Evaluation of Mitanin Programme in Chhattisgarh, India

Conducted by

Tata Institute of Social Sciences, Mumbai

Sponsored by

Department of Health and Family Welfare, Chhattisgarh
European Commission State Partnership Program

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Mitanins – The Frontline Workers

I alone cannot change the world, but I can cast a stone across the waters to create many ripples.

Mother Teresa

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Preface

The global health and development community has long recognised the importance of community health workers (CHWs) as critical human resources in health systems especially in developing countries. In order to meet the basic and immediate health care needs of the masses and to achieve universal health coverage (UHC) integrating CHWs into the existing health systems is imperative.

The newly formed state of Chhattisgarh in India was challenged with poor child and maternal health indicators especially in the underdeveloped tribal districts. The CHWs referred to as Mitanins in the state had since their induction improved health indicators in the tribal belts of the state. The research was designed to explore the role, responsibilities, needs and expectations and performance of the Mitanins. This is however not the first attempt to evaluate the functioning of the Mitanins in Chhattisgarh. The earlier evaluation studies undertaken separately in 2005 and 2011 indicated that the Mitanins were significant players in addressing the community health needs. These concurrent evaluations initiated and sanctioned by the government are indicative of their willingness and the sincere efforts to improve the existing programme. This evaluation study on Mitanin programme has been an enriching journey which has unravelled the perceptions and experiences of Mitanins. The findings are indicative of the level of their involvement, needs, expectations, challenges and scope of their current work that provided a deeper insight over how state could engage in the process of crucial policy decisions.

A participatory approach of engaging the local Mitanins from the marginalized communities in the health care delivery is truly a participatory model that improves the health outcomes in the community that is indeed encouraging, but certainly not easy. It takes unfathomable efforts to train, deploy and retain a single health worker especially in context of developing nations where compensations are not at par with the quality of service expected. But the programme is based on the principles of volunteerism and selfless service towards one's own community and the nation. Hence in spirit an aim to achieve the generous self actualisation goal of the community health workers adds further challenge to explore scope for nurturing altruistic values.

This report reiterates the importance of Mitanins and recommends altering some structures in order to enable the state to prepare their frontline health workers as one who are offering primary health care and strengthening the most grassroots health care system in rural India.

Dr. Shankar Das
Principal Investigator (PI)

Acknowledgement

The completion of working on this research project has been a long and arduous journey; nonetheless, the experience of researching through direct contacts with Mitanins, Anganwadi Workers, Auxiliary Nurse Midwives, Household respondents and Chhattisgarh State Health machineries including the various CMOs, DHOs, BMOs, DPMs and BPMs for providing vital insight into the Mitanin Programme had been more than rewarding.

The researchers would like to thank the Department Health and Family Planning, Government of Chhattisgarh for entrusting them with this important piece of research and for providing financial support. We would like to acknowledge with much appreciation the important role played by Dr. Kamalpreet Singh, Director, State Health Services and Dr. Kamlesh Jain, State Nodal Officer, European State Programme Partnership, they helped in providing all required support to complete the research project. We are highly obliged to Dr. Prabir Chatterjee (Executive Director, State Health Resource Centre), Mr. Samir Garg (SHRC Senior Programme Coordinator) and Mr. J.P. Mishra (Former Executive Director, State Health Resource Centre) for their assistance in providing all practical suggestions, sharing data, providing guidance in the entire process of work and invested their full effort to make this task successful.

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The entire research team comprising Dr. Siddhesh Talpade, Mr. Rakesh Prajapati and Ms. Ashwini Sambhare have given their best to this endeavour. Mr. Bhushan Lokmitra and Mr. Mangesh Jagdhane have also played an important role in contributing towards the project in adding contents and sharing their experience for outcome of this project.

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List of Abbreviation

ASHA	:	Accredited Social Health Activists
AYUSH	:	Ayurveda, Unani, Siddha and Homeopathy
ANM	:	Auxiliary Nurse Midwife
AWW	:	Anganwadi Worker
ANC	:	Antenatal Care
AIDS	:	Acquired Immunodeficiency Syndrome
BRP	:	Block Resource Person
BMO	:	Block Medical Officer
BPM	:	Block Programme Manager
CHW	:	Community Health Worker
CHV	:	Community Health Volunteer
CMHO	:	Chief Medical and Health Officer
CHC	:	Community Health Centers
CBOs	:	Community Based Organizations
DPT	:	Diphtheria, Pertussis, Tetanus
DRP	:	District Resource Person
DPM	:	District Programme Manager
EAG	:	Empowered Action Group
EUSPP	:	European Union State Partnership Programme
FHS	:	Family Health Survey
HIV	:	Human Immunodeficiency Virus
ICDS	:	Integrated Child Development Services
IMR	:	Infant Mortality Rate
LHW	:	Lady Health Worker
MCH	:	Mother and Child Health

MTP	:	Medical Termination of Pregnancy
MT	:	Mitanin Trainer
MMR	:	Maternal Mortality Rate
MOTT	:	Mobile Orientation and Training Team
NGO	:	Non-Governmental Organization
NHSRC	:	National Health Systems Resource Centre
NRHM	:	National Rural Health Mission
ORT	:	Oral Rehydration Therapy
ORS	:	Oral Rehydration Solution
PHC	:	Primary Health Center
PNC	:	Post Natal Care
PRI	:	Panchayati Raj Institution
PDS	:	Public Distribution System
RKS	:	Rogi Kalyan Samiti
SAC	:	State Advisory Committee
SPM	:	State Programme Manager
SHRC	:	State Health Resource Centre
TBAs	:	Traditional Birth Attendants
TB	:	Tuberculosis
VHW	:	Village Health Worker
VHG	:	Village Health Guide
VHND	:	Village Health and Nutrition Day
VHSNC	:	Village Health, Sanitation and Nutrition Committee

EXECUTIVE SUMMARY

The beginning of the millennium witnessed the initiation of the "Mitanin" programme by the state government of Chhattisgarh and the subsequent training of the newly inducted Mitanins by 2004. The programme treaded on the success trajectory with inputs from the external and internal evaluations in 2005 and 2011. The programme was improvised based on revised guidelines from NRHM in 2011 which recommended introduction of performance based incentives in areas of ANC, institutional deliveries, family planning measures and immunization. Another fruitful step towards community ownership was reforming the structure of the programme to include "Panchayat" in disbursement of the incentives. This structural change was in conjunction to the 73rd amendment of the Indian Constitution that requires the village level local self government to be an active part of the health and development. The Mitanin programme was a precursor to the ASHA programme under the National Rural Health Mission in 2005. While the contemporary Community Health Workers programme such as ASHA and Mitanin programme have become an indispensable part of health care delivery system, various critical concerns and challenges such as lack of clarity on roles and responsibilities, concerns over the working conditions and monetary benefits, adequacy of training and support system are influencing the effectiveness of the programme.

After a successful initiation and running of the programme for over a decade it was imperative to gain an insight into the roles and performance of the Mitanins, the grassroot workers for furthering the scope and quality of the programme. The previous evaluation studies undertaken separately in 2005 and 2011 suggested that the SHRC undertook to and succeeded in operationalzing a range of community led initiatives in health and most remarkably the Mitanin community health worker programme. The state government entrusted this crucial responsibility to the TISS, Mumbai for conducting external evaluation of the Mitanin Programme in relation to its performance. Thus the evaluation aimed to understand the perceptions and experiences about the "Roles and Performances" of Mitanins' in providing antenatal Care and other significant health care in the state of Chhattisgarh. The study was designed to encompass a multi-stakeholder perspective on the performance of the Mitanins which included the household beneficiaries and the co-workers of the Mitanins like the ANMs and AWWs, and various other key stakeholders. The study employed both qualitative and quantitative research approaches. The data and information was collected in two distinct phases; the preliminary stage concentrated on the review of pertinent literature on several community health worker initiatives at national and international level and the subsequent phase where primary data were collected through administering various research tools from Mitanins, ANMs, AWWs, and household beneficiaries.

The exploratory design of the evaluation research focused on the organization of the Mitanin services in the state of Chhattisgarh, recruitment and training of the Mitanins and the motivating factors influencing their entry into the programme. The broad set of key interacting variables in the context of roles and performance of Mitanin such as a) Mitanin Entry (recruitment, preparation, education/ training, planning, deployment); b) Enhancing Performance of Mitanin (supervision, career growth, compensation, (monetary/non-monetary); c) Attrition and Exit (drop-out, out-migration, resignation, career choice, health retirement); d) Mitanin Performance (Perception, experience, effectiveness/efficiency, productivity, availability, competence, responsiveness) were explored. In addition a detailed investigation was carried out about the communication and social mobilization (CSM) activities, maternal and child health activities by the Mitanins. Finally various compensation avenues, career development opportunities and reasons for attrition were also examined.

