme impact*

In general the team felt that the impact of the programme is yet to be seen since some processes (such as community involvement) were sidelined, and some necessary inputs (like drug-kit) are awaited in most areas. It must be said that there is no hard data on actual services by Mitanins either with the Mitanin or with the health system, hence it is indeed difficult to gauge the impact of the programme. Some interviews were suggestive:

In CHC Lohandiguda, Bastar it was reported (by trainers and DRPs) that deaths due to malaria, and gastroenteritis were minimized in the past year.

The SHRC director felt that malaria deaths in the state have halved thanks to the Mitanin programme treating fever cases with chloroquin tablets. This itself is a substantial public health gain. He also feels that the breastfeeding messages have reached even *paras* in backward areas.

However this positive note is not supported by community awareness and perceptions about the programme in most of the blocks we visited. Perhaps our instruments were not fine enough to measure the differences made on this account.

### *Utilization of Mitanin services*

Awareness about the services offered by Mitanins was found to be fairly low in all phases of the programme. About 26 % of *Gramwasi*'s were ignorant about the Mitanin Programme and about 20% did not know about the curative services offered by her. Of the balance, about 6% of villagers doubted the capacity of the Mitanin to provide medical treatment. Overall about 18% *Gramwasis* have availed of medical treatment from the Mitanin. Utilization of services has been higher in the pilot phase where

28.2% Gramwasis' availed the services, whereas the utilization dropped to about 10% in subsequent phases. About 6% of the respondents indicated their willingness to utilise medical treatment in future.

### *Improvement in ANM services after the Mitanin programme*

Interactions with Gramwasis' indicated that only 3% affirm that ANM services are better after the Mitanin programme. About 27% did not know about the programme. Another 27% answered 'don't know' and another 34% say 'they are as before'. The situation does not change for the better in any of the phases. In fact there is a drop from 7% to 0% from pilot phase to phase I.

### *Change in the village after the Mitanin programme*

28% of the sample respondents say that there was no change after initiation of the Mitanin programme in the village. About 14% talk of some favorable changes, of which health awareness was the most important (12%). About 58% of the total study sample falls into the negative club. In the pilot phase, the favorable responses increased slightly but also the affirmation that there was no change. In phase I the situation is more or less on the lines of the total study sample.

### *Comments*

The team feels that the Mitanins's potential is either not fully realized or has been underachieved so far in this programme. The major problems are on the input or supply side. Community empowerment and support, training, equipment, logistical support, remuneration and monitoring are weak processes in the programme. There are problems in both the content and context management of the programme. In the absence of crucial inputs, the Mitanins can not be expected to perform as per the ideals set up. There are arguably islands of achievement in activism by Mitanins. The general picture is however not of a vigorously functioning programme.

### *Summary of output-outcomes*

Is the programme any where close to the expected outcomes and impacts? Here is what the research team has found:

### *9. Summary of outcomes*

| Sl. No. | Broad objectives of programme | The study team findings |
|---|---|---|
| 1. | Selecting a Mitanin for every habitation | Nearly done, over 54,000 |
| 2. | Health education and improved public awareness of health issues | 27% gramwasis recollect some health education, not the details of content. Questionable effectiveness, Mitanins' families may have benefitted. |
| 3. | Improved utilization of existing public health care services. | Some referrals (23%) and mention of reduced diarrhea, increased immunization and MCH care |
| 4. | Initiating collective community level action for health and related development sectors. | Very few instances out of 96 Mitanins (about alcohol shops); Positive case studies from some blocks Koriya etc |
| 5. | Provision of immediate relief for common health problems | At present at low levels; 18% gramwasi's availed treatment. |
| 6. | Organizing women for health action and women's empowerment | 16% gramwasis' said there are Mahila Swasthya Samitis, little evidence of levels of functioning; ongoing programmes like SHGs may be helpful for Mitanins. |
| 7. | Sensitizing *panchayats* and build up of its understanding and capabilities in local health planning and programme implementation | 32% mitanins selected by gram panchayat, gram sabha or mahila mandal. Little panchayat involvement in health action – absent village plans |

### *Comments*

Of the outcomes expected, the availability of 54000 Mitanins in the state is the major gain. Arguably, some of them may have dropped out and may be replaced. An enrolment of this kind from poor people does raise a question—were they tacitly promised some money?

On most of the other points the programme has made small steps forward as discussed in the findings. The slow momentum was largely because there was paucity of adequate programme inputs. Some processes may have to be planned anew—for instance collective community action for health.

The belated supply of drugs and task-based payments does provide an entry point for reclaiming some of the lost ground in terms of outputs and outcomes. It may be used as a leverage to get some preconditions fulfilled. Work on objective 2 and 5 in the table can be started soon. For others, there has to be more inter sectoral involvement.

Action is awaited from the Government of Chhattisgarh to improve the public health system, especially regarding referral support and functioning of the primary heqlth care system (HSC, PHCs, CHCs).

### *Different Models Used*

Our mandate was to look at different models used to implement the programme using SWOT (strengths weaknesses, opportunities threats) principles, focusing on flexibility, participation, equity and effect on outcomes. However, within the given time and resources we could not do an in-depth study of this.

We had included in our sample a variety of administrative arrangements:

District RCH society running the programme - 1 block, 11 Mitanins

Run by Govt. alone - 6 blocks, 23 Mitanins

Government with NGO /through NGO - 2 blocks, 13 Mitanins

Entirely NGO run - 5 blocks, 49 Mitanins

However, as can be seen the quantitative data for each of these arrangements is not sufficient to draw conclusions.

### *Comments*

Based on in-depth interviews, observations and discussions among the team, we found that barring a few exceptions the programme looked fairly uniform on the ground. The issues related to payment of BRPs and Mitanins, problems in drug supply, and the haste in selection leading to short-cuts in communication and participatory processes have eclipsed other outcomes!

In general in the pilot phase areas, in NGO run blocks like Dhamtari, Dantewada, Gundardehi and others with use of flexible and intensive approaches, training input results were visible in the form of confident, vocal Mitanins engaging in social action. But in blocks like Durg even with NGO presence this was not so apparent.

Case studies of social action by mitanins in NGO supported blocks have been reported from northern districts eg. Manendragarh (mfc bulletin 2005).

