AN EXPLORATORY STUDY OF MITANIN PROGRAMME: AN INNOVATIVE EXPERIMENT IN THE TRAINING OF WOMEN HEALTH WORKERS IN TWO PILOT BLOCKS OF RAJNANDGAON AND DHAMTARI DISTRICTS IN CHATTISGARH

Dissertation submitted to Jawaharlal Nehru University
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MASTER OF PHILOSOPHY

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This dissertation entitled, **'An Exploratory Study of Mitanin Programme: An Innovative Experiment in the Training of Women Health Workers in Two Pilot Blocks of Rajnandgaon and Dhamtari Districts in Chattisgarh'** is submitted in partial fulfillment of the requirements for the award of **'Master of Philosophy'** of this University. This dissertation has not been submitted for any degree of this University or any other University and is my original work.

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We recommend that this dissertation to be placed before the examiners for evaluation.

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To
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LIST OF ABBREVIATIONS

AAI:	Action Aid India
ANM:	Auxiliary Nurse Midwife
AWW:	Anganwadi Worker
BRP:	Block Resource Person
CHC:	Community Health Centre
CHW:	Community Health Worker
DRP:	District Resource Person
GOC:	Government of Chattisgarh
GOI:	Government of India
JSR:	Jan Swasthya Rakshak
MPW:	Multi Purpose Worker
NGO:	Non Government Organization
PHC:	Primary Health Centre
SHRC:	State Health Resource Centre
TOT	Training of Trainers

INTRODUCTION

My initial notion of health and health care was that it is a specialized field, restricted to physicians and hospitals and the role of any person was minimal. With my varied experiences this perception of health care underwent a change.

During my post graduation, I got an opportunity to see and understand a very different kind of hospital both in its origin and functioning - Shaheed hospital. It has been set up by a trade union of mine workers in Chattisgarh. Apart from two to four doctors working there, the rest of the trained staff were the local people, not very educated but highly motivated. The hospital was not the central thing but rather it was seen as a part of the larger movement towards ensuring better health for people. The health workers, having years of experience and a close association with the doctors and hospital had a very good understanding of health and disease. This experience gave a new outlook on health and health care services. It cannot be confined to the realm of doctors and medical care institutions but health workers and communities can play an important part in health care.

Later, my work in the interior rural areas of Jharkhand with the Self Help Groups (SHG) made me understand the problems of health care in rural areas. The villages had no doctors. Auxiliary Nurse Midwives (ANMs) and Multi Purpose Workers (MPWs) were hardly seen in the villages. The population of folk nealers was also dwindling. The only relief to them was the 'quack' who provided them service in their own villages. The people also had an option of paying him later. The accessibility to the block CHC was further limited by absence of motorable roads and non availability of public transport. During monsoon the situation gets worsened as the villages got cut off from the main roads. Health expenditure was one of the major reasons for loans from the SHGs, preceded by agriculture. My involvement with the didis (women) of SHGs strengthened my belief that community involvement is vital in provisioning of health care. My further education in the field of public health helped me to form the linkages between issues, and broadened my perspectives on health.

In a visit to Chattisgarh, I came to know about the recently launched Mitanin Programme – a joint initiative of Government of Chattisgarh and Action Aid India. It was a training Programme for the women community health workers. It is having a

little resemblance with my vision of the didis in SHGs. Such programmes, experimented in small projects have been successful, but when it was implemented on a large scale, the results were not encouraging. So this was an opportunity for me to explore how this Programme would do when implemented in the whole of Chattisgarh state and how would this Programme try to build on the past experiences. Though this programme is a part of the larger reform process, I focused my study on the Mitanin Programme. This study is to understand if such programmes can bring in some changes of the lives of people where accessibility to health services is still a distant dream for many, whether the health worker can at least marginally decrease the number of children dying from the easily preventable deaths.

The Programme is significant because the state government is gradually backing off from investment in social sectors. And the new mantra is the involvement of NGOs. The challenge is for both sides, can NGO initiative infuse new life into an old theme? The government too cannot back off from primary health care, so can it empower women to initiate self care with defined basic minimum support? This is the question that compelled me to take up this research.

CHAPTER 1

EMERGENCE OF THE COMMUNITY HEALTH WORKER CONCEPT - A LITERATURE REVIEW

This chapter traces the evolution of the concept of the community health worker and how it still attracts the fancies of the planners and policy makers.

THE PLANNED APPROACH

With independence, India set out to a plan for the health of the people. Various committees were formed to guide the newly formed government to make appropriate plans. The overall health situation of India at that time was poor as compared to other countries and within the country, there was widespread disparity in the urban and rural areas. The coverage of health services in the rural areas was very unsatisfactory. The Bhore committee, 1946 reported that on an estimate, 70-75%of the total available doctors must be practicing in urban centers. The disparity in rural urban areas in doctor population ratio is wide. It was seen that rural urban ratio of doctor-population varied from 1:3 in Bengal to 1:49 in Sind province. Similarly great divide was also seen in medical institution and in the number of beds in rural and urban areas. In 1935, nearly half of the districts and three quarters of the municipalities in British India did not have any qualified health officers (GOI, 1946).

There was an overall shortage of health personnel at all levels but the need was more in the rural areas as in these areas, the distribution was very low. Noting this disparity, the rural areas were given priority by the various committees that were set up to review and to give recommendations on the health condition of the country.

The National Planning Committee (Sokhey committee), set up in 1938, and brought out the report in 1948, recommended that by the end of five years, the country was to have a Health Worker for every 1000 population. There were to be a Village Dispensary for ten villages or for an approximate population of 10,000 having a Licentiate doctor apart from two Maternity Workers and Health Visitors. Five of these Dispensaries were to be grouped under a District Hospital and ten of these District Centers were to be based on one Divisional Hospital.

Talking about the Health Workers, the Committee believed that, due to the dearth of trained medical personnel, the health needs of India can only be met 'by training specially a very large body of men to perform some of the simpler tasks', and

'thus the cornerstone of the scheme is a health worker'. The health worker was to be an intelligent young man or woman selected from the village itself, sent for nine months training in community and personnel hygiene, first aid, common ailments, and simple remedies and then returned to his or her village to 'spread the gospel'. The committee spoke about creating a 'missionary spirit' in the Health Workers and making them understand the social implications of medicine as a science (GOI 1948).

The Bhore Committee (1946) also gave priority to rural areas. The Committee clearly stated that the focal point was rural India, where 90% of the people lived. And moreover, the economy of the country rested on agriculture. The committee made two types of recommendation for the health service structure, the long term plan stretching over a period of 20-40 years and the short term programme covering two five Year Plan periods. In the long term plan, the smallest serving unit was to be the primary unit which would cover an approximate population of 20,000. About 30 of the primary units were to be assisted and supervised by a secondary unit so that the district could have five such secondary units.

Again in the long term plan, the Bhore committee recommended the 'Health Assistant' as male paramedics and Auxiliary Nurse Midwife as female paramedics. "The idea of creating a class of health worker known as the 'Health Assistant' has been conceived to provide a type of personnel for assisting the medical man and for relieving him of many of his minor duties both on the curative as well on the preventive side" (GOI 1946). However, the health assistant was given more importance in the short term plan, during the transition period, as the primary unit had fewer medical and other personnel. Moreover, they had to serve a larger population spread over a wider area than what was the case in the long term plan. The health assistants were to help to extend the preventive and curative health care even though it was limited in scope.

The Bhore Committee also recommended the setting of village health committee in every village consisting of five to seven voluntary workers who were to be selected by general approval of the villagers. They were to be trained in elementary functions, which was not to be too complicated in nature and time consuming. Their standing in the village, their local knowledge and their intimate contact with the

people was to help them influence the villagers to accept as well as help to carry out effectively the health measures designed to promote general welfare. They were supposed to carry out, without payment, the minor sanitary works as filling up of pools, draining of pits, and cleanliness with the support of the community. The committee believed that, 'the development of such local effort and the promotion of a spirit of self-help in the community are as important to the success of the health programme as the specific services which the trained health staff will be able to place at the disposal of the people' (GOI, 1946). It also questioned the need for the health assistant in the long run. It was assumed that with the increased facilities for institutional and domiciliary medical care, the need for the health assistant would be less. Then he or she can be engaged more in preventive work, with suitable alteration of training. This Committee had envisaged that when health assistants acquire sufficient experience their continuation of work can be best left to the judgment of the provincial authorities.

By 1950s out of the planned 5000, only 2800 PHCs had been set up, each covering a population of about 65,000-75,000. The subsequent committees also brought out the issue of low coverage in the rural areas and suggested measures to combat the problem.

Mudaliar Committee in 1961 proposed consolidation instead of expansion of services. It emphasized that expansion without a minimum infrastructural base is counterproductive. Given the fact that 10 years after Bhore Committee, there was a shortage of paramedics, it proposed placing one ANM and one Health Assistant for 10,000 population and leaving the surrounding areas without health workers and called it 'twilight zone' where the workers will visit only when called. The emphasis of this committee on evolving secondary and tertiary institutions infact left out rural areas from focused intervention. **Kartar Singh Committee,** (1974) suggested that unipurpose workers should be converted into multipurpose workers but only in areas where Malaria Programmes has entered consolidation phase.

In 1975, **Srivastava Committee** on medical education and support manpower, spoke about full utilization of the paraprofessional resources available in the community, and their supplementation by a well structured system of referral

services. The committee said that 'the professional expertise are very competent from a technical point of view but it what is needed at the community level is not so much of expertise as nearness to the community, its confidence, willingness to assist, low cost and capacity to spare the needed time. This can be done by selecting and training some of the individuals from the community, who will work on self-employment basis. This will serve three important purposes, 1) it would create an agency which is close to the people, has their confidence and is economical to operate, for providing the immediate, simple and day to day medical and their services needed by the community; 2) it will also create the foundation on which a superstructure of fully trained and referral services can be advantageously built; and 3) it would have created a pattern of medical and health services which would be qualitatively better than the present system and still remain within the financial resources that are likely to be available in the near future' (GOI 1975).

There would be periodical training for these individuals and the referral services will be made available to them. 'The emphasis on the creation of a large band of semi professional and part time health workers in the community itself is proposed merely as a second level supplementary personnel to fully trained professional and not as a substitute for them' (GOI, 1975). The committee advised not to convert them into a cadre and remunerate and supervise them but rather leave them free to work in the community based on the trust and confidence of the community. They will form the link between the community and the multipurpose workers functioning at the sub centre and the doctors at the PHC level.

The Committee accepted the **Kartar Singh Committee** report of converting the unipurpose workers into multipurpose workers but found it to be inadequate. It recommended that all the supervisory personnel be designated as 'Health Assistant' to highlight the role of assisting the work of the doctors at the level of forming a link between the PHC and the health workers. Both the local paraprofessional and the Health Assistant will bring in a change of the functions of the doctors who can now spend greater part of their time in referred cases and to the development of the preventive and promotive programmes of community medicine and health and not in providing simple medical relief.

But this committee very categorically said that the paraprofessionals in the local communities, the health workers and the health assistants cannot satisfactorily perform unless they are properly integrated into a well-organized referral system which would provide them with adequate support and guidance.

Overall, the committees brought about a gradual shift in the status of health workers from the community representatives to the auxiliary staff. The Bhore committee's recommendations of one PHC/20,000 populations could not be implemented. By 1977, the doctor population was reported to be 1: 3654.

PAUCITY OF SERVICES IN RURAL AREAS

The three year course of **licentiate doctors** was also discontinued. The Bhore committee said, 'with the limited resources available the committee thought that it can be concentrated on the production of the most highly trained, the basic doctor and discontinuance of the licentiate doctors'. The limited funds, they felt can be used more advantageously in training large number of essential ancillary personnel. The Committee had hoped that the 'Basic Doctor', when trained in sufficient number would serve the rural areas. Some of the members dissented from the view and strongly urged the continuance of the medical licentiate system. Later the Mukherjee Committee in 1966, said that 'it will be unfortunate if at the present stage the proposal for the revival of a short term medical course is accepted by government. The licentiate and the students trained in short term courses are not likely to settle down in rural areas as it is probably believed. Moreover, rural areas cannot be treated on a differential basis from urban areas. On the other hand, the training of several categories of paramedical personnel suggested, would meet the problems of filling up the gap in medical manpower requirements' (GOI 1966). But the health auxiliaries in rural areas were also far less than required.

There was a gradual shift from the assumption of the view of the Bhore committee that doctors would be going to the rural areas. By the time Srivastava Committee was formed it was recognized there was another alternative need for the rural areas, as the coverage of health services remained low.

The model of health care that was set up, was characterized by high cost, hospital based, curative services provided by doctors using elaborate diagnostic aids and equipments, became urban based, and absorbed a high percentage of health budget in technical hospitals (Sathyamala, 1992). This left with very little provision for the rural areas.

The prevailing model of health care together with the interests of various powerful groups in society was considered responsible for the severe imbalance that exists in our health services. All this was part of the social processes that pushed the technocentric model, favored doctors over paramedics, specialists over generalists, and urbanization of health services with neglect of rural areas. Increase in doctors did not change the situation as Bhore committee had thought. 'The major obstacles to more just and efficient health delivery systems are not the usually cited ones of limited resources, poor communication, or lack of technological knowledge and data but rather social systems that fail to place high value on the health care needs of the poor' (Mahler, 1978).

The trained Doctors were reluctant to go to rural areas. The reason as why the doctors prefer urban area is related to the social background that the students come from and their economic interests. Another reason is the medical education that is provided. The technical content of the medical education brings in a process of alienation, in terms of more prevalent diseases that India has or the due emphasis that needs to be given to socio, economic, cultural and political aspects of illhealth. Also in training of the doctors, the diagnostic aids are highly used which does not prepare the doctor to work in rural areas with minimum or no aids (Sathyamala 1992). As Fendall puts it, health professionals tend to remain in urban setting for which their 'elegant' training has equipped them close to hospitals and to modern health technologies (Fendall, 1992). Zubrigg has also talked about the 'cultural alienation' of the paramedics (Zubrigg, 1984).

The number of doctors far outnumbers the ANMs and nurses and the number of doctors trained per year also outnumbers the ANMs and the nurses trained, whereas the requirement is more for ANMs and nurses and less doctors as fewer people need

specialized care (Sathyamala, 1992). Distribution of doctors is uneven, migration towards urban area and other developed countries.

The Indian Medical Association strongly supported the doctors and it talked about doctors' rights and privileges. In 1952-53, it opposed the proposal of the UP legislature of compulsory village medical service for a period of 5 years for all medical graduates before starting independent practice. It termed the proposal as 'impracticable, undesirable and not likely to achieve the objective'. It suggested that for attracting young medical graduates to rural medical service the state government should provide for decent living accommodation for the medical staff, offer a living wage and extra compensatory allowances for education of children, etc., besides setting up equipped dispensaries and small hospital units in rural areas.

Then in 1971-72, IMA also protested against the Rs.180 crore scheme of Rural Medical Relief proposed by the union Ministry of Health, as in IMA's views 'it would amount to patronage of quackery' and providing the 'rural population medical relief of low standards'. The scheme was considerably watered down and its implementation deferred. In 1972-73, there was a renewed suggestion of the Government of India's ministry of the health to the state government to regularize the position of unqualified practitioner of medicine and the Kerala government decided to enact a bill for that purpose. This was strongly resented by the IMA and it urged the government not to recognize the unqualified persons as medical practitioners and instead suggested utilization of their services as auxiliary after proper training. When some state government proceeded with the 'regularization of quacks' IMA decided to observe All India Black day. The government again bowed down to the demands of the IMA, and accepted it demands. The government thus has always supported this body (Majumdar 1974).

THE EMERGENCE OF COMMUNITY HEALTH WORKER

By 1970s, then there was an upsurge of field experiments with Community Health Workers, through out the world. The Barefoot Doctors (peasant health workers) in China and the 'behyar mama rustai' (rural nurse/midwife) and 'behdast yar' (male health worker) in Iran are some good examples. The Alma Ata declaration

also emphasized the need for people's participation. Community Health Workers were thus given greater importance as prime actors in providing primary health care by national governments.

Definition of CHWs adopted at the interregional conference, on Community Health Workers, in 1986 (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 worker's (WHO, 1987).

There was great deal of discussions and publicizing of the possible contributions that the Community Health Worker can make. What was never questioned and confronted was the failure to build an infrastructure and manpower, which was envisaged. By 1976, there were 14 Medical colleges less than the required number (GOI, 1977). Instead of confronting the situation, there were different rationalizations given in favor of the Community Health Worker.

1. Only 10-20% of the patients need to be referred to doctor or hospital facilities, the rest can be taken care with a person trained in basic medical training like a village health worker, ANM, or a nurse. The director general of WHO, in a conference in 1973, had said that 'it is undeniable that there are important health problems, and some inexpensive technologies are available, and that one can train auxiliaries at low cost to provide some level of health care to millions and millions of people who are totally without health services. The real problem is not in lack of funds. Because in any field, with only 2% to 3% of conventional medical technology, it is possible to arrive at roughly 90% of a necessary quality of care. It means it is possible to standardize a tiny faction of a given medical technology so that one can train a health assistant within a relatively short time to provide health care' (Mahler, 1978).

2. The prevailing model of health care, which was characterized by technocentric, high cost, hospital based, curative services, was more tilted towards the urban areas which corner the bulk of health budget. The failures of

this system ended up with the medical needs of the poor in most third world countries, especially in rural areas, not being met, so an alternative was needed.

3. The earlier belief that the benefits of economic growth would trickle down to the poor did not seem to work. An alternative was needed. The need to find solution took on a new urgency as some form of medical help however minimal had to be provided to the poor to keep their 'dissatisfaction' under control. The new strategy had to be low cost, village based and culturally acceptable and China had provided an excellent example with their barefoot doctors. So the training of CHW was thus seen as an effective alternative strategy for meeting the health needs of the rural population.

4. According to Walt, 'for many working in the health field, training community members to provide some rudimentary health care was part of a larger ideology about development. Many small-scale projects trained people from the community to provide health care, but envisage such people as catalyst who could help communities understand about ill health and the factors causing it, and help them to change such conditions' (Walt 1991). The trainees were to be a primary member of the health team and not just an auxiliary. They were the agents of change in the development process, challenging the medical profession's monopoly in health care. The simple technical measure to combat disease can have only a partial impact due to conditions that are explicable largely in terms of environmental, socio-economic, cultural issues.

5. Skeet pointed out that the upsurge of interest in health auxiliaries in the 1970's has been a response to the unmet needs for basic health services. It is also a response to the recognition that curative medicine is only one aspect of health care, and the other preventive and positive health components can have a far greater impact on community health than conventional hospital based medicine (Skeet, 1978).

The concept of health worker, according to Frankel, had been there as a common practice in military medicine as well as colonial health services (Frankel,

1992). The reasons though were quite different. Earlier the health workers with higher education were desirable but due to the lack of resources, they had to be content with workers having limited educational experience. Also in the colonial period, of ten the Health Assistant was taken as subordinate to look after the needs of special inmates as in mental hospitals. Thus it led to a differential system of care but in a reverse order. In the 60s and 70s, the emphasis shifted from CHW being a subordinate with limited skills to a change agent, and a cadre with unique positive potential. The lack of professional qualification is said to reduce the distance between workers and people they serve.

Their closeness to the community gives them greater understanding and influence. But support is crucial. The rise in health auxiliaries is being seen as an easier means of communication between people and health educators (Skeet 1978). This remained a marginal influence in India, used by some NGOs alone while the CHW remained an entity to deal with a threatening gap in service provision.

In social terms, these workers occupy the space at the interface between the health sector and the local population. In cultural terms, they straddle differences between indigenous and cosmopolitan views of illness, (Kendall 1992), and tensions within cosmopolitan medicine between cure and prevention, (Heggenhougen and Magaripg-1992). But it is not conceivable that on a significant scale it will be possible for them to be healthy unless the governments are also actively promoting health for the people.

THE COMMUNITY HEALTH WORKERS IN INDIA

The paucity of the paramedicals in rural areas, the political need to arrange the democratic aspirations of rural population and the refusal of the doctors and mobility to force them were the factors behind rethinking in the official quarters regarding CHWs. The initiative came in the early 70s from the Congress government but it was finally implemented by the Janta government thus, getting the credit.

On 2nd of October 1977, the government launched the Community Health Workers Scheme to 'devote special attention to the health needs of the rural

population and to ensure people's participation in their own health activities'. The name of the scheme changed from Community Health Worker to Community Health Guide to Community Health Volunteer, here we would be referring it as Community Health Worker (CHW).

Under this scheme every village or community with a population of 1000 selects one person from among its residents, who was willing to serve the community and enjoyed its confidence. The CHW was given training in simple and basic health services for three months at the PHC to which he belonged. During training the CHW was taught the fundamentals of health and hygiene, treatment of common ailments, maternity and child health care, first aid etc. After training, the CHW goes back to the village to serve the community. The CHW was provided with a kit containing medicines and also a manual. The kit consisted of common medicines belonging to the modern system of medicine besides remedies under the traditional systems in vogue in that part of the country. The worker was expected to work in his/her spare time for two to three hours daily. During the period of training the CHW was paid a stipend of Rs.200 per month for three months. After training, the CHW was given an honorarium of Rs.50 per month for working with the community and also Rs.50 worth of medicines per month. It was a 100% centrally sponsored scheme with the objective of training persons elected by the community for primary health care (GOI, 1977).

The scheme suffered a setback in 1979 when it was included in the category entitled for 50% central assistance. The scheme was taken under Family Welfare Programme and 100% funding was resumed and a revised scheme was communicated to the states in 1981. The salient features of the scheme were that females should be selected as health guides and preferably by 30 years of age and should be residing in the village permanently. Male Health Workers were to be selected only if females were not available and preference was to be given to ex-servicemen, freedom fighter or a person known for his social services in the village. It was emphasized that the CHWs should not consider his role as a source of future employment in the government. The Worker is meant to be a vital link between the community and the health functionaries thereby ensuring community participation and preparing a cadre of volunteers selected by the community itself where socially inclined people can

provide primary health care services. With great emphasis on child survival and maternal health programmes in the year 1986, the states were requested to discontinue the services of male Health Workers and replace them by female Health Workers. The CHWs in different parts of the country got a stay order on the communications of GOI. Hence, the states were requested not to give effect to the earlier communications and continue with the male health workers who are on record. Except for four of the states, other states continue with male CHWs (GOI, 1977).

Apart from this, there were other community health worker programmes initiated by NGOs around this time like Aware for Welfare and Awakening Rural Environment (AWARE), Rural Unit for Health and Social Affairs (RUHSA), Comprehensive HDP Pachod, Comprehensive Rural Health Project (CRHP), Jamkhed. 'The emergence of NGOs generally depended on action-oriented individuals committed to the cause' (Koblinsky, 1994). And they are small projects, serving upto few lakhs of population. But as Koblinsky puts it, 'what the small scale, well manage projects cannot do, however, is provide organizational models for larger systems to reach the same achievement levels'.

The national health policy of 1982 envisaged 'universal provision of comprehensive primary health care services'. This required reorganization of health infrastructure, major modifications in the existing system of medical education and paramedical training, and integration of health plans with those health related sector, such as water supply and food production, as well as with socio-economic development processes. The policy gave pride of place to the CHW and expanded on community participation. But in the 80s, the path to health deviated considerably from that mapped out in 1982 policy. There was a virtual demise of CHW scheme, and with it almost all hope of community controlled health care.

