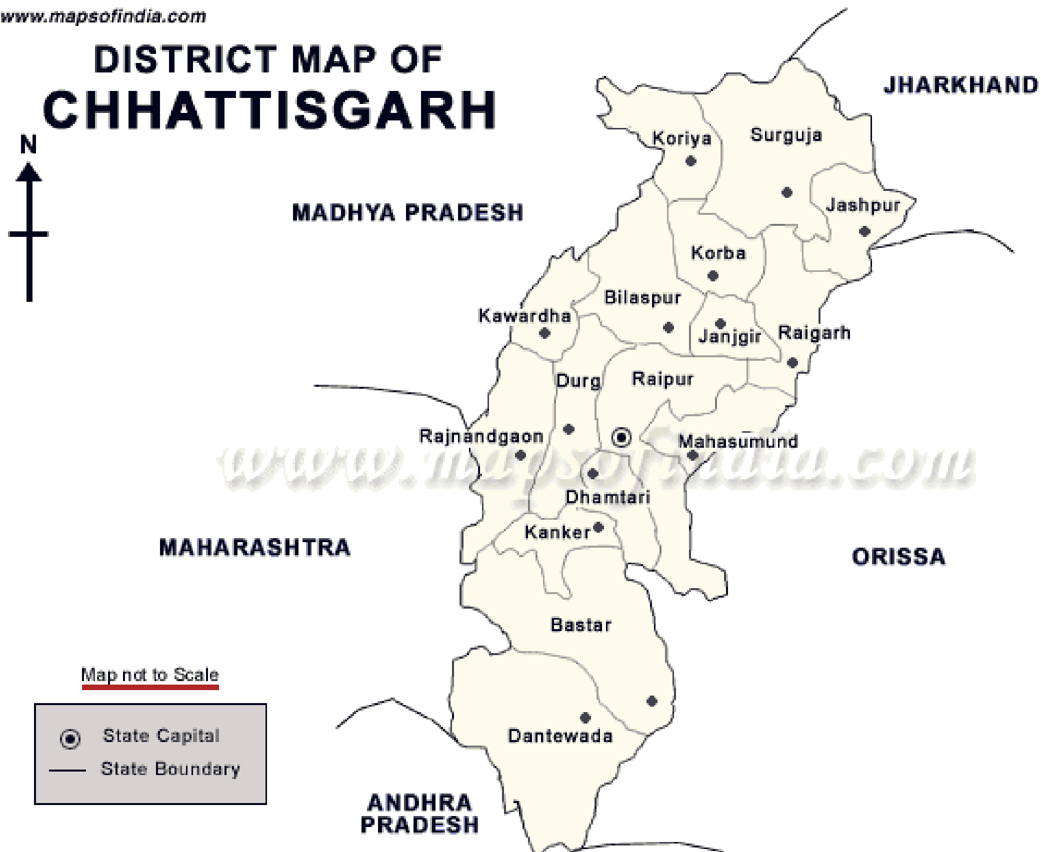
# The Mitanin Programme: the context, rationale and policy perspective

**The context:**

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




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

Chhattisgarh has approximately 34% Scheduled Tribe population, 12% Scheduled Caste population, and more than 50% Other Backward Classes. People are relatively poor. The State is rich in natural resources. It has large reserves of coal, and iron ore. It also has a lot of lime stone and Bauxite. Recently Diamond has been found in Chhattisgarh. Chhattisgarh has approximately 40% forest cover. The Literacy levels of Chhattisgarh are quite high. Health Statistics are on the other hand, still poor. Some important figures from the 2001 Census are given below: -

| Indicator | India | Chhattisgarh |
|---|---|---|
| Population | 102.70 | 2.07 |
| Decadal Growth Rate | 21.34 | 18.06 |
| Sex Ratio | 933 | 990 |
| Literacy Rate | 65.38 | 65.18 |
| Female Literacy Rate | 54.16 | 52.40 |