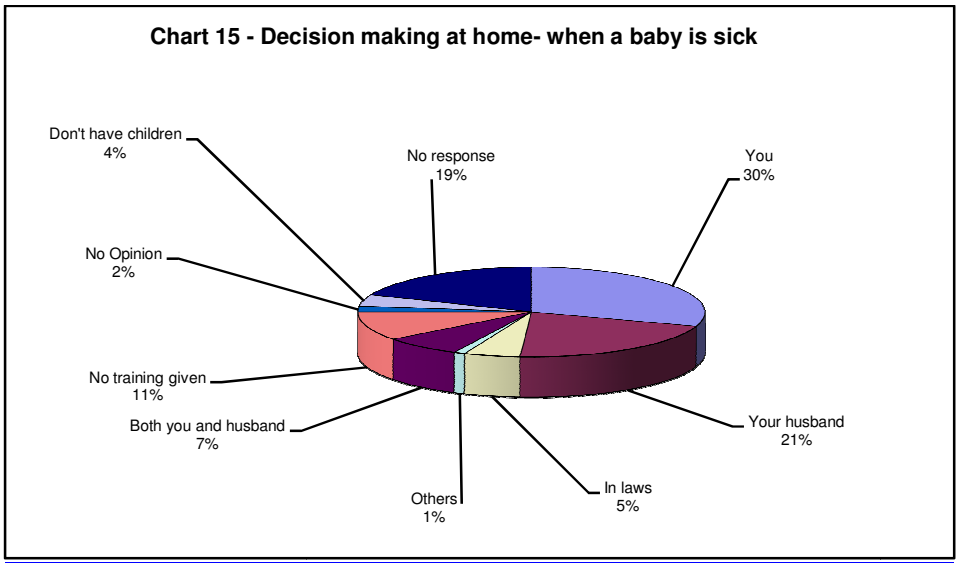
We are thus refraining from making comments or recommendations in respect to the different models based on these findings.

## *Gender and empowerment issues*

The field interactions focused on understanding the gender and empowerment perspective reflected in the programme. Three simple questions were used to generate discussion. The questions were related to wife beating; decision making relating to a sick child in the family; and problems with mid-day meals in village schools, and the type of actions the Mitanins would take up.

### *Opinion of Mitanins on wife beating*

In the aggregate sample about 35% Mitanins responded that the husband has no right to beat the wife. About 3% were for counseling. About 7% chose to make it a non issue by saying there was no violence in the village. Strangely about 17% said it was OK if it was the wife's fault. About 5% would not interfere and 19% did not respond. The phase-wise analysis does not bring out any variation in the responses. The gender sensitive category (responding, no 'right to beat', will counsel) comprised about 35 to 40% of the respondents in the three phases.




ıe second question on empowerment is about who makes the final decision to take a ck child in the family to the doctor. About 30% in the aggregate said that she would ke the decision. About 7% would take it in consultation with the husband.

ıe picture remains somewhat same in the pilot phase. In phase I, the husband and wife deciding about the referral are 23.7 and 28.9% each. In phase II six out of ten Mitanins would take a decision themselves and do not mention husband and three mention in-laws. However the sample is small. We could not assess if there were differences between communities and if the response would be different if it was a girl or boy child who was sick.

### *Mitanin action on school mid-day meals not coming to villages*

The third question on empowerment was if the midday meal programme in the school stopped for three months what would the Mitanins do. The responses were varied:

Complain to Gramsabha (17%); Complain to headmaster (9%); Complain to women's' group (2%), Sarpanch (10%) , Supervisor (1%). About 6% would organize the mid day meals from village homes. Thus, about 45% would take some positive action to deal with stoppage of mid day meals. In the pilot phase, about 58% would take positive

action. In phase I the positive response remains about the same. Non- respondens remain about 20 to 30% in the aggregate and phase wise analysis.

## Comments: Gender issues and empowerment in other aspects of the programme

The programme is almost entirely run by women on the ground, however, the planners are men! It was not clear to us whether and how deeply women's perspectives as articulated by themselves were integrated in the design and planning process.

We understand that progressive gender policies are adopted for SHRC staff. This policy was not very evident for the field staff or workers though. Women FCs, DRPs and BRPs travel to remote areas alone. In the field they are expected to fend for themselves. The salaries, even if paid, are not enough to sustain the hard work and travel. We were told that an allowance for stay in the field is given; however, appropriate facilities for overnight stay for a woman may not be available.

*Women prashikshaks* were not given any extra consideration or facility for commuting. They have to do considerable walking or cycling or travel on bad roads even when unwell or pregnant. There is no provision for maternity benefits for BRPs either. Similarly Mitanins (as they were never considered as workers!) are supposed to invest their time and energies for free! Why should only the women bear the entire cost or onus for this community good? We heard that some BRPs left their job due to pregnancy or childbirth or because of too much traveling. Some could undertake their responsibilities only with the help of husbands with motorbikes. Gender justice and fairness would require adequate remuneration, as well as better working conditions and support systems for the predominantly women based cadre. Further training inputs regarding gender analysis, gender and self – esteem, and gender perspectives on health problems including violence need to be built into the programme. Gender sensitisation of staff of the Department of Health is also required.

Plans for 'on-the-job coaching to Mitanins' and 'organization of training sessions close to villages' reflect both - special consideration for women, as much as operational convenience.

Empowerment especially of rural women is a long process and we did not expect to see a lot in such a short time. Anecdotal information on social action by women gave us some evidence of this process. There are of course other confounding programmes like *Didi* banks and CARE support to *Aanganwadis* – all of which contribute to the process of empowerment.

# *Future of Mitanins*

**Suggestions by Mitanins**

Of the 96 Mitanins interviewed 46 gave their suggestions for improving the programme. From the responses their interest in working becomes obvious, as do their difficulties.

***9. Suggestions by Mitanins for improving the programme***

| Suggestion | Mitanins # (Out of 46) | % of respondents |
|---|---|---|
| More training required | 20 | 44 |
| Drugs – more types, amount, regular supply | 17 | 37 |
| Compensation | 13 | 28 |
| Need improvements – help, guidance | 6 | 13 |
| More meetings, women and people to be oriented | 6 | 13 |
| cultural programmes, referral system, equipment like weighing balance | 4 | 9 |

# more than one response by individual Mitanins, hence the total differs.

**Other stakeholders' suggestions:**

A varying level of knowledge, including general ignorance about the programme details and a perception that Mitanins would provide free treatment is reflected in the responses to the question on 'suggestions for improvements' in the '*Gramwasis'* schedule. Of the total 101 interviews in 60 villages, only 24 had something to say! The main suggestions were for the Mitanin to do more home visits (6), to stock medicines (6), hold regular meetings in the village / *para* (5), and to involve villagers and Panchayats in selection (5). The need for Mitanins to have more training, practical experience, the need for raising awareness regarding the programme was mentioned.