The ICDS scheme in 1980s brought a 'package of supplementary nutrition, immunization, health check ups, referral, nutrition and health education and pre school education' through the anganwadi in every village. However, towards the end of 1980s economic processes led to stringent health budget, which took toll on state supported health care. The private sector gained considerably. In 1985, the pattern of health infrastructure was modified and a four-tier structure was created in rural health

systems. Targets were set up to meet the needs but it has been met at the expense of quality. Deficiency of staff was widespread in PHC. PHC services also deteriorated and as a result the primary health care system provides less than 8 percent of the medical care sought by rural households (Chatterjee, 1993).

The CHW programme was subjected to extensive sociological evaluation. Here we take out the key issues in the conceptualization and implementation of the Programme and discuss it.

Issues in Conceptualization

1. For the training, the scheme was dependent on the existing structures which already had problems as reported by the MPW committee.
2. The scheme did not pay adequate attention to the improvement efficiency of existing system by strengthening supervision, referral, and communication systems.
3. The CHW's role was to work as a bridge between the PHC and Community but the relationship between CHW and Health center became conflicting.
4. The system did not consider the problem of stratification in rural areas.
5. The selection of the CHWs was done by the Panchayat, which represents only a certain section of the village.

Banerji said that the CHW programme in India was jeopardized from the outset by conceptual errors. The planners ignored the social organization of rural communities, and made no provision to keep the people who dominate these communities from turning the programme to their selfish uses (Leslie 1985). Jobert mentioned that 'the political parties and elected representatives first saw in the programme a means of penetrating village political life. They even saw the programme's financial advantage as an occasion to ensure the gratitude of local client. Far from putting all their political weight in supporting the social reform brought by the programme, the political parties tended to integrate it into their clientilistic strategies' (Jobert 1985).

Issues in Implementation

Selection of the CHWs

In the CHW Programme, the PHC doctors were given charge of organizing the selection, and to avoid political confrontation, they adopted the least risk strategy. 'In many cases the doctors did not go to village to organize information meetings, they simply contacted the village head and few local leaders. Key role was played by heads or local councilors (Jobert, 1985).

Bose in his study of Punjab and Haryana has pointed out that there have been operational deficiencies, one is the gap in the flow of relevant information from the health services to the village communities. The circular used by the PHC did not 'explain the logic of the scheme fully'. The result was that the contact between the PHC and the panchayat was limited to the operational aspects of selecting the CHW for training. The village leaders, especially members of Panchayat looked upon the scheme as one that provided an opportunity for employment of a local person (Bose, 1983). Qadeer's study of CHWs in Shahdol district of MP has shown that due to constraints of PHC staff, their belief in the programme and reluctance to take additional work meant that the selection was left to the discretion of the Panchayat and therefore to the whims of the Sarpanch and the Upsarpanch. 'Of the 36 interviewed, 22 said that they were informed by the Sarpanch about the scheme, one by the PHC staff and two heard from friends. People had no information regarding the scheme in general and about the selection in their villages'. The framework of looking of community health programme has been through Caste, landholding, had played an important role in the selection of the CHWs (Qadeer 1985).

This trend is also seen in experiences reported of other countries like Zambia. This is reported almost universally (Frankel 1992). It further reduces access to health care for the underprivileged.

Jobert has pointed out that for candidates, predominance of economic considerations was obvious. Several case studies showed that a fair number of CHWs

depended seriously on the programme stipends for survival. For these reasons, employment considerations very rapidly became more important than social service in the volunteers motivation.

Even though, Evaluations in different countries have indicated that women perform better than men (Frankel 1992). **Women** were almost eliminated. The NIFHW evaluation study showed that about 90%of the CHWs were men. Bose, in his study has shown that only 6.3 percent of CHWs were women though 70 percent of the users were women and children (Bose 1983).

Training

This is crucial as this is where the much-touted transfer of knowledge from professional institution to community representative has to take place. However, launching the operation very fast in as many district as possible, led the reformers to rely on existing institutions, without any power to modify substantially either the orientation or the personnel. The official text has recognized the inefficiency and cultural isolation of PHCs in rural community but still the training of health workers were to be done by them (Qadeer 1977, Jobert 1985).

Health planning should start from the ground up and help to adapt services and technologies to the community's needs and resources which imply reconstruction of entire health systems based on community needs. It was planned that a series of efforts would be undertaken to reorient medical research and education towards the goals of community medicine, parallel to the CHW Programme, but that did not happen. Moreover, the reformers had to rely only on existing infrastructure for their training programme. Jobert showed that the existing structures for training were predominated with family planning activities and 'very far from participation approach to health'. The planners did not recognize that the trainers. Also not enough information was available for diagnosis of community morbidity, more dependency was there on the foreign research studies. The essential basis of CHW training manual was greatly inspired by standard manuals set out by the WHO. The CHWs work was limited, corresponding to the different national programmes. 'The main part of the training was designed as if the volunteers' exclusive role would be to serve as extra

labour for PHC personnel. The social dimension of health was completely left out' (Jobert 1985). The evaluation of the scheme by the NIFHW found that, there was apathy to the scheme by the state government officials. The instructors, quite often were themselves untrained in the goals and methods of this programme. The evaluation has revealed that 40 percent of the PHC staff engaged in the training of CHWs comprised those who did not have any training themselves. And they at times did not use or distribute the training manuals to the trainees. There was inadequate emphasis of field demonstration. The trainees after the training had a better grasp of the curative allopathic medicine taught in the programme rather than the public health measures and the preventive measures. The indigenous systems were largely ignored (Leslie Charles, 1985).

Continuing education is important for effective CHW programme. In China a structured cycle of continuing education included visits to the commune hospital, formal additional training courses on a regular basis, as well as visit to the barefoot doctor's health post form a variety of health workers, including the supervisor (Flahualt 1978). But the continuing education should not just be visits of the supervisor or CHW's monthly meetings to the health center. This was lacking in the CHW scheme.

People's response

The ambiguous position of the CHWs between the community and the health sector may lead to conflict of interest in attempting to please either part. The CHWs are by definition marginal to both the formal health care system on the one hand, and the social setting of health care on the other. This marginal role between the community and the health sector can lead to their acceptance by neither (Frankel, 1992). The CHWs have been appreciated by the rural people as they now had someone in the village that could be easily approached at any time during day or night for assisting them in treating illness or in arranging to get the illness treated at the sub center, PHC or any other government medical institutions (Bose, 1983). At the same time, another study by Desai has shown that the health centre staff valued the CHWs support in areas like family planning, where the villagers were reluctant to come forward. The involvement of the CHWs with such an unpopular scheme had caused a

strong identification of the CHW with the government rather than community aspirations (Desai 1992). The very title, community health worker, could be seen as a terminological attempt to gloss over the tension inherent in this marginal position. Progress can only be achieved by acknowledging this tension, in order to attempt harnessing it where possible or diffusing it where not (Frankel 1992).

Support groups

Support groups within the community are an essential prerequisite for the CHW programme. These relationships must also be given some sort of institutional framework which may counteract the fissile tendencies within each CHW area, increase the accountability of the CHW to the people he or she serves, and makes events at periphery more visible to those at the centre (Frankel, 1992). Experiences in countries like Bolivia and Ecuador has shown this necessity (Bastein 1990, Mangelsdorf 1988). It should be some sort of support group within the community served, which articulates actively with the health sector (WHO 1984). The training and other tasks involved in the support of the support groups are an important component of supervision of the CHWs (WHO 1987). But in the Indian context, the selection of the candidates had been influenced by the stratification of the village community which further makes accessibility to the CHW difficult for the socio-economically weaker sections.

Linkages

The outcome of the CHW programme is largely determined by the nature of the links between the health sector and the community. Where CHW programmes are likely to be the vehicles for PHC, the key to success must lie in the nature of the relationship between peripheral services and the health care system that supports them.

Supervision

Lack of supervision has been reported to be a major area of failure. In an interregional study by WHO, all the eleven participating countries have reported that

lack of interest in supervision by supervising was a problem (WHO 1984). Supervisors are mostly health care personnel. Regular visits to health centers can allow continuing education, discussion of problems, and exchange of information, but such opportunities are often missed (WHO study group 1989), and supervision can all too often be equated with involving the CHW in performing routine health centre tasks (Walt 1990). Frankel has argued for mobilizing a special cadre of CHW supervisors with sufficient training and management ability to maintain motivation in a task which has proved widely problematic. The costs of such a cadre of health workers, including their wages, transport costs, training, and support would fall to the health sector this may be seen as basic investment in any serious CHW programme (Frankel 1992). Also some sort of joint responsibility must be the ideal, where supervision is shared between the community being served and the health sector. Community supervision would concentrate upon accountability, while the health sector focuses upon more technical aspects. The success of such an arrangement will depend upon the strength and coherence of the support group, as well as its proper support by the CHW supervisor and other members of the health team.

Referral arrangements

One of the rational for CHW is when resources are limited; it is not cost effective for the treatment to be given higher in the referral hierarchy when they could equally successfully be given at the lower level. Secondly the role of CHW is very limited in curative care so it is essential for an adequate referral system for equitable and complete service. The physical distance, cost, social distance, a poor opinion of the health centre, domestic or other commitment can pose as barrier for effective referral. Links between the community and the health centre, mediated by the support group and supervisor, may help to increase successful referral, which can also represent an educational opportunity (WHO, 1987).

Supply system

Problems in the regular supplies of drugs and general supplies to CHW are widely reported. General shortages throughout the health system are likely to be felt first at the periphery as health centers become reluctant to distribute scarce items. As

curative role of the CHW is one of the key functions, securing an adequate supply system is a matter of critical importance for establishing effective CHW programmes. Shortage of drug supply lead to a lose of faith in CHW (Walt,1990). This has been the major problem in Tanzania (Heggenhougen and Magari 1992) where frustration has set in due to the inability to provide competent curative services because of drug services. In Sudan and Ethiopia, the distribution problems led to the failure to offer a continuous service, and hence a lessening of confidence in the programme (WHO 1980).

Relation with other health personnel

Another concern is the potential threat that the CHW may represent to other groups of health workers. Desai have said that the CHW scheme in India has been hampered by the bias of other health professionals whom he considers as over-bureaucratic and too professional. There may be role strains especially when the nurses are not involved in the planning processes and they do not understand their cultural beliefs of the workers and they are expected to train them.

Relationship with other healing systems

The aim of integrating modern medicine and traditional medical system is often talked about as a guiding principle of CHW programme, but how it is done in practice is the major issue. When talking of integration, it is important to 'stress the crucial difference between the conceptual framework that underpin traditional medical systems and the body of empirical techniques offered by traditional practitioners; that is the difference between traditional medicines and traditional medicine'. The Chinese barefoot doctors are often taken as a model of integration of traditional medicine and the modern medicine. But in China, 'the concepts of disequilibrium of the elements and other fundamental tenets of the traditional system were not incorporated into barefoot doctors activities, so that medical practice was conducted largely according to allopathic principles' (Bibeau 1985). There is a larger need to integrate the people's traditional means of pursuing health with the ideas of preventive medicine.

Another key issue is political will. CHW programmes are most likely to succeed where they are an expression of a conscious political choice to promote the living standards of the less advantaged sections of the population (Bossert and Parker, 1984). When the intention of promotion CHW is to influence the broader precursors of ill health, their activities are likely to highlight those aspects of environmental disadvantage that relate to inequality (Stark 1985). This sort of activity can expose the effective CHW to personal danger (Werner 1982 and Stark 1985).

Based on the conceptualization of the programme, depends the status, the role expected or the training imparted to the CHWs, and thus their contributions. One can view CHW's contribution as stretching along a continuum between two poles from CHWs as extenders of health services to CHWs as change agents (Walt 1991) or catalyst of development process. Werner used the term community supportive and community oppressive (Werner 1978).

The community supportive programme or functions are those which favorably influence the long range welfare of the community that helps it stand on its own feet, that genuinely encourages responsibility, initiatives, decision making and self reliance at the community level, that build upon human dignity.

The community oppressive programmes or functions are those which invariably giving lip service to the above aspects of community inputs, are fundamentally authoritarian, paternalistic or are structures and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions, those which in long run are crippling to the dynamics of the community.

Understanding this is important since 'the great variations in range and type of skills performed by the village health workers in different programme has less to do with the personal potential, local conditions or available funding than it has to do with the preconceived attitudes and bias of health programme planners, consultants and instructors '. (Werner 1978).

The Jan Swasthya Rakshak (JSR) Scheme

Under these conditions, a second attempt was made in Madhya Pradesh, with a new scheme of community health workers called the Jan Swasthya Rakshak (JSR) Programme, launched in 1994-95. To assess whether this exercise was based on adequate analysis of the experience with CHW scheme, it is necessary to grasp the programmes weakness at the conceptual level and problems with the implementation. Community Health Cell, Bangalore did the review of the JSR scheme. The review showed that the scheme was to follow almost the same fate as the CHW scheme.

Most of the ***selection*** has been done by the sarpanch, and the selection process has been limited to giving an application to the sarpanch and getting it approved. Wherever there was more than one candidate, the selection was done on the basis of merit. 'Both the JSRs and the Gram Panchayat think about recruitments rather than selection of JSR. The Department of Health Service has only administrative, not technical control, over the selection processes' (CHC 2001).

Eighty-five percent of the JSR have been reported to be ***male***. Only in one district, due to the initiative of the district Collector, the Anganwadi Workers were chosen as JSRs. Higher education level as criteria is an inherent bias towards women. The evaluation study says that there is a virtue in making the programme a woman centered one. Firstly, the women would come in the JSR after marriage, village shifting and child bearing and therefore after 25 years, which make them more matured candidates. Secondly, they are not the only bread earner of the family and that makes the aspiration for earning will be for supplementary income, not running the family. The women JSRs will bring a depth to the programme content and women health and child health can benefit from the women JSR. 'Men just make it an entirely curative, pills-for-ills Programme' (CHC 2001).

In the ***training*** part, the JSR is no different from CHW, the Medical Officer is supposed to give the training, and three-fourth of the trainings take place in PHC/CHC. The link between objective-training-practices was very weak and there was no plan for continuing education.

In the JSR programme evaluation it was seen that the JSRs do not have a clear understanding of the roles and functioning of the ***village health committee***. Also, there was no ***formal linkage*** with the ***government***. The JSRs were expected to attend monthly PHC meetings but they were not paid any travel allowance. 16 out of 22 JSR have denied existence of any monitoring.

Overall, the study showed that the community was not aware of the JSR Programme, there was inadequate linkage with the health service system, there was wide range of curative care provided by the practicing JSR and injections were used with inadequate caution.

The Non Government Organization (NGO) experience.

NGOs involving CHWs started in India around the same time as the National Programme. As part of NGO's objectives, most projects wanted to influence or inform the government Programme. Unlike the government Programme, the philosophical base of many of the private projects was broader than health. The NGOs depended on action-oriented individuals committed to the cause; the feature credited with their success.

The selection process, which, had set the tone for the government Programme, was more lengthy and involved in NGOs and efforts were made to incorporate the different sections of the village in the process.

Support

There is a higher degree of support and supervision in the CHWs supported by NGOs as compared to the government CHW. The CHW in NGOs work in team as primary health care is a team effort, and this is distinctly different from the CHWs of National Programme, where they have expressed their isolation and lack of support. In most of the projects, continuous interaction is seen with the team members who 'provides a connection, and encourages and supports the CHWs' enthusiasm to work and their own development' (Koblinsky 1994). The regular contacts of the CHWs with the people through home visits 'suggested greater coverage for the

disadvantaged also and an increase in the use of services effected by projects' (Koblinsky 1994).

Overall the small coverage area of the NGOs meant a more intensive and close support, supervision, monitoring of the Programme which made the difference.

The formation of a new state of Chattisgarh again saw the emergence of a new scheme of Community Health Workers: the Swasthya Mitanin Programme.

EVOLUTION OF THE MITANIN PROGRAMME

The government of Chattisgarh and the Action Aid India initiated the process of a community health worker concept - the Mitanin[1] Programme. It was aimed broadly to select, train and deploy a Mitanin in every hamlet. For funding of this programme, it made a policy decision to utilize the funds of the European commission's sector investment programme. For this, a need of partnership with the 'civil society' was felt. The regional office of Action Aid India was requested to facilitate to bring in the leading NGO's of the state. The government of Chattisgarh and Action Aid jointly organized a three-day workshop in January 2002. This workshop was attended by the leading health activists and NGOs from across the state, other parts of India and representatives of the European commission.

The main stress was to formulate a programme which will be:-

1. Community based
2. Have strong element of women's empowerment
3. A programme that would lead to multisectoral approach to health care where health is linked to poverty, gender and other social sector inputs.
4. Strong level of decentralization – a pivot around which the health system can be decentralized.

There were others in the formation of the programme who contributed by bringing in different aspects to this programme. Some participants articulated the

[1] Mitanin in local tradition is a long time female friend chosen carefully and fortified by a ritual declaration that binds two girls to help each other lifelong 'in every joy and sorrow'.

rights based approach more and brought in greater accountability of the state health system. Programme advisor, EU, brought in the perspective of reforms of the larger health system, how can the health system be changed, bring about changes in policy and planning with looking into the interests of the people, which will run parallel to the Mitanin Programme.

At the workshop there was consensus especially from the leading NGOs of the state that the 'Mitanin' programme is 'unlikely to succeed unless wide ranging structural reforms were undertaken by the Government of Chattisgarh to change the existing laws, policies, programmes and institutions of the state delivery system. To achieve the vision of 'health for all' there was a need to make a transition from the existing health services to community based health services'(GOC, 2003).

A number of areas were identified which needed structural changes. The focus was mainly on strengthening community health systems, primary and district level health delivery systems, health surveillance and epidemic control. The areas of reform are given in appendix-1.This was to make the Mitanin Programme meaningful.

There have been efforts to learn from the past failures and some innovations were done.

- The women were purposively chosen as the Mitanins,
- For a better selection process, the Programme tries to bring in three innovations, a process of social mobilization before the selection is done through kalajatha[2], the actual selection is done through a trained facilitator, and choosing the hamlet as a unit of Programme instead of the village.
- Curative care is given a supplementary part and not the central emphasis, so in the trainings, the preventive aspect is first introduced and deployed, and then the Mitanins are trained on curative aspects.
- For continuous training and support to the Mitanin a team of 20 trainers have been formed. Apart from the 20 days of camp based training which are spread over a period of 18 months, the trainer is supposed to go to the Mitanin in her village and maintain contact and the needed support.

[2] A local troupe which performs plays in villages

- Another issue was honorarium where the planners decided not to give any honorarium to the Mitanin, the reason they thought was the Mitanin should not be overloaded with work so that she have to face any loss of livelihood, and moreover, any compensation would mean interference in the selection process from the dominant sections of the village. Compensation, they thought would mean that the community would fall back and the burden of work will solely her task.
- The Mitanin Programme 'recognizes that considerable areas of intervention depend on the availability and accessibility of good health services that cannot be substituted for by community action' (SHRC, 2003). The Programme spells out parallel measures needed to improve the health service system and this component have to be linked to the Mitanin's work so that both aspects mutually reinforce one another.
- The Programme has brought in partnership at all the levels of implementing the Programme, to cover up the limitation in both the sectors.

The workshop became the initiative for the formalization of the Mitanin Programme. However, this final structure was worked by the government through the State Health Resource Centre with the recommendation of State Advisory Committee and the NGOs were involved in a big way in decision-making and gave them the freedom to experiment as well as follow the government structure if they so wished. This study is an attempt to see how much the lessons of the past contributed to the conceptualization and implementation of the Mitanin Programme.

CHAPTER 2

RESEARCH METHODOLOGY

This chapter outlines the conceptual framework of the study based on the literature reviewed, gives the design of the research and a brief overview of the study area.

CONCEPTUAL FRAMEWORK

The expanding modern medical care in postcolonial third world countries had to face the challenge of resource paucity and skilled manpower. India was no exception and like other South Asian countries it met the challenge by mobilizing its traditional and common people. Thus, there is a history of use of traditional systems of medicine and incorporating them in provision of services and of attempting to involve traditional dais and traditional medical practitioners to expand the service provision.

In this effort for building adequate manpower, two strategies were used. These were the use of paraprofessionals and volunteers other than traditional birth attendants. Paramedical personnel were seen as auxiliary workers that do simple tasks to free the doctor for more complex function and they remain under the medical supervision. The position of the health volunteers however, has been changing, at times ambiguous and often full of tension. Our review shows two clear approaches towards the later. While the health workers conceived of in the thirties and forties were largely the traditional practitioners used to fill in the gaps of paramedical works. In the 1970s the state conceptualised health worker as people's representatives.

After the third plan when doctors started resisting village posting and large gaps in services created political dissatisfaction in rural areas, use of traditional practitioners and even Rural medical practitioners were seen as a feasible alternative. This means that from limited auxiliary function the village health worker acquired the role of medical caregiver. The 1977 scheme of Raj Narain known as Community Health Workers (CHWs) was the fullest reflection of the shift. While it meant an initial investment in training and then ongoing drug supply and honorarium, it failed to strengthen the health service system for several reasons:

1. In the name of community only a handful of elite participated in the selection process that left out the poorer sections in the village.
2. The patronage of panchayat institutions meant CHWs could use it as private business.
3. The PHC workers saw this new cadre of CHWs as rivals rather than supporters.
4. The Medical Officers saw the CHWs as family planning agents who can help them reach their targets.
5. Even the CHWs, who were good, did not get support for referral cases as the PHC remained ill equipped and no changes were brought in the health delivery system.
6. The training provided was weak and it was to train the CHWs more as auxiliary. Training was given for first aid, which was not enough to provide medical care to the people.
7. The supply of drugs was not given proper emphasis even though the drug shortage was reported widely.
8. There was lack of support and supervision of the CHWs.
9. Disillusionment of CHWs was seen related to their role.
10. This was not a voluntary scheme.

Jan Swasthya Rakshak Programme of Madhya Pradesh Government was in no way different than the earlier programmes. In this context, the Mitanin Programme came up after the formation of Chattisgarh as a new state in 2000. The objectives of this Programme was to:

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

It is clear that these objectives can be met only if all the mistakes of the past are corrected and not only health service institutions but also all the village institutions support the Mitanin Programme. In other words the linkages between Mitanins, communities, health services and the Panchayats are the focus of our conceptualization. These cover the training, supervision, the process of selection, the relationship with the health workers, referral systems, support systems and the status and role of Mitanins that influence her own perceptions. Thus the study explores how different implementing agencies approach the programme objectives and these linkages.

OBJECTIVES OF THE STUDY

To explore the extent to which Mitanin Programme is an improvement over the Jan Swasthya Rakshak scheme through an analysis of its conceptualization, implementation and community involvement. To achieve this objective we need to do the following:

- To understand the Mitanin Programme from the planners perspective.
- To understand the Mitanin's perception of this Programme.
- To study the implementation process of the Mitanin Programme by two different implementing agencies and bring out the differences within them.

