

Building on the Past: The Mitanin Programme's Approach to Community Health Action

Introduction:

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

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

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

1. Women as Health workers:

One fundamental shift in the Mitanin programme from its immediate local predecessor – the Jan Swasthya Rakshak programme is the choice of all health workers as women. This is by no means however a new shift in the world of community health action and many programmes in the voluntary sector have always made this choice. The reasons are many and well known. Women reach out to women on health issues much better and easier than men do. And for the focus of health intervention to remain on women and child the need to recruit women as programme implementers cannot be overstated. Women perceive health care as a major priority for social action. Culturally the health of the children and the men in the household are the women's responsibility. When children fall sick even in educated families where both are employed, women would stay back to care for them much more often than men. When women fall sick other women in the household – the daughter-in-law or the daughter are more likely to nurse them, than the men. Indeed the problem with such cultural orientation is often that too low a value is set on the woman's own health care needs- that becoming secondary to all other caring roles. This cultural conditioning however makes it easy for women to perceive health care as a priority area for necessary intervention. Studies on women in elected panchayats also bear this out.

To this we may add one more reason that underlies this choice of women as CHWs. There is a lesser trend for women CHWs to settle down as quacks than men. This trend is

not well documented enough. The experience of the male CHW settling down into quackery is often from a number of major design flaws in the programme- and their being men is only part of it. Yet the trend is unmistakable, and in a context of limited employment opportunity and an almost completely unregulated private sector, not surprising.

Equally important in the Mitanin programme design is the choice of trainers/ facilitators as women. Being aware that the higher order of capabilities and mobility needed in training roles may not be readily available in every area the programme starts with facilitators in the selection phase who can be of either gender. These are often men. Then when the programme after three to six months transits to the Mitanin training and support stage, the programme reselects the facilitators this time insisting on almost all trainers being women- with some flexibility to accommodate the most effective men of the earlier period. This as a consequence means more investment into trainer training and a slower rate of programme picking up optimal effectiveness levels. However these are not adverse consequences – they have their advantages. The effect of the local leadership becoming feminized is a significant contribution towards the goal of the women's empowerment.

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

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

2. The Selection Process:

One of the key issues in Community Health Worker programmes has been the selection of the health worker. One general principle emerges that since the purpose of such a programme is to reach the unreached as effectively as possible, persons who are selected as community health workers must be sensitive and have empathy with the poorest and the most marginalized, if not be someone drawn from their own ranks. Another equally important principle is that if it is indeed community action then such a person must be owned by the community as acting on its behalf- not at the behest of the government , much less a philanthropic institution or funding agency. Of course both these principles flow from a perception of health worker as part of a social process for empowerment- for social and economic justice. There are philanthropic initiatives which see health care as

charity or benevolence for whom such criteria would not be necessary. But as the ActionAid motto goes: what is needed in the world is not charity it is justice. If we accept this premise then the best way of attaining these values is when the facilitating organisation has a close tradition in working with the community for securing the rights of the poor. And the longer their presence and the deeper their work the more likely they are to make the right choice. Indeed Organisations like CEHAT would call for a prolonged contact on rights based work over one to two years before the process of health worker selection is initiated. There is really no other certain way of knowing that a selection is correct.

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

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

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

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

- **The trained facilitator:**

The village must make the choice. This is critical. And this must be made in a general body of the village or at least a meeting with good attendance. But for the village to make a correct choice it must be well informed about the programme and be able to clarify what is expected of the village and of the Mitanin. A trained facilitator undertakes this task. An even more important task of the facilitator is to ensure that all the sections(stakeholders in current parlance)in the village are informed and discussed with separately and that the views and needs of the weaker sections and the women are articulated and find place in the final decision. This requires that the facilitator can identify different points of view and negotiate between

them with a partisanship for the poorer amongst them. A five or six day training programme has been devised specifically to impart the necessary understanding and skills. Further the choice of the facilitator itself becomes a one or two month process with a small process for constitution of the district group who would choose the facilitators. A guidebook for this training and detailed guidelines on the selection process and evolution of careful indices for monitoring these processes form part of the strategy.