One each has said that 'they want a doctor' and 'there should be no Government involvement in running the programme – it does not work and is a waste of money!'

There was almost a unanimous demand for more training – more topics, skills inputs and longer duration, greater frequency, refresher training and even more training of trainers – from all stake holders. Topics identified by the AWWs /ANMs, Prashikshaks and Mitanins were:

- Training of Trainers – training skills;
- Treatment of diseases – TB, Malaria, Leprosy, women's health, reproductive and child health;
- Communication skills, negotiation – how to handle panchayat members, how to organize people;
- Management of social problems eg. alcoholism.

- All interviewees were asked for their suggestions to further improve the programme. Very useful lists emerged from this exercise:
- Capacity development through more training on disease treatment and skills training;
- More frequent training, refresher courses;
- Training in communication and negotiation skills;
- Timely supplies of drugs, replenishments;
- Provision of basic equipment for Mitanins like weighing scales;
- More interaction with villagers and *panchayats*;
- Raising awareness among women;
- Compensation for work;
- Coordination among NGOs, Mitanins, Government staff and AWWs;
- Training of Trainers for guiding Mitanins;
- More women trainers;
- Motivating Mitanins; and
- Home visits /surveys.

## *Critical Questions*

The internal evaluation document has candidly described factors shaping this programme:

*"The final shape that the programme design took and the blistering pace of the programme was the resultant of this negotiation between the "January 2002 design" and the political urgencies/compulsions of the day. This interaction continues to shape the programme even up to the present and is likely to define it in the coming period also."* While political will has helped to start and keep up the momentum of the programme, could professional judgement about essential community health processes be more assertive? The counterproductive effects of a "failure" of a large scale programme also need to be considered. Are decisions subject only to negotiation or also based on public health principles and ethics?

Apart from the planners' reality is the ground reality of village development and the prevailing health and health care situation. The programme has to base itself in this reality too.

An article in the public domain by one of the SHRC governing board members has raised critical issues. Other governing board members and stakeholders have also raised important issue of concern including adverse effects of the very rapid scale up of the programme. These need to be reflected upon in an open, non-defensive manner if this important state-wide initiative has to respond meaningfully to the needs and aspirations of people, and to meet its objectives.

The impression of the team is that there is a gap between the aspirations about the Mitanins' function and the ground realities. Several questions emerging from this evaluation exercise based on ground reality as of mid 2005 are raised below:

- How to deal with the communication failure and lack of ownership of the programme by the people?

- There has been either a miscommunication about Mitanin's expected role or a mismatch between Mitanins' needs /aspirations and the programme design; or both. How to correct this?

- Lack of communication or common understanding within the system and weak linkages with the public health system is detrimental to the functioning of the Mitanins and consequently their status in the villages. How to make the system more responsive and accountable?

- Selection processes were weak and some inappropriate selections have harmed the programme at places. How to do away with inappropriate candidates and re-select new ones? Is it possible to involve other existing health workers as Mitanins?

- Inadequate human resource planning and management for grass roots functionaries especially the prashikshaks may lead to collapse of the programme. What then should be the plan for the future?

- The supply mechanism for drugs is not defined. Lack of this facility undermines Mitanins' utility for the villagers and consequently hampers their performance of other roles. What should be the operational mechanism for supply of drugs?

- Although cooperation of Mitanins is reported with ANMs / AWWs; there is neither formal involvement of the ICDS structure nor active involvement of most ANMs. How to develop a more formal planned approach to inter-sectoral coordination/ convergence?

- To improve quality and sustainability of the programme, how to develop a flexible and really participatory learning programme ?

- How can leadership at different levels, and human and financial resources for this initiative be sustained?

## 9. Limitations of the Study

This study has to be read and understood bearing several limitations in mind:

The evaluation was undertaken at very short notice by eight resource persons from different parts of the country. The time to undertake the evaluation was short. A suitable qualitative methodology was therefore selected, with experienced evaluators. We had to do with a fairly small sample of Mitanins. However we have taken care that the sample is well spread out and representative.

Budget constraints prevented us from visiting the areas for a second time for any further research, which is often necessary for qualitative studies.

The short notice, of just 15 days to put the study team together and initiate work, meant that different researchers had to plan their visits during different time slots. This reduced the possibility of adequate common time together for fine tuning the enquiry-instruments and approaches. However use of emails, and mobiles helped us bridge the distances and gaps. An unbudgeted meeting was held to discuss preliminary findings. Further discussions though required could not be organised through a meeting.

There is no systematic MIS data on the performance of the health system for 2 \2-3 consecutive years even on the website of GOC. It is therefore difficult to attempt impact/outcome analysis of the programme.

There is no data on what Mitanins do as tasks in the community, nor do the Mitanins keep any monthly record of activities. The study can not deal with this aspect within the timeframe of this evaluation study. Therefore even 'output' measurement could not be attempted in this study.

On the other hand even the public health system does not keep any systematic records of what the Mitanin does in terms of referrals, blood slides, drug-dispensing etc. For instance very few referral slips were found in the health institutions and these did not tally with the number of referrals said to have been made. Therefore it is difficult to estimate the quantum and quality of interaction between the Mitanins and the health system. The Mitanin is expected to assist in many tasks and it is difficult to measure this without systematic records. This study is therefore unable to measure quantum and quality of interaction between the health system and the Mitanin programme. The same is the case with her interface with the Anganwadi /ICDS system.

Study team members shoulder major responsibilities in their respective organizations. In future concerned authorities need to plan evaluations well in time, as the evaluations are written into the Mitanin project proposals right from the beginning. Last minute hasty work reflects on the overall project management.

## *Confounding factors*

In the pilot areas and indeed in several other blocks other development and women's empowerment initiatives are underway in the form of SHGs and NGO activities. All these have an effect on the levels of awareness and empowerment of the communities and women. In any study of this kind, these can not be separated.

## *10. A Four Perspective analysis of the Mitanin study*

This study was done with the following four perspectives taken into consideration—a) the community, b) the planners, c) the mitanins, and d) the BRP-DRP and health system staff. The accompanying figure at the end of this section presents the four perspectives in which some overlap is assumed. How did the study findings conform to the four perspectives? Given below is a brief overview.

### A. The Community (Gramwasi)

At this stage of the programme, the community is aware of the programme, but does not find the programme useful enough. A small proportion of the community needs and expectations from the programme are satisfied as yet. Drugs and medical relief is only part of the list. The bigger problem is how the planners perceive the community needs and expectations. The panchayat and gram sabha are inadequately involved in implementation of this programme.