Some other important Health Indicators are given below: -

| INDICATOR | INDIA | CHHATTISGARH |
|---|---|---|
| Population | 98.13 | 2.06 |
| HDI | 45 | 39 |
| Sex Ratio (1991) | 927 | 985 |
| Crude Birth Rate (SRS 2003) | 25.4 | 26.3 |
| Crude Death Rate (SRS 2003) | 8.4 | 8.8 |
| Total Fertility Rate (1997) | 3.3 | 3.6 |
| IMR (SRS 2003) | 66 | 76 |
| Couple Protection Rate by Sterilization %) | 30.2 | 29.5 |
| Adult Literacy Rate (age 15-34) | | |
| Total | 56.86 | 46.62 |
| Male | 69.56 | 64.13 |
| Female | 43.48 | 29.14 |
| Scheduled Caste Population (%) 1991 | 16.73 | 12.2 |
| Scheduled Tribe Population (%) 1991 | 7.95 | 32.46 |
| Urban Population (%)1991 | 25.7 | 17.4 |
| Percentage of Married Women in 15-19 age group (1991) | 35.3 | 41.89 |
| Proportion of Women in Work Force (1991) | 22.3 | 40.99 |
| Proportion of Farm Labor in work force (1991) | 26.1 | 23.06 |
| Houses with Electrification (%) 1991 | 42.4 | 31.67 |
| Houses with Safe Drinking Water (%) 1991 | 62.3 | 51.1 |

| Villages connected with mettle roads (%) 1991 | 36.96 | 20.84 |
| --- | --- | --- |

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

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

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

Being a new State we have no infrastructure in many fields. There is no drug-testing laboratory in Chhattisgarh. Medicines can therefore not be tested in the State. Similarly there is no facility to test food adulteration in the State. There is no institute to train health workers in the State. A good system to collect health statistics also does not exist

in the State. A good Information, Education, and Communication machinery is need to ensure community participation in health. It is simply lacking in the State.

## Needs of Primary Health

At present Health Services are focused on cure of diseases. Enough attention is not paid to promotion of health, and prevention of diseases. Though a big system of Primary Health, having Sub Health Centers, Primary Health Centers, and Community Health Centers, has been created, during the last few years, yet this system is not able to work according to expectations. It is necessary to improve this system. The following needs to be done for this: -

1. Make a system of Public Health based on the community, in which people should be able to solve their day-to-day health problems themselves with the help of local doctors. The help of many Non-government organizations existing in the state and the Private Sector should be taken for this.
2. In order to empower communities for Public Health it is necessary to develop an understanding of Public Health among the social workers, and communities, and develop capacity to solve ordinary health problems at local level. Training of voluntary workers, and people working in social sectors will have to be organized for this. This will have to be done on a large scale, and the efforts of voluntary workers will have to be integrated with governmental efforts.
3. A good referral system will have to be developed for such decentralization of Health services, so that people know clearly where they have to go for solution of problems, which they cannot solve at local levels.
4. Full assistance of Local Government institutions should be taken for the decentralization of Health Services. There is a very developed and capable system of Panchayati Raj institutions and Urban Local Bodies in Chhattisgarh. These institutions have been given full responsibility for Public Health by law. It is necessary that these institutions are trained to make their full use in the health sector, and adequate powers are delegated to them.
5. While planning for expansion of health services it is necessary to keep in mind the rights of the disadvantages classes. Many studies have shown that the poor are not able to take advantage of the schemes, which the government has made for the poor. Therefore we must ensure during the planning process itself that the benefits of the scheme go to the target group. New strategies, making use of the private sector will have to be examined for this.
6. Our programmes should help innovations, and provide full opportunities to new ideas.
7. Training of people working in the government system will also be necessary, so that they are able to work in partnership with Local Government institutions, Non-government organizations, and Private sector for empowerment of people to benefit the disadvantaged classes.
8. There is a big challenge to bring the doctors of Indian Systems of Medicine, and other systems of Medicine in the mainstream of Public Health. People in villages

often times have great faith on these systems of Medicine. These systems of Medicine have sufficient human resources too. It is necessary to plan for their maximum development, and maximum use in Public Health.