STUDY AREA

Chattisgarh came into existence on 1st November 2000 when it separated from Madhya Pradesh. It is the ninth largest state of India in terms of area and ranks seventeenth on the basis of population. Chattisgarh state has 16 districts, 146 blocks, 19,720 villages and 54,000 hamlets. The health care infrastructure is inadequate. There are only nine district hospitals, and only 114 Community Health Centers in 146 blocks. The state can be broadly divided into three-tropographical regions viz., the northern hilly regions, the central plain region and the southern hilly region. The central plain region is largely a non-tribal belt and the rest of the regions are tribal belts.

The Mitanin Programme was started in May 2002. The programme has been implemented in three phases. In the **pilot phase**, the Programme was implemented in 14 blocks starting on May 2002. In the pilot phase nine districts were covered. Two blocks in the five districts and one block each in four districts were encompassed. Among the 14 blocks in two blocks the district chief medical officers implemented the pilot phase and in the rest varying NGOs implemented it. The **first phase** was implemented in 66 blocks from December 2002 and the **second phase** is being implemented in the rest of the blocks starting from January 2004.

SELECTION OF THE STUDY POPULATION

For the purpose of the study, the researcher decided to choose the study population from the 14 pilot blocks. This would allow making a better assessment of the Programme in this area, as the Mitanin Programme was implemented first here compared to other blocks. It was also noted that the inputs and supervision in these blocks were more intensive which is unlikely to happen in the first and second phase. Both the phase cover blocks that are spread over vast areas. In the pilot blocks, there are seven different agencies, which implement the Mitanin Programmes. Six of them were NGO's like Rupantar, Bharat Gyan Vigyan Samiti, Zilla Saksharta Samiti, Raigarh Ambikapur Health Association, Ramakrishna Mission Ashram and Lokshakti. One government-implementing agency was the district health service in Rajnandgaon district.

For the study the researcher selected two different implementing agencies, district health service implementing agency in Rajnandgaon district and Rupantar (an NGO) in Dhamtari district. They were chosen for the following reasons:

- The district health service in Rajnandgaon was the only government-implementing agency and it followed the norms as stated by the State Health Resource Centre (SHRC).
- Among the NGO's, Rupantar implementing the Mitanin Programme in Dhamtari district was selected because it deviated from the SHRC norms and brought in some changes in training and other inputs. Rest of the NGO's followed more or less the SHRC module.

In Rajnandgaon district out of two blocks namely Ghumka and Dongargaon pilot blocks, Ghumka was selected for the study. Traveling to this block was convenient for the researcher. Rupantar has taken up the pilot blocks of Nagri and Magarlod in Dhamtari district. In Nagri it has been working since the last decade in areas like education, food security and health. In Magarlod block, Rupantar has entered only to implement the Mitanin Programme and therefore this block was chosen. Thus, the study area comprised of Ghumka block in Rajnandgaon and Magarlod block in Dhamtari district run by the state government and NGO respectively.

OVERVIEW OF THE STUDY VILLAGES

Rajnandgaon district came into existence on 26th January 1973 after the division of Durg district. In 1998, Kawardha was bifurcated from this district. Rajnandgaon contributes 6.16 percent of the total population of Chattisgarh. Ghumka is one of the nine blocks of the district. There are 162 villages in Ghumka village.

Dhamtari District was formed on 6th July 1998, dividing the Raipur District, the current capital of Chattisgarh, and Mahasumund. Dhamtari is a small district having a population of 7,03,569 (2001 census), which has only 3.38% of Chattisgarh's total population. Magarlod is one of the four blocks in Dhamtari. There are 116 villages in Magarlod block. Both the districts are located in the plain region and are quite similar. Here we give the description of the villages of both the blocks.

Majority of the villages in Magarlod and Ghumka blocks have approach roads, the main roads having tar roads and the interior villages have kaccha roads. Buses and jeeps are modes of public transport available to the people. The buses are not very frequent and ply only on the main roads. The jeeps also run on the main roads but are more frequent.

The main economic activity of the people is agriculture. Rice is the major crop of the region. The rabi crop includes khesari (*Lathyrus Sativus*), bengal gram. Rice is cultivated in a very small proportion irrigated. Some area is also covered by

forests and provides them forest products like mahua[3] and kendu[4] leaves. Rice mills are also seen in Magarlod block and in adjacent areas. There are 106 rice mills in Dhamtari.

Most of the houses in the villages were mud or semi pucca houses, with tiled roofs and some thatched roofs. Almost all the houses had a small verandah, a backyard and a small land known as the '*bari*', in which vegetables are grown. Tubewells are the main source of drinking water for the village and for other purpose water is used from the well and pond.

In Dhamtari district, there are two Community Health Centres (CHC), 14 Primary health Centres (PHC) with an average population of 50,255 per PHC. There are 139 sub centres covering an average population of 5062 per sub centre. Magarlod block has one CHC, which presently has 15 beds. Recently 15 more beds have been sanctioned

In Rajnandgaon district, there are nine Community Health Centres (CHC), 22 Primary health Centres (PHC), with an average population of 58,264 per PHC. There are 214 sub centres covering an average population of 5990 per sub centre.

Dhamtari has mixed caste groups with both tribal and non-tribal population. Rajnandgaon is largely non-tribal. Both Magarlod and Ghumka blocks are largely non-tribal. The villages have different hamlets, but not strictly according to caste lines. There are hamlets, which had mixed castes, especially the hamlets that have come up recently. Where there are mixed castes in the village the schedule castes are in minority and stay on the village outskirt. In most of the villages visited Other Backward Class population are in majority to the total village population. The villages provide almost a similar picture. Here a brief description about three villages where the study was conducted has been described.

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[3] Mahua (*Madhuca Latifolia*), its flowers, when it falls from the trees are collected and dried in sun, it is sold in the local market and are used to make liquor.

[4] Kendu (*Diospyros Melanoxylon*) leaves are collected from the forests, which is bought by the forest department.

Brijkuli Village

The village Brijkuli comprises of 115 houses, inhabited by 168 households. It has an approach road that crosses the village midway. On one side of the main road there are 35 houses and rest of the houses on the other side. A forest surrounds this village and along the road leading to the forest wood is cut and transported out. The forest does not fall within the jurisdiction of the forest department. Most of the houses including that of Sarpanch's house are mud house. Tiles were mostly used for roof and some of the houses had thatch roof. Wood is abundantly used in the construction of the houses.

The caste break up of the village households is as follows:

- Nagarchi (SC) 01
- Rawat- (OBC) 07
- Sinha (OBC) 25
- Gond (ST) 12
- Sahu (OBC) 13
- Lohar- 04
- Kalar (OBC) 35
- Nai- (OBC) 03
- Devangan (OBC) 01
- Mishra (GEN) 01
- Kamar (ST) 12

The settlements of the different castes are intermixed in the villages, except for 'Kamars' who stay in the periphery of the village. The land holding ranges from 14-16 acres for very few families, where as others hold between 3-4 acres. The Kamars do not own any land. They work as daily wage labourers and also collect 'mahua' and 'tendu' leaves from forests. Apart from agriculture, which is the main source of income, collecting forest product in the month of March and April is another source of income for the villagers. Other forest product like 'chironji' is also available from the forest. For 'mahua' collection, men, women and children go to forests to their marked trees and collect the mahua in the early mornings. This is then dried and sold to the middlemen. The families who are a little well off store mahua for

few months and then sell off when the rates increase upto Rs10/kilo from the present Rs.5/kilo. This mahua is used for making liquor after fermenting the dried mahua.

There is a panchayat building and an Anganwadi centre in this village. The health sub centre is quite far from the village and can be reached by bus that takes around 10 minutes. There were three private medical practitioners in that village.

There are five committees formed in that village for various functionaries. Those committees are Vansamiti (forest committee), Self Help Group (for savings), Manas Mandali (for reciting Ramayana), Jan Jagaran Samiti (for stopping alcohol) and health committee. Recently health committee has been formed.

Village Choti Kareli

This is a relatively bigger village and has about 725 houses with a population of 4750. It has three hamlets, the Chandapara, Mahuapara, and Beech basti. The caste wise break up of the households are:-

- Devangan (OBC) 40-45 houses – 500
- Sahu (OBC) - 1500
- Sinha (OBC) - 750
- Yadav (OBC) - 400
- Patel (OBC) - 250
- Satnami (SC) - 900
- Dhruv (ST) - 400

The Satnami in this village do not stay in the main hamlet, but they stay on the sides of Beech basti and Mahuapara. This is a bigger village so this village has got a primary school, anganwadi, etc.

Sengabhata village

This village has 105 families. Most of them are Sahus (OBC), apart from them, there are 12 Nirmalkar (OBC) families, three Soni families and four Lohar

families. The Lohar families in this village also reside on the outskirts of the village. This village is on the main road. The nearest health centre is the neighboring village, which is at a distance of not more than two kilometers.

SELECTION OF THE VILLAGES AND MITANINS

Given the time constraints, distance and problems of transportation, it was decided to visit villages for one or two days and get information on Mitanins' families, people's views on Mitanin and village committees in addition to understanding the structure of the villages. This exploration was purely purposive depending on the work routine of the trainers with whom the researcher traveled (but worked independently except when researcher had to observe the proceedings). Ten villages in Ghumka and six in Magarlod were surveyed. To get an in-depth understanding of the social structure in these villages, house-to-house survey of caste structure was done in one village of Ghumka and two villages of Magarlod. From both sets of villages, six Mitanins each were interviewed in detail and their homes visited to assess their background and their support structures. In the selection of Mitanins also we had to depend on availability as often not all Mitanins of the villages were there. Hence their selection is also purposive. The selection permits only qualitative assessment and we are therefore not trying to generalize.

KIND OF DATA REQUIRED

The researcher required primary and as well as secondary data in order to study the objectives. They were as follows:

1. Structure of the Mitanin Programme
2. Trainers and co-ordinators views and perception.
3. Selection process of the Mitanins.
4. Training programme of the Mitanins
5. Mitanins perception of their roles, their activities and health problems.
6. Mitanins perception of government service.
7. Nature of support Mitanins have received during their work from the auxiliary nurse midwives, family and the Mitanin Programme.
8. Role of the health committee in the villages

Secondary data was explored through various state government literature available on the Mitanin Programme.

TIME FRAME

The study was conducted in two phases. The **first phase** was the initial exploratory phase wherein the researcher went through the literature related to this area in order to develop an understanding of the community health workers programme and the issues involved in it. This enabled the researcher to develop a framework, which was further worked upon after the field-visit.

In the **second phase** data was collected from the study area over a phase of four and a half month. During this phase support was taken from the State Health Resource Centre in Raipur and the two implementing agencies, Rupantar in Dhamtari and district health service team in Rajnandgaon.

In the initial period the researcher went to the villages understand the village setting and observe the implementation process of Mitanin Programme, activities of the mitanins, their meetings. The researcher also spoke to different people related to the Programme to understand and grasp the issues in the Programme. Following this the fieldwork was started with Dhamtari and later Rajnandgaon was taken up. Ten villages in two blocks were covered. Only those villages could be covered from where trainers' available. Interaction with the people in the field, village visits were made and the trainings attended. This helped to review the interview schedule and the questionnaire for the Mitanins and interview guide for trainers and DRPs, which were reworked and finalized. Questionnaires were used because all Mitanins were available for a short time during the training programme. Only those who could not write were interviewed to fill in the questionnaire.

The researcher also attended

1) Different training Programmes
2) The village health committee meetings
3) The trainers meetings
4) Two workshops conducted by SHRC in Raipur related to evaluation of the Programme.

The data related to the Mitanins, trainings was collected from the villages where training was going on and during this period key people like the coordinator, the nodal officer, the PHC doctor were identified who were interviewed later. To them an interview guide was administered. For the travel the implementing agencies extended help to the researcher. The trainers accompanied the researcher to the field otherwise access to the villages would have been difficult.

SELECTION OF MITANINS, TRAINERS AND PROGRAMME MANAGERS

Mitanins have been studied at two levels. For quantitative assessment the training centers were used to apply interview schedule or get the questionnaire filled and at the village level where during field visits, the Mitanin were interviewed in detail depending upon the availability. For administration of questionnaires, the training centre was chosen as it provided an opportunity to get a large number of Mitanins together and from all the villages of that training centre, it also allowed the researcher to observe the training process. In Rajnandgaon, the questionnaires filled in the two trainings Programmes were not enough, so the researcher had to visit villages to administer additional questionnaires. The villages were chosen which had more number of Mitanins, or with villages, which were close to each other. Mobility was also a factor, so the researcher accompanied trainers who had vehicles. A total of 32 Mitanins in Rajnandgaon and 40 Mitanins in Dhamtari filled in the questionnaires. Only one refused to participate. When the trainers were interviewed, care was taken that both the non-government trainers and the ANMs as trainers were covered.

Key people like health personnel, DRP of both blocks, coordinator, nodal officer and CMO in Rajnandgaon, Binayak from Rupantar, Regional Manager of ActionAid India, SHRC director were identified and interviewed.

RESEARCH TECHNIQUES

The different techniques used were interviews, questionnaires, interview schedules, observation and group discussion.

Interviews – The Mitanins were interviewed in detail only in their village, mostly in the Mitanin's house. The village was chosen based on convenience sampling. In a village all Mitanins who were available and gave consent were interviewed. In-depth interview demanded a relaxed atmosphere where she could speak freely without fear of being reprimanded. This was not possible in training meetings. The limitation of one strategy was that only Mitanins could be interviewed but the interviews were rich and in-depth. The researcher had first built a rapport as she had met most of the Mitanins in previous training; she walked around the village with the Mitanins before the interview. The researcher first gave her introduction and her purpose and then she proceeded with the interview. A semi structured open-ended interview schedule was used.

For the trainers' interviews, the rapport was made easier because the researcher had a series of interactions with the trainers in both the blocks, in trainings and their meetings, or, in their fields before the interviews. A semi structured open-ended interview schedule was used for the interview.

The **questionnaires** were administered to the mitanins in the training centers in both the blocks and in Rajnandgaon the researcher also had to go to their village. The questionnaire was pilot tested and took lot of time to fill them.

Observation was used throughout the data collection. The researcher used this extensively when she attended the DRP training, the BRP training, the BRP fortnightly meetings of both the blocks and the health committee meetings, and during the family visits by the Mitanins. Other activities like the health mela and the Mitanin Sammelan in Rajnandgaon district was also attended by the researcher.

Group discussions were done in both the blocks with the trainers. The group discussion with the trainers was done in the trainer's meetings.

For the **secondary data**, the SHRC publications were used, the training modules, field report of the trainers, the radio Programme script was used. All this was in addition to the published literature reviewed to understand village health worker and community health worker Programme.

LIMITATIONS

- The public transport to the villages was very poor and so the researcher had to depend on the trainers or the organization for transport. As a result the researcher had to choose those villages where the trainer had some of her own work.
- Since the field was spread out a lot of time went in traveling and due to time constraint only a qualitative assessment could be done,
- As the scheme has just started, we could only evaluate the initial phase of intervention, a repeat analysis after a year of work will be needed for further assessment.

CHAPTER 3

STRUCTURE AND IMPLEMENTATION OF MITANIN PROGRAMME

The formation of a new state of Chattisgarh saw the government taking some new initiatives in the provision of health care. One of the initiatives was that of Community Health Worker Programme – the Swasthya Mitanin Programme[5]. The Programme tried to incorporate the lessons learned from the past failures and develop an innovative plan. This chapter looks into the Programme details and its process of implementation.

STRUCTURE OF THE PROGRAMME

The Mitanin Programme was part of the Health Sector Reform (HSR) Programme under the Sector Investment Programme funded by European Union. HSR envisaged 'strengthening public health system to achieve comprehensive universal primary health care'. The framework of the Mitanin Programme has been done in close consultation with NGOs and leading health activists of the state. They formed a **State Advisory Committee** to monitor the progress and also to help in the designing and its implementation. A **State Health Resource Centre (SHRC)**, an autonomous institution was set up as an additional technical capacity to the government of Chattisgarh to implement the Mitanin Programme apart from the other initiatives in the reform process. The major task of SHRC in the Mitanin Programme was to design, implement, monitor and support the Programme.

State Advisory Committee

The State Advisory Committee included representatives from NGOs like Rupantar, Jan Swasthya Sahyog, Zilla Saksharta Samiti, Bharat Gyan Vigyan Samiti, Raigarh and Ambikapur Health Society, and Ramkrishna Mission. These NGOs, working in the field of health, were a part of the Programme designing process. Senior state officials and representatives of funding agencies were also part of this State Advisory Committee. The health secretary chairs the committee and member secretary is the regional manager of Action Aid India. The committee also came in for setting the objectives and detailing of training material. Fourteen blocks were

[5] When the Programme was launched, it was named Indira Swasthya Mitanin Programme but after the defeat of Congress government and the BJP government coming to power in December 2003, 'Indira' was removed and it was named 'Swasthya Mitanin Programme'.

identified for implementation of the pilot phase to be done by the organizations that had been working in that area. These were:

1. Nagri and Magarlod blocks in Dhamtari district by Rupantar
2. Dondi Lohara and Gunder Dahi blocks in Durg by Zilla Saksharta Samiti
3. Marwahi in Bilaspur and Podiuppoda blocks in Korba Bharat Gyan Vigyan Samiti.
4. Batauli in Sarguja and Pharsabahar blocks in Jashpur by Raigarh and Ambiapur Health society.
5. Kharsia and Pusaur blocks in Raigarh by Lok Shakti
6. Narainpur and Orchha blocks in Bastar by Ramkrishna Mission
7. Ghumka and Dongargaon blocks in Rajnandgaon by the district chief medical officers' team.

The pilot phase of the Programme had a high profile launch by the then chief minister of Chattisgarh, Mr, Ajit Jogi at Bilaspur, on 25th of May, 2002. The implementing agencies in the pilot blocks initially had different approaches, but by middle of October 2002, a more or less unified approach to the training material and training strategy and a common Programme design was sought.

State Health Resource Center (SHRC)

State Health Resource Center was set up by October, 2002 to support this process of designing, implementing and facilitating the Mitanin Programme. ActionAid was requested to set up this SHRC along with Government of Chattisgarh (GOC) support. The terms of reference for SHRC were agreed upon, and a Memorandum of Understanding (MOU) was signed by Action Aid (country director) and Secretary Health, GOC. The MOU defines the SHRC as *'an additional technical capacity to the Department of Health and Family Welfare'* in designing the reform agenda, developing operational guidelines for implementation of Reform Programme and arranging/providing on-going technical supporting to the District Health Administration and other Programme Managers in implementing this Reform Programme. The objectives laid down in the MoU defines the goals of partnership as making structural changes in state health policy and practicing 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. This would be mainly done by strengthening community health systems, 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 **role of SHRC** in the Mitanin Programme, as mentioned in the MoU is stated below:

- Assisting in the finalization of the community-based health Programme of the GOC ('Mitanin' scheme)
- Assisting in designing a social mobilization campaign for popularizing the idea of 'people's health in people's hands' and creating effective demand for the Programme
- Assisting in designing the media and communications strategy and package for the Programme
- Assisting in developing operationalisation details and implementation schedules for the Mitanin Programme
- Assisting in developing all training modules and pedagogy for the Mitanin Programme
- Assisting in monitoring and evaluation of the Programme
- Assisting in the co-ordination and logistics for the training Programmes

The SHRC comprises of one director, two Programme directors and 26 field coordinators, one accountant, one office attendant. The field coordinators have a responsibility of 3-4 blocks, where they oversee the implementation of the Programme and are link between the SHRC and the implementing body.

The unit of planning and implementation is the block level by the block Mitanin committee. The Programme is coordinated, monitored and supervised at the district level by the district health society. The implementation of the Programme is done by both NGOs and government. Where the NGO is the implementing body, the NGO staffs look after the programme. In the government set up, a **nodal officer** has

been appointed in every district to facilitate the process of implementation of the Programme. At the block level, the **District Resource Persons (DRPs)** are the key people, who will look into the whole Programme including training, and the working of the Mitanins. The team constitutes of three person chosen from every block. Two of them are drawn from the voluntary sector and one is from the government staff. The **facilitators (prerak)** are the people who are trained to facilitate the selection process of the Mitanin in the hamlet. For this, every block was to have about 15 facilitators, but depending on the geographical area, it can go up to 20. The facilitators were to be preferably from the same area and preferentially women. For the training of the Mitanins, there are **Block Resource Person /trainer /samanvay samiti karyakarta.** In a block, there were about twenty trainers (non-government), and five ANMs who are supposed to give the training in the training camps and also provide support to the Mitanins in between trainings. The facilitators could be the trainer, especially the women facilitator, the composition was changed only when needed. Each trainer is supposed to provide support for about 20 Mitanins. The following section looks into the personnel in detail, about their functioning, and their role, with special emphasis on the two blocks of study, Ghumka in Rajnandgaon and Magarlod in Dhamtari.

SELECTION AND TRAINING OF KEY PERSONNEL

District Resource Person (DRP) Team

The selection of the DRP team in Ghumka was done by the Chief Medical Officer (CMO) and the nodal officer (of the Mitanin Programme). Out of the three DRP, two were from the government staff, one of them was health supervisor (male), also the coordinator of the Mitanin Programme, and the other government staff was a senior LHV. From the non government sector, they choose a person working in Nehru Yuva Kendra (NYK). (She is from Rajnandgaon, has done her graduation and is working in NYK for the last one year). In Magarlod, where Rupantar is implementing the Programme, the DRP are both, people working in the organization and selected from the villages.

The SHRC's state training team gives **training** to these DRP, at the state level at Raipur. The trainings are attended by the DRPs from both the non government sector and government sector. A differentiation within these two groups was observed, where members from each group preferred to mingle within their own group. The government staff reported that, many of them have been informed about the training, just a few days in advance. Except for the training date and venue, further information about the Programme was not available. One of the government DRPs even reported that when she was reluctant to go for a five-day training Programme, she was told to attend the first day training so that her attendance is marked and then she can leave. Since the selection is done by the CMO, the person has no say in this and it is taken more as an official order, for many of the government staff, it is just an extra work. In such circumstances, when the candidate is not given any prior information about the Programme and attendance is just taken as a mere formality, the candidate is not too keen for this Programme.

The training is divided into different phases. All the phases are residential trainings held at Raipur.

- The first phase was introduction to the Programme, to train the DRPs for selection and training of facilitators for selection of Mitanins.
- The second phase was to train the trainers for training of the first three training modules.
- The third phase was to train the trainers for training on the village health register and for reinforcing the earlier trainings.
- The fourth phase training was on women's health and malaria.
- The fifth phase was on the drug kit.
- Another two trainings (yet to happen at the time of data collection) were supposed to be on communicable diseases and the village health plan.

For the trainings, both the theoretical and the practical aspects of work are incorporated. The teaching includes both classroom teaching and practical demonstration. Classroom teachings are through lectures, group discussions, group presentations, role plays, use of folk songs. Practical demonstration included field trip

like one of them was undertaken in one village to find out the source of malaria parasite. In this exercise, the DRPs were divided into small groups and they did transect walk, and also collected information on various aspects like mosquito breeding areas, availability of health services and caste class structure in the villages. Later few villagers were called and the DRPs discussed their findings with the villagers on potential sources of mosquito breeding. The DRPs are supposed to do this exercise in their respective blocks with the trainers and then with the Mitanins. In this exercise, the involvement and the enthusiasm of the groups varied, some, especially the old government staffs were not very enthusiastic.