### *B. The Planners perspective*

The primary concerns such as achieving 'all women mitanins and coverage' have been met in this programme. The issue of low costs without long term liabilities are also met. However the increase in both demand and supply side factors of the health system are yet to be met. The health system linkage is yet to be well established. The programme is launched and training of variable quality has taken place at different levels in most parts of the state, but follow up health action at a larger scale is yet to begin, and hence many of the concerns are not tested. Although all of them are legitimate concerns for any planner, some of them may be self defeating. For instance, the low cost no liability principle actually means the scheme is disposable and is not built to last. The planners need to really take a hard look at what has been achieved in terms of addressing health and health care needs by this programme once the 54,000 Mitanins are in place and fully trained.

### *C. The Mitanins*

It is evident that the Mitanins' primary concerns for remuneration, proper drug supply and support are not yet met at this stage of the programme. Many of them complained about the amount of time spent by them. Their learning need is partly satisfied, but needs to be further strengthened in stages later. There may be higher and enlightened needs like self-actualization, gender issues, and participating in or building up a women's movement, and. But the programme is yet to reach this stage. Since the primary concerns are yet to be met, the planners and managers need to work on basic issues and priorities first.

### *D. The Support System*

The health staff, AWW, the FCs, BRP and DRPs are the main support systems of the Mitanin programme. The health staff is concerned about the

adversarial role of the Mitanin. Their primary interest is in making their own work easy. Many of them see this possibility -like bringing children for MCH clinics or treating malaria fever. The AWW is yet to be officially involved. The BRP - DRP support system is struggling for its own survival. It is quite possible that health staff may be concerned about Mitanins work affecting their private earning from medical services. The medical officers did not feel fully involved in the programme, but were generally supportive about the programme. However several of them were skeptical about the role of the Mitanin programme.

The four perspectives offer important insights about the why and how of the programme. Some of the concerns may be contradictory and opposing. The programme planners' major job is to augment areas of strength and address and engage the major concerns of each perspective. The planners in this case have to look at all the three 'other' perspectives beyond their own. In a true participatory spirit, the different concerns have to evolve and find spaces. Failure to adequately address and engage the different concerns will create aberrations. Analyzing these systematically:

- The neglect of the Mitanin perspective may result in high attrition, reducing the programme to a mere paper scheme.

- The neglect of the community concerns may reduce the scheme to a sarkari one where people will largely bypass it and look for other help (like RMPs)

- The neglect of support staff's concerns may hurt the support structure and linkages with the public health system. The first major job is to get over the adversarial engagement and find a groove for cooperation and collaboration.

And none of the planners concerns, however lofty and justified as in this case, can materialize without answering the genuine concerns of the three other stakeholders. It may need self reflection on the part of planners and all the other constituencies regarding survival issues of Mitanins, the BRP-DRPs; the issue of reasonable drug supply; service orientation, with replacement of an adversarial engagement by a cooperative one. For this to happen, the planners may have to change some assumptions.

We believe that generating a perspective analysis is an important part of this study, rather than only generation of rates and ratios from surveys. This is the true purpose of a qualitative study of a programme as complex as that of the Mitanin. The programme can undertake mid- course correction and the four-perspective analysis could provide a systematic basis to move forward.

# The Four Perspectives

**1. THE COMMUNITY (felt needs)**

- Primary medical services
- Quality of care
- Promptness,
- Good behavior,
- No exploitation.
- Health information,
- Linkages, referral support
- Low cost

**2. MITANIN**

- Time,
- Wages-remuneration,
- Supplies, support
- Respect,
- More learning
- safe- hassle free
- Supports. links

**3. THE HEALTH STAFF/SYSTEM**

- Should be an ally, not adversary
- Feasible-selection, implementation, logistics, monitoring
- Generate community's cooperation and response
- NHP friendly

**4. THE PLANNER**

- Preventive and promotive care,
- National Health programmes including FP, RCH,
- No irrational private practice
- AYUSH inclusion
- Gender, equity concerns
- Costs, sustainability, durability,
- Programme feasibility,
- Administrative liability,
- Linkages with the public health system
- Demand generation for services and
- Supply of services at grassroots
- Quality of care,
- Legal safety, feasibility
- Political misuse

# SWOT Analysis of the Mitanin Programme

Taking an overview, some of the strengths, weaknesses, opportunities and threats of the statewide Mitanin programme in Chhattisgarh are as follows:

## STRENGTHS

1. Unlike the 1978 GOI Community Health Volunteer scheme and the Madhya Pradesh government *Jan Swasthya Rakshak* scheme, the Mitanin programme was **not a stand alone community health worker training programme**, but a part of a broader comprehensive strategy, the other arm of which was **strengthening the public health system** through a health sector reform process.

2. Conscious efforts were made to **study and learn from past experiences**. There were discussed, written as reports and then published as a document discussing conceptual issues and operational guidelines. While opinions may differ on some points, there is a clearly laid out framework for debate and discussion. Key learnings from earlier experiences were integrated into framing the Mitanin programme even though the most important of them viz, building and maintaining trust with the community and the necessity of building the credibility of the CHW have not yet been fully realized. The first steps have been laid for what is a longer term process requiring widespread support and effort.

3. **Establishing and sustaining a working relationship between diverse stakeholders**, at state level to initiate and give direction. This group included the bureaucratic and technical leadership from the state, NGOs, movements, donors, professionals and activists through the State Advisory Committee (SAC). The different life experiences, perspectives and approaches of members of this group, and the creative tensions that emerged from this mix, have benefited the initiative whenever the issues raised were taken seriously. The SAC is one of the systems that can provide checks and balances to the programme, if its spirit is kept alive and functioning; if it is not reorganized; and if members do not retreat into themselves or get too defensive or combative.

4. **Establishing the State Health Resource Centre as an** innovative institutional mechanism that was autonomous and outside the government, but working in partnership with it, was very necessary in the Chhattisgarh context to initiate, catalyze and support such a programme. This may be of relevance to other states as well as a short term measure. It was able to overcome the inertia inherent in any established bureaucracy and to work across boundaries, linking people with each other, and getting programmes off the gerund. (Even the naxalites have approved of the Mitanin Programme!).

5. **Involvement of a broad range of civil society organizations and NGOs at different levels** from the high powered State Advisory Committee; to governance of SHRC; NGO partners taking responsibility for an entire block with direct funding; as trainers/DRPs/BRPs; and partners at district and sub district level. NGO involvement was also a recommendation of the MP-JSR evaluation.