A triangulation of methods facilitated comprehensive understanding of perspectives and complete picture of the social reality. The qualitative methods encompassed semi-structured interviews, field observation, in-depth interviews, focus group discussions, review of documents and other materials and the quantitative methods comprised of structured interview schedules and standard inventories. The study aimed to focus on conducting comparative analysis of the variable with similar construct and characteristics, while variables with different backgrounds and features were analyzed for in-depth understanding of the programme. The study covered five representative divisions of Chhattisgarh state namely Bastar Division, Durg Division, Raipur Division, Bilaspur Division, Surguja Division. The following 15 districts both from the old and newly formed Districts were conveniently selected. The proposed sampling size of the study was 1200 Mitanin interviews, 1500 Households interviews, 500 interviews with Auxiliary Nurse and Midwives (ANMs), 500 interviews with Anganwadi Workers (AWWs), 20 each category in-depth interviews with Block Medical Officer, Block Programme Manager, Mitanin Trainer, Key personnel of NGOs, 15 each in-depth interview with District Programme Manager, District Resource Person (DRP), Members of Panchayati Raj Institutions, and 3 in-depth interviews with key personnel of the State Health Resource Center.

The socio-demographic variables of the study indicated the Mitanins largely hailed from the younger age group of 26 years to 35 years; most of them were married (94 per cent) and 97 per cent of them identified themselves as Hindus with middle level of school education. The Mitanins were recognized and selected through the local community consultation process. While a great majority of them belonged to the poor socio-economic strata of the same community. Most of the Mitanins were found to be active community health workers and had continually served the community for nearly 8-11 years. Largely the Mitanins belonged to their own hamlets which ensured their proximity, affinity to their local communities. It was reported that the Mitanins were selected by the popular consensus in the community meetings of the Gram Sabhas headed by the village heads of thePan-

chayat. It is also important to note that most Mitanins reported that their intrinsic motivation was the driving force behind their engagement in the community health services; further the emerging and critical health needs of their communities sustained their interest. However, their discussions and concerns regarding the financial incentives, regular monthly salary, travel reimbursements and economic adversity had dominated the substantial part of the discussion during the interviews. Most of the Minatins had expressed their concerns regarding the hardship that they undergo to procure the small amount of monthly incentives. In this connection many expressed it would therefore a welcomed initiative if the state launches a monthly payment scheme for the Mitanins. While exploring the views on various roles, responsibilities and tasks performed by the Mitanins, the most of the secondary respondents such as ANMs, AWWs, Household and Panchayat members reported that the Mitanin were mainly engaged in the health education and communication activities on pregnancy, nutrition, immunization to the pregnant women in the local communities, in addition they accompany the pregnant women to the health centres for delivery and visit respective home for newborn care. Though, most of the Mitanins identified and registered pregnant women for ANC and provided IFA tablets, however, their understanding of the risk factors in pregnant women, neonatal immunization for Polio and Hepatitis B at birth could have been better. On the other hand they effectively managed malnutrition and but showed relatively less understanding about the contraceptives and lacked promotion of family planning options among men and information about MTP services for those women who sought these services. The Mitanins were effective in community mobilization and generating community participations but needed help in maintaining systematic records and documentation.

Regarding the training status, it was found that maximum of the Mitanins had attended the training and had received the training materials. All the Mitanins shared that the infrastructure, residential facility, food served during the training programme needed greater improvement. Though the Mitanins found the training they received were quite useful, they reported a lack of practical inputs, supervision and demonstrations. Another challenge which they faced in their day-to-day functioning was sporadic refilling of drug kits resulting in scarcity of essential drugs which evokes a negative response from the community. The recording and documentation was found to be poor amongst the Mitanin, particularly updating drug kit stock register, records of immunization and other related records were not maintained satisfactorily.

While some of the Mitanin expressed greater significance and optimism in the programme in their personal life which built their personal capacity, has provided them confidence, meaningfulness and some amount of financial sustainability. A few of them even aspired to be a Mitanin trainer, many desired to have more responsible government job, several wished to join local politics and a many others wanted to save enough to ensure a decent life for themselves and better education for

their children. Maximum number of the respondents reported that the average time they spent on community health work was just 1 to 3 hours daily. A number of main perceptible changes brought by the Mitanin programme, as shared by ANMs, AWWs and other health care professionals include - increase in immunization, increase of mothers and children attendance in Village Health Meetings, increase access of public health facilities etc.

Some of the Mitanin reported that in the initial stages of their work in the tribal Padas they encountered phenomenal hardship when tribal groups were skeptical and frightened to get their children immunized. However, with the gradual and concerted work there is some change in the tribal community and mothers are asking about the immunization of their children. Several Mitanin believed that they earned trust and reputation of the people and managed to carve out a niche for her own. Many of them claimed that it is due to the Mitanin intervention that there is more number of rural women opting for institutional deliveries. In addition they are capable of early detection of common illnesses such as diarrhea and malaria, TB etc. and administer basic care.

A great majority of the respondents expressed that the programme has a definite scope of reaching a higher standard of community health care in the state provided there are reforms and improvements in areas of regular and refresher training, better and regular payment/incentives mechanisms, provision of essential medication and transport facilities. There is also a need to check the growing attrition rate among the Mitanin which could be prevented by providing psychosocial support from the supervisors. The job of a Mitanin is challenging and nature of their daily chore may require frequent reinforcement, close supervision, clarifications of doubts and imparting newer information on health issues.

There is a pressing need for mobilizing financial and human resources to the underperforming regions of the state to enhance political and administrative commitment towards the Mitanin programmes. It was also recommended that the supervisory and monitoring mechanisms must be enhanced for increased accountability from the PRIs to extend the needed support to the Mitanins including timely disbursement of the incentives. It is vital to relook at the financial requirements of the Mitanins and establish management systems to identify groups of better performing Mitanins and provide them fixed honorariums. Finally the priority should be managing constraints and bottlenecks in relation to the essential drug supply and incentive disbursement for the retention and effective performance of the Mitanins.

The Mitanins played a vital role in narrowing the gap between NRHM and the communities therefore it is important to keep the Mitanins motivated to function efficiently and address health, nutrition and sanitation issues and improve provision of proficient community services. The success of

NRHM relied on community engagement and community participation which plays a key role in addressing the issues of inequity and inequality among poor. Under the NRHM the huge community level human resources - Mitanin, ANMs, AWWs can be considered as a very important human capital investment. This report is an endeavour to present significant insights into the structural and operational mechanisms of Mitanin in the health care delivery system in the state of Chhattisgarh, the policymakers and programme managers may utilize the finding and recommendation for further improvement in the management and implementation of the state health services.

Over the decades, the intervention of community health workers in healthcare delivery has increasingly widened as they are inevitable to meet the universal healthcare provision and the millennium development goals. The rural women in the state of Chhattisgarh consider becoming a Mitanin as a good prospect to be empowered individually, socially and more importantly financially. In this context empowering rural women as Mitanins who do not have alternate job opportunities can be a replicable and sustainable model for community health care at a larger level. The programme had largely motivated and empowered the local women on community health based on internal locus of control and motivation. This implies that with appropriate recruitment, training and supervision the rural women can be organized for community health care delivery.

The inner motivation to gain social recognition, earn knowledge in the areas of health, a sense of social responsibility and self-efficacy motivated them to become Mitanin. On the other hand due to their poor socioeconomic circumstances it was also a prime concern of large section of Mitanin to be driven by the external reinforces such as a government job and a monthly income. The state healthcare delivery system improvements might further motivate and enable them to gain the community trust. The Mitanin management and administration needs amendments to ensure adequate supportive supervision, skill and knowledge enhancement and enabling working modalities and a rewarding working model for large and heterogeneous section of Mitanin those who hails from the poor socioeconomic strata of the society.

Originally the Mitanin programme was conceived with impressive vision of an innovative community health care model which considerably contributed to the health and development in the state of Chhattisgarh. Given the array of findings in various studies that contains both positive and negative observations of Mitanin programme; however programme is necessary for the health system in Chhattisgarh to further strengthen its foundation in the community. It certainly needs alterations by reinforcing and integrating strengthens and achievements that paved the way to good health, on the other hand correcting the drawbacks to increase its effectiveness and role. Without corrective measures at this crucial juncture the programme may lose further credibility despite the good impact it made so far. Generally most successful Community Health Programmes learn and mature

biologically from the practical experiences and the ground realities. Globally and nationally there is adequate literature about what works and what do not work. The case of Mitanin Programme in health sector of the state has grown organically and it should further develop more responsive to people's health needs.

Chapter 1

INTRODUCTION

Antenatal Care

Chapter 1
INTRODUCTION

Time and again the health policy researchers and planners had drawn the attention on human resources as one of the most essential ingredient for the successful health systems performance. It is often reported that there is growing human resource crisis, particularly in poor resource counties. In India the chronic shortage of well-trained health workers particularly most acutely felt in the inaccessible and remote rural areas that need them most.

In this context community health workers have emerged as promising catalysts to strengthen the public health systems. There is an increasing feasibility for successfully engaging community health workers tackle the shortage of health care workers, mostly in the developing countries. The concept of availing the community resources to provide for the primary health care is around six decades old. The primary health care evolution is full of innumerable experiences ranging from large-scale national programmes to small-scale, community-based initiatives. The ever changing socio-economic, demographic, community and epidemiological structures and health organizations worldwide demand renewed and revised community health worker programmes, which are assumed to be able to face the challenges produced by the changing environments.