## ***"Mitanin"*: The Community Health Worker Scheme**

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

1. To some persons the meaning of community participation is wholehearted acceptance of Government schemes by the people. They feel Government knows what is best for the people, and therefore makes the policies and programmes, which are best suited for their good. If people do not benefit from such programmes it is their own fault, as they do not participate fully in Government schemes.
2. Some people feel that community participation means demand generation for the services provided by the Government. If this view is accepted it will mean that though all services are readily available to the people, they do not make use of these services, as they do not know what is good for them. Government should therefore launch Information, Education, and Communication (IEC) programmes, so that people understand the importance of using the services. According to this view also the blame rests squarely at the people for not using services.
3. Still other people feel that the community can participate in Government programmes in service delivery as well. These people acknowledge that the service delivery mechanism of the Government may not be foolproof, and therefore people may not have access to services. They thus feel that Community can help the Government in service delivery. The concept of depot holders of simple medicines, and contraceptives is such a concept. Most planners in Government now realize that the outreach of Government staff is limited. They also accept that increase in the numbers of Government employees to increase the outreach to all the habitations is not cost effective. The decision of the Planning Commission of India to freeze the number of Sub-Health-Centers at the 1991 population level is the result of such realization and a very real resource crunch. Still these people do not really accept the ability of communities to plan and work for their own good. They do not believe in the "Empowerment Approach"
4. There is a very small group of people who has faith in the ability and the power o the communities to shape their own destiny. This group of people feels that community participation should mean empowering the community to plan and work for their development. They feel that Government should help the community in making their own village health plan, and implement it. This should however not become an excuse for withdrawal of the Government, but should the lead to a more meaningful partnership between the Government and the Community. "Right to Health" is an inalienable right of the people, and it is the duty of the Government not only to make all the services available to the people,

but also empower the communities so that they can demand, and get what is due to them.

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

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

**1. <u>Responsibilities of the Community and Panchayat:</u>**

**1.1.** Publicity of the scheme in the communities.

**1.2.** Mobilizing the communities for Health.

**1.3.** Helping the communities to identify one *"Mitanin"* for each habitation.

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

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

Some suggestions for the compensation package are: -

The community may pay the *Mitanin* directly a fixed amount, either in cash or in kind (in the form of grain). This can be monthly or yearly. Payment to be made in kind every year at harvest time.

The Panchayat may decide to pay the *Mitanin* something from their funds.

The community may decide to pay the *MItanin* a certain amount either in cash or kind for services rendered as user fee.

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

Cash contribution by each family to be paid to the "Mitanin" every week/month/year or cash fee at predetermined rates for services to the individual families.

Any other method of compensation, which the community and the "Mitanin" agree upon.

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

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

2. **Guarantees by the Government:**

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

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

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

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

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

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

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

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

1. Action Aid India was identified as a strategic partner NGO for the scheme, and the State Government entered into an agreement with Action Aid India for this purpose.
2. A dedicated core team of professionals was developed at the State level for the implementation of this scheme. This team is called the State Health Resource Center (SHRC). The personnel for this core team have been drawn from NGOs working in the field of Health from all over the country.

3. Training modules for the *Mitanin* were developed. The modules are in many parts. There is an inception training, which is given to every newly recruited *Mitanin*, and then other training capsules, which are administered at the Primary health center or training institutions at regular intervals, as the *Mitanin* starts her work. The training module is in Hindi, and has been made keeping in mind that the trainee is a neo-literate. The module has lots of practical exercises, and field work. Difficult concepts should are explained with examples from the local environment. The training has a provision of being run at the pace of the learner, and takes into consideration different learning styles, and different learning capacity of different people. The training module has detailed and clear cut instructions for the trainers. Good quality and appropriate teaching-learning material is being developed.
4. Development of a training package of training of trainers (TOT).
5. Training of trainers.
6. Publicity of the scheme, and training of Panchayati Raj representatives.
7. Community Mobilization.
8. Identification of *Mitanins.* More than 20000 *Mitanins* have already been identified, and have undergone the first phase of training.
9. The continuing training of the *Mitanin* and her integration with the Health Delivery System is an ongoing activity in all the *Mitanin* blocks.
10. Certain activities which are important for the programme include Training of PHC doctors and training of MPW (M) and ANM. These activities should be started soon.

**Role of "Mitanin"**

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

1. She will give health education to the community of the habitation.
2. She will take on the leadership role in all Public Health activities of the village, and will encourage community service for public health specially in -
    a. Cleanliness of the village.
    b. Ensuring safety of drinking water.