6. **The selection of women as health workers** was an important decision, based on the JSR evaluation recommendations. This decision was a major shift from previous state run programmes in India. Participation of men may need to be considered later. The 'Jan Mangal' couple based approach from Rajasthan is one method. Men as health workers alongside women health workers, have been effective in Jammu and Kashmir and elsewhere. They can address health problems of men, especially reproductive health family planning etc.

7. **Establishing the hamlet *(para)* as the unit for** a community health worker rather than using a population norm is a very important shift in order to ensure geographical and social access.

8. **Adopting a mix of preventive, curative and community organizational roles** for the Mitanins, including an explicit demand creation for the right to health.

9. **Efforts at raising community awareness about the** Mitanin programme through *Kalajathas* and radio programmes. The need for community involvement was raised by the JSR evaluation report. The underlying philosophy and experience of using *kalajathas* came from the literacy campaign. Its effectiveness, reach and recall about its messages will be discussed later.

10. The overall **positive approach of the staff of the Department of Health towards** the programme.

11. **The continuation of the programme** beyond change of government and of key staff.

12. Developing and **publishing good quality Hindi training material** for *preraks, prashikshaks* and *Mitanins* in adequate quantity. They have been well illustrated, and widely distributed.

13. **Documentation** of processes; efforts at **internal evaluation** and developing a **monitoring system** have been of great value.

14. **Use of symbols** *to* identify various drugs in the drug kit is an innovative practice.

**WEAKNESSES**

1. This **programme is to a fair extent a planner – dominated** one, with experts including from NGOs assuming and generalizing the perspectives and concerns of the community, the Mitanins, and the public health and support system staff; the planners and diverse stakeholders, represent views of all the other three sectors from different blocks. While operational necessity and the scale and time-frame of a statewide intervention may partly account for this, and keeping in mind that Mitanin feedback from the internal evaluation has been considered, there is still an asymmetry in power and knowledge. A combination of a top down and bottom up approach is required. Mechanisms for regular block-wise feedback based on which modifications are made could be made operational in a phased manner.

2. **The up scaling of the programme was too** fast. The pressure to reach the promised goal of having Mitanins everywhere was done within unrealistic timeframes. This has had an adverse effect on quality of training, supervision and health action at community level, as well as on community processes and programme processes. This state driven pace inevitably results in top down approaches that steamroll across genuine people's participation.

3. The programme was based on **volunteerism** by poor village women with relatively peripheral importance to primary curative care (first contact care), and a parallel support structure that was both inexperienced in health work and essentially short-term. At the ground level unreal promises have been made regarding getting government jobs and payment. This results in uncertainty and loss of confidence in the programme. This approach will not help to ground the programme or achieve health outcomes.

4. While some see a conflict between use of a rights based approach along with a service based approach, this need not be the case. A combination of the two approaches is possible. Village level health activists are required to improve governance and accountability of the heath related system. There is need for more discussion and greater clarity about operationalising the two approaches in a complementary manner.

5. There is need to recognize that the Indian health system lacks a village level service functionary, that the PHC-SC system has difficulties in providing basic health care at community level however we stretch the ANM-MPW duo on the 3000 – 5000 population even in good terrain. Hence the need of a CHW or Mitanin to fill the gap. While this was conceptually recognized, the operational requirements of a statewide intervention may not have been fully realized. High expectations for quick results; hasty decisions and rapid scaling up; with inadequate training capacity at most levels; inadequate skill development; supply, support and referral systems that do not deliver; and short term planning have taken place; perhaps inadvertently.

The programme is now struggling with the usual problems that beset large scale CHW programmes. Minimal to low performance by Mitanins who are raising questions about remuneration, medicines and proper training. It is difficult to recognize if the programme is working adequately, beyond the areas which have special features like good NGOs, or good local leadership. Without mid-course correction, immediate help and a longer term vision, the programme may not reach its potential.

6. **The long delay in supply of medicines and replenishment has** denied the programme a cutting edge or entry point that most CHW **programmes use**. The programme was not very keen, or rather reluctant, on curatives. This was denial of a felt need by the community and the perceived need by Mitanins. Now the policy of free medicine distribution by Mitanins will finish off whatever little they supply with difficulty. This is a double edged weapon. It will trash the valuable but free medicines given by the Mitanins, and also create a moral pressure on her if they are over. The programme has not sufficiently thought through this issue.

7. Near complete **neglect of AYUSH** in the mitanin programme, except some mention in the books, has deprived the programme of one way of rooting in community resources and also denied AYUSH its rightful place in the Mitanin Programme.

8. The Mitanin programme expected **community participation and civil society participation as vital** preconditions, but went on to spread the programme without ensuring the same everywhere. The programme, in a sense, needs to strengthen its linkages with the community. This will be an important task before the programme.

9. **The process of community based selection of Mitanin** so well described is not taking place on the ground in the large majority of cases. It seems that the Mitanin herself was often not consulted and sometimes did not know she was selected till the deed was done. The community (*gramsabha)* often had no recollection of any election process. Am ad-hoc arbitrary method was often used for selection through two to three people who become like local gatekeepers. In some areas when the *davapeti* part came some mitanins were dropped without their consent or knowledge and other replacements were brought in, as medicines were seen as an asset that attracted people with various interests,

10. **The trainers particularly BRPs though** often enthusiastic lack the experience, expertise and skills required for training. The quality of trainers and training of trainers needs much more careful attention. Training, backup support and follow-up are key components in good NGO community health worker programmes. What is being "transmitted" is very basic, minimal health literacy. There is a need to develop a resource pool of trainers with the requisite knowledge and experience in health work. The trainers often have only a little more general education that the Mitanin, and are just a little ahead of the Mitanins in health "knowledge" which is relatively superficial, without any experience of seeing or handling people suffering with ill-health. Preventive, promotive, curative and public health work needs knowledge and experience. They also need communication, interpersonal and teaching skills.

11. **Community processes are also weak**. People in the hamlets *(paras)* often don't know what the Mitanin does, if they know who she is. Community

participation and involvement is workable and necessary for health improvement. However the Mitanin programme leadership and training processes have not given this adequate attention. They could facilitate it by giving the Mitanins the necessary perspective, self-confidence and group skills. This is not possible in a programme that provides only 23 days of intermittent training a year.