The achievement of millennium development goals seems impossible without the engagement of these community health workers (CHWs) in grassroots healthcare delivery. There is ample research evidence which supports the noteworthy contribution of CHWs towards improving the utilization of health services and health outcomes. It also argued that they could play pivotal role in health care delivery and could be the indispensable part of the universal health coverage schemes.

Rifkin and Bhatia (2010) contend that community based health management sustained by community participation including household visits by health workers, community group discussions and meetings for inculcating literacy and creating health awareness, outreach workers providing health services in the community and a community level health worker has quantifiable effects on improvement of maternal and child health and survival. Community health programmes which are people oriented, involving people from the community, controlled and managed by the people with the involvement of the community health workers can substantially resolve the health related problems of the community. The constructive community engagement activities can effectually influence the preventive, promotional and curative aspects of the community health especially by provid-

ing health related knowledge and developing public health skills among the women of the community. In each of the CHW programmes in different parts of the world there have been much strength and some weaknesses.

1.1 CHWs – Contextual Descriptions and Definitions

The Alma Ata conference of 1978 has been a constructive force in conceiving the identities of the community health workers which vary remarkably in terms of the description, classification and designations (WHO, 2010, Witmer, et al., 1995, Lehmann & Sanders, 2007). Numerous regions, various urban and rural areas in different countries owing to their multiplicity of health indicators, needs and infrastructure developed their particular form of Community Health Workers (Love, et al., 1997, Perry, 2013, Rowe, 2005). Health promoters, Community Health Aides, Community Health volunteers, Barefoot Doctors, Health Agents, Family Welfare Educators, and Health Auxiliaries are some of the appellations given to Community Health Workers in different parts of the world (WHO January 2007, Lehmann & Sanders, 2007, Love, et al., 1997, Perry, 2013, Rowe, 2005, Witmer, et al., 1995).

The World Health Organisation (2010) described "Community health workers should be *elected by the communities* should be a *part of the community* where they work should be *accountable to the communities* for their activities, should be sustained by the health system but not necessarily be a part of its organization, and have relatively lesser training than the professional workers". WHO had offered a democratic element to these community health structures shifting the onus to the communities and their representatives to be concious and aware about health related issues and seek medical help whereever required.

Although the definitions of the community health workers differ in various regions of the world depending on the context and health care needs and demands yet the following characteristics of the CHWs remain universal:

- CHWs have robust socio-cultural networks to the communities they belong to;
- CHWs serve as intercessors between communities and organized health services and systems
- CHWs improve heath literacy, conduct advocacy drives concentrating on empowering individuals and communities and thereby improving the community health.

Witmer et al. (1995) in their definition add the functionality element to their definition calling them a connecting link between the healthcare service users and providers to create health awareness in such communities which were traditionally marginalized in terms of access to primary healthcare. The definition reinforces the importance of CHWs in social mobilization and they should identify, assess the local health needs, discover novel solutions and apply them effectively in the community setting. CHWs are

expected to be accountable to the regional socio-cultural norms to ensure community inclusion and entitlement and usually work with the underserved communities and are native to the community in which they work ethnically, linguistically, socioeconomically, and experientially (Brennan & Israel, 2008; Love et al., 1997). Thus a CHW is an interface between community and the health establishments to expedite access to health services and develop the quality and ensure that the health service delivery is culturally competent. Their contribution towards strengthening the grassroots' health care delivery is invaluable, yet there is less clarity with respect to their training and remuneration. Rifkin stipulates (2003) that exploitation of the community health workers should be avoided maintaining the strengths of the community action and low level trained workers. Addressing the lack of systematic planning and funding the training and supervision provisions should be the priority for such programmes. Rifkin (2009) asserts that assessment of retention, efficiency and budgets for all units of health workers including the community health workers should also be included in the routine evaluations of these community health worker programmes.

1.2 Global CHW Programme: Establishment, Situation and Reconsideration

After the culmination of World War II the formation of international organizations like World Health Organization and United Nations implicated the concept of utilisation of the community members to provide basic healthcare services to their respective communities. Internationally the CHW programmes have been acknowledged for their accomplishment in improving the health status of the communities in the Low and Middle Income countries (Godlee, et al., 2004; Hall & Taylor, 2003).

The success stories of the CHWs are especially encouraging; in many African and Asian countries CHWs have reduced the burden of health care professionals and in situations where there are serious scarcities of qualified professionals preventing and treating communicable and non-communicable diseases like malaria, tuberculosis, HIV/AIDS etc. (Campbell & Mzaidume, 2001; Love, et al., 1997; Rhode, et al., 2008). The CHWs perform numerous health related activities and responsibilities such as health promotion and education, maternal and child health services and family planning awareness, provision of safe drinking water, primary treatment for simple respiratory, gastric complaints and infections, health related data collection, record keeping and referrals.

The shortage of human resources for the underdeveloped health infrastructure in developing world has encouraged the establishment of community health workers programme (Hall & Taylor, 2003). It is a vital aspect of health provision in various developing countries is to edify villagers to provide basic health care services to the local communities (Frankel 1992). Thus

in the contemporary fragmented healthcare delivery system in the developing country settings the CHWs were viewed as potential solution to reduce the obstacle of deficiency of human resources. Werner (1981) suggested two categories of the community health programmes which hold true even in present day context:

a) **Community supportive programmes** are those that influence the long range welfare of the community that helps it stand on its own feet that genuinely encourage responsibility, initiative, decision making and self-reliance at the community level that build upon human dignity

b) **Community oppressive programmes** are those which are fundamentally authoritarian, paternalistic or are structured and carry out in such a way that they effectively encourage greater dependency servility and unquestioning acceptance of outside regulations and decisions, and in long term cripple the dynamics of the community.

Explaining the types of influences that the community programmes would etch on their communities, Werner found that small non-government initiatives usually had a community supportive effect crafting community welfare, whereas large scale government initiatives with the involvement of foreign fund and experts projecting community participation usually adopted paternalistic approach that gradually imposed initiative destroying norms.

The key aspect of the community health programmes are the human resources not just because of their skills and contributions to primary healthcare but due to the close relationship with the communities. Community Health workers in low and middle income countries are undergoing revitalization and regeneration with training facilities, an analogous trend witnessed in the 1980s (Rifkin, et al., 2008).

Globally primary healthcare issues like maternal and child health, vaccination, population control, prevention of communicable and non-communicable diseases, nutrition, water and sanitation and health promotion are addressed by community health workers (Witmer et al., 1995). Prominence of difficulties associated with maternal and child health inspired the CHW programmes to employ females in comparison to male workers (Rowe et al., 2005). Conversely programmes in Iran, Bhutan Thailand and Bolivia have greater participation of male workers (Perry, 2013).

Community health workers have also been classified according to the programmes they belong to and as per the qualifications and trainings they receive and the duties and responsibilities they performs.

- CHWs that are paid full time workers trained from institutions or have received several months of training involved in national CHW programmes like the Auxiliary Health Workers (AHW) and Health Extension Workers (HEW)

- CHWs working as volunteers on a regular basis with initial training for weeks followed with short training sessions receiving incentives that are performance or commission comprise of a cadre of CHWs called Community Health Volunteers – Regular
- CHWs working as volunteers with minimal commitment with less training comprise of a cadre of CHWs called Community Health Volunteers – Intermittent
- Apart from above classification there are some Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs) that have their versions of CHWs which are not related to the public-sector programmes

1.3 Origin and Early History of Community Health Worker Programs

Russia pioneers the concept of community health workers in as early as 17th -18th century they called as "Feldshers". They were people from the community without any formal medical qualifications were given field training to assist physicians and offer elementary medical care to military personals and underprivileged rural population in the absence of medical professional (Pérez & Martinez, 2008). They were entrusted with various tasks like primary medical, surgical and midwifery care services in many rural ambulatories. In modern context too, the *"Feldshers"* have gained paramount importance in the national health promotion programme (Love et al., 1997).

The counterparts of *"Feldshers"* in China were the barefoot doctors being the first instance of large scale CHW programme (Berman et al., 1987). The foundation for the barefoot doctors programme was laid by Dr. John B Grant alongwith a community developer Y.C. James (Jimmy). Yen who trained the illiterate farmers (who sometimes even could not afford shoes – hence the name) in treating wounds, recording and assisting deliveries of the babies, health promotion and first skills, vaccination and delivering basic medical care (Xuegui, 1990). Representing the primary healthcare at the grass root levels the Barefoot doctors would dispense Chinese and Conventional medicines sometimes growing their own medical herbs. Barefoot doctors as promoters of preventive public health practices functioned to improve the health status of the rural communities (Berman, et al., 1987; Xuegui, 1990). Achievement of China's barefoot doctors has been recorded by both Chinese and western researchers. In 1975 with 1.6 million barefoot doctors 90% of China's villages had rural healthcare with better quality of life. With studies confirming the improvement in the health status of China's population with specific success of reduction in infant mortality and with rise in the life expectancy, however the reasons for these improvements remain disputed (Xiaoping, 2012). Researchers have expressed different opinions about the impact of the barefoot doctors, with few praising the barefoot doctors for increasing the life expectancy and reducing the infant mortality (Smith,

2000). Some researchers however, express alternate viewpoints (Zhou 1996).