c. Making a parapet wall on all wells and covering all wells.
d. Making soak pits and proper drainage system in villages.
e. Teaching proper drinking water storage practices to the people.
f. Encouraging people to make and use sanitary latrines.
g. Taking care of the health of women and children specially promoting good health practices by -
    i. Teaching good nutrition practices.
    ii. Teaching good breast feeding and weaning practices.
    iii. Taking care of iron and iodine deficiency by propagating the use of iron folic acid pills, and iodized salt.
    iv. Propagating the use of iron and Vitamin A rich foods, and giving supplementary Vitamin A to children.
    v. Ensure regular weighing of children to monitor growth and development.
    vi. Ensure at least 3 Ante natal checkups for all pregnant women.
    vii. Ensure that all deliveries are institutional deliveries.
    viii. Ensure 100% registration of births, death, marriages, and pregnancies.
    ix. Provide consultation on MTP services.
    x. Provide consultation on Family Planning services, and ensure regular supplies of contraceptives.
    xi. Help women in reproductive health.
    xii. Provide counseling to youth on matter related to adolescence, puberty and sexuality, with special reference to STD, and HIV AIDS.
    xiii. Important health education inputs on diseases like Malaria, Leprosy, Tuberculosis, Diarrhoea and Dysentery.
    xiv. Be a link between the Government Health system, and the community for all National Health Programmes.
    xv. Provide Health Education for other important things.

3. She will provide first aid, and over the counter (OTC) drugs for minor ailments.
4. She will be trained in taking care of common illnesses in the village, and will gradually take on the responsibility for treating these diseases in the village. This will be done gradually during the refresher training organized every fortnight in the sector hospitals. The emphasis in these trainings will be on skill development. The "Mitanin" will be allowed to treat diseases only when she has attained the required proficiency levels in both knowledge and skills. She will be examined periodically, and given certificates of proficiency. The important thing in deciding whether she should be allowed to treat a disease is the confidence, which she has in her own ability, and the confidence, which the sector health team has in her ability. A detailed system of examination, and certification will be worked out.
5. She will be given the knowledge to refer all cases beyond her competence to the proper place where they can receive proper health care.
6. **Relationship with the ANM and other Health Staff: -** The ANM and other health staff will look at her as the most important asset in the habitation through which they can reach out to the community. The "Mitanin" will look at the ANM

as her chief source of knowledge and strength. The two will not be competitors but will complement each other. Essentially the interrelationship of the "Mitanin" and the ANM or other sector health staff will be positive fulfilling, rewarding, friendly and supportive.

a. **The ANM will do the following for the "Mitanin"** -
   i. Train the "Mitanin" in the fortnightly refresher training courses.
   ii. Teach skills to her by making her do things under supervision.
   iii. Conduct examinations at frequent intervals for certification.
   iv. Be the main link between the "Mitanin" and the health system.
   v. Provide support to her in all difficult situations.
   vi. Build confidence of the "Mitanin" in taking care of the village community.
   vii. Be the chief spokesperson of all the "Mitanins" in her area to the government system.
   viii. Ensure supplies of health education material, essential drugs, record keeping material, contraceptives, etc.
   ix. Counsel the "Mitanin" in her work specially in unforeseen situations.
   x. Provide legitimacy to the health related work of the "Mitanin" in the community.
   xi. Help the "Mitanin" in all referrals.

b. **The "Mitanin" will do the following for the ANM -**
   i. Provide support to her in the community of the habitation for all Public Health work.
   ii. Provide her basic data about the community of the habitation.
   iii. Help her in the registration of marriages, pregnancies, births and deaths.
   iv. Determine the contraceptive preferences of the community and help the ANM in the CNAA strategy of family planning.
   v. Be the main source of information about the community of the habitation.
   vi. Create an environment in favor of positive health in the community.
   vii. Help the ANM in staying in the village, and organizing camps and other health related activities.
   viii. Provide legitimacy to the Public Health work of the ANM in the community.
   ix. Help the ANM in surveillance of important diseases.
   x. Help the ANM in organizing relief, and in the prevention of epidemics.
   xi. Help the ANM in all health related campaigns.

7. **Relationship with PRIs -** "Mitanins" will work in close association with PRIs. The selection of "Mitanins", and the agreement between the "Mitannin" and the community of the habitation will be approved by the Gram Sabha". Public Health is an important function of PRIs under the 73rd Constitution amendment. At present the PRIs do not have any mechanism of performing this important

function. With the introduction of the "Mitanin" scheme the PRIs will be able to discharge their duties easily. Civil society, and a free press are important pillars of a democracy. These two do not really exist in a village. The "Mitanin" can perform the functions of both "organized civil society", and a "free press" in a village to provide succor to and sustain democracy at the Village Panchayat level. She will be in constant dialogue with the people of the village on all important issues, and therefore she is competent to be the voice of the civil society. Similarly she will the main source of transmitting information about development schemes, and work of the Panchayat, and government to the people. In this manner she is similar to the free press.