12. **Financing problems have adversely affected the programme. Fund flows and financing mechanisms need to ensure** regular, full and adequate payment to trainers. There have been irregularities and shortfalls in payments to BRPs (p*rashikshaks)* and DRPs.

    **Financial compensation of Mitanins** is a must, without belittling the value of voluntarism if anything definite is expected from them as duty.

    **Transparency, accountability and timeliness** of payments at district, block and local level has not been as it should. Calling the *prashikshak* the key stone of the project and then leaving their meager remuneration in the hands of a system that has repeatedly not delivered their compensation has significantly and adversely affected their morale and their output. A body like SHRC which is not directly dealing with the funds should be responsible for this to happen.

13. **An eighteen month project cycle is too short**. In several areas people thought that this programme had closed. Ideally there should be a ten year perspective as part of a health systems approach.

14. **Critical training gaps in the programme include**: irregular, short trainings with long gaps in between result in trainees forgetting what they have been taught; training material that is not sensitive to local knowledge, culture and language of people in *adivasi areas* in several districts; inadequate time is allotted to each topic to get even a rudimentary understanding of complex issues such as child health, women's health, administration of simple medication; training gets reduced to single line slogans / messages; predominance of didactic methods of teaching; lack of teaching aids; lack of assessment of learners, based on which a certification could be done.

**OPPORTUNITIES**

1. A statewide group largely of women with some knowledge in health and social mobilization skills has been created, with presence of large numbers of Mitanins, *prashikshaks,* DRPs, nodal officers, and field coordinators in all blocks. This work needs to be consolidated, improved in quality and built upon.

2. There is generally a lot of good will towards the programme from a number of important stakeholders. This must be utilized and continued through good communication with them.

3. There is a high degree of enthusiasm and commitment among field coordinators and even among DRPs and BRPs. A human resource development plan for them with more hands on, skill based training; exposure visits etc would continue their evolution into good trainers.

4. A good organizational system is in place. This would need to be continued and strengthened.

5. Availability of resources and interest from a variety of people/institutions/donors/groups within the state and the country.

**THREATS**

1. Too early a closure of the Mitanin programme after three years of functioning as has been planned / suggested would be premature and may result in loss of whatever gains have been made.

2. Insufficient, irregular fund flows with corruption small and big at different levels.

3. Co-option of the programme by various vested interests.

4. Any change in the environment that has so far been supportive.

5. Non-involvement of the panchayat system.

6. Blindness of the programme that may develop to contextual issues or political economy factors.

7. Over statement of achievements or excessive defensiveness by programme managers about field realities.

8. Trivialization of the need of rural people for good and regular first contact medical care.

# 12. Summary Conclusions and Recommendations

The mitanin or community health worker programme, along with strengthening of the public health system, are necessary for the people of Chhattisgarh to realize their aspirations for better health. The programme has shown that it is a learning, evolving intervention. The gaps that have emerged between planning and practice at the field level, some of which are inevitable in the best of circumstances, should not be used to prematurely close the programme or deny it funding. Efforts should be made to introduce measures to bridge the gaps. This initiative needs all the support, funds, management inputs and public involvement that the GOC, the SHRC and other bodies can generate through partnerships that promote the public good with equity.

Several components of the initiative are very good – such as the establishment of a dedicated, autonomous body, the SHRC to steer and manage the programme; *kalajathas* and radio publicity to increase community awareness; well made training manuals available at district, block and local level; a statewide organizational structure with governance mechanisms and parallel support structures; an all women scheme; the widely spread large numbers of mitanins present even in small *paras,* with habitations and not populations as the unit; committed teams of *preraks, prashikshaks;* active support and goodwill from the Ministry and Department of Health; and ability to negotiate, advocate and generate support and solidarity from a variety of stakeholders. There are other strengths as well.

The NGO experience of better implementation and innovation was partly evident in some areas, for instance the activism in Manendragarh; the somewhat better programme in the literate Dhamtari block by Dhamtari Mission Hospital, and in the RAHA project area; in Dantewada, parts of Bastar and elsewhere. But here too, problems of supplies and payments from the health system exist. On the whole, preconditions of community action and civil society partnership are so far not met adequately by the programme as we saw it. Adequate effort, time and resources are required for this critical component.

Though the mitanin programme has been fairly well thought through and constructed, the implementation process has revealed certain issues regarding design which need consideration. Priority needs to be given to longer term planning and costing of the programme with monetary incentives for mitanins; ensuring fund flows with transparency, public accountability and without delays; good skill based training of longer duration with experienced trainers and ongoing training of trainers; strengthened primary medical care by mitanins after accreditation and adequate medicine supply; improved public health system functioning at all levels along with better linkages and logistics.

## Recommendations for the Mitanin Programme

Based on the findings from all components of this study, on reflection of the overall experience, and the learnings from past experiences of the research team in small and large-scale CHW projects, the following recommendations are made to help the future development of the programme.

**Objectives:** The mitanin and health sector strengthening programme needs to be based in the context of development as a whole. Greater clarity is required regarding expectations of different constituencies from the mitanin programme. The functions and tasks of the mitanin could be defined once again in the context of the experience so far and of the recently launched National Rural Health Mission and the role of the ASHA (Accredited Social Health Activist). However continuity needs to be maintained to avoid confusion. There is need for constant reinforcement and communication regarding the evolving objectives of the programme.

**Strategy:** Districts and blocks must be given some 'autonomy' to run the programme with freedom to change track (within the overall guidelines), and bring in innovations and modifications in relation to local situations and needs. Mechanisms to obtain feedback and suggestions for improvement/ innovation from the community, Mitanins, ANMs, BRPs, etc. must be put in place. Activism should be focused on issues such as lack of access to basic health determinants and access to quality health care as per entitlements assured by our Constitutional provisions and the international treaties signed by Govt. of India. It need not be personalized against health staff, but should address the underlying issues ensuring accountability of the public sector to the people.

**Community involvement:** This is the pillar of any community based health programme, and the involvement of *gram panchayats* particularly must be ensured in the mitanin programme. The people have to be involved in defining the role of the 'Mitanin'. Greater community awareness, support and ownership of the process is required to ensure its effectiveness. Adequate human and financial resources as well as organizational mechanisms will be required for this programme over the next five to seven years and longer.

**Linkages:** The ANM – anganwadi worker – mitanin link needs to be strengthened at the field level. In addition, the ANMs and health staff need to be involved in the training of Mitanins on an ongoing basis. Collaboration and working with the Department's of Panchayati Raj Institutions, Rural (and Urban) Development, Women and Child Development and Education is necessary. Recognition of the Mitanins will need to be brought to the notice of the newly elected *panchayats,* and recorded officially where not already done. The public health system must recognize the mitanins through a formal mechanism, providing them some form of identity. Referral linkages need to be strengthened. Working linkages with health and social movements also need strengthening.