- **Hamlet as unit of programme:**

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

- **Social Mobilisation:**

The process of selection is not going to be effective unless there are many women who volunteer to take up this task and from whom based on criteria the most suited is selected. Even those women not selected as Mitantins would be involved in the women's committees. The process of selection is also not going to be effective if the village does not enthusiastically take part in the selection process thereby owning the programme as its own. But for this to happen one needs not only knowledge and motivation but also a certain additional factor – the collective will to action. The process of generating this is what has been termed social mobilisation. A charismatic leader or very respected proactive individual may elicit this but such a person is not available in most villages. Often a successful local developmental initiative or peoples movement has created the enthusiasm and the readiness to embrace such initiatives. In many villages in Chhattisgarh, women's credit cooperatives have played this role. But even these are too few to cover even a significant number of hamlets. Therefore in addition to other dimensions a social mobilisation campaign centred on the kalajatha is built into the selection phase. This role of the kalajatha is a lesson learned from the mass literacy campaigns of the nineties, which was spearheaded by kalajathas largely initiated and organised by the Bharat Gyan Vigyan Samiti. The kalajatha, a travelling troupe of artistes uses a carefully constructed set of plays and songs prepared by the best of playwrights and musicians of this genre and it uses the

local cultural idiom and art forms to convey the spirit of the programme and its objectives. In the rural context this is very effective – a way in which the message is easily internalised by its audience. Along with the meetings, the conventional forms of publicity and the group discussions before and after the kalajatha establish social mobilisation for this programme.

3. The role of curative care:

Another important point of departure from most other earlier community care programmes is the “supplementary- not central” role given to first contact curative care. Most earlier programmes run by NGOs believed, quite correctly, that though preventive care is more important than curative care, since curative care is a felt need and an urgent priority, intervention has to begin with curative care to win the support of the community. In practice the focus remained largely in providing prompt curative care. Interventions in preventive aspects have been moderate. These programmes were pathsetters in showing that with such first contact curative care delivered by CHWs considerable improvements in health indices, especially in infant mortality, could be demonstrated. This has been demonstrated now from all over the world- by a wide number of programmes. In India itself publicised papers from Jamkhed, the SEARCH programme of Ghadchiroli, the Mandwa Programme of FRCH, the RUHSA programme of Vellore and the SEWA rural programme of Bharuch -to name a few- have amply demonstrated this.

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

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

In such a setting of low access to quality care initiating the programme with curative care is to ask for the entire selection process and the community perception of the programme to be vitiated by this culture of irrational curative care. Especially when recruited through government functionaries in areas of limited community mobilisation, and when monitoring and support is so weak, the effect of initiating with curative care would be like an honorarium- the grant of the opportunity to establish oneself in this trade and thereby earn a livelihood becomes a privilege to be distributed as patronage. We must also keep in mind that there are in this state one year and three year courses in paramedicals and in alternative medicine playing precisely this role of generating livelihoods in curative care and therefore such a misinterpretation of the Mitandin's role would be natural.

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

The Mitandin programme does recognise the need for rational curative care but to surmount the above problems it is so designed that all the preventive care components are introduced and deployed before the curative care training is delivered. Thus the Mitandin is already established in an active preventive and promotive role in most villages as of today and curative care has not been introduced yet. This would never really happen given the prevailing perception of health care if she began with a curative role.

Designing a vibrant preventive role whose effects can be seen and demonstrated is also essential to this strategy and this has been achieved by the programme in the area of child health, women's health and in communicable disease control.

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

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

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

4. Honorarium – to give or not to give

Most community health worker programmes provide for an honorarium. Most NGO led community health worker programmes upto the eighties always had a modest honorarium for its CHWs. So had govt programmes. The original CHW programme planned for Rs 600 a year (in the late seventies) and the JSR programme gave a training stipend of about Rs 3000 for six months. Recent versions of the CHW programme run by NGOs propose that drugs can be provided to CHWs who can sell these with a small mark up to provide her with some compensation. The JSR programme on the other hand implicitly encouraged services provided to be charged fees to provide remuneration for their work. But as we described earlier in today's unregulated private sector and dominating culture of irrational medicine it led rapidly into the worst forms of quackery. Yet the question remains- Can a programme be run without compensating the Mitani for her work? And close on its heels is another question- Is it fair to do so, even if we can do so? Indeed the non-provision of a honorarium in the Mitani programme is one of the most contentious issues of the whole programme design. The Mitani programme does not provide for any honorarium whatsoever. After the first year there is an understanding that for each day of training a livelihood compensation loss of Rs 50 per day, or Rs 100 for two days of training every month shall be paid- but nothing beyond that. Her participation has to be sustained only by motivation and support. The main reasons advanced in favour of payment are the need to compensate for loss of livelihood and the concern that one cannot secure participation of women without it. There is also the concern that even if we secure participation initially we cannot sustain participation without the monetary incentive and it is difficult to retrain every time there is a drop out. There is also the reasoning that when everyone else in the health system is paid it would be unfair and discriminatory not to pay this woman- the poorest in the chain- for her services.