The DRP after the first training, is supposed to meet the CMO, Collector, BMO the nodal officer (they have already been oriented by the SHRC about the Mitanin Programme) and discuss about the implementation of the Programme. Thereafter he /she will have to look into 1) Social mobilization in the block – use of posters, pamphlets, slogans and kalajatha – its selection, training, and staging in the villages. 2) Selection of Mitanins - selection of facilitators and then the Mitanins through the facilitators. 3) Training of Mitanins – creating a cadre of trainers and training them for the training of the Mitanins. 4) Monitoring and support – monitoring and providing the necessary support through the trainers. 5) Evaluation of the training Programme.

Facilitator (prerak)

In Ghumka, the facilitators were selected from the government staff approved by the BMO. In this block, 18 facilitators that were selected were all male. In the other block of Rajnandgaon, the Dongargaon block, 15 facilitators were chosen, which had 10 male and 5 female as facilitators. The criteria for the selection of the facilitators were,

- Well educated, at least till twelfth,
- Good communication skill,
- Interested in social work,
- Have a good past record,
- Knows the local dialect.

In Magarlod, Rupantar had few people who had been working with them. These people in the villages helped to locate, some new people who were then trained.

The selected facilitators are trained by the DRPs. The facilitator training is five day training based on the facilitator's manual. In Ghumka, the facilitators' training was held in two training sessions in the district. In Magarlod, one day training was held after an interval of every 15 days starting from the month of July till September.

Content of the training for facilitators

The training is divided into eight modules. The first module is about introduction and objectives of the Programme. The second module deals with poverty analysis, where they try to understand poverty in terms of inequality of opportunities. The third module is on gender analysis. It talks about difference between sex and gender, looks into the workload of both the sexes and the status of women, women's rights. The fourth module deals with group formation, its importance. The fifth is on motivation, and the sixth module is on communication and the last is to know the community. After the selection of the Mitanins, the facilitator's job is over. The Mitanin will then be given the training by the trainers.

Block Resource Person /trainer /samanvay samiti karyakarta

The trainers are supposed to give training and support to the selected Mitanins. The trainers were to be selected with a proper geographical distribution, one per cluster of gram Panchayats. The norms laid down by the SHRC says that the trainer should be educated, from the same block (sankul), she should be able to travel to the villages regularly to meet the Mitanins, should know the local dialect. The Programme has to be flexible so that in future if any of the trainers is not being able to work properly she can be changed. A Mitanin, if she has the potential could also be chosen as a trainer.

In Ghumka, the trainers were selected by the BMO. A total of 25 trainers were selected, 8 from the government sector and 17 from non-government. Since all the facilitators of this block were male, none of them were retained as trainers. The

criteria for the non-government trainer was, a female, the person should be at least twelfth pass, should be interested in social service and should know the local dialect, should know the customs and traditions of the villages, should have a knowledge of the different relationships existing in the villages and should have good communication skills. In this block, most of the trainers are based in the district, few are in the age group of 19-23 years, who are also doing their graduation. There is still a shortage of trainers, as there are about 40 Mitanins who do not have the support of a trainer and the authorities do not find the ANM in these places to be good so that she can support the Mitanins.

In Magarlod block, there were 13 trainers. Nine out of the 15 facilitators have been retained and four new have been added. There are only two women as trainers. The age-group of these trainers range from 23 to 30 and it is more than the Ghumka trainers.

Training of trainers

The training of trainers is held in the districts and is done by the DRPs, but monitoring and some back up is provided by the field coordinators in Ghumka block and Rupantar in Magarlod block. The training given to the trainers is similar to what they will have to give to the Mitanins, in terms of content and phases. This content and phases are dealt in greater detail in the section on training of Mitanins. In Ghumka, the first Training of trainers was done in the presence of the SHRC members, in the month of November and December 2002. In Magarlod, most of the facilitators had been retained as trainers.

Honorarium

The trainers are expected to go to the villages and provide some in-service training, apart from the camp based training. Due to the intensity and the time required, the trainer would not be able to work for any other means of livelihood. For the government trainers, no extra amount is paid, as the villages they are supposed to cover falls in their area. So an honorarium of not more than Rs1000/month is paid to the non – government trainers. This is Rs50/day considering she works for 20 days in

a month, this includes the number of days she has to give or receive training, and pay visit to the Mitanins in their respective villages. In Ghumka, this amount is Rs750/month, but the trainers say that their money is held if all of them do not finish a specified task in the field. During the data collection period, they were not paid for the last two months as the health committee they were supposed to form was not formed in all the hamlets. In Magarlod the amount that is paid to the trainers was Rs1000/month. In pilot phase the money was directly sent Rajnandgaon district, is transferred to the district health authority from the SHRC. In case of NGOs, the money is given to the NGO who then disburse the amount.

The **trainer meetings** are held every fortnight in both the blocks. These meetings are to review the work of the trainers, discuss any problems if they have and plan for the future. The meetings mainly revolve around the work that they were supposed to do and how much of it they have managed to complete. In Ghumka, the trainers also submit a field report of their activities.

Mitanins

Selection of the Mitanins involves social mobilization in the villages and it is followed by the selection procedure by the facilitators and the village people.

Social mobilization

Different strategies were used for the publicity of the Mitanin Programme prior to the actual selection process. Those were posters, pamphlets, slogan writing in walls. The posters and key messages for these campaigns were brought out by SHRC. In Ghumka, pamphlets by the district medical authority were distributed in the name of the CMO. In Magarlod, a survey was also undertaken to assess the need of the Programme, apart from posters and slogan writing.

Another method used was Kalajatha[6]. Two Kalajatha teams had been constituted in every block. Each team was to constitute of not more than 12 members. These were mostly the local already existing Kalajatha teams who were supposed to go to cover all the villages in the block and give performances. These performances were supposed to raise critical questions related to health issues and talk about the concept of Mitanin Programme. A seven-day camp is also organized where they were trained about the Mitanin Programme. A letter is also issued from the district authority to the Sarpanch in this regard. The pilot blocks were asked to do publicity of the Mitanin Programme through such cultural programmes, but Kalajatha was not formalized at that time. So Ghumka block used the local dance party for cultural performances but could not cover all the Panchayats. In Magarlod though, they had used Kalajatha, focusing on the Programme's objectives. It was done in 45 villages of both the blocks of Magarlod and Nagri. Focus was more on the remote villages of the two blocks.

A radio Programme on the Mitanin Programme has also been broadcasted which tries to build a public image of Mitanin and her work. It covered topics like women's health, child's health and disease like malaria. It is supposed to catalyze women's health committees.

For **selection of the Mitanins** the block is divided in small areas; these could be based on 'hat' the weekly market. It would be based on the geographical closeness and not according to Panchayat. A facilitator is appointed for every area, who facilitates the selection of the Mitanin. For the difficult areas, there is a special committee.

The actual selection of the Mitanins requires that the facilitator should go to the village, hold a meeting in every hamlet with the villagers, especially women. The facilitator is supposed to tell about the Mitanin Programme, 'Mitanin is their representative who would monitor the public health services to ensure that these reach the people properly. She should work as an organizer for community initiatives in health care. And she will have a medical kit to help with minor illness and for first

[6] Kalajatha are done by local troupes which uses traditional folk medium including songs, dances, plays and satires to spread specific messages.

contact care in more serious illness' (SHRC 2003). The community selects a Mitanin, preferably a woman who is married, would be supported by the family in this work, it will be good if she has been involved in any voluntary work for the village in the past. If no such woman was available, then a young woman who was willing to volunteer was desired. Though education is not a criterion, a good level of literacy is desirable. The facilitator was supposed to ensure that the poorer sections are also consulted for the selection and the selected Mitanin should be comfortable and welcome to their houses.

One of the facilitators in Ghumka, said that since there were lot of villages, he could not follow the laid down process for selection of the Mitanin. So in few villages, he could hold meetings and in some other villages, he spoke to few of the villagers and selected the Mitanins. Since he is the MPW, and knows the area well, he has an idea of women in the villages who can work as Mitanin. One DRP of Dongargaon block of Rajnandgaon district says that mostly there were government staff for the selection and unless, they are given orders, they do not do the work. So even they were told about the selection earlier, they did it in the last moment, they did it within 3-7 days and so they have not followed the laid down procedure. The selection process according to him needs a lot of time since it requires more than one visit to every village.

In Magarlod, after the social mobilization, they called for a meeting in the village. The announcement of the meeting is done by an announcer in the whole village, on direction from the Sarpanch, this is called 'muniyadi'. In the meeting the facilitator told about the Mitanin Programme and initiated the selection process. At times more than one meeting was needed for the selection.

In few villages, they had problem in selection where even after lot of efforts, the people were not coming together. Then they asked the Panchayat to suggest suitable candidate for the Programme and contacted them if they were interested. A facilitator reported that there is still one village in this block where after lot of efforts, no Mitanin have been selected even after a lot of social mobilization, including Kalajatha. In this particular village, since people are not at all interested, they have

not selected any Mitanin in this village. After selection of Mitanins, they had a Mitanin Sammelan (gathering) at the block level on 12th of March 2003.

The **role of the Mitanin**, outlined by SHRC is:-

- Giving health education and improving health awareness.
- Giving information about the different government Programmes, schemes and entitlements.
- Improve the utilization of services.
- Provide a measure of immediate relief to health problems through the provision of first contact curative care at the hamlet level and help the community avoid needless, expensive, often hazardous care.
- Organise community, especially women and weaker sections on health care issues.
- Sensitise Panchayats and build up its capabilities.

Training of the Mitanins

After the selection of the Mitanins, training is given to the Mitanins by the team of 25 trainers in the block. The trained trainers are divided in five groups with each group consisting of five members, so that even if some trainers are not well equipped, they would still have two to three good trainers in the group. Each of the teams trains two batches of Mitanin of 40 women per batch. Thus there would be 10 training camps in a block to cover 400 Mitanins held as 5 parallel camps in first round and then 5 more parallel camps the next week. This has to be continued in every 4-6 weeks as per schedule. The training, if possible would be for 4 days and if not then it would be 3 days training. Apart from the camp based training, there is in-service training for the Mitanins provided by the trainers. 'Given the low literacy levels and lack of previous exposure to such work, it is unrealistic to expect most Mitanins to grasp adequately from camp based teaching. Unless the trainer goes to her village and goes house to house with her and helps her with meetings etc once or twice a month – they would find it very difficult to pick up' (SHRC 2003). The camp based trainings are in 7 phases, to be given in 20 days, spread out over a year.

The programme *content* at the *camp* according to SHRC would be as follows:-

1. First round of training – three days residential –In this the Mitanin has an introduction to the Programme and its approach, linkage of health to poverty. They also learn about existing public health services, child health which includes malnutrition, its causes, as a major focus. Diarrhea, its causes, prevention.
2. Second round of training – two days, preferably residential – reinforce child health training and all issues of the first round.
3. Third round of training – reinforce earlier inputs and cover women's health in detail, includes, the health problems of women, their social dimension, adolescence, pregnancy, RTI, STD, anemia, public health entitlements, violence.
4. Fourth round of training - which may be two days non- residential or three days, covers one or two communicable disease. This round is repeated to cover more communicable diseases, if these diseases are a local health priority.
5. Fifth round of training – should be at least four days residential – introduces the village medical kit and first contact curative care aspects.
6. Sixth round of training – another three days of training, reinforces the curative care aspects.
7. Final- towards the end of the Programme a three day residential training Programme and how to assess local health status and draw up a local health plan.

The second part is the *in-service training*. The trainer meets the Mitanin one or two days every month, and each trainer are supposed to support about 20 Mitanins. The trainer can ask the Mitanins of the nearby hamlets to come together so that in service training could be provided to a small group rather than individually. In between every phase, the Mitanin should discuss in the villages with the health committee and are supposed to go to every house where the trainer helps and get some basic information about every family. After the fifth phase, the trainer will be in the field with the Mitanin for 20 days.

In Ghumka, these training modules prescribed by the SHRC have been followed. The first training of the Mitanins was done in the month of December 2002 to February 2003. There were 18 training centers and the training in all the centers were completed in three rounds. In all the training there are not less than 3 trainers, where one was be from the government and two from voluntary sector. The gap between the two trainings has been large. The training schedule in one of Ghumka block centre as given below shows quite a gap.

Training schedule

First training - 26th -28th December 2002

Second training - 13th -14th March 2003

Third training - 22nd -24th August 2003

Fourth training - 14th-15th January 2004

This kind of long irregular intervals between the training schedule leads to the lapse of the learning process among the Mitanins in the early phase.

A total of 610 Mitanins had been selected and about 550 Mitanins had received training. The rest have dropped out and have not been replaced, in some places, other Mitanin have been asked to cover these areas now without a Mitanin.

In between the trainings, the trainers provide support to the Mitanins. After the first and the second round of training, where they are trained about the structure of the health services also, they learn it through filling up the village health register, where information related to her village's sub-centre, PHC, CHC have to be filled. The trainer and the ANM or MPW helps to fill in this data. Apart from this, information about all the families in the hamlet has to be filled in the village health register, this way she would be visiting all the families. After the third phase, where women's health is taught, the Mitanin would be going to the houses and talk about women's health and a women's health committee had to be formed.

In Magarlod block, Rupantar follows a different module of training. The trainings are one day trainings, held in every month.

1. First round of training – in this the Mitanin gets an introduction to health, to the Programme, its objective, the right to health services, health as a right.
2. The second round of training is a repetition of health as a right, child health, malnutrition, diarrhea, information on filling up the village health register.
3. Third training deals with women's health, rights, equality, adolescence, anemia, pregnancy, RTI, STD, malaria, medicines for malaria and slide making.
4. The fourth round of training is a repetition of health rights and women's rights, reproductive disease, dosage of medicines and practice with village health register.
5. Fifth training is on communicable disease – malaria, symptom, measures of control, village visit.
6. Sixth training is on T.B, AIDS, and discussion on skin disease and its medicines.
7. Lessons on child's health and medicines are repeated in the seventh round.

In the subsequent round of trainings, the above mentioned topics would again be repeated along with dosage of medicines. Practice of making slides will also be repeated. Prior to the commencement of a new session, the previously learned lessons are reinforced and thereafter a new topic is started.

The trainings were held in 11 centers, the trainings in all the centers are completed in two rounds. For the trainings, apart from the 13 trainers, called Samanvayak Samiti Karyakarta, there are 8 nurses, and 5 health workers of Rupantar from Nagri who are in the field since the last 10years. The trainings in one of the training centers have been done in the following dates:-

First training – 17th September 2003, Second training – 31st October 2003
Third training – 5th December 2003, Fourth training – 9th January 2004
Fifth training – 20th February 2004, Sixth Training – 18th March 2004

The training Programme schedule of Rupantar shows a significant difference in comparison to the above discussed training schedule. The gap in the training schedule of Rupantar was very small and it was also one day Programme. This was primarily done to establish it as a part of routine monthly Programme of Mitanin's work schedule.

After the first training, the Mitanin is supposed to fill the training manual-2, (an introduction to public health services and facilities), where some basic data about the village is to be filled in. After the third training, the Mitanin would have to identify malaria cases in their village. After the third training, they have to start filling in the village health register. The family visits have to be started after the sixth training. The health committee has been formed, right at the very beginning, so the Mitanins are expected to have regular meetings in the village.

Trainings in Ghumka -

The training of the Mitanins is done in different clusters, where the Mitanins from the nearby villages come. In one of the fourth trainings attended by the researcher, which was a repetition of the earlier trainings, the trainees were formed in small groups and they were asked questions based on the earlier learning. The groups were given marks if they could answer it correctly. The set of questions was prepared by the trainers. On the second and the last day of the training, all the questions, especially which were answered wrong was read out from the book. The book's words are taken to be the ultimate answer. Though they said that they have discussed all these in earlier trainings, still this time any major discussions was absent. In the first part when the LHV was taking the class, it was quite boring as she was just reading out from the book. After the NGO trainer came, she took over and tried to make the readings a little interesting, she read out as she was walking in the small room. The Mitanins were rarely asked questions and it was more of a one way lecture. Very few efforts were made to link the village's problems with the training or the practical aspect of work. A dai, who was also present didn't seem interested, she said that she knows all that is taught here. There were few enthusiastic Mitanins also, who where able to answer when asked. But when the DRP toured the training centers, and

he spoke to the Mitanins, he diverts from the book and talks about women's status, their problems, their prevention, etc.

Training in Magarlod

In Magarlod, the trainings are one day trainings, and it starts from the repetition of the earlier topics and introduction of a new topic. the ANM talks about more of the technical thing, in terms of diseases and when some old karyakarta of Rupantar talk, they talk more in terms in what the Mitanin should try and do like to see if the anganwadi is giving Daliya properly and talk more on various aspects of health rights. The method adopted here was also lecture method, but the Mitanins also started asking questions when one started. The questions were even related to a taboo subject as pain during sex, which the women otherwise do not bring out.

Modes of support to the Mitanin

At the village level, the Mitanin would be getting support from the ***health committee***. The health committee constituting of seven to fifteen members should represent at least one member per ten households. The members were to be selected by the Mitanin soon after her selection. The health committee members are supposed to help the Mitanin in her work in implementing in the village, the Mitanin will share all the information, she gets from the training with them.

In the villages of Ghumka, the committee has been formed after the third or fourth training. The instruction given to the trainers was that they have to ask the Mitanins to locate women who can help her and the number has to be minimum of seven including the Mitanin. Then signatures have to be taken from them in a piece of paper. Till the month of April most of the committees were formed. The following is an extract of the trainer's words, which she said while forming a committee.

> "The committee members will be to support the Mitanin (sahyogi). There will be a meeting once a month in the village so there is no need to go out of the village for training. It will be about adolescent girls, women, kids, making of blood slides, ORS, use of clean clothes in menses, all these training is being

given to the Mitanin and this information will be passed on to the health committee members. For the family visits, 2-3 people can go together to the different houses. For the slides, the committee will have to keep a note as how many slides are being made, how many pregnant women are given advice and so on. The committee will get information, sitting in the village. If anyone needs medicine, she will come to the committee. This is what is expected from the committee, how to give medicines, how to make slides. What you will have to focus more on the mother, child, and adolescent. So are you interested to join?"

In many places, a proper meeting could not be held and the members have been contacted individually due to the busy agricultural season. Therefore the clarity of their roles is doubted. In one of the villages, when the Mitanin went for collecting information to fill up the village health register, she was not willing and was asking as what benefit will she get out of this, and said that earlier also she has had to give signature to the Mitanin, referring to the health committee.

In Magarlod, the health committee was formed on the day of selection of the Mitanin, the women who had gathered for the selection became part of the committee. But meetings have not been regular. An extract of the trainers words in one of the first health committee meetings in the village.

"After independence, government thought of how health care can reach to the rural poor. Different efforts were made in districts, in blocks and now in villages. But right now, we have IMR of 85 and a high CMR. Malaria is still prevalent. Overall there is no improvement in health but why? The Chattisgarh government formed a committee and discussed on this issue and they came out with a Community Health Worker Programme – the Mitanin Programme. The Mitanin will be the person in the community who can provide the basic primary care and medicines she can be with the Panchayats for the rights of the people. Health is our right. Manak padhati (standard treatment method) should be used. But why a woman from the village has been chosen? The reason is that she will stay in the village forever. The word Mitanin has been given because Mitanin has a very deep significant meaning. In Chattisgarhi it

means a close friend. She will be your 'dukh such ki sathi' – will support you both in times of problems and happiness. The Mitanin in your community will also be like a friend who will be there to help in times of crisis.No government can take away this Programme. This Programme will give information and knowledge about your health, your child's health. And this knowledge will be always there for you. The Mitanin will help you, support you and you also need to help Mitanin so that services improve in villages".

Thereafter Rupantar's field coordinator added:

"But what is the need of the committee is this just the Mitanin's work? The committee is there because a committee is needed that has to be supportive, not just in health but in other aspects also like Anganwadi food which should be distributed, is being sold. Or issues like women's status in terms of food, women's health, child's health, women's rights and her pain in the context of wife beating".

This particular trainer of Magarlod is comparatively better than the rest of the trainers. But there seemed to be a marked difference in the approach of both the trainers.

One of the reasons can also be the profile of the trainers in both the blocks. The trainers in Ghumka block are young girls, few of them based in Rajnandgaon district itself. For most of them this has given them an opportunity through which they are coming out of their homes and are able to talk to people, to officials. This had come up in the discussions quite often, as how the Programme has helped them. On the other hand, the trainers in Magarlod block are, except for two, all males, from the villages. They are in their late 20s, married and having a family.

The ***Panchayat*** is also supposed to help the Mitanin. A secretary in a Panchayat in Ghumka says that he has heard about the Mitanin Programme but does not know the details of the Programme. He knows that it is for health, for cleanliness and it is good that the women now have some scope to learn. He said that the earlier JSR scheme had failed because a lot of JSRs migrated out in search of work. So the

Mitanin should be there for a population of 250 people so that even if lots of people migrate, at least 50% Mitanins will always be there in the village and thus these 50% can cover all the areas. He says that the Panchayat was not informed about the Mitanin Programme but if any one puts up an agenda, then they are ready to discuss about it.

In Magarlod, the Sarpanch was involved in the selection process as they are supposed to call the meeting and after selection of the Mitanin, they approved it in paper. But still, one of the women Sarpanch thought the Mitanin Programme to be a savings group!

In terms of outside support, the ***trainer*** plays a very important role. She will be regularly visiting her, will support her in village visits and if needed will give training. She is supposed to visit every Mitanin at least twice in every month, encourage and support her.

The ANM, AWW, MPW are also supposed to support the Mitanin and would be in contact. The Mitanin is not to be as a subordinate but if the ANM needs help, she can request the Mitanin to help her in Programme like pulse polio.

The health officers, will also try to keep the spirit of the Mitanin high. He, on the request of the Mitanin will tour the village. In some health Programmes, can provide economic support also. A *referral card* is also planned which will be used when the Mitanin will be referring patients to the health centre.

Evaluation

The Mitanins are graded by the trainers. The conditions for grade A is:

1. The Mitanin should have attended the trainings.
2. She is doing family visits.
3. Along with family visit, she is filling up the village health register.
4. Have formed the health committee and that is working.

For grade B, any of the above three criteria are met, for grade C, any of the two and for grade D, any one criteria should be met by the Mitanin. The trainers grade the Mitanins in every 14 days and submit it in their fortnight meetings. Apart from this there are few other forms which are used for monitoring, to be filled in by the trainer, DRP, Nodal officer regularly and monitor the Mitanin Programme at the different levels.