**Number of mitanins:** The ground reality of the villages needs to be considered while deciding the number of community health workers. The issue of drop outs and proxy Mitanin must be addressed. There is a need to identify the numbers of each of these. The programme could be thinned down by some acceptable means, reducing the number of Mitanins to consolidate and optimize the programme.

**Misuse:** Disputable Mitanins or those with potential conflict of interests, like those directly related to health practitioners, JSRs, RMPs, Ayurved ratna, and doctors should not be given medicines.

**Education:** A minimum level of education is required for the mitanins, but there should be flexibility in communities where such women are not available so that underprivileged communities who need the services the most are not discriminated against.

**Community mobilization:** The fact that the Mitanins need skills to mobilize communities, strengthen women's groups to increase demand generation and pressurize the system has to be addressed. This requires specialized training and support systems. *Kalajathas* and radio programmes must be increased and supported.

**Health Education:** Greater focus needs to be given to the non-clinical function of the mitanins which includes health education and health promotion to address the basic determinants of health and to improve community capacity and self-reliance to maintain their health and to take action where required against health inequities.

**Medical Care:** Primary medical care, which was present in the design itself is still an unmet need. This major weakness has the potential to bring down the programme sooner or later. The community health worker (mitanin), anganwadi worker and ANM have to be able to provide minimum first contact care which includes care and guidance for women's health. If medicines are to be given to the Mitanins, they must be adequately trained and supervised for this and the supply of drugs has to be regular. The supply of drugs should be given only after having done a thorough assessment of the knowledge and competence of Mitanins to undertake this responsibility, and providing for logistics related to regular drug supply, etc. Mitanins should be well equipped with minimum essential drugs so as to treat minor and medium illnesses in the village. AYUSH and non-drug remedies should be included. There could be a separate system of medical consumable supplies in addition to the public health system. Some suggest that the cost of drugs or part of the cost can be collected from the users so as to sustain the program (though this will need to be viewed against the social context of Chhattisgarh – there are different views in the team about this). Training on herbal medicines and non drug therapy must be increased. All Mitanins who are providing curative care to the community should be closely monitored and mechanisms for maintaining patient records must be ensured. The duration and frequency of trainings need to be increased. There must be a

regulation about Mitanins doing curative care, which will also cover the charging of money from the community if this is introduced. The costs of managing user fee collection by over 50,000 mitanins is likely to be more than the amount of user fees collected. Therefore very careful thought needs to be given to introducing cost-recovery mechanisms at this level. Referral and supervisory systems need to be strongly in position. Hence this component will need to be developed in a phased manner in small areas (blocks or PHCs) based on pre-conditions being met. The Consumer Protection Act is in place to protect patients against malpractice and the state will need to take responsible steps to ensure access to quality medical care.

**Budget:** The financial resource inputs into the Mitanin programme must be increased based on a longer term costing of different components.

**Morale:** The Mitanins require a certain status and respect in the community, for which they need to have the relevant useful knowledge and skills; power over some resources; working linkages with the health system; improved status within their own families; and economic independence. Efforts must be made to maintain the morale of the health workers throughout the entire programme and not just at Raipur.

**Training:** The training of trainers needs strengthening as the quality of the trainers' capacity, knowledge and skills are important. It would be useful to have dedicated training and post-training support teams. Medical officers, ANMs and health staff require regular orientation and increasing responsibility for the Mitanin programme, by being involved in the training process and providing additional linkages to the public health system. Pedagogical skills, communication skills and group skills need to be enhanced. Building up of knowledge and skills, communication skills and group skills need to be enhanced. Building up of health knowledge and skills, through continuing medical education and consolidation of gains through iterative training is necessary. Training programme should be participatory using active learning and adult learning principles. Simulation exercises, games and role plays, audio visual teaching aides (including CDs where appropriate) should be used. A monitoring of the quality of the training program particularly at field level should be done. There need to be refresher training sessions and monthly reviews by experts in health. A different training approach must be devised for non-literates. A pool of trainers fluent in the different languages in the state need to be built up. Introducing assessment of trainees needs to be considered. Those who do not meet the required standards could be dropped from the programme. These are complex measures to introduce at a statewide level and this is what needs time and effort..

**Monitoring:** There is a need to assess the work of Mitanins regularly at block level and to bring in modifications based on the assessment to strengthen the programme. A monitoring and evaluation system should be established with findings being used at block level.

**Remuneration:** The Mitanins must be given some remuneration in cash or compensation through other means for health promotion, preventive and curative care, as their livelihood also needs to be thought of. Money need not be delivered through the health system but through the *gram panchayat* or self help groups / other system. Her accountability is to the community. The remuneration can be linked to performance.

**Support:** SHRC must be continued for three to five years (or longer if it continues to be effective) and be given a definite agenda regarding the Mitanin programme, with a system of checks and balances and accountability. The district and sub-district organizational structures and mechanisms for Mitanin training, follow-up and monitoring must be expanded (however none of these should become ends in themselves and additional layers of bureaucracy). Other support systems and mechanisms to build morale and capacity: for logistics and supplies; and financial flows etc. must be strengthened. Linkages with the public health system have to be strengthened. The primary heath care system (CHC, PHC, /SC) and the referral systems need to be functional and responsive to back up the Mitanins.

**Sustainability:** Serious thought need to be given to organizational development and human resource development issues related to the cadres being developed and employed. Questions such as what would the DRPs, BRPs, *preraks* and mitanins do five to ten years later need to be considered. Plans for their nurture, growth and development and sustainability need to be made. The support of *panchayat's,* community and government departments related to health, along with a functioning logistics and supply system and compensation for the Mitanins is necessary for the long-term sustainability of the programme.

**Vision:** The programme must have a long term perspective so that the Mitanins can evolve from being a community health worker to advisor, consultant and a resource person for the health and wellbeing of women, men and children of the village/habitation.

**Lessons:** The weaknesses and challenges identified in the study should not be ignored. We are sure they will be viewed constructively and necessary modifications made. The positive aspects of the programme need further strengthening. The positive learning from the Mitanin programme and the principles underlying then, along with the challenges and constraints need to be shared in a systematic and objective manner with the states wherein the National Rural Health Mission and the Accredited Social Health Activists programme are being initiated. Sharing with the Ministry of Health, GOI, the officials concerned with health in the Planning Commission and with Depts. of Health of different state governments should be organized through workshops for objective discussion. Other donor, NGO and professional partners also need to be involved in this process of dialogue and ongoing learning. The documentation process that has been introduced already should be continued, with wider dissemination at national level and in academic circles.