The considerations behind the Mitani programme design that does not provide for any honorarium for the Mitani are many.

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

The greater concern and reason for not paying compensation is that while the amounts considered are too meagre to amount to a livelihood, the payment would make the entire burden of work solely her task and the community would fall back. From an organiser of women and the community, from being seen as representative of community monitoring the health services on their behalf, -paying her would make her the lowest paid employee of the department – with all its attendant consequences. This perhaps accounts for the greatest disquiet within the health department about the non- payment. For very often the very persons most vocal within the department about non payment could be equally

reluctant about parting with travelling allowance for the woman to come to the training camp, or spending the full amount provided in the budget for the food expenses, which on the other hand is very much provided for and her due.

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

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

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

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

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5. Training and Support to the Mitanin:

The most important lesson for any CHW programme from all the past examples of NGO success stories, a lesson somehow not adequately noticed by government programmes, is the need for continuous training and support. Even NGO advocacy of CHW programmes often fails to bring enough emphasis to bear on this most central message of their own experience. Every single NGO led community health action that has been successful has had a dedicated and motivated leadership *constantly engaged in training and in regular contact and support of its workforce*. The NGO programme leadership meets with the workers regularly, troubleshoots their problems, constantly updates their knowledge and keeps their motivation alive- making timely replacements with retraining, wherever gaps occur. It is axiomatic in the NGO world that if we are not having regular meeting of the health workers and not regularly visiting them the programme would fail- invariably.

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

The Mitanin programme has learnt from these lessons. Its training strategy envisages 20 days of camp based training and 30 days of on-the-job training. Training is staggered over a year and the maximum training at any given time is 4 or 5 days— usually two or three days. This way one does not have to withdraw the Mitanin from the community or her family or her livelihood for any long period of time. In each round of training one aspect of health care is introduced. Then she starts working in her hamlet on that aspect. A trainer visits her and helps her initiate work on that aspect reinforcing training on the job and building up her confidence to do so. When she gains confidence in this aspect the next round of training occurs and she learns the next aspect and again she goes back and with on the job support masters that aspect and starts working on it.

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

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

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

Almost 80% of the project budget goes to this training and support aspect alone.

6. Mitanin programme as health sector reform:

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

Many NGO programmes here and world wide were based on the premise that as the public health system is not working, at least in so far as reaching the poor was concerned- a more effective way of reaching the poor was needed. No synergy with the public health system was considered – giving up the latter as a lost cause. And curiously there was often a considerable agreement on this between radical proponents of health rights approach and in those whose work was an extension of philanthropy. Often such CHW programmes had their own referral centre. Only a few amongst them sought synergy with the public health system. In the era of globalisation and an ideologically

driven retreat of the state, this lessened role for the government in health care provision became even more attractive and public policy increasingly talked of handing over areas and programmes to the NGO sector- not as part of a planned way to increase effectiveness but as a shift in responsibility and as giving up on a more proactive government role. In particular the cost effectiveness of the CHW programmes as compared to conventional public health systems seemed to find favour with international funding agencies.

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

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

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

While one is convinced that by health education inputs and first contact curative care substantial improvements in health status can be gained, the Mitandin programme recognises that considerable areas of intervention depend on the availability and accessibility of good quality health services, that cannot be substituted for by community action. To do so would be only an unethical attempt to use community health worker programmes to transfer the blame of ill-health back on to the community. In contrast access to such services, in an affordable way for the poor, is a basic human right and the health worker programme must move towards such a goal and not become a substitute for such movement.

Even within the logic of CHW as mere extension worker, a poor quality of public health system dooms the programme. Thus the health workers are persuaded to make blood smears and send them . If they stop, it is usually not for want of payment or skills, but

because they never get back any reports in time. Similarly antenatal check ups can be improved. But if there is nowhere to send a complicated case to for a Cesarean section, then the motivation to detect high risk cases early becomes that much weaker. Of all the likely causes of programme failure the one least explored in discussions and yet most likely to be the cause is the failure of the system itself.

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

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

7. State – Civil society partnership:

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

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

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

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

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

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

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

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

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

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

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

The seven conditions for success:

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