Programme Personnel's view on the Selection and Training Procedure

The trainers from Ghumka block gave a range of views on different issues of selection

- The trainers talked to, are of the opinion that adequate publicity was not done before the selection process. Kalajatha was not done in most of the places, even where it was done, it happened after or during the first round of the training. Had the kalajatha been used for publicity before the selection of the Mitanin, things would have been easier and more people would have known about it and more women would have come out. One of the trainers said that the interest is increasing as people are getting to know more about the Programme. In some places the Mitanin are referred to as Mitanin with her name, like 'Radha Mitanin'. Especially after the medicine round, this Programme will be known widely. In most of the villages, there are women's savings groups and this has benefited the Programme as more women know about this Programme through this.
- There was confusion in the beginning of the Programme. Panchayat did the initial selection of the Mitanins. And that list of Mitanins according to the trainers, had very 'high level' people – influential people, mostly from the higher class and relatives of the Panchayat members, women who would not have come out. After that another circular came which said that the facilitators will do the selection. Then the first list was cancelled, though there may have been some problems in some of the villages. Then the selection was done by the facilitators.
- Many of the trainers were not satisfied with the way the selection was done. In many places meetings was not done with the villagers and therefore not many people know about this Programme. At places the trainer had initial problems in

locating the Mitanin in the village. The government staff as trainers admitted that the facilitators did not get adequate time required for the selection. After the facilitators training, they just had 8-15 days in hand and in this time they were expected to go to the villages at least 2-3 times, first tell the people about the Programme and then if they are not convinced, have to go again and then the community selects the Mitanin in every hamlet. Yet, one of the DRP commented that mostly there were government workers from whom the selection was made and unless, they are given orders, they do not do the work. So, even when they were told about the selection earlier, they did it in the last moment, they did it within 3-7 days and so they have not gone through the proper process. The selection process needs a lot of time.

- One of the ANMs, also involved in the selection process says that in her area as facilitator, all the 33 Mitanins were chosen and all of them through meetings. It may not have an attendance of 30-40 people but definitely there were 10-15 people. One of the criteria was to choose women whom everyone will listen to. Selection was done in Panchayat meetings, where few villagers were also asked about their opinion. But what they are witnessing is that the Mitanins who have been selected through a village meeting are working well. But where the selection has not been done properly, the Mitanins are backing out. During the selection time, they did not have this much detail about the Programme, so in lot of places, they have just put the names so that no place is left out. Though earlier the people did not understand this Programme, but after the meeting, and also the fact that they know them as government staff helped. But the initial reaction was more of doing a formality, or a negative reaction. Few of the Mitanins got attached thinking that if they get attached to the health department, in future, they might get some help in health problems, family's problems, and medicines.
- Another problem was the message that had been conveyed to the Mitanins at the time of their selection. What the trainers are discovering now is that there are a lot of women who are not interested to do family visits, don't like going to all the houses. The problem, they consider has been in the selection process. When the selection was done, the facilitators have gone to the village and asked the woman to sign, they were just told that they will get medicines and will have to distribute it. No one told them that they will have to do family visit, have to go for trainings,

have to go PHC, CHC meetings, etc. And if there's any problem the facilitator will take care. What was needed was to explain things to her properly that she has to step out of her house, go for training, learn, talk to the women in the hamlet but hey have not explained it this way. Now the selected Mitanins are not interested to go to houses and come for training. The trainers complain that people who are working in the field are having problems, not the one who do the selection. She says that she then tries to make the Mitanins do the work or else, she herself goes and visits the houses.

- But one of the criteria was selection of poor women as Mitanins. Since they are not educated they had problems in training. Few of them are backing out, with so many books, they are not being able to manage. Also the lower classes are having problems as they earn daily wages and it is difficult to work, attend trainings. But some of them are very enthusiastic, like one Mitanin had left her daily wages and had come to attend the Programme.
- The training is focused more with matters related to mother and child health, diet immunization. They talk about what is health, women's problems, and child's health. Pregnancy, the precautions that need to be taken, the regular check up needed, post natal care, child care, immunization are components they find important. In the trainings, the trainers also tell about the home remedies, especially for simple problems like cough, pain, fever, and about ORS. They also like this section as it can be done with whatever is available. In topics like menstruation, the women have opened up and they have started speaking and have got new information. But the LHV says that the Mitanin will have to limit to advice. Whatever they do not understand, they have to refer it to ANM, or PHC and should not take risks. Another ANM says that in the training, apart from the RCH, they should cover other topics as well. She should have multipurpose information (jankari) so that when there is need, she will be able to help. There should be more information on general illness like headaches, first aid, insect bites, burns etc because these things happen in the village and at that time the doctors are not available immediately. And more because the Mitanin lives in the village, she should have the knowledge about all these. One of the voluntary trainers says that the training is good. Few medicines are being taught in the trainings but other medicines for the same disease should also be taught. For

example, paracetamol does not benefit as much as other drugs do. The other drugs take two to three days instead of eight in paraceutamol. So the other drugs should also be taught.

- Another opinion is that some of the other topics like drinking water source are there in the books, but nothing has been done about those, they should be incorporated in the Mitanin's work. Panchayats participation should be increased. In Panchayat meetings, Mitanins should be called so that people respect her in the villages. The Panch, Sarpanch, also do not get money but they get a lot of respect and likewise, Mitanins should get a lot of respect. The first and the third objectives of improving health education and awareness and community initiatives in communicable diseases have been covered in the trainings but the second objective of improving utilization of the health services, it depends on how much is the ANM giving and also how much people receive. The ANMs who are there in the Programme are interested, so they try and are more responsible. But there are other government staffs who are not attached to this Programme, they do not know how much response will they be giving to the Programme. The sub-centre should be good, so that the Mitanin is able to function.
- In training, they are instructed to teach from the books only and nothing outside of those, especially for the voluntary trainers. Even if they want to talk about other things, they can only share their experiences but they cannot make this thing write in the Mitanin's copy.
- One DRP accepts that there is a hierarchy when the government trainers and the voluntary trainers come together only the former dominates, and not everyone can raise their voice. The DRP being in the government sector considers the Programme as an overload for them, and they do not have a say in taking up this Programme. As there are different lines of commands the DRP said that they feel contradicting pressures. When they get order for Mitanin Programme, they dare not reveal that to their officer otherwise, he gives them more work to stop them.
- The number of trainings should increase because, the gap between two trainings is of two to three months. There should be some meeting in between, at least once a month, so that the Mitanins do not forget what they have learnt in the training. Recently, they have started a meeting of few Mitanins together, forming a cluster. This can happen once or twice a month, this will help the Mitanin in retaining as

well as to clear doubts. The training will have to go on for the Mitanins. When the trainers are in touch with the Mitanins, then they will be interested. Then if they find some problems in visiting homes or otherwise, they can share the problems with the trainer when she visits their village and they together can go to those houses again and try to solve the problems together. This way the knowledge and the skills of the Mitanin will improve. A LHV comments, if she does not reach to all the people, then at least the Mitanin will reach every household.

In Magarlod block, the trainers gave their views on different aspects of training, on what more can be included and training duration and schedule.

- The ANM trainer felt that all the important diseases like diarrhea and malaria are covered and whatever was needed is covered. But there should be provision of practical training which is an important component. The other trainers spoke about inclusion of jaundice, women's infertility, pneumonia, asthama which are prevalent, also uterus cancer in women since this is very much prevalent in the villages and if some information is given in this regard, at least the causes. Also kidney problems, about problems in bones, mental illness and breast cancer, these things should also be included in the trainings.
- For the training duration also, they said there are requests from the Mitanin to make it a two day training Programme. The Mitanin training in this block is one day per month, the logic, as told is to establish the cycle and should become a normal part of the schedule of the Mitanins, though in remote areas, a two days training can be held. Earlier they had done it for two days with the consensus of all the trainers but then from Rupantar, they had said that the training should be for duration of one month. Had the training been for two days, it would have helped in bringing in an intimacy between the Mitanins and the learning would also have been much different. In one of the forest villages, where accessibility is difficult, they have done the training in this way and the results have been much better. They used to repeat a lot of things and then the Mitanins started opening up, within two trainings, there was a difference. The village people also see that there is this banner and some training is going on. They get to know about the Programme and become curious about it. They also ask how long the training will be there and what is

this Programme. One of the trainers thinks that the training on medicine should be a four day training Programme where field should also be included. First the medicines should be given and then the Mitanin will work in village and then again they will be trained and then again the field. This is necessary because most of the Mitanins are not adequately educated and they will be doing this type of work for the first time. So they will not be able to grasp easily as the trainer herself had problems in training. Another felt that because the training is held once a month, the Mitanins learn the things then they forget it as they get engrossed in their work. Maybe in between trainings if they have some repetition, then it will be good, because one month gap is not good even for educated people.

- One of the trainers commented that the training of trainers' book is quite boring. It should be made more interesting. And in the books meant for the Mitanins, there are a lot of words which the Mitanin will not be able to understand, so simple words should be used. They as trainers use their own words while giving training. Outsiders could also be called for the training, this way they get motivated more.

The training imparted by the two implementing agencies brings about a difference in their training sessions. The training provided by the government agency is mechanical in nature as the training modules are considered as the only source of learning for the Mitanins.

CHAPTER 4

MITANINS AND THEIR PERCEPTION OF THE PROGRAMME

This chapter looks at the Programme through the Mitanin's perspectives. It tries to explore the socio-economic background of the Mitanins and takes an in-depth look into their selection process. Support from different quarters is one of the important factors for a woman, especially when she steps out of her household to work. This factor has been studied in detail for the Mitanins who were selected for the Programme. This has helped to look at how the support from different section was rendered to the women who went out in the villages to work as Mitanins. Along with this the researcher also made an effort to study the Mitanins understanding of the Programme as it is vital to the way Mitanins render the services in the long run.

BACKGROUND OF THE MITANINS

In **Ghumka** block of Rajnandgaon district, about 46 percent of the Mitanins are in the age group of 21-30 years. 28 percent are in the age group of 31-40 years and the rest of 12 percent fall in the above 40 years age group category. Nine percent of the Mitanins were illiterate, 25 percent of them had studied till fifth class. 38 percent were educated till class six to nine and 25 percent till ninth to twelfth. Three percent studied more than class 12^{th}. Majority of Mitanin's families (62 percent) were dependent on agriculture as their source of income, 25 percent were labourers and 6 percent had government jobs and equal percent of Mitanin's families had some petty business along with agriculture. 12 percent of the Mitanins were landless, 25 percent said that they had land but less than 2 acres, 38 percent said that they had two to five acres of land, 6 percent reported that they had 5-10 acres of land and 6 percent said that they had more than 10 acres of land. Majority of the Mitanins (84 percent) were from other backward classes and 6 percent were each from schedule caste and general category. 3 percent did not respond and there was no member of Mitanin from scheduled tribe.

In **Magarlod** block of Dhamtari district, majority, about 65 percent of the Mitanins were in the age group of 21-30 years. A further division reveals that out of 65 percent, 42 percent were in the age group of 20-25 percent and the rest of 23 percent belonged to 26-30 years category. And the rest of 35 percent are in the age group of 31-40 years. There was no Mitanin in the sample, above 40 years. There were ten percent of the Mitanins who have studied till fifth class, another 70 percent

who have studied till class sixth to ninth, and the rest of 20 percent of Mitanin have studied till class ninth to twelfth. In this block also, majority of Mitanin's families (57.5 percent) were dependent on agriculture as their major source of income. Another 35.5 percent were labourers, five percent were dependent on some petty business along with agriculture. About 12 percent of the Mitanins were landless, 32 percent said that they have land but less than two acres. Another twenty percent said that their family own two to five acres of land and 15 percent said that they have five to ten acres of land, seven percent said that they own more than ten acre of land and 12 percent did not respond. Majority of the Mitanins (72 percent) are from the other backward classes, seven percent from schedule class and twelve percent from the scheduled tribe. There were two percent from the general category and another two percent was Muslim.

THE MITANIN'S VIEWS ON SELECTION

The selection of the Community health workers had been one of the key issues in Community Health Worker Programmes. Looking at the past experiences, the Mitanin Programme had tried to address the issue of selection process with innovations. The selection of the Mitanin by the trained facilitators was preceded by social mobilization in the village. The actual selection of the Mitanins involved that; the facilitator went to every village to conduct a meeting in every hamlet with the villagers, particularly with women. The facilitator explained about the Mitanin Programme as per its norms. 'Mitanin was their representative who would monitor the public health services to ensure that those services reached the people properly. She was to work as an organizer for community initiatives in health care. And she would have a medical kit to help with minor illness and for first contact care in more serious illnesses. The community selected a Mitanin, preferably a woman who was married and supported by the family in that work. It was considered good that the woman had been involved in voluntary work for the betterment of the village. If no such woman were available, then a young woman who was willing to volunteer would be selected. Though education was not a criterion but a good level of literacy was desirable. The facilitator was to ensure that the poorer sections were also entitled for the selection where the selected Mitanins were to be comfortable in relating to the weaker sections in the village.

In **Ghumka**, the norms of Mitanin selection had not been followed in all the cases. In some cases like Arla village, the selection was done according to laid down procedure. Here the facilitator, which had an attendance of about 20-25 people, called a village meeting mostly women, including the Anganwadi worker (AWW). When the women of the village suggested the name of the primary school teacher's wife as Mitanin, she did not commit herself directly, she asked the villagers to seek permission from her husband for becoming Mitanin. She agreed to become the Mitanin only after her husband permitted her. In another village named Saloni, the selection of Mitanin was done through self-help group (SHG). Here, in a meeting of 50-60 people the Multi Purpose Worker (MPW) told about the Mitanin programme and asked to choose a Mitanin in every hamlet. In the SHG meeting the selection of Mitanin was discussed. In the SHG meeting, the AWW suggested one of the women of her choice of becoming Mitanin, she replied affirmatively and others also agreed and were chose her as Mitanin. In another village, only the men, 10-15 in number including the village elders, Panch, and other village people, attended the meeting. They nominated a Mitanin for their hamlet on their own and informed her to be Mitanin. They neither took the proposed Mitanin's consent nor consulted any other women in the village.

But in many cases, the Mitanins were approached directly by the facilitators, or the health personnel helped the facilitator to locate the woman who according to them fitted the criteria to be a Mitanin. They usually selected the women who were well known in the village and were literate. They saw to it that the 'women who can do something', and who are 'active'. As in the case of Kumari Bai, the elders of the village consider her to be an appropriate person as she can speak well. Whenever an important person comes to the village, she is generally approached as she is always at home and can interact easily with people. She has also campaigned for a political candidate who belongs to her community. Hence the ANM approached Kumari Bai for the post of Mitanin.

When one looks into the background of the women in this block, who have been directly chosen by the facilitators, one finds that all of them were from a better socio economic class. From a sample of 28 such Mitanins, there were, six who were from 'better-off families and are outspoken', another six of them were those who were

'active or are involved in some social activities in the village. Five of them have been chosen because the facilitator thought that 'they can do the work, and can distribute medicines', three of them are AWW assistant, and two are trained dais. One is a Sarpanch's wife and one is the wife of Jan Swasthya Rakshak (JSR)[7]. One was chosen as she is active in the SHG and for two of the Mitanins, no specific attribute was found.

Most of the facilitators were the male health supervisors or the MPWs. Owing to their long years of work in the villages, they are familiar to people and have good rapport with them. These contacts helped them in directly approaching the woman and her family about the Mitanin programme. One of the facilitators said that they had to cover many villages to find suitable women for the Mitanin programme. Hence they always could not stick to the prescribed criteria. So in some of the villages they had meetings and in others they spoke to some villagers and selected the Mitanin. The trainers, who are supposed to go to the Mitanins in between every training phase, complain that they had problems in locating the Mitanin in the village as no one knew about the Mitanins. One of the trainers said that after the selection they have to face problems with the Mitanins as the facilitators are not around.

When the facilitator goes to the village for the selection of Mitanin, according to SHRC module, he/she should say about the Mitanin programme to the people, 'Mitanin is their representative who would monitor the public health services to ensure that these reach the people properly. She should work as an organizer for community initiatives in health care. And she would have a medical kit to help with minor illness and for first contact care in more serious illness' (SHRC, 2003).

But when the Mitanins were asked to recall, what was told to them at the time of choosing them as Mitanins, either in the meeting or directly, they gave some very different answers, which did not go along with the prescribed norm. In some places, the facilitator said that she would be distributing medicines. In the village Arla too where the meeting was done, the MPW said that a Mitanin has to be chosen from the hamlet whose role would be to give medicines. At that point of time, the women did

[7] A CHW programme of the Government of Madhya Pradesh .

not know anything else about the Programme apart from the fact that they had to give medicines. Kamla, was also approached by the ANM to be Mitanin of her hamlet and was told that all she has to do is to distribute the medicines that would be given from the health department. She was not informed about the training. Mitu, another Mitanin was also told that she would be given some medicines for small illness, and some training would be given for that. The people in the hamlet do not need to go to the doctor anymore for small illness.

Another reason given was the knowledge that she would acquire from the training. Sarita, the Mitanin from village Bhedikala, was told by the ANM that she would be getting knowledge about health and cleanliness and that too free of cost. Another Mitanin Ashwani was persuaded by the MPW, Lady Health Visitor (LHV), ANM, and the Anganwadi worker. She was told that she would have to go for training to Ghumka, and would gain a lot of knowledge. There she would be told about the women health and child health, adolescence, etc. nothing was told about money, just that she can get detailed information later. The objectives were not clearly laid down by the facilitators and to the Mitanin the message did not come out very clearly.

In **Magarlod**, ideally the selection of the Mitanins was to be done in the village meetings, after some publicity about the Programme by means of Kalajatha[8], posters, etc. For the meetings, the facilitator gives a letter to the Panchayat asking them to do a '*muniyadi*'- a formal announcement in the village by the announcer. In the meeting the facilitator is supposed to explain the Mitanin Programme and ask for volunteers who would like to work as Mitanin. The selection of the Mitanins in most of the places was done in meetings, as per the norm. But the attendance in the meetings varied from 15 to 50 women in different villages. One of the reasons for low attendance in many villages was that these village meetings were held in the main agricultural season. Another reason given by a facilitator was the apathy for the government scheme. He said that despite the publicity that they had done, the people were not very enthusiastic when this Programme was launched. They dismissed this as any other government Programme, and that won't last. People did not come forward for the meetings and so they had major problems in selection of Mitanins.

[8] Kalajatha is a play performed by local troupe in the villages which uses folk songs, dances.

Even in places where the meeting was done, when we tried to assess the level of motivation in the Mitanins it came out that not many women had volunteered or were initially very enthusiastic. Rather it was often the situation she was in, that prompted her to join the Programme. From the interviews done it was seen that the women's name was proposed due to the special status that they enjoyed in the village or the conditions like the time that one would have to devote. And in very few cases, her motivation stood out as the reason for her selection. Like in Saroj and Mona's case, they both were selected, as they both are literate and can also devote some time for this Programme. Saroj has a flourmill at home and someone is required to be always present at home. Her three small children demand attention and she has to respond to that as there is no elder in the family who can look after the children. She is educated till eighth standard. There was no other suitable candidate as everyone goes out to work and as a Mitanin. The woman is expected to give some 2-3 hours of her time at least three to four days a week. So the women in her hamlet selected her as the Mitanin. Saroj is also the wife of one of the facilitator

In Mona's hamlet also, there was no one to volunteer for this Programme and the options for the hamlet were very few as the criteria was literacy and one who can devote some time for this work. Mona is the wife of a schoolteacher, and she does not go out for work. So she was chosen as the Mitanin. In the village Megha, the meeting was called by the Sarpanch, for the selection of Mitanins, it had an attendance of about 23 women, and men, though lesser in number were also present. In Rupantar, the worker and the facilitator spoke about the role of the Mitanin that she would have to discuss about health and would have to take care of the community. The Sarpanch had suggested Sonabai's name and she could not say no to him. In yet another case, in the selection meeting where about 20-22 women were present, the facilitator spoke about the Mitanin Programme, about the training, that it would deal with various health problems that women undergo like white discharge, etc. and in serious cases the patient has to be referred to the hospital. No one knew about the Programme before, except for Kesri Bai whose husband is the facilitator. And the women were not willing to work without any remuneration. They prompted Kesri to join and then she agreed, the rest of the people formed the health committee and now as Kesri puts it, everyone wants to be the Mitanin.

In some places, the first Mitanin had dropped out due to various reasons. The process of selection for a replacement differed in these villages. In village Sengabhata, she was chosen by the first Mitanin, in Brijkuli, it was by the facilitator followed by yet another meeting and in Araud, it was Neeta's (the present mitanin) personal interest and the community support. In Sengabhata, the first Mitanin was selected by a village meeting, where people including the members of the Panchayat were present. About 40 women were present in that meeting. It was said that the training duration would be of 18 months and at the end, a free medical kit would be provided. The Mitanin who was chosen, dropped out after five trainings, as her husband and family was shifting to Raipur. So the responsibility was given to the present Mitanin who was a member of the health committee and has gone around with the earlier Mitanin to all the families, and is familiar with the work. In Brijkuli, a village consisting of 115 houses, two Mitanins were chosen, but both of them left after some time. No one else was prepared for this work. The trainer knows Radha's father-in-law and he requested him to allow his new daughter-in-law to join this Programme. Her father-in-law spoke to her regarding this and asked to attend one round of training Programme. After one round of training, a meeting of village women were called. In this meeting about 50 women were present. They then accepted her as the Mitanin. And being the new daughter-in-law, they promised to support her. In Araud, the present Mitanin showed a keen interest in the Mitanin Programme, as this would give her the opportunity to learn a lot of new things. She was a replacement to the earlier Mitanin who was not eager to share information with the village women. So the people in the hamlet decided in favour of this new Mitanin. She is the daughter of this village and is known to have an attitude of helping others. When the second Mitanin is chosen in the village, they know about the Programme and the decision to join is a conscious decision.

Also there were exceptions where women were not present in village meetings held for the selection of Mitanins. As seen in villages like Choti kareli, consisting of 725 houses with a population of 4750 where eight Mitanins were selected and village Bakori, a small village of 70-75 households, and a population of about 500 people where one Mitanin has been selected. Here the Sarpanch had a meeting in the village

where only the men were present. They selected the Mitanin and informed her through her in laws.

Presence of the family member in the meeting was an important factor for the woman. In all the cases the husband was present in the selection process at least even if he did not participate actively in the selection. The women said that if the husband had not agreed to this, then few of the women would not have joined as Mitanin. There was only one Mitanin who was unmarried.

As per the operational guidelines for the Mitanin Programme stated by SHRC, one of the reason for choosing hamlet as the unit of Programme instead of the village was, there were different groups occupying different positions in the power relationships especially based on caste. As they tend to inhabit in different hamlets, they select a Mitanin from each hamlet so as to ensure participation from all sections. But what is generally seen in the villages is that, even the hamlets do not have exclusive caste groups, but rather they have mixed groups.

Like Brijkuli village has a total of 115 houses and 168 households. The village has only one household of general caste, one Schedule caste (SC) and 22 Schedule Tribes (ST), and 74 Other Backward Class (OBC), families. Radha is the only Mitanin, of the village. She belongs to OBC. Sengabhata village has 105 families. Most of them are Sahus (OBC), apart from them. There are 12 Nirmalkar (OBC) families, three Soni families and four Lohar families. There are two Mitanins in the village, selected in a village meeting, where one was from Soni caste and another Sahu caste. The Mitanin who belong to Soni caste was unable to continue and so in her place, a Sahu has been chosen as the Mitanin. Similarly, Bakori is a small village with 70-75 households and a population of about 500 people. The village has got people from different castes like Routh, Gond, Lohar and Sahu. The Mitanin is from Sahu community. Most of the 18-20 women present in the first health committee meeting were from Sahu community only. The hamlets do not have exclusive caste groups but taking the hamlet as the unit rather than the village has definitely given an opportunity for better representation of different castes.