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**Appendix 1**

# DOCUMENTS STUDIED

**Review of Books (manuals) prepared for the Mitanin programme**

**Book 1 : *Janata Ka Swasthya Janata Ke hath* (Mitanin workbook – introductory)**

What literacy level is expected of the Mitanin to be able to read this book is not clear. The very first three sentences have 32, 31, 43 words in each sentence. This is not suitable for any health workers, and low literacy groups. This lengthy sentences pattern recurs in almost all books.

Pictures are OK.

Lessons include:

- Understanding health (includes causes of ill health, malnutrition, pollution, male domination, hard labor, mental tension, lack of health services, lack of health education).
- Some general topics.
- Understanding illness and their types.
- Health as a right, Mitanin programme (includes objectives as follows using health services
- Community diagnoses of illnesses and primary care, first aid, mobilizing women, village help plan) and the methods of achieving of these objectives.
- General issues like working hours, training programmes, skills training, no honorarium, women's health and rights

**Book 2: *Hamara hak hamari hakikat***

Lessons include:

- Introduction
- Knowing the village
- Accessing health care
- Overview of health staff
- Treating illnesses
- Child birth
- Health sub center
- Child health services
- Family planning services
- Primary health center
- Community health Center
- Controlling illnesses (outbreaks)
- Making available medicines
- Other health related topics

**Some comments**

- Long sentences, (48 words in third sentence on page 19);
- A4 size without columns, use of *saral* Hindi but not spoken Hindi;
- good use of exercises and assignments.

**Book 3: *Hamare Bacche unki cehat* (Our children and their health)**

Lessons include:

- Overview of child health
- Preventing malnutrition
- Preventing diarrhoea
- Coughs and colds
- Serious illnesses and immunization to protect against them
- Talking to families

**Some comments:**

- Needless dwelling on state statistics.
- The discussion format for lesson 1 is good but is it good enough as a lesson for Mitanins?
- No mention of porridge (semi solid substance like kheer in the section on child feeding, little editing effort)
- No mention of learning objectives in any lesson including in this book
- Sometimes learning objectives are mentioned as on page 32, complex construction of sentences like on page 33.
- Home treatment for nasal congestion in colds is putting salt water drops in the Nostrils. Very twisted sentences as on page 35 para I.

**Book 4: *Mitanin tor mor goth***

Lessons include:

- Women's health and equality
- Adolescence
- Anemia
- Community health in pregnancy
- Right to health care in child birth
- Special illness of women
- Women and violence
- Empowerment

**Some comments:**

- Abstracts words (page I)
- Use of words like iron should be replaced by *loha*

- Need to replace complex medicine names by simple words (page 16) eg. Albenda instead of albendazol.
- No mention of HIV/ AIDS.

**Book 5: *Mitanin Davapeti***

Lessons include:

- Recap
- Understanding illnesses – symptoms and immunity etc.
- Anatomy and physiology
- Common infections and fever
- Other infections including diarrhoea
- Injections and saline
- Drug box

**Some comments:**

- Good use of pictures
- No list of contents
- Too many different topics under the name of davapeti book

**List of medicines recommended in this book:**

1. Paracetamol
2. ORS
3. Albendazole
4. Iron
5. Cotrimaxazole
6. Metronidazole
7. Chloroquine
8. Antacid
9. G.V. Paint
10. Gamma BHC

**Book 6 : Community action for Health – *Chalbo Mitanin Sang***

Lessons include: (no list of contents)

- Community participation and methods (include motivation, understanding, organization)
- Preventing water borne illnesses
- Malaria and Mitanin

**Some comments:**

- Good use of pictures and layout
- A/8 format which is very unusual for these books

**Book 7 : *Badhbo Mitanin sang* (Panchayat and health)**

- Story format for Panchayat and health. Use of drama format where ministers and collectors are interactive with panchayat heads.

- Swastha Panchayat Yojana with 26 points for action. These 26 points include the following page 40 – 43.

- Basic health services – (12 points) immunization, ANC, hospital births, child birth by trained attendant, birth weight taking, early breast feeding, blood smear report, ehloroqine availability, contra safety services, Contact with households, panchayat swasthya samiti, mahila swasthya samiti.

- Water and sanitation includes three points – Waste water pools, safe drinking water, latrines.

- Food security – (4 points) includes Anganwadi, mid day meal, fair price shops, antyodaya yojana.

- School education includes two points – school entry and registration, malnutrition.
- Child health and others includes 5 points – proportion of low birth rate, age of marriage, spacing, neonatal deaths, incidence of diarrhea and jaundice in the village.

- This is a good scoring system for village health. In the end on page 44, there is a tally sheet for total score of each *para.*

**Book 8: *Gramswasthya* Register**

This is a pictorial record book for family health facts. Each family record sheet includes the following:

- Identing data: Name of house hold, members, occupation, women under 45 years, under 5 children number.
- Vital events data: Marriage details, pregnancy, birth and death.
- Chronic illnesses – blindness, TB, leprosy disability
- U 5 child health – Vitamin A dose (5) worms, nutrition grade for child 1,2,3
- Immunization record, BCG, DPT , Polio and measeals and boosters.
- Family planning details – needs, NSV, tubectomy, condom, Mala D, Copper T.
- This register has 50 family tasks of this type.
- A next part contain 9 case cards of pregnant women. Each card has the following parts.
- Registration, EDD , risk, 3 checks of ANC (Anemia, BP, Swollen feet, weight, TT, FS, Foetal movement FHS.

Who attended birth (TBA, nurse, doctor) where (at home, hospital), how (normal, difficult, medical treatment, was it fatal), outcome (live born, still birth, abortion, boy or girl)
New born care (breast feeding), birth rate.
Immunization (BCG, DPT3, Polio 3, meseals, boosters.

The next part carries two pages for out break of illnesses. The illnesses include diarrhea, measles, jaundice, polio and high fever. The columns provide name of illnesses, date, how many affected, how many died, when reported, what did the health department do? The next part of last 2 pages carries instructions about the use of this register.

This is a very good pictorial record for village health care by Mitanins. The Mitanins have to just mark against each picture. The *prashikshak* will help the Mitanins in the home visits to complete these records.

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