While WHO report attributed the development in the health status to the improvement in the living conditions, nutrition and political will in China to spend 1% of its GDP on nutritional programs and enhancements of the education facilities. Thus it can be viewed that the improvement in the health status of the rural Chinese populations resulted from the integration of the barefoot doctors in the healthcare system with the political reorganizations, community mobilization drives and campaigns, economic growth, nutritional reforms improved literacy opportunities an exercising controls on the medical professions.

In India the Bhore committee in 1946 reported that on an estimate 70-75 percent of the total available doctors practiced in urban centers. Then the model of health care had to face the challenge due to paucity of material and skilled human resources. Initially the concept of health visitor was given importance that was gradually replaced by auxiliary health workers who were professionally trained to form a part of health care delivery services and ease some simple functions of the medical doctor. During late 70s, with well-known experiments of community health worker around the world, India also laid emphasis on CHW. However, slowly the rigor faded away except certain innovations such as Saathin in Rajasthan, Jan Swasthya Rakshak in Madhya Pradesh and in 2000 Mitanin in Chattisgarh, later in 2005 such initiatives and innovations resurfaced in the National Rural Health Mission in the form of Accredited Social Health Activists (ASHA).

Importantly, the crucial approach of community health workers got gradually recognized in many parts of the poor world as a viable strategy to strengthen the primary health care thus leading to several community health worker programmes globally (Love et al., 1997). Health decisions and choices were greatly influenced by the peer network in the disadvantaged communities and this rationale was employed for the inclusion of community health workers in primary health care services (Godlee, et al., 2004; Joshi & George, 2012; Pérez & Martinez, 2008).

1.4 Ineffectuality of the Community Health Worker Programs of 1980 and 1990s

Numerous community health worker programmes failed in the 1980-90s due to lack of sufficient training of the CHWs, unrealistic expectations, improper planning, inadequate funding to provide remunerations, deficiency in support systems, non-integrated health system and an underestimation of the effort and input required to make them work. This reduced and dented the credibility of the CHW concept and lead to the failure of community health worker programmes in the 1980s (WHO, 2007). Moreover the political preferences led to the selection of individuals who were not motivated and

suitable to become efficient community health workers.

The evidences suggest that extensive community health workers program were unsuccessful in the 1980-90s due to the reduced response to the PHC movement propagated in the Alma-Ata. Additionally, the global recession caused by the oil crisis compelled the World Bank to advise the national governments to curtail public sector funding (Perry, 2013). Thus lack of financial resources led to expiration of national level CHW programs. However, there are evidences that point towards the main reason for the devaluation of the CHW programs such as unrealistic expectations, lack of planning, lack of sustainability and improper quality maintenance (Berman et al., 1987). Deficient political drive and will to promote PHC relegated effective CHW programs to secondary status and formed an understanding that such programs had few long-term benefits. Brennan & Israel, (2008) illustrated that the community health workers expected to be selected by the community were often appointed by the health personnel. Moreover their duties were also designed by the health staff rather than community initiated and driven. While planning such programs there are evidences that demonstrated inefficient management of resources for training, supervision, CHW incentives and drug supplies creating issues for sustainability of CHW programs (Appleford, 2013).

The extended demands for the funds and supervisory inputs beyond the original estimation led to the decline of large-scale CHW programmes and therefore compelled the governments to suspend their CHW programmes (Appleford, 2013). Lack of consideration for community development was another prime factor for the failure of these programmes. Studies suggest that the CHW programs should not emphasize on creating groups of non-professional health workers but should have capacity to set up and form communities own development programs including health improvement (Brennan & Israel, 2008; Godlee et al., 2004; Cepikua & Giordano, 2013).

1.5 Highlights of Few Successful Community Health Worker Programs of the late 1980s

Brazil had successfully launched a massive drive for attainment of universal health care in the 1980s. Programs like SESP i.e., Special Service for Public Health and Unified System of Health were initiated with the aim of creating a movement to provide social protection, social mobilization, and expansion of social rights by considering health as an important social and political dimension (Jurberg & Humphreys, 2010). These programs comprised the 'health visitor' who delivered immunizations, information, and various other MCH interventions (Macinko et al., 2006). Owing to the success of these programs Brazil became the first middle income country to provide free antiretroviral therapy to the HIV/AIDS patients (Perry, 2013).

Similar interventions were planned in Bangladesh, where the Bangladesh Rural Advancement Committee (BRAC) in 1970s involved male paramedics reinstating the Barefoot Doctor ideology of China, but this strategy failed to deliver. Following this failure, in 1980s BRAC engaged female CHWs receiving nominal training in health promotion and disease prevention (Hossain et al., 2004). The number of these female volunteers called *"Shashthya Shebikas"* (Health service-women) who were often illiterate steadily increased from 1080 in the year 1990 to 70,000 by the year 2008 (UNICEF, 2004). Serving as primary source of health information through household visits in 250-300 houses monthly, these *"Shashthya Shebikas"* work together with trained traditional birth attendants (TBAs) in the villages, as well as organize women to contribute in national disease control campaigns, attend clinics for basic MCH services, and conduct growth monitoring of children (UNICEF, 2004). Being a self-sustaining program, Perry (2013) suggested that it has made an important contribution to Bangladesh's development in reducing under-5 mortality and to its national TB control program. In Nepal, too the initial effort of introducing the Female Community Health Volunteer as a health delivery personnel in 1988 did not meet with success due to lack of government funding. The reintroduction of the program led to the involvement of the female volunteers, who along-with their traditional functions of family planning and first aid also distributed Vitamin A capsules twice every year under the "National Vitamin-A Program" proposed by the government (Thapa et al., 2005). Recent reports suggest that 40,000 FCHVs have taken on expanded responsibilities that include detection and treatment of common childhood diseases (including pneumonia), distribution of oral contraceptives, and promotion of available health services for first aid, antenatal care, Family Planning, and immunization (Perry, 2013).

However, it is reported that rapid reduction in the under-five mortality and public health improvements have been the achievements of these large scale CHW programmes, however the reasons for these successes can be attributed to political stewardship, adequate resourcing, good programme management and continued training and education.

1.6 Revival of CHW Programmes since 2000s

By the 1990s several government CHW programmes had declined because of the operational difficulties that involved in integrating them into national programmes. Health activists and researchers also questioned whether the community health workers were empowered or oppressed as a result of the existing, socioeconomic political structures, bureaucracies, and lack of support from health professionals (Wiggins et al., 2013). However an obligation for (or economic demand for) decentralization of health services and the need to develop horizontal grass-root level health strategies in-

volving the regions with low socio-economic growth and emphasis on primary preventive health care with consideration of poverty, gender and equity issues sparked the revitalized interest in community health programs (Pérez & Martinez, 2008; Wiggins, et al., 2013).

At the dawn of the new millennium many countries reaccelerated their investments in large scale CHW programs. Pakistan initiated the Lady Health Worker (LHW) programme in 1992 increased tremendously in the early 2000s, to accommodate 100,000 workers serving 70% of the rural communities by 2004 (Haq, et al., 2008; Hossain, et al., 2004). India after learning from the failed Health Guide Scheme of 1970s has reinvested in cadres of rural community health workers at large scale with aim of linking the communities and families to the most elemental level of formal healthcare system. The National Rural Health Mission (NRHM) in India originated in 2005 involve more than 800,000workers called as Accredited Social Health Activists (ASHAs) (Bajpai & Dholakia, May 2011).

However, in some places evidence about the effectiveness of the CHWs programmes continues to increase. This has increased the enthusiasm to invest in such programmes a strategy to achieve the Millennium Development Goals that also emphasize on primary health care, maternal and child health. It is essential to focus on the barriers that prevent growth and sustenance of the large scale community health workers programmes. The current interest lies mainly in community health workers as care providers but this can be problematic as large-scale government training programmes often lack standards, supervision and resources.

In Africa during the early 2000s, various political leaders and benefactors attempted to revive CHW programmes to address the issues of lack of basic infrastructure in major health facilities, low standards of health awareness in many distant rural areas with poor health education (Campbell & Mzaidume, December 2001). Although with rich and varied diversity of local languages, social rituals and customs, there were traditional, inappropriate health seeking patterns and poor maternal and child care that contributed significantly to the burden of disease in part of the African continent. An example of this apprehensive attempt to reinvent CHW programmes was that in South Africa where a dormant CHW program that had been previously abandoned was reactivated (Haines et al., 2007). The Health Extension Workers of Ethiopia in 2004 and Health Surveillance Assistants (HSAs) in Malawi recruited by the Ministry of Health receiving Integrated Community Case Management training to combat diarrhea and similar infections in children are some other examples of revival of such CHW programmes (Perry, 2013).

Earlier reports and evaluations of the CHW programmes advocated that the success of such programmes depended on the respect and support the CHWs receive from their gov-

ernments, health service officials and workers and the communities they belong to and serve (Marmot, et al., 2008; Rapporta, et al., June 2008; Rhode, et al., 2008). A combination of delegation and skills, execution of standard management procedures, cohesive information systems and essential drug supplies are features of effective community health programmes, further the CHWs are not burdened by excessive non achievable roles and responsibilities (Rifkin, et al., 2008). The World Health Organization (2007) proposes that appropriate selection of community oriented health workers, continuing education, involvement and reorientation of health service personals, training courses, improvement of administration, regulation and support are non-negotiable requirements. These should be backed up with relentless political leadership and will along with significant constant resourcing.