The Mitanins are supposed to be the representatives of the hamlet. The process of selection is an important instrument for this. To a large extent it influences the ownership that the people have for the Mitanin. But what is seen is that the selection of the Mitanins is guided by several factors like literacy, the availability of the volunteer, and the time she can spare from her other work for this Programme. The selection of Mitanins inevitably gets entangled within the existing structure of the village in terms of gender relation within families and status related to the caste and the class as that determines education and time availability.

The **reason why the women joined this programme** was when they were nominated or selected as a Mitanin and not necessarily because of her enthusiasm about the programme. In **Ghumka** some of the Mitanin like Geeta and Gayatri got interested in the Programme as they thought that this would give them an opportunity to learn new things about health. Geeta felt that the knowledge would be beneficial for her children also. She can tell others in the community and do social service. Gayatri said that she was eager to learn things, especially about health, and to move ahead in life. If one has the knowledge about health, then the whole family is benefited, something she did not have even after being educated. Then there were other Mitanins like Sarita who did not know much about the programme but she just wanted to explore. She didn't realise that she would have to disseminate the information she got, to the other villagers also. Kamla thought that it is just the distribution of medicines, which interested her and she would not have problems in doing that job. Now that she has to go for trainings, she is finding it difficult as she says that she can't walk that far and she does not have anyone to drop her to the training centre. But some Mitanins like Kumari bai and Ashwani were actually hesitant to join this programme. Kumari said she was a little hesitant in the beginning as she educated till fifth standard and did not have the confidence. She thought there were lots of young educated women who were more capable of the job. Her work included receiving training and telling the other women in the hamlet based on what she had learnt from the training Programme. The elders had chosen her so she had to accept it. She believed that 'since the government had brought the order, the villagers should implement it or else it would be a failure'. Ashwani could not say 'no' to the facilitator because one of the people accompanying the facilitator was a distant relative of her. So she said that she would do only if she could manage the work. She

was afraid that she wouldn't be able to devote much of time to work as she has her small children to take care of at home. But as of now, she claimed, she attended all the training and did all the family visits and filled up the village health register properly.

The trainers in this block complained that since the objective of the programme and the role of the Mitanin were not stated clearly to the Mitanin at the time of selection, the trainers were facing problems when the Mitanins did not show keen interest in the work. The trainers found it difficult to get the village survey or family visit done by the Mitanin, in many places. The Mitanins come out of their houses only when the trainer goes to her hamlet, some of the Mitanins are even reluctant to accompany the trainer for family visits.

In **Magarlod block**, once the name has been put forward either by the other women or by the Panchayat members, the reason why the women agreed to be the Mitanin also varied. Someone like Neeta, who has been chosen after the first Mitanin dropped out, has seen and understood the Programme and was keen to join. She thought that this would give her an opportunity to learn a lot of new things. Even though she has studied till class seventh, she does not remember much of those things and through this training she would learn a lot of new things and would share it with the other women in her village. Kesri saw this as an opportunity to move out of the house and she was willing to serve. She generally sits at home, but this Programme would give an opportunity to go out everyday for 2-3 hours of her house and she would be able to move out of the village for training once a month. Unfortunately, the training centre was in her village. Earlier just after marriage, she wanted to join the anganwadi but her father and mother-in-law didn't approve of it. Later, they repented about it. This time she looks at this programme as another opportunity and her in-laws have fully supported her in this. And she believes that for any work, one should have the support of the whole family. Another Mitanin in Sengabhata, found the training very useful, as she was part of the health committee and had seen the earlier Mitanin getting the training. This training, she thought would give her a lot of knowledge, and this would prevent her from going to the doctor for small things. This kind of training is rarely given free of cost, so she can take benefit from it. This would not take up much of her time as she would have to go to the training just once a month and the rest of the days, she can manage after her other work. For Radha, a new bride in the

village, this was more of an exploration. She thought that since everyone is encouraging her to join this Programme, so why not give it a try. She thinks that there should be development in the village and women should be more aware. And now that she has joined, she would see what she can do.

For the women, the Mitanin Programme gave them an opportunity to get training, thus increasing their knowledge which would be useful for them and their families, which otherwise is hard to access. It was also an opportunity to go out of the house, a platform, for the women and for someone like Radha it was an opportunity to go out and explore.

After attending some of the training sessions and initiation into work, they have very different reasons to offer. Now they speak more about their role as Mitanin which had been shaped after the training. This becomes clear when all the five Mitanins of a village spoke in front of a group of 40 women in the Panchayat building about why did they joined this Programme. They were asked about the reasons for joining this Programme. The five Mitanins spoke about reporting of diseases including polio, handicap, to the Auxiliary Nurse Midwife (ANM) taking care for other small illness when they get the medicines later, about child's health and immunization. Then for malaria, she would have to keep the surroundings clean so that she can prevent breeding of mosquitoes. And after training she would also be able to identify the symptoms of malaria. They spoke about the Mitanin, being a woman, would be more effective. Women have lots of internal problems, and diseases like white discharge, which they cannot speak to others but only to women. Women also have lots of minor ailments and they don't take adequate care of themselves. They need to rest along with their work. Since now there is a Mitanin in every hamlet, she would be able to listen to problems and understand and refer to the ANM if needed. She needs to explain all this to others in the community.

Further exploration of this perception in both the blocks showed that (refer table 4:1), in Magarlod block, after they started attending the training, about 37.5 percent of the Mitanins said that they wanted to look into prevention and curative aspect of health. They saw their role as taking care of the village, distribution of medicines along with care of children and pregnant women. Another 25 percent of the

Mitanins spoke about social issues or bringing a change in the society to improve the conditions of villages. In Ghumka block, 25 percent of the Mitanin spoke about health education, which included awareness on health, nutrition, diseases etc. About 19 percent of Mitanin said that they wanted to do service, and that's why they joined the Programme. nine percent spoke exclusively on prevention aspect. In both the blocks though, very less percent, two percent in Magarlod and ten percent in Ghumka spoke exclusively about their interest in curative work.

Table 4:1 Post Training Perception of Mitanins Motivation in two Blocks of Dhamtari and Rajnandgaon District

Mitanin's Perception	Blocks			
	Magarlod Block		Ghumka Block	
	No. of Respondents	%	No. of Respondents	%
Health education	7	17.5	8	25.0
Prevention	-	-	3	9.4
Cure	1	2.5	3	9.4
Care	15	37.5	6	18.8
Social issues	10	25.0	6	18.8
Health rights	3	7.5	-	-
Gender	2	5.0	1	3.1
Community/panchayat	1	2.5	-	-
No response	1	2.5	5	15.6
Total	40	100.0	32	100.0

THE TRAINING OF MITANINS, THEIR VIEWS

In **Ghumka Block**, when the interviews were done, the Mitanins had undertaken their fourth round of training. The training centers were generally the Panchayat building or the school building and even the PHC are used as a training centre in one of the places. There are eighteen training centers in this block. The training duration in the first and third phase of training is of three days and it is two days in second and fourth phase, which are repetition of the previous trainings. The trainings were done after a very long gap of 2-3 months, which according to the Mitanins, made it difficult to remember whatever had been taught to them, as they got busy with their household work.

There were at least three trainers for every training centre. That included one ANM or LHV and the rest were the non – government trainers. Both the categories participated in the training process. But few of the non-government trainers had reported that they were not very happy with the government trainers' attitude. The ANM were working in the field of health for a long time that made them well versed with the subject. One of the non-government trainer complained that they did not get much of a chance in the training as the government trainers mostly conducted the sessions.

The trainers were asked to follow strictly the training manual and were told to teach only that to the Mitanins. Lecture and practical demonstration were used as methods of training. In the second and fourth rounds, which are revisions of the earlier training rounds, the Mitanins are divided in groups and assessment of their knowledge is made in these small groups.

When the data was collected, the fifth round of training that includes medicines was not completed. This fifth phase of training is a special attraction for the Mitanins and the trainers also project it that way that 'if one does not attend this training, then there's no gain'. One of the Mitanins was not enthusiastic about the Programme and had attended only one out of the four rounds of training, as she found it difficult to walk and go to a different village to attend the training. But when she was told about the fifth phase of training, she also promptly agreed to come. In the interviews, Women's health was another topic that came up during discussions. This includes, care during pregnancy, her diet, food after delivery, feeding of first milk of mother to the baby, use of iron tablets, cleanliness during menstruation, white discharge. They also talked about subjects like child's health, diarrhoea, malaria, cough cold, cleanliness, malnutrition, home remedies, making of slides, one talked about Mitanin's objective, about the determinants of good health, the do's and don'ts of family visit.

Kumari, a Mitanin talked about the change in her practices after the training. She said that earlier, after delivery, they didn't feed the child immediately, but this time when her granddaughter was born, she fed her within the first hour. The Mitanins considered the training very helpful because they got a lot of health related

information and as one Mitanin Gayatri put it, it's was very good opportunity for them to learn otherwise even if she wanted to learn, there was no scope for that kind of learning. The training has also helped the Mitanins to move out of the house, interact with other Mitanins.

In **Magarlod Block** most of the women had finished five rounds of trainings when the interviews were conducted. The trainings were held at an interval of one month. The training centers are mostly the Panchayat building or the school building in a village, and Mitanin from seven to nine villages gather at this centre. There are 11 such training centers in Magarlod. The training duration is one month that starts at around 11 a.m. in the morning as the Mitanins come after finishing some of their household chores. In between they have lunch and tea, which is provided in the training. The session ends in the evening. According to many of the Mitanins, they get training for one day and then they can come back and get engrossed in their household work for one month, then again they go back for the training They tend to forget many things in this time duration. So they have different opinion of the training schedule, one of the Mitanin want it to be for a period of one month so that they can retain the content of the training and they don't have to think about home. Another Mitanin said that they had discussed it among themselves and they believed that it should be at least after duration of 15 days. Others too want the period of training to be extended.

For the trainings, there are two categories of trainers, the ANM and the health workers of Rupantar. The health workers have been working in another block of Dhamtari for the last 10 years with Rupantar. The sessions are taken by both of them and if there is any clash of dates with the ANM and she is not able to attend the training, then the health worker takes the whole session. The trainers (samanvayak karyakarta), coordinates the arrangements and attend the trainings also. Later on they are the ones who are supposed to go to the villages, maintain contact with the Mitanins in the village and support them. So they have to have a certain knowledge base so that they can support the Mitanins. For the trainings, the training manuals are used as a guide for the sessions. Both lecture method and practical demonstration for example, preparation of slides etc are used in the trainings. In the training most of things have been covered like cough, pregnancy, malaria, T.B, leprosy, but respiratory

diseases are not covered. For the Mitanins, the trainings are places where they come out and meet Mitanin from different villages. One of the Mitanin said that she enjoys the training, she gets to eat food together with the other Mitanins. They enjoy this new thing that they are getting from the Programme, to move out from the house alone, which most of them never did before.

When the Mitanins were asked to recall of what they had learnt from the training, in both the blocks, the Mitanins spoke about the curative aspects that they had been taught in the trainings (Table 4.2). The curative aspects mainly include pregnancy and other communicable diseases like malaria, T.B., diarrhoea, etc. In Magarlod, apart from these, the Mitanins mentioned about the slide making. This curative aspect along with health education was reported by 22 percent in Magarlod and 28 percent in Ghumka. The high recall of curative aspects of the training may be because of the fact that this is the felt need of the Mitanins, so sessions on malaria or slide making are remembered more. Mitanins also recalled sessions on gender discrimination or other such social issues with some of the curative aspects. So overall, when the Mitanins talk about what they have learnt from the trainings, there is not much of a difference in both the blocks.

Table 4:2 Mitanins area of Learning from the Training programme in two Blocks of Dhamtari and Rajnandgaon District

Areas of learning	Blocks			
	Magarlod Block		Ghumka Block	
	No. of Respondents	%	No. of Respondents	%
RCH	-	-	2	6.3
Disease	6	15.0	-	-
Health education / home remedies	3	7.5	4	12.5
Social issues	-	-	2	6.2
Curative aspect	15	37.5	13	40.6
Cure and social issues	6	15.0	2	6.3
Cure and health education	9	22.5	9	28.1
No response	1	2.5	-	-
Total	40	100.0	32	100.0

MITANINS UNDERSTANDING OF THE OBJECTIVES OF THE PROGRAMME

When the Mitanins are to carry out a very important role, one need to look into how they themselves think about the objective of this Programme and see if it differs from the implementers' objective. Kumari Bai, a Mitanin from Dhondiya village of Ghumka Block says, "After the training we know about undernutrition, and its consequences, the causes for diseases. The purpose of the Mitanin Programme is that the people should know about these things and then find out measures, which can keep the people to be healthy. One of the things is that we have to look into the aspect of food, whether people have enough and if they do not have then we have to see to it that the facilities by the government like provision of supplementary food from the Anganwadi and other schemes for the poor are reaching the needy. Housing and clothing are also factors affecting health. But I am helpless, what can I do, I can only give advice because it's the Panchayat which can do lot of things like, transport or vehicle for taking a BPL woman for delivery to the health centre".

The Mitanin, Kumari Bai is an exception when she talks about these issues. Most of the Mitanin in **Ghumka block** spoke about the objective of the Programme as dispensing of health related information, health education and information of care of pregnant mother. About 56 percent of the women spoke of the objective about health education that includes awareness on health related issues, information on health facilities (Table 4.3). The Mitanins said that the objective according to them was that the Mitanin would be able to go to every house and talk about health, which would benefit the people. About 28 percent spoke about both the preventive and curative aspects and the Mitanin Programme addressed that aspect. They also spoke about solving small problems at the level of the community. About 3 percent of the Mitanins brought out the other objectives like service to the people. For Ashwani the Mitanin Programme is to get connected to people, "ek dusre se jurne ke liye". In Magarlod block, the figures are a little different, about 30 percent of the Mitanins said that they think that the objective of this Programme is to spread health education, and 25 percent spoke about social issues and ten percent spoke exclusively on gender and another five percent on health rights.

Table 4.3: Mitanins Understanding of the Programme in two Blocks of Dhamtari and Rajnandgaon District

Mitanin's understanding of the Programme	Blocks			
	Magarlod Block		Ghumka Block	
	No. of Respondents	%	No. of Respondents	%
Health Education	12	30.0	18	56.3
Cure	1	2.5	2	6.3
Care	5	12.5	9	28.1
Social Issues	10	25.0	2	6.3
Health Rights	2	5.0	-	-
Gender	4	10.0	-	-
Community/Panchayat	2	5.0	-	-
No Response	4	10.0	1	3.1
Total	40	100.0	32	100.0

From the interviews, of Mitanins in **Magarlod Block**, it was found that the objectives have revolved around the concept that the Mitanin being a woman would benefit the women. The Mitanins talk about giving advice, referring patients and giving medicines and also community action. Some even look at their role as similar to the ANM, the exception being that the people have greater access to them. Like Radha, said the Mitanin Programme has been evolved so that women would be able to know in detail about the women specific health problems. Kesri said that women couldn't go out by themselves and get treatment; they cannot share lot of their problems with anyone. But since she is a Mitanin (friend), the women would be able to open up to her and share her problems with her. And the Mitanin can help in her own ways like she can give advice, or take her to the hospital or to the ANM.

In diseases like malaria if the Panch, Sarpanch cooperates, they together can remove malaria. Another Mitanin had to say that that one person cannot do much, but when five people get together, they can do much more. ('Muthi mein takat hai'). The nurse has been telling the same things but things have not worked out, but if five people said that the same thing, now, then people would listen to them. Neeta also said that Mitanin, with the help and support of the people, would be able to utilize the services of health centre more. The Mitanin would give the health related information to the people. There should be no differentiation between boys and girls and they should get equal rights.

The Mitanin of Senghabhata, when asked about the role of Mitanin, she said, 'it is very much similar to the ANM'. When asked in what ways she is different from ANM and when there is an ANM, why does the village need another Mitanin, she said that the Mitanin is there to give support at every juncture. The ANM is there in the neighboring village only but she stays in her hamlet and she would be able to support her people more. In one of the health committee it was asked, that in spite of so many people being present like ANM, Anganwadi worker (AWW), Jan Swasthya Rakshak (JSR)[9], Depot holder, why do they need a separate cadre of the Mitanin. They replied that the ANM does not stay in the village; she comes once in a week or 15 days or even more, this time they have not seen her for a long time. The AWW stays in the Anganwadi, she does not have time for other things. She has to spend more time looking at the daliya, the children and their official meetings. The pregnant women and other for small children, the women cannot open up to other people, but the Mitanin is a friend with whom she can talk and share.

The Mitanin from Megha said that there are lots of poor people and she would be giving medicines to them but unlike the *jhola chap*, they would not give unnecessary medicines or injections. Now people would not be going to the *jhola chap*. But the rich would not come to these people, as they would be going to the private doctors. The health committee members in one of the villages said that the Mitanin can save their money, which till now they have been giving to the *'jhola chap'*. One of the *'jhola chap'* doctors gave his opinion on the Mitanin Programme, he believes that the Programme is especially for the pregnant women and children. He does not consider the Mitanin to be a threat. The government medicines anyway won't be of much help and the choice entirely depends on the patients, whoever they want to choose. They go to the patient's house anytime they call them and that is their advantage.

Though Mitanins brought in the issue of gender justice, giving medicines especially to the poor and about disseminating information about the health services and reaching the health services but the aspect of right to health services or putting pressure on health services was not raised much. Perhaps it is too early to expect

[9] JSR is the community health worker scheme of Madhya Pradesh Government started in 1994.

something drastic like this and as Dr. Binayak of Rupantar said that they need one more year to get the Mitanin come up with these issues. At present as a Mitanin herself said, they look at themselves as another cadre of workers added to the already existing cadres of AWW, ANM, JSR, etc. Her advantage is that she is a woman and is more accessible to the people in her village.

MITANIN'S PERCEPTION OF THEIR ROLE

The Mitanin's role and her work in the village will be determined by the way they visualize themselves. They were still undergoing training at the time of the data collection. In Ghumka block, about 44 percent spoke about health education. In Magarlod, this percent was lower at 28 percent. Nine percent saw their role in the area of curative aspect in Ghumka whereas, in Magarlod, the corresponding figure was 25 percent (table 4.4). In Magarlod, Ten percent of the Mitanins spoke about health and gender rights.

Table 4.4: Mitanin's Perception of Her Role in two Blocks of Dhamtari and Rajnandgaon District

Mitanin's Perception of her role	Blocks			
	Magarlod Block		Ghumka Block	
	No. of Respondents	%	No. of Respondents	%
Health education	11	27.5	14	43.7
Cure	3	7.5	3	9.4
Care	10	25.0	5	15.6
Social issues	10	25.0	9	28.1
Health rights	3	7.5	-	-
Gender	1	2.5	-	-
No response	2	5.0	1	3.1
Total	40	100.0	32	100.0

From the interviews of the Mitanins, in **Ghumka Block,** it was found that their perception of future role was more in health education and many of the Mitanins spelled out work in terms of giving medicines in the community.

Dhameshwari a Mitanin from village Dhamansara, said she would learn about medicines and then would give the medicine to women as needed, but for that she was to remember the things. With the gap between the two trainings, she found it difficult

to remember the things that were taught. In future, Sarita, another Mitanin says she will be giving medicines to patients in her village though mostly people go to private care. She would advice that even if the people go to the 'jhola chap', they should resist using injections for the small kids.

Another Mitanin said that if someone in her hamlet is ill that person could make use of the depot holder. Later she can also give some medicines but only after she is taught and if the patient is very serious, she will refer the patient to the hospital. Because the training will equip her for taking care of small illness and any major illness have to be referred.

For some of the Mitanins, the role was not very clear like Kamla said that she would do whatever was told to her. One of the Mitanins said that slowly the people would understand more, she would see to the health of the village. When she was asked about her role, she said that she would follow whatever order was given to her for example she might have to distribute medicines. Ashwani also had questions on her future such as, is the last one, the fifth phase of training, how would she be able to move further ahead? After she completes the training, she will give some medicines to the people, but she doubts whether there will be a regular supply of medicines. One Mitanin Geeta says that she will do this work till she is alive. In future, she would do social service and with the new information that she got from the training, she would visit families and would tell it to the people. Gayatri believed that in future the programme would help her to help the poor. She would take especially the poor patients to the hospitals, and would help in getting the benefit of the various government schemes for such people. She would give information about the schemes and help in getting the money from the Panchayat because the people would not know about most of the schemes like the Aayushmati scheme (a scheme where pregnant women below the poverty line are given Rs.500 for the first two children).

In **Magarlod Block,** the Mitanins think about their role more in the curative side including treating small illness, giving advice and referring patients. But this is coupled with other preventive aspects and social issues, which they want to address. Mona said that after she gets the complete training, she would move out of the house and help people in their village and would give medicines. One of the Mitanins in

Megha, said that she would go for medicines and advice, along with the other social issues. Radha said that, after the complete training, she would have to survey the village, would see if women were having any health problems, especially if pregnant women have any problems, or any other inner problems which they have not been able to share. She would give iron tablets if needed. Kesri bai also said that after the training, she would also distribute medicines discuss with the women about their problems, for example with pregnant woman about her diet, with the parents about the child's immunisation and diet etc. With the help of Panch and Sarpanch, they would try to remove malaria by keeping the wells covered, closing the pits. When she would not be able to help the person, she would advice them to take the patient to the hospital. Neeta of Araud wants to serve the people in her village. She would work according to what is taught to her in the training. Whatever problems are there, Mitanin would have some solution, and otherwise she would advice the person to go to the CHC. Not much of medicines would be prescribed, like most of the women who come to her at present with complaint of pain, can get better only if they take rest, they do not need any medicines.

In Megha the Mitanins said that they see themselves, as smaller than the ANM. And so there is a major apprehension about the supply of medicines. They need a regular supply of medicines which would publicize the Programme. They can even go on strike if they do not get regular supply of medicines. The problem for them would be that if they give medicines to one person in the village, saying no to another person due to unavailability will create tensions. Non-availability or inconsistent supply of medicine would create problems for them and affect their reputation.

Kesri talks about women's violence, she said that that they would do something against it, about men's polygamy, marriage of girls below 18yrs and dowry. The health committee can play a big role in that. The Mitanin in Sengabhata through this Programme visualises that no child should be malnourished, there should be no disease. The Mitanin would give advice to women and can accompany her to the health service when needed. In future whether this Programme would succeed would depend on their work and also the village people would need to support them, this would determine their success. But it seems to them that this Programme is a

good one and it should continue. In Megha, another Mitanin talks about their identity, after they are trained, they will have an identity (parichay) in the village, and even small children would know them as Mitanins.

The Mitanins look at the future more in terms of their social position, their identity and their job in distribution of medicines, and for referral, for prevention of disease. About one fourth of Mitanins talk about the support they need from the community and their role in raising social issues.

MITANIN'S PERCEPTION OF GOVERNMENT SERVICES

The Mitanin Programme talks about a close linkage with the existing health service system and this is vital for the success of the Programme. One needs to look into the perception of the Mitanins about the health services to which they have been attached for the last one-year.