a. **Panchayats will do the following for the "Mitanin" -**
    i. Gram Sabha will approve the selection of "Mitanin", and also the agreement between the "Mitanin" and the community of the habitation.
    ii. Panchayats will ensure that the community of the habitation honour their side of the agreement.
    iii. Panchayats may decide to pay the "Mitanin" something for the services they render.
    iv. Panchayats will help in the irrigation of the "Mitanin land" if provided by the community of the habitation or the collector.
    v. Panchayats will monitor the work of the "Mitanin", and if they find that the "Mitanin" has not performed her duties well, the Panchayat may remove her, and ask the community of the habitation to select a new "Mitanin".
    vi. Panchayats will ensure that the "Mitanins" get good training, and get regular supplies of publicity material, contraceptives, essential drugs, and other things.
    vii. Panchayats may use the "Mitanin" in the implementation and monitoring of other welfare, and community empowerment schemes.

b. **"Mitanin" will do the following for PRIs -**
    i. She will send regular reports to the Panchayat about the health status of the community.
    ii. She will attend meetings of the Panchayat whenever she is asked to do so by the Panchayat, and will give all information about the health status of the habitation, which is necessary for the Panchayat to make informed decisions about the programmes, and schemes being run in the habitation.
    iii. She will help the Panchayat to implement, and monitor such other welfare schemes, and community empowerment schemes, as the Panchayat may require her to.
    iv. She will follow all lawful instructions of the Panchayats.

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

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

**Selection of "Mitanins"**

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

The selection process follows the following steps: -

1. A series of workshops and sensitization meetings were held at the state level and district level to orient the representatives of PRIs and key officials and convince them about the scheme. PRI representatives not only understood the full import of the scheme, but are also committed to its success.
2. A team of facilitators was then selected and trained to sensitize the community in each habitation, and help the community in the selection of the "Mitanin". One team of facilitators was trained for each block. It was ensured that facilitators know the local language well, understand the local culture, have positive social attitudes, and faith in the inherent strength of communities, are good communicators, know how to work with groups and are willing to live in villages with the villagers, and make night halts in villages. Some examples of persons selected as facilitators are: -
    i. CDPO or Supervisor of ICDS.
    ii. ANM or LHV.
    iii. Village level workers of various government departments.
    iv. Panches.
    v. Members of Didi Banks (Credit and thrift groups of women)
    vi. Members of Zila Saksharta Samitis.
    vii. Members of Watershed committees or JFM comittees.
    viii. NGO workers.
3. The facilitator then visited the selected habitation as many times as necessary. Often they made night halts in the habitation. They spent time with the community, so that the community feels that they have become one with them, and freely share their joys and concerns. This is a rather prolonged process, and should not be hastened.
4. Once the facilitator has the confidence of the village community, the subject of the "Mitanin" scheme is discussed with them. The concept is explained in detail. The facilitator then discusses the possible choices, and the pros and cons of

choosing various prospective women as "Mitanins" These discussions are held in an informal environment. The facilitator tries to develop consensus amongst the members of the community on the choice of the "Mitanin". The facilitator also discusses with the prospective "Mitanins" the things, which the job entails, and the responsibilities, which they will have to undertake.

5. Once the facilitator is convinced that a consensus is emerging on the choice of "Mitanin", the facilitator calls a meeting of the community of the habitation to make a formal choice. In this meeting the voluntary nature of this work and the possible different ways of the community compensating the "Mitanin" for her services are also discussed freely.
6. A number of village level activities, which are mobilisational in nature, are carried out. Of this the use of the kalajatha for spreading the spirit of the programme and enthusing the people to participate in this programme is one major step. There can be other major publicity and mobilisational activities like wall writings, posters, meetings, cultural events etc to build interest in the programme.
7. Once this stage has been reached, a formal meeting of the Gram Sabha may be called, and the agreement approved by the "Gram Sabha". The sarpanch of the Panchayat will then endorse the agreement, and then send a request to the Block programme team to train the "Mitanin"

## Training of "Mitanins"

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

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

1. Attitudes: **-** The training is designed to bring in positive attitudes in the "Mitanin" about the power of people, empowerment of women, the strength of community work etc.
2. Knowledge: **-** She is given knowledge about basic concepts in Public Health, various Government schemes, and programmes, National Health Programmes, Signs and Symptoms of common diseases, etc.
3. Skills: **-** Skills relating to communication, management, group behavior etc. will be developed during the course of the training. Skills relating to disease treatment are also developed.

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

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

The specific skills she would be trained in include: -

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

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

**In conclusion:**

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