1.7 Mitanin's the Community Health Workers: Scope and Importance

In India, Chhattisgarh was new state formed in 2000 that had a population of 20 million and all the characteristics of a rural, underserved community, with low health and education indicators. The formation of the new state was seen as an opportunity to "strengthen measures to improve health and health care". There was political commitment and pressure from the highest level, to form a new community health programme with the Chief Minister taking personal interest in its launch and progress. The Mitanin programme is a visionary and pioneering community health workers initiative started by the Govt. of Chhattisgarh in partnership with the civil society organizations and the sponsorship from the European Union. The programme initiation was a collaborative effort between the state, NGOs and funders, who set up a dedicated structure – the State Health Resource Centre (SHRC) – which was charged with operationalizing and managing the programme (SOCHARA, 2005). As a result the "Mitanin" programme was initiated by the state government of Chhattisgarh in 2002. The programme was seen to be following the long tradition of Indian CHW programmes and was preceded by intensive studies of these previous experiences. The core idea was to have a Mitanin (trained community health worker) for every one of the 54,000 tola's / para's (hamlets) in the state. The Mitanin programme further progressed to lay foundation for the ASHA programme by the National Rural Health Mission.

Considering the enormity and universal coverage of the state, initially the entire Mitanin Programme was initiated in three phases. The first phase was initiated in May 2002 in 14 blocks of the state. By December 2002, half of the remaining blocks, a total of 66 were brought under the programme comprising the second phase. The third phase which began in December 2003, brought the remaining blocks under the programme umbrella. By 2006 other vital elements like village level planning, strengthening clini-

cal skills of Mitanins in child care and introduction of AYUSH component were institutionalized in all the blocks of the states (GoC, 2010).

Mitanins have been appositely defined as outreach women volunteers who attend to the health care needs of the communities, engage in social mobilization and advocacy of health issues (SHRC 2003a; Sundararaman, 2007). The valuable lessons learnt from the Mitanin programme contributed to the development of countrywide CHW programme called the Accredited Social Health Activist (ASHA) under the National Rural Health Mission (2005a, 2005b), giving them a national identity. Many studies in India have elucidated that the Mitanins have successfully addressed the social determinants of health (Sundararaman 2007; National Health Systems Research Center [NHSRC] 2010). This fact is also supported by research on developing countries by Lehman and Sanders (2007) (cited in Nandi & Schneider 2014).

With evidence from around the world, there is little doubt that community health workers have emerged to be a powerful link between communities and the healthcare delivery systems. There is also robust indication that the CHCs could significantly contribute towards the betterment of health outcomes. However, it could only be possible when there is an institutionalized selection and training process after their recruitment. Also, they must be continually and adequately supported by the government otherwise the program may not bear the encouraging outcomes.

The CHW programmes are therefore not replacement to formal rural health care delivery systems. They are just the bridges between the systemic care and the communities especially the inaccessible ones. The edifice of such programmes is community partnership and ownership failing which the programme merely is a lip service in the formal beaureucratic health systems. The community health workers are crucial for the achievement of the health related MDGs and because a vast majority of people in India live in rural areas beyond the reach of well-staffed and well-provisioned health care.

"Mitanin" programme covered the entire state with initial deployment of the Mitanins and successive training by 2004. Several external and internal evaluations were conducted including those by the SOCHARA in 2005 and EUSPP in 2011 respectively. The Mitanin programme incorporated the incentivization of the Mitanins based on the revised guidelines of the NRHM by 2011 which allocated performance based incentives for the Mitanins focusing on the areas like ANC, institutional deliveries, family planning measures and immunization. Further the Mitanin programme was subjected to the reforms that included the introduction of the "Panchayat" in disbursement of the incentives by 2013 based on the 73rd amendment of the Indian Constitution that required the "Panchayat" in the villages to be an active part of the village health development.

Chapter 2

LITERATURE REVIEW

Family Health Education

Chapter 2

LITERATURE REVIEW

Community Health Workers and Mitanin Programme

2.1 India and its Community Health Initiatives

At the inception, the public health initiatives in colonial India were largely restricted to British civilian and military cantonments. The heart and soul of these programmes remained the early diagnosis and treatment of contagious epidemics like Malaria, Cholera and Plague. The target population of these programmes was the British civilians and army personnel depriving the Indian masses who remained oblivious and deprived of the benefits. Most Indian households struggled for basic sanitation, water and waste disposal facilities making them vulnerable to cholera and plague; thus increasing mortality rates amongst Indians. The healthcare reforms were introduced following independence with a view to initiate socio-economic development and improvement in the standard of living of the general population. The current Indian Public Health system has developed from the primitive health care frameworks implemented during the British colonial period. Health in largely a state subject but central government has a contributory role in the formulation of policy directive and implementing large scale national health programs.

The Bhore Committee has rendered a landmark contribution in development of the public health administrations. The noteworthy addition to the health infrastructure has been the strengthening of the rural healthcare with the establishment of the Sub-Centers, Primary Health Centers and CHCs in early post colonial period. The committee also proposed the setting up of village health committees to confirm public cooperation support and participation in the development of health programmes.

The valuable addition to the primary health care systems has been the advocacy for the community health workers through various Committees in the post independence era (Bajpai & Dholakia, May 2011; Shrivastava & Shrivastava, 2012). These multi-purpose workers could enhance as allied professionals if they are equipped with proper training and skill. To this effect, the *Srivastava* committee recommended the development of community health worker programmes suggesting that the primary health services like the nutrition, health education and family planning should be organized within the community with the training of suitable personnel (Shrivastava & Shrivastava, 2012). The focus of such training was to generate community health volunteer from the community belonging to the groups of teachers, postmasters, and "gram sevaks"

(village helpers) with the aim of provision of comprehensive health services as allied professionals (NHSRC, 2010; Scott & Shanker, 2010) thus becoming a community health service that was more accountable to the community.

Following the success of the small scale CHW programmes involving the third sector, the government of India launched the Community Health Workers programmes in 1977 that underwent terminology changes to Community Health Volunteer (CHV) programme in 1980 to Village health Guides in 1981 (Bajpai & Dholakia, May 2011; NHSRC, 2010).

The Community Health Volunteer programme comprised of selection of one CHV per 1000 people by the villagers and these volunteers were equipped with medicines for treatment of basic ailments. The programme faced barriers like resistance from the medical professionals, demands for payment and vacillating government policies with regard to funding. Furthermore lack of motivation among the volunteers whose selection was politically influenced, inadequate training with poor accountability towards communities and low connecting links with health services that resulted in the termination of the program (Joshi & George, 2012). Moreover, the scheme could not spread its roots and hence there was lack of ownership and confusions amongst the CHWs as regards to their roles and responsibilities which further accelerated its decline. The training of the CHWs was limited with focus only on certain curative complaints and the training sessions completely neglecting preventive and promotion of health measures leading to frustration and de-motivation among the CHWs and the communities they served. Contrary to the beliefs of the government that the CHWs were accountable to the communities that they served, many CHWs, health professionals that they served the communities considered them as government employees. This led to the CHWs demanding higher salaries than incentives. Large numbers of CHWs were registered by 1980, and only a few of them functioned effectively. Later India's Village Health Guides Scheme was launched to provide simple health promotional, preventive, and curative services to the rural population by the Village Health Guides. Under this centralized scheme which was funded though the Family Welfare Programme of the Centre, the health guides were appointed by the government. However, that scheme too frizzled out and could not create substantial changes in the health indicators of the rural population in India.

Maru (1983) spelled out the objectives of Village Health Guide scheme as - providing basic preventive, health promotional and curative care at people's door-steps and involving rural population in the provision, monitoring and control of basic health services, symbolizing the famous phrase "people's health in people's hand" along with creation of a resource person trusted by

the local communities serving as a link between primary health center and the community.

In the year 2000-2001, following a review of the system including the work profiles of CHWs by the central government committee focusing on the issues of their abilities, incentives and sustainability, the government withdrew its funding (Joshi & George, 2012).

At the same time the third sector has played a significant role through number of successful projects. In Orissa, a project called MOTT (Mobile Orientation and Training Team) set up CHW projects in the rural regions. The highlight of this programme was community participation of the programme wherein communities planned their health care programme, its cost, type and location of the health centers. The communities further selected the women who were to be trained from the women in their community (Kaithathara, 1990). Another project which was a value addition to the community involvement was SEARCH (Society for Education, Action and Research in Community Health) set up in 1985. The founders chose Gadchiroli Tribal District which was known for its poverty and deprived conditions with high infant mortality rates in rural Maharashtra. They then created a home-based package of neonatal care that had been delivered by trained and equipped village women (Bang et al., 2005). Though, the home based neo natal programme succeeded in reducing the infant mortality rate from a staggering 121 per 1000 live births in 1988 to 30 per 1000 in 2003, this initiative could not be transformed into a national programme as it failed to produce similar results at large scale.