In, **Ghumka Block,** the Mitanins preferred private care to government service. Though one of the Mitanin said that the services improved a little and the other said that people started going more to the government. The common reasons for the dissatisfaction, was the delay in the blood test reports, absence of proper care, charging extra money, and most medicines not being available from the government centre. Even for villages where the MPW stays in the same village, the people are not very keen to go to him because he charges money. In the government health centre, report for the malaria tests take a long time, so people prefer to go to the private labs where they get the reports faster. The MPW said that it would take time to bring a change. One of the Mitanins further clarifies that people generally go to government hospital for the major illness otherwise they go for private care. People who don't speak up, they generally go to private care because in government one really needs to speak up to get things done. Also lot of people feel that in government, there are either no doctors or no drugs, so there is no point in wasting one's time over there. In one of the discussions with Mitanins, this apathy to the government sector came out very openly, the Mitanins talked about the extra money spent in the government services. They said that for a small cut, the government hospital had to shell out Rs150/- to the nurse. The doctors won't ask for money but the hospital workers

demand money. Even after delivery, the child is not sent back unless some amount is given to them. Also, there are delays in the reports of malaria tests so they do not have an answer to the people. They have lost trust on the government service. Even their family talked poorly about government services. They felt bad about it and few Mitanins left because they had to listen to the people's comments in the village. In another village, Dhondiya, the Mitanins holds the view that the services given in the government sector are not of good quality but have now improved a lot as compared to earlier services. They said that the government should take care of the people.

The Mitanins have raised the issue in the training that all the facilities are not available, proper care are not given to the patients and the government personnel do not provide good care in spite of the fact that they are so well paid. The health personnel reply that slowly there will be improvement in the delivery of care. On probing as to what they could do about this, they said that they could do it collectively. If the government has given the rights to them, they will have to sit up and listen. In village, Arla, the Mitanins discussed among themselves about the delay in the reports of the slides. They had come up with the suggestion that if every village or every sub - centre had had the facility of checking the slides, they could get the reports on time. All the Mitanins were of the view that these were the major problems and something should be done to rectify that. In Mitanin, Dhameshwari's village, the Anganwadi did not give daliya powder properly though she went for the training, so the women had told her that she should go and talk about this to the AWW.

When Mitanin have to refer patients to the hospital, they ask people to go to the government hospital though they themselves are not very positive about it. She was more willing to go to private doctors. But for the referrals, Mitanins would anyway have to tell people to go to the government sector. She only adds up, "If you don't get any care then better go for private care".

In the district hospital of Rajnandgaon, the Chief Medical Officer himself attends to the cases that has been referred by the Mitanins, and referral cards are to given to the Mitanins which is expected to smoothen the process of referrals.

In **Magarlod Block,** the Mitanins have not yet undergone the full training, but as told to them they have started referring cases to the hospitals or to the ANMs though it is limited to very few patients as of now. All the Mitanins except the ones where the villages have people who are comparatively well off have reported to refer patients to the health services or to the ANM. Mitanins have referred especially T.B. cases, and two cases of white discharge patients to the CHC or the government hospital. In few cases Mitanin herself had accompanied the patient to the hospital. Referral is supposed to be done to the government sector. But few people have also gone to the private doctor by themselves after Mitanin suggested that the problem needs to be seen by a doctor. Mitanins also reported to have referred cases to the ANM in the village.

But the Mitanins have widely reported their dissatisfaction with the government health delivery system. They are dissatisfied with the behaviour of health personnel, the unavailability of laboratory and medicines, inaccessibility of the health services, and the role of ANMs and AWWs. Few of the Mitanins have reported that they do not go to the government doctor. They rather prefer to go to the private doctor when the need arises. The women in the village said that the behaviour, especially of the lower ranks personnel was very rude towards the patients. They perceived that in the government hospitals, the treatment provided is not of a very good quality. Government service is free but there have been failures also like in many cases, even after the operation (sterilisation) women have had children. Then, according to a Mitanin from Senghabahta, even the government doctors, gives care to the patients according to the class that they belong to. In terms of cost, going to the health centre would mean losing at least half day's work, added to it is the cost of the local transport of the patient and the caretaker, accompanying the patient. The medicines that are prescribed are expensive and the patients have to buy it from outside medical shop, there is no help in that matter. In private sector they do take money but the treatment provided, according to the Mitanins is better. In the village the Mitanin prefers to go to the *'jhola chap* doctors'. They are the people in the village who go from door to door in the village and treats patients. Most of them have got the training and knowledge by being associated and worked with or worked with some other person who may or may not be a qualified doctor. The Mitanin said that they are easily available, but the government hospital is too far from their village. The 'jhola

chap' can attend to a patient anytime in the day or night, especially when the patient is bed ridden. The economics also work out well, because for a jhola chap doctor present in their village, they have to pay Rs20 and it would take the same amount to go to the CHC. So 'it is better to go to a private doctor in the village and save one's time'.

In another village, the Mitanins spoke about the state of the CHC. They said that the doctors and other staff openly ask for money from the patients, though the Mitanins are not charged the compulsory user fees, that goes to the 'rogi kalyan samiti'[10]. (None of the Mitanins had the idea that the fees is for the betterment of the services and BPL patients have a provision of getting medicines free up to a certain limit). They were citing examples when relatives had to shell out money to get the dead bodies after the post – mortem, which is a fixed Rs300/-. Medicines have to be bought from some shop and at times they even said that which lab they should go to, to get the tests done. Reports of blood slide for malaria tests in the health centre takes a lot of time. One of the Mitanin reported that the ANM was reusing the syringe and when she had pointed this out to her, the ANM replied back that if she has any problems with it then not to get her child injected. The distribution of daliya[11] from the Anganwadi is not for everyone, like presently she is not getting it, she has been told that she is well off and so she is not eligible for this. There are problems in accessing the government services and the village has found better option in the 'jhola chap' doctors who are more accessible and save them time. The poor perception of the health services can be a barrier for effective referral. But the Mitanins do not question the non-delivery of services much. It has been raised only by one of the Mitanins the issue of medicines not provided by the hospital. This Mitanin belongs to lower economic strata. These Mitanins have used the services themselves while many of the rest have not been using the services though they said that they would like to explore it by taking patients along with them at a later stage. Another Mitanin who spoke about the ANM and the Anganwadi Daliya, has questioned them only when it concerned her. The Mitanins do talk about health as a right but that is yet to seep as an important idea to them.

[10] the user fees that is charged goes to the rogi kalian samiti and this committee decides its spending.
[11] Daliya is the nutritional supplement distributed by the Anganwadi in every village under the ICDS scheme, for providing nutrition to children, pregnant and lactating women.

The most important thing as one of the trainers' puts it is that they themselves do not know what the facilities are provided at the PHC or the CHC. It's only when they know about these things that they can ask for these facilities. Some of the trainers though, have started raising questions when they go to the health centre with some patients. One of the trainers, Bhagat said that in the last three months, the government hospital it seems has improved its services. People are getting a few medicines that were earlier difficult to get. Earlier the reports for blood test of malaria used to come in very late ranging from 7 to 15 days. Now the reporting time has reduced a little bit. Patients can now get their report within three days. He said that when he goes, he gets the report within an hour. Some problems are of course there like non-availability of DOTS medicines and injections. They have begun to ask about this to the hospital authorities. He feels that facilities for rabies treatment or gynaecological operations are also needed at CHC, as these are quite common and it is difficult for the person to go to the district hospital.

One of the health personnel, a health supervisor in Magarlod block CHC, said that they have medicines, there is Rogi Kalyan Samiti in the CHC, from where they can buy medicines if they do not get the supply. Before the Chattisgarh state was formed, they had problems in procuring medicines, so they had to prescribe medicines from outside but things have improved after the formation of the new state. Also the PHC has been converted into CHC, in 1996. Earlier there was only one doctor, now they have four doctors, instead of just 15 beds, another 15 beds are also going to be added. The medicines are available now. About 85 percent of the Mitanins have reported that they get the support from the ANM presently. Another 11 percent have reported that she does not give them the needed support and three percent of the Mitanin said that the ANM asks them to tell the patients to report to her.

The Mitanins perception of government services is no different in both the blocks. It was just that the Mitanins in the Ghumka block were initially a little hesitant to talk about this, but later as they opened up, their perception didn't seem any different from the other block. The disturbing trend is that the Mitanins have started to refer few patients, but due to the sad state of government centers, the patients have gone to the private practitioners. A senior government doctor says that as the Mitanins will start referring cases and patients will come, there will be more sensitizing of the

doctors. Mitanins have been given priority and complaints from them regarding personnel or services will be attended first.

WAYS THE PROGRAMME HELPED THE MITANIN

The programme has helped the Mitanins in terms of knowledge but more important for them this has given them the platform to come out of their houses, and for many, it's the identity as a Mitanin that has boosted their confidence.

As one of the Mitanin in **Ghumka Block,** said that, she used to be confined to the house after marriage but now at least she could move out of the house and had learnt to talk to people. Another Mitanin said she felt good that after being associated to this programme she had gone to houses that she had never been before. Before becoming Mitanin, she had never moved around in the whole hamlet. Earlier she used to be in the house, very quiet, she was not able to speak up but now she could speak and discussed with the villagers. Some pointed out to the fact that they had been selected as a Mitanin from the village, and that had given them a sense of identity that made them happy. Some other Mitanins laid emphasis on the benefit from training in terms of knowledge, which they did not have earlier. For Dhameshwari it is the time she gets for her training, she gets off from her other work. She feels that the programme is good. Even if the training had been once a month, she would have still gone for it as she can manage to take some time for the Programme. Another Mitanin Sarita also adds that she is happy being a Mitanin and the village people know her as Mitanin but again at home, everything is the same, she feels that 'inspite of knowing, she has to act ignorant'. She still has to wait for her husband's orders; and she can act only when her husband says something.

The training had given the women an opportunity to move out of the house to meet different people. This had given them a lot of confidence.

In terms of knowledge, the Mitanins felt that they had acquired a lot of knowledge, which would help them, their family and the village. They specially mentioned about the home remedies, about good food in low budget. It was hard for

people to find doctors and the sub-centre was too far for them so the people could not access it, so they went to the Mitanins whom they could get suggestions about home remedies. Earlier the villagers spent lot of money to private doctors.

In **Magarlod Block,** many of the women spoke about the changes that they feel in themselves after the training. As a Mitanin, the women have got an opportunity to move out of the house, this chance to go out, and get one day free for herself is liberating. For one of the Mitanins, this was the first time she got chance to out after her marriage. She feels that 'adolescence has come back'. She was the only girl at home and here also she does not have any other woman in the house, except her old mother-in-law. She was not allowed to go out at home and here also. But now they do not say that anything but help in the household chores when she goes out for training. In the training also she is able to meet so many people. The training is a good meeting point to meet especially the Mitanins from other villages. It feels like a family. Yet for some others it is an achievement that they now have been able to speak out in front of people. They were able to go in front of the health personnel and were able to speak to them, or. 'The fear and hesitation has gone out to an extent', 'Have got the courage to speak' in even in front of 20-25 women. These experiences were commonly repeated.

Some have seen this as a very good learning experience; the knowledge that they gain from the training is of great help for them and their families. Some Mitanin said that they like sharing their knowledge with the other women in the village. And one said that she gets to meet with other people of the community. She mentioned "they will come and tell me about their problem because they know that I have the knowledge". In Araud village, apart from the health committee, they have also been able to initiate a group for singing devotional songs, known as the 'ramayan mandali'.

The Programme especially the process of training has helped them to move out and meet other women, a respite from their routine of their household chores. They now have greater confidence to speak and the second thing that clearly stands out is that the knowledge they gain would help their family. The knowledge would also help in a social standing in the village.

The Mitanin in Sengabhata feel they still need a kalajatha type of Programme to bring in awareness about the Mitanin Programme, as every one still does not understand the objectives of the Mitanin Programme. She adds that the name Mitanin is very good. It's the women who have more problems, they have to carry the load and they cannot share it with the men. Women can open up only with the women. So the Mitanin Programme would greatly help the women. Mona thinks that the big doctors cannot educate about diseases in each and every village. So these trained Mitanin can educate the people about the diseases. When the Mitanins tell about all these, it would be of great benefit for the whole community. Yet another Mitanin feels that the Mitanins should have a separate identity, when people see them, they should be able to recognise that they are the Mitanins somewhat like the nurses. If they get regular medicines, then they will be happy.

SUPPORT TO THE MITANIN FROM HER FAMILY

In **Ghumka Block,** most of the women had been approached through their respective husbands and it was only when their husbands gave the permission the health worker contacted them to be the Mitanin. So in most of the cases, the Mitanins have the full support of their family. Even when the selection was done in the meeting like in Gayatri's case, she had asked the women who suggested her name, to seek permission from her husband first. And once he agreed she committed for this Programme. It is only in Sarita's case even though her husband is not very appreciative of this Programme, and he has asked her not to go, as it is wasteful according to him. She still insists that she is keen on this Programme and for the training and adds that this information that she gets in the training is free and she will not get this type of training elsewhere.

In two of Mitanin's houses it was seen, the husband is more proactive, he encourages the wife, by sharing the workload when she goes for training or helping in reading or writing. The husband's support is a very important factor.

In **Magarlod Block,** the work of Mitanin requires going out to the training centre located in a different village for training and she also needs to make regular visit to all the houses in her hamlet. Therefore the support of the family in this respect

is very vital. Exploration with the Mitanins showed that 40 percent of them received proactive support from their in laws that is they take care of children and help in household chores when she goes for training. One of the Mitanins said that her husband encouraged her to read books that are provided in the training, and 32 percent said that their families give them full support. 12 percent reported that they do not face any restrictions at home when they go for trainings or in the village. Another 8 percent said that their husband had given permission at the time of joining so he has to support her now. There were eight percent of the Mitanins who said that they do not get a positive response from home. Yet, one of the Mitanins stated that she would be continuing with the Programme, whatever the conditions. Yet another said that her after becoming a Mitanin, she has started getting visitors in the home, and this in some way has increased her status in the family. One of the Mitanins from Araud said that earlier if she went out, her husband used to ask where she was going, but now it's her work and in fact he encourages her. She tries to finish off her work fast and then even if some work is left, she leaves for her training. They help her out in the rest of the work. She said that if they get the freedom, they should also do their duty, as she is the daughter-in-law.

The support of the family is vital and lots of times, the support is in the form of permission to join the Programme, the permission to go out in the village, for training, encouraging the Mitanin to go out and help in her household chores.

RESPONSE FROM THE COMMUNITY

The quantitative data (Table 4.5) has showed that Mitanin's find that there is an overall positive response from the people. In Magarlod, 73 percent say so and in Ghumka, 47 percent are positive and another 22 percent have gradually changed their perception or are aware about the selection of Mitanin. In Ghumka, 13 percent of Mitanin have said that the people in the village do not respond well, either they are not interested, or they think that the Mitanins get paid for their services and do not show interest or the women get busy in their work in the fields and do not have the time for the Mitanin.

Table 4: 5 Mitanin Perception of Community Response in two Blocks of Dhamtari and Rajnandgaon District

Mitanin Perception of Community Response	Blocks			
	Magarlod Block		Ghumka Block	
	No. of Respondents	%	No. of Respondents	%
People are positive	29	72.5	15	46.9
People don't respond well	-	-	4	12.5
There's a gradual change in people's perception	1	2.5	6	18.8
People are aware about mitanin selection	1	2.5	1	3.1
Mixed reaction from people	-	-	2	6.3
Questioning, doubtful	1	2.5	1	3.1
More proactive response of people	4	10.0	-	-
No response	4	10.0	3	9.4
Total	40	100.0	32	100.0

In Gayatri's hamlet also, people was supportive. As she was taught in the training, she tried to implement few things like cleanliness near the hand pump. She got the full cooperation of the villagers in this regard and they stopped cleaning utensils near the hand pump, even when she was not there, there were other people who saw into it so that no one washed utensils over there. In her hamlet, there was a malnourished child where she tried to intervene and tried getting the child's due from the Anganwadi. She told the reason of getting support from people that people had known her (she is the wife of the primary school teacher). Also in this village, people have come together for village needs. There were potholes in the road in her village, the government had dumped the raw material (Murram) and the village people themselves have leveled it. She said that there was no need to ask people in the village both the men and women to take the initiative. The women had already started coming to her place asking for medicines. She said that she would be able to give medicines some time later after she acquired some more knowledge. In some of the other places, the Mitanins got a mixed response. They got good response from the poor people but not so much from the richer class, and in some places, the response from the older women were not so positive. The reason stated by the Mitanins was that the poor were more understanding, gave more importance to what Mitanins said

to them and they followed that. For them their advice was needed as they did not have many options, but the richer people had the options and went to the private doctors to get medicines from there. The richer people said that if those medicines of Rs.100 could not cure, then what could the Mitanin do? For the elders, one of the Mitanin said that the elders were not willing to listen to her; this formed about 25% of the women according to the mitanin. When the Mitanin talked about the need to bring some of the changes in certain practices like breastfeeding the child after delivery, the women said that they had been following the practices and carrying on since such a long period of time, and they did not feel the need to change. The Mitanins now think that there were so many children deaths due to those practices, so those were wrong practices and they need to be changed. These were observed in other places also when the Mitanin denounced the old customs and practices and saw that as a cause of ill health. No efforts were made to see if they tried to explore some of the older customs or practices, which the older generation had been using, or practices before the modern medicine was available to them. In the long run, this may lead to people in looking at the Mitanin more as a person from the 'other side' and would not get the necessary support that is needed for her from the people.

Then someone like Kumari clearly stated that whether people listened to her advice or not it depended on the availability of the things at home. Otherwise they said that they could not do it. There were also practical problems like the Mitanin said that the BPL people could take the ration from the PDS but what happened was that the PDS situated about 10-15 km away from the village that become difficult for the people to access it. So whatever was available from their resources, they had to go for that.

In some of the villages, the concept of Mitanin was not cleared and people did not know much about the Programme. For example in Dhamansara village, when the people asked for medicines, the Mitanin said that she had not got training for the medicines, she would respond to it later when the complete training was done. She said that her work was to tell the people but the people did not have time as they had to go to earn. Another Mitanin of the same village believed that for this Mitanin programme, she was to have the support of other women so that she could give medicines to them. People questioned as what was this Mitanin programme and when

would she complete her training, she told them that she had been taking the training and later on she would get medicines that could be distributed to them. She did not prefer to talk much about it.

The response of the community was based on their perceptions of Mitanin's role. That perception was shaped by inputs from the facilitator at the time of selection, and the Mitanins' work in the village and also the experienced of earlier programmes. For some women like Dhameshwari, Geeta or Kamla talked of medicines and the community was to look upon them as people who would have the medicines. For Gayatri, Sarita and Kumari, it was medicine and also advices that they gave to the community where they had got different responses

In **Magarlod Block**, the responses from the people to the Mitanin Programme are mixed. Radha has the full support of her community. She feels that she definitely needs the support of the people because she would have to work with them. And she does not see any problem in that because women in this village have already shown their unity when they came together for stopping alcohol. She feels more excited. About 72 percent of the Mitanins have spoken about the support they get from the people. Kesari has got mixed responses in her village especially during village survey, at some places she was greeted well and some places, people did not want to get the survey done. People in the village know about the Mitanin Programme and are aware about the selection of the Mitanin from their village, but they are not very clear about the role of the Mitanin. The Mitanin in Sengabhata and Megha report that people ask for medicines, since she is the Mitanin, she must have got some medicines. Mona feels she does not have a very favourable environment in the village. No one listens to her advice. The people in her village do not tell her about the illness for example, a person living very close to her house, even on asking have not disclosed about the illness. But the person goes to the private doctor for the treatment of his tuberculosis.

One of the Mitanins in Megha, a big village on the roadside where there are lots of educated youths, said that young boys of the hamlet laugh at her. When she goes for training they tease her and ask "where is she going? To become a doctor? I am having pain, give me medicines" she replies that she would give when she gets the

complete training and the medicines also. The other Mitanin from the same village also said that people laugh at her, especially when she holds the books and goes. But she cannot reply back to them because she is the daughter-in-law of that village. Especially if the males comments at her, she does not reply anything. When she tells about T.B, people said that that they have shown in the big hospitals and haven't got cured, what the government would do. In Araud, villagers said that that the Mitanin get something (monetary compensation) or else they would not be so happy, they won't go for the trainings and all. They said that that the Mitanins must be getting the medicines and they are selling it off, or using it for themselves. The elders in the village said that that this Programme after 4-5 years would not be there. The men said that that older women should have been chosen. In Choti kareli, some of the villagers said that "these new people are going to tell me what to feed my child after I have brought up four children". Some of the responses the Mitanin gets are like what would the Mitanin do? Or they are told that they are wasting government's money, when the money stops, this Programme would stop.

The villagers' response is generally a mixed one, though most of the interviews that do not show a positive response are mostly from the big villages. They go to the Mitanin for some minor illness in the hope of getting some medicines, but even that is not met. One of the reasons that people are not very clear of the role of the Mitanin may be because of the low level of interaction of the Mitanin with the community as a Mitanin. The Mitanin has only gone to all the houses for the survey, for filling up her village health register. In places, she has not covered all the houses. In Bakori village, after the Mitanin had attended two out of three phases of training, the other women in the village still did not know about the Programme. Another such village is Brijkuli, here the land holding ranges from 14-16 acres for very few families to 3-4 acres. The kamars, a Schedule Tribe, do not have any land. They work as daily wage labourers and also collect mahua[12] and tendu[13] leaves from forests. When the Mitanin was asked, how many houses has she covered for the survey, she said that she has covered all the houses. When asked about the kamars, she said that she has not been there, the reason that her family members said that that those people are always

[12] Mahua (*Madhuca Latifolia*), its flowers, when it falls from the trees are collected and dried in sun, it is sold in the local market and are used to make liquor.
[13] tendu (*Diospyros Melanoxylon*) leaves are collected from the forests, which is bought by the forest department.

drunk, there is no point in going to their houses. Their houses are very close to her house.

A family visited had five children; almost everyone had been suffering from cough from the last 15 days. Their father has also recently contracted the illness. The kamars complain that the ANM does not come to their area (there were 12 houses of the kamar community in that locality) they complain that she comes to the village, but goes to the middle part of the village to some of the shops and go off. There is no point in going to the nearest sub centre as it is too far, have to go in a bus and there may be no one present. They do not know about the Mitanin Programme, have not heard about it. They did not know about the meeting of the health committee that was held in the Panchayat building.

Another such village is Senghabhata village which has 105 families and two Mitanins. Most of them are sahu, there are 12 nirmalkar families, three soni families and four lohar families. The lohar family stays on the outskirts of the village.

In the Lohar hamlet a woman who has four daughters, one son, and carrying a child has a husband suffering from T.B. She has got 4 daughters, 1 son and carrying one child. Her husband is suffering from T.B. they do not have money to go to get the X-ray done. She cooks food for the mid-day meal scheme. After she gets the pay from the Sarpanch then she would be able to take her husband to the hospital. She gets Rs20/day. But she does not know if she is entitled to get the money on holidays when she does not cook. Now they have Rs150/- with them, and that would be enough for going to Nawapara, a nearby town, for the X-ray but if extra money is needed then it will fall short. So he is waiting to get some cash in hand and then he would go. His medicines are over. She does not know anything about the Mitanin Programme. The Mitanins in the village has covered all the houses according to them but have not covered these houses on the outskirts of the village.

As one of the Samanvay samiti karyakarta, in a health committee puts it, 'the Mitanin is the link between the government and the people, they would have to make the samiti very strong and for that they need to have regular meetings, which would make it stronger'.

ROLE OF THE HEALTH COMMITTEE

In **Ghumka Block,** the health committee in most of the villages had been formed at around the time of the interviews. Apart from the Mitanin, there were six other women in the committee who had been chosen by the Mitanin herself. There was a strong presence of Self Help Groups in this area, almost all the villages was having a SHG group. Many of the Mitanin were also part of the SHG and they had chosen the SHG members as members of the health committee. Sarita reported that she discussed about women's health in one of their meetings. In many places, the role of the health committee was not clear, neither the Mitanin nor the committee members. The trainer was asked to go in the village and form the committee, which was entrusted to the Mitanins. The Mitanins in places like Dhamansara (the Mitanin in this village is said not to be working effectively) did not explain the women why she was asked for their signature. A committee member was later asked as she had signed the paper, "now what is she going to get?" Another Mitanin explained that the committee was needed when she would not be there in the village, especially when someone fell ill, they would have to keep the things properly and report to when needed. The committee to her seemed more of an auxiliary rather than a support.

But for Gayatri the committee was very significant she said that samiti was a good concept. The family would not say no when they moved out with the samiti. Before the formation of samiti also they always used to go out with her and ready to accompany her, so there weren't any problems in forming the samiti.

In **Magarlod Block,** the health committee has been formed in most of the places, but the meetings have not been regular. But the Mitanins talk about the importance of these committees. One of the villages where the health committee has not been formed, is a village where there are some well off people and the community bonding seems less in those villages, the Mitanins also talked about not getting proper support in these villages. They also added that they have to go and reach out to the women more. In Senghabhata, where the Mitanin is from a comparatively upper class, the Mitanins said that the health committee is formed to spread the knowledge and also to support the Mitanin. Women do not want to travel all alone always so it is good that the committee would be there to support it. But in her village the health

committee meeting was held just once. Apart from the survey of the village, they have not done family visits, they would be starting very soon. The health committee meetings are not the only means of spreading the learning from the training, it can also be done when people meet in the hamlet, when they go to fetch water, in the Self Help Groups (SHG) meetings that they have every week. Kesri sees the health committee as a platform where they can raise the social issues with the support of the other women. In Araud village, the committee has helped one woman so far where the woman was having problems at her in-laws place. Her husband used to beat her and made her life difficult. She then came back to her father's home in Aurad. The committee got together and helped her file a case for divorce.

The villages where the social bonding is not good the committee meetings are less frequent. In some of the villages there is a presence of SHG, which aids the process. But the health committee in itself does not represent all the castes or classes. When the selection was carried some women were present in that meeting they were selected as the Health committee members. The selection process and the home visit after the trainings for survey and dissemination of information is so designed that all the families know about the Programme. But still there are lacunas and the Mitanin have not reached all the houses of their hamlets. Though the Mitanins also realise the potential of the health committees, it has not been fully functional till now.

PROBLEMS WITH THE PROGRAMME

In **Ghumka Block,** the Mitanins spoke about the problems that they had with the programme that was mostly linked with training except for Gayatri, who spoke about her helplessness. She said that there were problems like one person was very poor in the village; he was not able to take treatment. The MPW charges for the injections where everyone could not afford this. In that situation of the poor she felt that she could only give advice and could tell them about the different schemes that the government had been involved.

Other than that there were practical difficulties. For the training, the information was given just one day in advance, which would mean that money might or might not be present in the house, and then it became difficult for them. Then,

where there were parents-in-law, it was again difficult to ask for money. Then she had to give back whatever money she got in the training. Also due to the presence of her parents-in-law, it was difficult to go out and covered all the houses especially when she had small kids. As for the other Mitanin, she just has one kid who is grown up, she is educated till BA and does not have her in-laws, and so she can move around more freely. She does not like roaming alone in the village. Whatever she knew, she filled in the register for few houses, rest she had to go and filled in. Dhameshwari says, in this programme, good things were taught, but they listened and they got busy in their lives and they tended to forget it. The gap between two trainings was quite a lot of 2-3 months. If the training were after 15 days then it would have been fine for her. In Dhondiya, apart from Kumari, the other Mitanin did not go for the training regularly, then she was left alone to go to the training centre. At times she felt as if she has got stuck. She did not like going alone; it would be good if someone were there with her. Also people started asking her for medicines though she had not been provided with medicines so far. For the training, Kamla could not walk to the other village to attend the training. She did not have anyone to drop her and it was difficult for her to go alone. Geeta had not faced any problems so far.

In **Magarlod Block,** the problems that the Mitanin have mentioned for the Programme are varied. The most urgent problems are with the community where it is difficult for the people to get together for support. The community feels that it is the work of the Mitanin and they do not have to anything to do with it. Then there are the problems with the government services, the quality of care and the needs for early reports of blood test for malaria are urgent. Mitanins also find that monthly training to be inconvenient as they cannot retain whatever they learnt.

HONORARIUM

In both the blocks, the Mitanin said that if they would have been given some money, then it would have been better but otherwise also they would be doing the work. One Mitanin said that she wants to serve and does her work but if there were money, she would be able to do the service better. Geeta said that she would do the work till she is alive. At least her name would be there. But if money is given, then there are no problems. She sometimes thinks about money and sometimes she does

not think about it. That was health related service; at least her children would be benefited from it. One of the Mitanin says that they do not expect money now but later on, after their training is over, they expect something. In Magarlod Block in one of the training sessions, when the Mitanins were asked about their motivation, their first response was service, but slowly voices from the group came out that they should get something for it, some monetary support. Few of the Mitanins said that even though they think it as service to the people, their family said that that they should get something from this. One of the Mitanin said that she is here for service to the people. She would look after the hamlet and the government would look after her. (haman basti ki seva, sarkar hamar seva). But if she gets the money then it would be good for her. Whatever work one does, for the initial period, she would have to do it for free, at least in the training period. Then later only one starts getting paid.

Then there were few who say that they just want to learn like Dhameshwari, it would benefit her family and she will work others in the village, especially who have small kids. Kumari says that she does not have the greed for money; she will be doing service in whatever way she can do. And if money had been offered, lots of people would have jumped in this programme and no one would have asked for a 5th pass woman like her.

HEALTH PROBLEMS IN VILLAGE

In **Ghumka Block,** when the Mitanins were asked about the health related problems in their villages, 23 percent spoke about diseases present in their villages and same number spoke that the people did not follow the hygienic practices that they should follow. The diseases that were mentioned include diarrhoea, jaundice, malaria, measles and pneumonia. 19 percent of the Mitanins said that the diseases were due to things like poverty, (this is taught to them in the training) and same percent of Mitanins felt that everything was fine with their villages. 5 percent of Mitanins said that the health services were not adequate. Geeta bai said that her village was bigger than the other villages and that village had got an Ayurvedic hospital. People from nearby villages came there for treatment. Lots of people were referred to the district hospital and therefore a PHC should also be started there so that people were not supposed to go that far to the district. Kumari bai was of the view that the health

problems or the main disease in the village varied according to the seasons. And the main reason for poor health was poverty; people did not get sufficient food to eat.

In **Magarlod Block,** half of the Mitanins spoke about the non availability of health services, and another 16.3 percent spoke about the diseases prevalent along with lack of support from the health services. Three percent thought that everything is fine with their village. The rest complained that the people are not following the norms that they should. About the diseases, Radha from Brijkuli village said that there are not major diseases, but the year 2002 had an epidemic of malaria in the village. In Sengabhata, sickle cell anaemia and T.B. are the two diseases that are widespread in the village. According to Neeta, the main diseases, found in her village are T.B, white discharge and piles. People do not have much knowledge about T.B. in her hamlet everyone goes for daily wage work and also consume lot of bidi and tobacco. There is a lack of cleanliness, which may lead to White discharge weakness also comes in. Lots of people don't open up to her.

CHAPTER 5

DISCUSSION

Disparity in the provision of the Health Services in the rural areas was seen at the time of independence itself. So the rural areas were given special emphasis in the various committee set-ups for the assessment and recommendation of health interventions. The committees gave various recommendations for the infrastructure development and manpower. To cover the rural areas the use of para-professionals and volunteers was envisaged, along with the 'basic doctors'. The para –professionals were trained as auxiliaries, to make the doctor's task simpler. The licentiate doctor course was taken out, to have a uniform course in medical education. It was hoped that with the increasing numbers of the doctors, gradually the rural areas will be covered up, but that did not happen.

The health workers were initially used to fill in the gaps, but later were seen as alternatives to make up for the paucity of the manpower along with its unique advantages in rural areas. In the 70s, field experiments in Community Health Worker(CHW) throughout the world and also in India by different Non Government Organizations, were highlighted.

In 1978, the GOI launched the CHW scheme, but there were some major flaws in it. The scheme was implemented without any major changes in the existing health service structure, and was dependent on the same structure for its supervision, support, and monitoring. Also only a few section of the village participated in the process due to the existing power structure in the village. Without correcting the flaws the same Programme was repeated in Madhya Pradesh Government as Jan Swasthya Rakshak. The Mitanin Programme comes up in this context in the new state of Chattisgarh.

The present study was an attempt to explore how this Mitanin Programme tries to learn from the past failures of Community Health Worker's Scheme. For this purpose the study looks at the Programme in two out of 14 pilot blocks where this Programme has been implemented by two different agencies. The implementing agency of the Mitanin Programme in Ghumka block was Government agency and in Magarlod Block it was a Non-government organization called Rupantar. The time period of the study conducted was December 2003-april 2004. This is an ambitious Programme, where the Mitanin expected to cover the social, environmental, medical

and gender aspects. The Mitanin Programme has introduced some innovations at the level of conceptualization.

1. It focuses on women workers therefore choosing women who are the most needy who have the potential of becoming a good communicator.
2. It focuses on women's health. Her awareness about how to deal with the health problems, available services and health education in the area of reproductive and child health, communicable diseases, under nutrition, and empowerment of women through these. As compared to the government programmes, the NGO studied took this aspect very seriously and introduced concepts of gender, women's social status, need for collective action, health rights.
3. Selection process was innovative because there was preparatory work which was expected to happen by making the community aware and make them select the Mitanin.
4. Apart from the camp based trainings which are spread out over a period of eighteen months, in service trainings are provided to the Mitanins. The trainers visit the Mitanins regularly in between the trainings.
5. There is involvement of Non government organization at all levels of the Programme, the responsibility of implementing has totally been given to NGOs and even where the government is implementing there is involvement of non government people as trainers
6. For providing support to the Mitanins, different support structures were conceptualized, like the women's health committee and involvement of the panchayat, which will provide support to the Mitanin at the village level.
7. The Mitanin was asked to share the information and knowledge that she got in the training, with the other women in her hamlet, visits to families are a part of her in-service training.

Some of the issues that emerge through this research at the implementation level are:

Contrary to earlier schemes, where the Panchayat is supposed to do the selection through ' Community Participation' in this Programme, a team of facilitators are created who help in the process of selection of Mitanins. But what comes out is, in the government implementing agency of Ghumka the government staffs were appointed as the facilitators. This has created an additional responsibility for them. With their overloaded existing responsibilities, they found it difficult to follow the laid down regulatory process of selection of Mitanins in village meetings. It was found that the Selection of Mitanins in the village meetings did not happen as per the procedures defined, it was often bypassed. Thus where Mitanins were properly selected, they learnt, got involved and were enthusiastic but where they were simply named by the facilitator without the approval of village women they did not necessarily turn out to be willing workers.

Mitanins' selection was not voluntarily from her side. Either the woman was approached or nominated without any consultation with her. Before the woman joined as Mitanin, she did not have adequate knowledge about her work, about the training that she has to undergo in a different village, about the home visits that she is supposed to do.

For the women to become a Mitanin, it required that they should be preferably literate willing to spare some time for the Programme, with the acceptance from their family. There is a great emphasis on reading the training modules where the uneducated Mitanin gets discouraged. In the study it was found that the landless labourers were fairly well represented in the proportion of Mitanins, however, those women who worked as daily wage labourers found it difficult to participate as Mitanins. This was not only for the reason of wage earning but also at times through poor literacy levels.

The intervals between two trainings were large which made it difficult for the Mitanins to retain the lessons from her previous trainings. In the training, there was a lot of emphasis on the written words. Participation is low in the trainings, and lecture

method is widely used. The training does not include the details of the services that the PHC or the subcentre is supposed to provide, which will help the Mitanin to raise critical questions on the availability of services. Similarly they need to be given information on the other government schemes which only few people in the village have access to ensuring a wider utilization of such schemes.

The Mitanins have started visiting families and give messages of health education related to mother and child's health in Ghumka block. It was observed that when the trainer and the Mitanin went to the respective houses allocated to the Mitanin, the advice given was related to women's and child's health. Rather than trying to look at her problems from her side, the advice given by the trainers was mechanical. The attitude was 'I know what you need'. For example, the advice of using oil with Dal in females and undernourished child without considering whether it was really possible. Thus a lot depend on the trainers. The Rupantar workers were yet to start field visits and were relatively bettering this aspect.

This Programme has provided the women with an opportunity to come out of their villages to other villages. For many of the women, going to a different village, without her husband or family was a new experience. She got an opportunity to learn about her health, which is otherwise not easily available. They have opened up and started talking about some topics that were taboo such as RTI, STDs.

Though the selection process and the family visits after each training are so designed that the whole hamlet knows about the Programme, exclusions are still there. A lot of people do not know about the Programme and most of the times, they are the most needy who do not have access to the health facilities due to their low socio economic conditions. Also the role of the Mitanin is not very clear to the people, they find this absurd that she is a health worker but cannot provide medicines to them. People doubt if she is really unpaid for her services. Though the very poor were thus still to be covered, Mitanins were known more among the poor and lower middle families rather than the rich who relied more on private practitioner. This was also because Mitanins had no drugs to dispense. A lot will depend upon regular supplies of drugs which are essential to keep the Mitanin motivated and the people satisfied.

The support given to the Mitanin forms a very crucial component in sustaining the Programme. This has come out as a major difference in the government CHW scheme and the CHW scheme by the different NGOs. The trainers in the Mitanin Programme form a very good link between the Programme implementers and the Mitanins. But the other support needs to be strengthened. One of these supports is the health committees which are formed to provide support to the Mitanin within the village. These committees are formed in both the blocks but they have not started functioning properly. The committee members and even the Mitanins are not very clear of the role of the health committee. The Panchayat, in the policy forms an important support, but not much efforts have been made to link up the Mitanin with the Panchayat. This relationship needs to be strengthened. With the Mitanin needing to perform wide variety of tasks, the Mitanin needs support from different quarters all the more.

At present, the health personnel who are involved in the Programme and senior officials know about this Programme, but the doctors in the PHC and other staff in the sub centre do not have the full knowledge about the Programme, though most of the personnel have heard about it. The Mitanins at the village level are suppose to interact with these staff, and therefore the whole of the health personnel needs to be given an orientation of the Programme.

There is an urgent need for the increase in the quality and response of the health care services. The policy document has identified certain areas that need reform in the health services, and parallel efforts are on, but at a lesser pace. The people identify the Mitanins with the government health services and when the people do not get a good response from the health services when referred by Mitanin, the Mitanins' are left to answer the people. With the non availability of services and no support from the health services, the Mitanins also refer patients to private care.

There were some differences in the approach of the two implementing agencies and as revealed by our data.

The process of selection of Magarlod block was found to be closer to the laid down procedure of the SHRC. In Ghumka block, the facilitators were the government health personnel and their knowledge of the households and families helped them in contacting the woman directly and nominate them as Mitanins. However it did not always work well.

The training intervals between two trainings were found to be longer (two to four months) in Ghumka block, which made it difficult for the Mitanins to retain their lessons. In Magarlod block, the training duration was shorter but it was a one day training Programme. This meant, till the time the Mitanins arrived and arrangements were made, lot of time was spent.

The component of health rights, gender were highlighted more in Magarlod block, in the trainings and in the interaction of trainers and Mitanins. The demand for services by the trainers and Mitanins was up to the level of the ANM, MPW and Anganwadi and very few trainers went up to the PHC asking for faster delivery of blood slides or like services. But the trainers were still not aware of all the services that should be available in the PHC or CHC. In Ghumka, the emphasis of the trainers and the Mitanins was more on aspects of health education, though at individual level, some of the Mitanins have started questioning the services.

Visits by the trainers were more systematic and regular in Ghumka block. Being under the government health personnel, they were expected to make regular visits, maintain field diaries, grade Mitanins and report it. In Magarlod block, the trainers visited the Mitanins but due to their other engagements, there was irregularity. Reporting was done in the trainers meetings in both the blocks.

Thus both systems have their strength and weaknesses. Therefore, for an effective Mitanin Programme, there should be cooperation between both the health services and the Mitanin. This has to be done by sensitizing both and strengthening the health service system. When the Mitanins are foreseen as social activists, there will be conflicts with the health services, which may affect the working links of the Mitanin. It will be difficult to sustain this kind of social activism, by the government system. On the other hand, unless there is some institutional support for the Mitanin

like Panchayat, Health committee, or youth group in the village, it will be difficult to sustain. Thus in practice the Programme has to make clear choices and the NGOs that collaborate with it will have to innovate methods of strengthening the government system.

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APPENDIX I

Interview Guide for Trainers.

1. Objectives, how do they find the scheme?
2. Selection process, ownership of community, the problems, their views.
3. Social mobilization and its importance.
4. Training process- their role, content, training methods.
5. Support from Health Service systems, community and family.
6. Future role of Mitanins.
7. Supervision of Mitanins.
8. Role and future of trainers.
9. Positives and negatives on Mitanin Programme, according to trainers.

APPENDIX II

Questionnaire for Mitanins.

- Name.
- Village.
- Age.
- Education.
- Training phase.
- Income sources.
- Land holding.
- Caste.
- Members in family.
- What do you understand by Mitanin Programme?
- How did you come to know about this Programme?
- What motivated you to be the Mitanin?
- How were you selected if in a village meeting then,
  (a) Who were the people who had come to the meeting?
  (b) Approximately how many people were there?
  (c) Who proposed your name first?
- What is going to be your future role?
- What have you learnt so far in training?
- What support do you get from family?
- What support do you get form ANM?
- What support do you get from people?
- What kinds of problems do you face till now and what do you expect in future?

** The questionnaire was used as an interview schedule for the Mitanins who could not read and write*

APPENDIX III

Interview guide for Mitanins

- Background
  - Age
  - Education
  - Income sources
  - Landholding
  - Caste
  - Members in family
- Selection
  - Mobilization in village
  - Selection procedure
  - The facilitators
  - Her motivation
  - Role of husband
  - Reaction of family
- Training
  - Training venue, distance
  - Problems in commuting
  - Training content
  - Trainers attitude
  - Duration, interval of training
  - In-service training
  - Visits of trainers
- Support
  - From family
  - From community
  - Health committee
  - From health personnel
  - From other institutions
- Perception of the Programme, its benefits
- Future role
- Referrals

APPENDIX IV

Areas of health care reform in Chattisgarh

o.	Area of Reform	Role of SHRC (in collaboration with AAI)
1.	Community Based Health Services	• Assisting in the finalisation of the community-based health programme of the GOC ('Mitanin' scheme) • Assisting in designing a social mobilisation campaign for popularising the idea of 'people's health in people's hands' and creating effective demand for the programme • Assisting in designing the media and communications strategy and package for the programme • Assisting in developing operationalisation details and implementation schedules for the Mitanin programme • Assisting in developing all training modules and pedagogy for the Mitanin programme (see annexure) • Assisting in monitoring and evaluation of the programme • Assisting in the co-ordination and logistics for the training programmes
2.	Delegation and Decentralisation	• Assist GOC in developing an autonomy package for (a) integrated District Health & Family Welfare Agency (DHA), (b) Hospitals, (c) programme managers at district and facility levels and (d) PRIs and ULBs. • Planning of devolution of financial powers and other resources, specifically financial resources to PRIs and ULBs. • Strengthening system of transperancy and the right to information and social audits.
3.	Strengthening health intelligence, surveillance, epidemiology and planning	• Review of current systems of health intelligence and surveillance, and proposing reforms in integrating the Mitanin scheme. • Developing systems of village and district health plans, with community participation. • Improving the quality, reliability and analysis of health statistics.
4.	Control of Epidemics	• Improving community and primary health care systems for (a) prevention (b) early detection (c) early intervention (d) early prevention of morbidity and mortality because of epidemics
5.	Health problems of poor people	• Participatory studies of major health problems of rural and urban poor people • Participatory plans at local, district and state levels to overcome these health problems of poor people.
6.	Capacity building	• Assisting in identifying capacity building needs and training packages for the DHA officials and Hospital managers to enable them to perform their new role effectively. • Assisting identifying capacity building needs and designing training packages for the PRIs, starting from the Gram Sabha level as well ULBs to make devolution of powers to control government health institutions and services effective. • Assisting in building capacities to utilise existing funds, draw budgets and plan interventions.

o.	Area of Reform	Role of SHRC (in collaboration with AAI)
		• Assisting in building capacities to develop accountable community mechanisms, like social audits to effectively manage and monitor the local health department.
7.	Rational Drug Use Policy	• Develop a rational drug use Policy for the state • Monitor the implementation of the rational drug use policy • Establish transparent systems for community monitoring of the implementation of this rational drug use policy.
8.	Improving internal systems of the Department of Public Health	• Identifying internal systems which need reform • Proposing changes for identified areas of reform
9.	Workforce management and transfer policy	• Assisting in the development of a workforce management policy which is clear and transparent.
10.	Drug distribution and logistics	• Assisting in identifying bottlenecks in the distribution and supply of drugs • Conduct a feasibility study to set up a parastatal organisation for the distribution and logistics of drug supply across the state • Based on the recommendations of the study, suggest policy norms and guidelines to further extend the reach of the state drug distribution network • Monitor the implementation of the new drug distribution norms.
11	Uniform Treatment Clinical Protocols	• Recommend standardised clinical protocols across the state at the primary, secondary and tertiary level.
12	Management Information System	• Assisting GOC in designing comprehensive computerised Management Information System for the Health Department from the Mitanin upto the district level • Assisting GOC in the user need analysis as well define outputs expected from the MIS across all levels • Assisting GOC in the process flow analysis of the Department • Assisting GOC in feasibility of hardware platforms and software across all levels of users within the health department • Assisting GOC in the development of atleast two web-sites – one for the Mitanin programme and one for the health department of the GOC
13	Decentralised Laboratory Services	• Assisting in developing low cost diagnostic tools and systems for decentralising laboratory services to the primary care level • Assisting in developing training packages for 'barefoot laboratory assistants' across the state
	Mainstreaming	• Studying feasibility of integrating some aspects of traditionally

o.	Area of Reform	Role of SHRC (in collaboration with AAI)
14.	of Indian Systems of Medicine esp. tribal medicines into the state health system	practised tribal medicine in Chhattisgarh
15.	Drug resistance in malaria	• Studying extent of drug resistance (to cholroquine) in selected areas of Chhattisgarh • Focussing on the incidence and prevalence of forest-fringe malaria in Chhattisgarh and recommend comprehensive treatment protocols for malaria

Source: GOC, SHRC 2003 Mitanin Programme: Conceptual Issues and Operational Guidelines, Working Papers 2. State Health Resource Centre (SHRC). Raipur.