2.2 Development of the Community Health Programme in Chhattisgarh

The state of Chhattisgarh was created on 1 November 2000 by partitioning 16 Chhattisgarhi-speaking southeastern districts of Madhya Pradesh that opened up plethora of opportunities as well as challenges in the rural health coverage. The population of the state according to the 2011 census stands at about 25 million and all the characteristics of a rural, underprivileged community was significantly challenged in the health, education and other development indicators. While there was unmatched political will and commitment for bringing about overall development, the task was seemingly daunting with poor indicators of health. Consequently the community health programme - a collaborative effort envisaged between the state, NGOs and the funders that set up a dedicated structure known as the State Health Resource Centre (SHRC) (Society for Community Health Awareness, 2003). At the initial stage the state government followed the legacy of the community health worker programmes and launched the "Mitanin" programme in 2002. The core idea was to engage a Mitanin (trained community health worker) for every 54 000 tola's/para's (hamlets) in the state. The Mitanin programme further progressed to lay foundation for the ASHA programme by

the National Rural Health Mission launched in 2005 for providing the marginalized population with accessible, accountable, effective and affordable primary health services (Shrivastava & Shrivastava, 2012; Bajpai & Dholakia, May 2011). The prime objective of the NRHM was to adopt an integrated approach for improving health by considering the determinants like nutrition, safe drinking water, hygiene and sanitation witnessed growth in the healthcare expenditure from 0.9% to 2-3% of the GDP with increased mobilization and community engagement in the health services provision in the respective state (Bajpai & Dholakia, May 2011). Initially, under the NRHM the roles of the CHWs were limited to family planning and promotion of institutional births as related to conceived the role of CHWs to focus only on the issues like family planning and promotion of institutional births but it was later refuted by the civil societies that sensed the limiting the role to be detrimental to the progress and development of large scale CHWs programmes. The community health workers under this programme at the village level would act as bond between the rural poor and the health service system; playing a key role in accomplishing the national and local health policy issues. The planning incorporated the best practices and lessons learnt from various programmes which advocated and encouraged the CHW programmes. Some of these programmes like" SEARCH in Gadchiroli, Maharashtra exhibited the improvement in the child and maternal health standards by female CHWs with less formal qualification and education but receiving strong support and training inputs (Joshi & George, 2012). The ASHA programme in many states was based on the existing CHW programmes like the Anganwadi Centre helpers in Rajasthan, Women health volunteers of Andhra Pradesh and the Mitanins in the state of Chhattisgarh all were adopted and absorbed by the ASHA programme. However the Mitanin in the state of Chhattisgarh has retained its name for socio-cultural reasons (NHSRC, 2010).

2.3 Mitanin in the State of Chhattisgarh

Mitanin – meaning a female friend in local Chhattisgarhi language has its origin in the traditional customs and ceremonial bonding between girls from different families ensuring help to be provided to each other during crisis. This local cultural customs was adopted to develop a new cadre of health workers called the "*Swasthya Mitanin*" (Health workers called Mitanin) that was the foundation for the Mitanin CHV programme in Chhattisgarh (Shukla, 2003).

Mitanin programme in Chhattisgarh endures inspiration from the various CHW programmes at national and state level but also lays foundation for the further development of ASHA program advocated and promoted by the National Rural Health Mission (Shrivastava & Shrivastava, 2012; SHRC, 2003). The Mitanin program is recognized as well established community health volunteer programme in vast Chhattisgarh

state health systems working for the improvement of health care services (NRHM, 2011-2012; SHRC, 2003).

a. Conceptualization of the Mitanin Programme as Part of Health Sector Reform

Increased disease incidence and prevalence with poor health services utilization resulted from lack of health awareness, education and reduced accessibility to health services. This underdeveloped public health sector was also a result of the prevailing diverse socio-economic and cultural outlook of the rural population in Chhattisgarh (Shukla, 2003). The efforts between the government and civil society in 2002 was renewed to resolve the public health predicament in the Chhattisgarh state led to conceptualization of community health volunteer programme called the Mitanin programme. The seven fundamental principles formulated by the SHRC depended upon the past experiences of community health programmes - the key point to got strengthen in the Mitanin programme (SHRC, 2003)

1. Women as Community Health Workers.
2. Well-planned social mobilization through ensured community selection process.
3. Continuous and ongoing training and support in the programme.
4. No financial payments in the first year and later limited incentives.
5. Supplementary and not central role for curative care.
6. Linkage to a parallel public health strengthening initiatives.
7. State civil society partnership at all levels of programme management

b. Objectives of the Programme

- Broad Objectives of the Mitanin Programme (Sundararaman, 2003) To enhancing public health awareness among the communities through effective health education, communication and promotion
- To upgrade the utilization of the existing public health services by making the rural masses aware about the services and creating in them a sense of entitlement
- To originate a cooperative and collective action emphasizing on the health and related development sectors at community level.
- To provide immediate relief for basic health ailments in the community.
- To articulate a process for women empowerment by organizing women from the different social backgrounds for a collective health action.
- To sensitize *"Panchayats"* (local-self government in rural areas) and augment its understanding and competences in local health planning and programme implementation

The Mitanin programme consciously endeavoured to eliminate the challenges faced by earlier community health workers programmes by establishing a sustained working environment between diverse stakeholders, at the state level to induce and provide directions. The group in-

cluded the bureaucratic and technical leadership from the state, NGOs, donors, professionals and activists representing the State Advisory Committee (SAC). Around 67,000 Mitanin serve in over 70,000 hamlets, and were supported by 3,000 women engaged as middle-level supervisors (Shukla, 2003). The following Table 2.1 elucidated the district coverage and numbers of Mitanins serving in the state of Chhattisgarh.

TABLE 2.1: District-wise Enumeration of Mitanins

Sr. No.	Name of the District	Number of Mitanins Functional
1.	Bastar	5236
2.	Bijapur	1410
3.	Bilaspur	4913
4.	Dantewada	2433
5.	Dhamtari	1793
6.	Durg	5755
7.	Janjgir-Champa	3954
8.	Jashpur	3677
9.	Kanker	3259
10.	Kawardha	1950
11.	Korba	2899
12.	Koria	2643
13.	Mahasamund	2276
14.	Narayanpur	442
15.	Raigarh	3971
16.	Raipur	6795
17.	Rajnandgaon	4487
18.	Surguja	9488
Total Number of Mitanins		**67,381**

Source: Mitanin Data SHRC, Chhattisgarh accessed 20-05-2014
(http://www.shsrc.org/MitaninDataDistrictWise.htm)

2.4 Selection of CHW – Mitanins

Being community health workers they are selected by the local community as a female health volunteer. After the recruitment, the Mitanins are trained to serve her own village and trained in community medicine (Bajpai & Dholakia, May 2011). The eligibility criteria for selection are that they must belong to the age-group of 25-45 years with minimum 8 years of formal education and must possess some leadership attributes. It was often reiterated that the Mitanins are not salaried health staff but volunteers receiving task based incentives (Bhattacharya et al., 2001).

The selection of the Mitanins in the hamlet level meetings called *"Gram Sabha"* (village meetings) were done by the communities and appropriated by the "*Panchayat*" (local village self-government body) (Patnaik, 2003). The selection of the Mitanins was also aided by a "*Prerak*" (facilitator) safeguarding the rights of marginalized communities to participate in the decision making process to select their own Mitanin from their respective communities. Large scale community mobilization initiatives like *"Kalajathas"* also support the selection of Mitanins (Sundararaman, 2003).

2.5 Roles and Responsibilities of Mitanins

Mitanins were trained and supported to conduct household outreach health activities, including essential care of newborns, nutritional counseling, case management of childhood illness,

and rights-based activities (e.g. access to basic public services, women's empowerment activities, and mobilization around ICDS and mid-day meals). The duties of Mitanin included health education, promotion and creating awareness about facilities of health services, treatment of basic illnesses, provide first aid for minor injuries, referral advices to healthcare-services, community mobilization and create entitlement to health promotion and disease prevention, and augment women empowerment (Patnaik, 2003; Shukla, 2003; Sundararaman, 2006).

The role of the Mitanin was conceptualized as village based preventive and promotion worker, who would also works on health rights and provides basic first aid and curative care. The curative role was seen as supplementary rather than central to her work at a community based health worker (Mishra, 2011). Under NRHM, ASHAs had been assigned the responsibility to counsel women regarding early registration, birth preparedness, adequate ante natal care, safe delivery, postnatal care etc. and to mobilize the community and facilitate them in accessing these services for improvement in maternal health (Singh, et al., 2010). The studies suggested that most of the ASHAs were aware about their responsibility regarding ante natal care, immunization, tuberculosis, leprosy, malaria, high risk pregnancy but none of the ASHA were having specific information on schedule of immunization, and how to detect TB & leprosy cases (Swain, 2008). Some other research illustrates that not more than 20% of ASHAs had knowledge about registration of births and deaths, assisting Auxiliary Nurse Midwife (ANM) in village health planning, creating awareness on basic sanitation and personal hygiene (NHSRC, 2010). Evidences also revealed that only 16.3 percent ASHAs knew about their role in motivating the community on toilet construction while just 23 % ASHAs were aware that they are supposed to provide medical care for minor ailments (Scott & Shanker, 2010). The results of a study indicated that overall ASHAs spent more time on bureaucratic official formalities, less time on field activities with only 22% aware of the clear NRHM guidelines for ASHAs (Bajpai & Dholakia, May 2011).

2.6 Assessment and Regulation of the Function of the Mitanins

The performances of the Mitanins are monitored through management information system reports filled by the Mitanin trainer after obtaining verbal information in their cluster meetings. These MIS reports are aggregated by the block and district coordinators at their respective office levels. Parameter for measuring the performance of the Mitanins were (Shukla, 2003)

1. The 6 designated visits provided to the number of newborns
2. Encouragement given to pregnant women to take up ANC check ups
3. Nutritional advice provided during the visits to children less than 3 years of age

4. Medicines and treatment given including advice on home and herbal remedies
5. Referrals given for institutional deliveries and for treatment of diseases like TB, Leprosy, and cataract
6. Support provided to women against domestic violence
7. Cases acknowledged and improved in relation to nutritional security and social exclusion

There are three important stakeholders those who are the backbone of Mitanin training, supervision and quality maintenance.

2.7 Mitanin Trainers (MTs)

Selected from the clusters of Mitanin through a written examination by a Block-level Committee headed by BMO these trainers provided on job training and conducted hamlet level cluster meetings with Mitanins. Most of these trainers being women were paid by the BMOs on the basis of tasks performed. They facilitates planning and implementation of village health plans in collaboration with Village Health, Sanitation and Nutrition Committees (VHSNCs) and plays a major role in the record keeping and providing benefit to the Mitanins through their welfare fund. The performance evaluations of these trainers were conducted by the District Coordinators in consultation with Block Coordinators (SHRC, 2008).

Block Coordinators: they are mainly responsible for the ToT (Training of Trainers) to MTs in residential camps; plan Mitanin trainings with BMOs to supervise Mitanin Training; on-the-job training, support in solving problems and monitoring MTs by participating in home visits, hamlet level meetings, VHSNC meetings; support District Coordinator for fortnightly meetings, compile monthly MIS reports; verify monthly work done by MTs; interact with BMO to seek support for field-level problems; attend one District-level meeting in a month (SHRC, 2003).

District Coordinators: They are appointed by SHRC and have no structured, formal office. Their role is mostly field based and they provide classroom training to the Block Coordinators and supervise training of MTs (SHRC, 2003).

2.8 Training of the Mitanins

The Mitanins receive 20 days of camp based training consisting of 18 rounds. Each round comprises 4-5 days of training and about 30 days of internship. These 18 training sessions include understanding health services with emphasis on child health and nutrition, introduction of village health register for recording health events and status, women's health, community control of malaria and waterborne diseases, Mitanin drug kit and first aid, role of communities in Tuberculosis and Leprosy control, health planning at the level of "*Panchayat*" (local village self-governing body), food & social security entitlements with social mobilization to safeguard vulnerable communities, home based herbal remedies, neonatal and child survival aiming at impacting IMR, the

role of Mitanins in Village Health & Sanitation Committees, addressing issues related to child feeding. Trainings were supported by the block training team with one Mitanin trainer for 20 Mitanins and about 20 per block who were also supported by the government nurses. The coordinating teams consist of block coordinators, one Government official, two volunteers per block as district resource persons. Various training guides and materials focusing on the topics mentioned above were devised along-with a Mitanin Drug Kit, Guidebook having the management of common illnesses was used for the training programmes.

There were indications from research studies about dividing the training sessions of the ASHAs in to small groups for effective and interactive understanding of the sessions focusing on subjects like maternal and child health, issues related to reproductive processes and diseases. A government facilitated program of integrated management of neonatal and childhood illnesses was launched for the skill development of the ASHAs which plays a vital role in providing inputs in the post natal care (Bajpai, 2011).

However, many studies indicated the inappropriateness of the amount, quality and assessment of the training material with discrepancies observed between the course materials and training period. It also stated that several ASHAs have not received complete training which would result in additional training burden over the state health authorities due to inadequate an inefficient training highlighting the need for increased supervision, better management of training modules (Bajpai, 2011). In such a scenario on the ground demands periodical refresher training engaging themes like vaccination, ante natal care with training for managing high risk cases requiring prompt referrals will further update the skills thereby refining quality of services and facilitate further increase in the utilization of existing health facilities and services (Shrivastava, 2012, Bajpai, 2011).

2.9 Incentives and Compensation for the Mitanins (ASHA)

Considering the fact that financial compensation or remuneration is a significant motivational factor influencing the performance of the community health workers in developing nations, the Government of India introduced a performance based payment method to support the ASHA programme (Bhattacharya et al., 2001). The Mitanin programme in its initial phase of planning and designing concentrated on the social mobilization as prime tool for encouraging community participation. However, there was a need for operational organization to ensure regular incentive payment through a commitment by the village communities (Shukla, 2003).

The SOCHARA evaluation reiterates that lack of monetary incentives cause around 10% attrition in the Mitanin programme. However, some allied health workers believed that intro-

duction of the incentive system in the Mitanin programme would lead to negative consequences in the programme. The review of 2005 illustrated the fact that the community health workers and the resource personnel from the blocks and districts associated with the Mitanin programme along with the Mitanins and their families considered the issue of compensation or remuneration as an issue of utmost importance.

The report by SOCHARA (2003) categorically mentioned that remunerations were considered a necessity by the Mitanins. The Mitanins contended that the responsibility for provision of public health services rests with the State Government and they must financially remunerate those who work towards attaining this objective. The Mitanins hesitated to travel long distance for health activities without incentives. Comparing their responsibilities to the health care delivery of other health care workers, the Mitanins felt that they should also get monthly salaries like the health officers do. The launch of NRHM and incorporation of the Mitanins under the ASHA scheme introduced the hope of task based incentive but there were no operational provisions to make these payments.

2.10 Outcome and Benefits of the Mitanin Programme

However, there were advantages too and the expected outcomes of the Mitanin Programme are summarized as follows -

- Availability of trained Mitanins in every village
- Effective delivery of health education to enhance health awareness on topics like breast feeding, immunization, family planning, primary health care at the community level
- To ensure better utilization of health services by the community through health promotion done by the Mitanins
- Mitanins possess the required skills and drugs to treat basic illnesses and health complaints
- On the ground empowerment of the women and creation of women's movement to bring about a social change became a reality through the Mitanin Programme
- Generated effective changes in the village health planning system and stimulated the village self-governing bodies to be accountable to the health systems of the village.
- The Mitanin programme does impact the health activities to effect changes in the health indicators like IMR, MMR etc.
- Development and consolidation of the public health systems to advance responsiveness.

2.11 Health Outcome Indicators

Since the changes in the health statistics are multi-factorial it is not appropriate to attribute these changes to single health programme. The service delivery in the Mitanin programmes depend upon other community health workers like ANM's and AWW's, therefore the achieve-

ments in improving the health status of the communities is a collective effort of these related cadres of health workers.

The following table enumerates the positive changes in the health indicators in Chhattisgarh during the activity years of Mitanins

TABLE 2.2: Health Indicators in Chhattisgarh

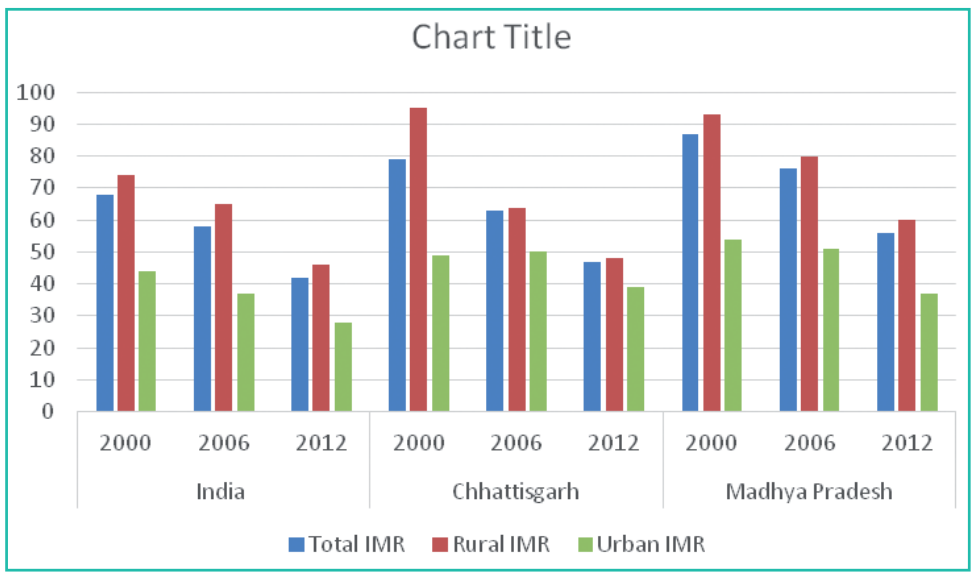
Positive Indicators	Health Indicators in Chhattisgarh			
	DLHS 2*	DLHS 3**	CES 2009	Change from DLHS 3
Proportion (%) of mothers who had at least 3 ante- natal care visits for their last birth	44.4	51.2	71.4	20.2
Institutional Delivery	18.1	18.1	45	27
Proportion (%) of births assisted by health personnel	11.1	14.1	55	40.9
Proportion (%) of children below 3 years who were breast-fed within an hour of birth	29.5	50.1	44.1	7.2
Proportion (%) of children who are exclusively breast-fed for 5 months	NA	78.3	90.5	12.2
Proportion (%) of children 12-23 months fully immunized	56.9	59.6	57.3	-2.7
Proportion (%) of children 12-23 months who have received measles immunization	66.7	69.7	73.1	3.4
Proportion (%) of children 12-23 months vitamin A in last 6 months	32.4	65.1	56.2	-8.9
Proportion (%) of children with diarrhea in last 2 weeks who received ORS	41.7	36.6	74.1	37.5
Proportion (%) of children with ARI in last 2 weeks who were seen by an health facility	63.3	68.1	83.3	15.2
***Source**- DLHS 2, ** DLHS 3, CES 2009*				

However, to analyze and understand the programmatic effect IMR in Chhattisgarh during the activity years of Mitanin programme from 2000 to present had indicated somewhat positive results. The graph below showed that the change in total, rural and urban IMR from the creation of the new state till now based on SRS data (Year 2000, 2006 and 2012 of SRS data are shown). The data from India, and Madhya Pradesh were compared with the state of Chhattisgarh, indicators in comparison with infant mortality rates as indicated below.

TABLE 2.3: Compatative Analasys Infant Mortality

	India			Chhattisgarh			Madhya Pradesh		
	2000	2006	2012	2000	2006	2012	2000	2006	2012
Total IMR	68	58	42	79	63	47	87	76	56
Rural IMR	74	65	46	95	64	48	93	80	60
Urban IMR	44	37	28	49	50	39	54	51	37

FIREGE 2.1: Compatative Analasys Infant Mortality



Thus the data indicated that the state of Chhattisgarh has seen a drop of 47 point in rural IMR and 10 points of urban IMR within 10 years of Mitanin programme as compared to a 28 point drop in rural IMR and 16 point drop in urban IMR in all India. On the other hand a 33 point drop in rural IMR and 17 point drop in urban IMR in the state of Madhya Pradesh. Though it cannot be conclusively said that it is solely due to the implementation of the mitanin programme but it certainly indicates a positive effect of the programme on the inaccessible rural population.

2.12 Breast feeding and IMR

The data from UNICEF suggests that Breast feeding has improved during the Mitanin programme. There has been a significant increase from 27% in 2002 to 88% in 2006 in the breast feeding practices which could be attributed to Mitanin programme as it supervised constituent of the programme (SHRC, 2008). The study by the EUTA (2011) also confirmed that Colostrums feeding increased from about 25 percent to about 80 percent in years of Mitanin activity.

The infant mortality rate too registered a decline in Chhattisgarh which is currently estimated to 47 per 1000 births according to the latest available data. The infant mortality rate is comparatively high in the rural areas as compared to the urban areas (APIP, 2012-13). The changes cannot be alone attributed to the Mitanin programme however marked reduction have been observed in the mortality rates after the implementation and expansion of the Mitanin programme. The evidence suggests that the sharpest reduction in the IMR occurred during the expansion phase of Mitanin programme which was apparently before the advent of *"Janani Suraksha Yojana"* (EUSPP, 2011). The available data indicates that there has been a constant progress in rural health indicators after the introduction of the Mitanin programme.

2.13 Progress in other Reproductive and Child Health Services

There also has been substantial increase in immunization coverage from 22 % after the NFHS-2 to 49 % following the NFHS-3. The vaccination programme targeting the six major illnesses in children aged 12-23 months experienced higher percentage of vaccination in children from urban areas (75%) who received all the vaccines in comparison to 43% in rural areas (APIP, 2012-13). Immunization rates of the children receiving all the vaccines were higher in the girls 51% than the boys (47%). The NFHS-3 also illustrated that coverage of three doses of DPT and measles increased by 22-23 percentages and BCG also increased from 74 to 85 percent. Only 3 percent of children did not receive any vaccinations at all (APIP, 2012-13). Percentage of women receiving some kind of antenatal care increased from 57% in year 1999 (NFHS-2) to 89% in the year 2005(NFHS-3). However, due to health service supply side constraints, increase in institutional delivery was minimal from 14% to 16% only (SHRC, 2008). These figures however testify to an improved community level utilization of health services – one of the objectives of the programme.

2.14 Health Seeking Behavior

The tribal and rural societies in Chhattisgarh accepting neonatal and infant mortality as part of life; these preconceived notions needed immediate attention in terms of changing their health seeking behavior and making quality health care at their community. Subsequent to the Mitanin programme a positive change has been observed in the perceptions of the vulnerable communities and there is a growing

insistence that every single child death is unacceptable and it is preventable (SHRC, 2008). These outcomes are much a consequence of social mobilization as it is of the Mitanins' door to door counseling. Household visits by the Mitanins on the day of delivery, third day and another visit before tenth day is responsible for the affirmative changes in neonatal Care (EUSPP, 2011; Society for Community Health Awareness, 2003).

2.15 Disease Control

The Mitanins have made noteworthy contributions by reducing the state health burden of diseases like malaria, leprosy and tuberculosis. The Mitanin drug kits equipped with the medicine effective against Malaria are successfully employed by the Mitanins in treating primary symptoms and then referring appropriately to public healthcare. Massive health campaigns against tuberculosis and leprosy focusing on improved understanding of the disease, early diagnosis and it treatment options has helped to a large extent (EUSPP, 2011). Referral directed communication through the Mitanins have strengthened the public and community health systems in terms of abilities and approachability and is further reinforced by Mitanin referral desks regularly managed by the Mitanins and their trainers (Garg, 2006).

2.16 Women Empowerment and Mitanin Programme

Women empowerment was one of the prime objectives of the Mitanin programme that ensured better control and accessibility over resources for women. Creating health services accessible to women addressed the problem of gender equity and advanced the role of women in healthcare decision making. Difficult to measure the empowerment of women due to Mitanin programme, there are reports that through the programme women-friendly health services and women health care providers invigorated many social activities conducted by women at village and hamlet level. Result of this social contribution of Mitanin programme is reflected through the fact that many women candidates are being elected to the "*Panchayats"* (local self-government) (SHRC, 2008).

2.17 Recent Advances

There are many examples of successful integration of these mitanin workers in various programmes and schemes. A study by Vir et al., (2014) on the impact of intervention on the nutritional status involving Mitanins who undertook family-level counseling and mobilized the community to improve coverage of maternal and child health services in the state. It was observed that the inputs in the project group (PG) scaled up in the entire state within 3 years of implementation. The project demonstrated the potential for improving the nutritional status of population with the help of community mobilization brought about by the Mitanins in collaboration with the Integrated Child Development Services (ICDS) and the Public Distribution System (PDS).

The scheme called "*Nava Jatan*" launched at "*Kondagaon*" district in the year 2012 aimed to ensure positive changes in the nutritional status of the children in the state by involving "*Anganwadi"* workers with the help of self-help groups, Mitanin voluntary institutions to produce psycho-social behavioral change among the communities. The scheme had the objective of reducing the child mortality through a programme called "*Suposhan Abhiyan*" (Good Nutrition Programme) to reduce malnutrition the community health volunteers in form of Mitanins were given training through community based management practices (APIP, 2012-13).

The several remote and recent, internal or external evaluation studies on Mitanin programme conducted by governmental, non-governmental and various health professional organizations have indicated improved mortality and health determinants and indicators with improved availability and accessibility to health services. Mitanins have contributed substantially in social mobilization, activation and their services have addressed issues of gender and health equity. While evaluative studies have recognized that the Mitanin programmes have had a significant impact on the health and socio-economic determinants of the state of Chhattisgarh, there still remains a big gap in terms of quantitative and qualitative analysis of the data related to Mitanin programme. Understanding the importance of community involvement through JSR evaluation report and thereby employing *"Kalajathas"* for the task of creating community awareness about the programme was a key factor within the Mitanin programme. The roles of the Mitanins were unique blend of preventive, curative and community organization which focused on an unambiguous demand formulation for the right to health. The functional unit for the community health workers was a hamlet rather than the traditional population norm thus signifying a paradigm shift from the previous CHW programmes and this shift ensured geographical and social access. Women were primarily considered for the health worker programme based on the recommendations by the JSR report which again was shift in the ideology of the previous community health programmes in India. However, men should also be incorporated based on the successful examples of couple based approach as observed in "*Jan Mangal"* programme in Rajasthan. Men can be effectively involved to address health problems of men and promote family planning measures among the male population of the habitat. Creating the State Health Resource Centre as a significant institutional mechanism that was autonomous and outside the government, but working in partnership with it, was very crucial in the newly formed Chhattisgarh state. This was aimed to enable inter-sectoral collaboration, overcoming bureaucratic bottle necks, involvement of civil society organizations at various levels in the programme implementation.

2.18 Weaknesses of the Mitanin Programme

The previous studies indicated that the programme witnessed planner domination having experts including NGO partners generalizing the concerns and perceptions of the Mitanins, communities and public health support system. The stakeholders and planners represented the outlooks of all different sectors associated with the Mitanin programme from diverse blocks. An asymmetry in the power and knowledge existed in the programme and could be accounted by the operational need of the intervention which is bound by the scale and time frame. The need for combination of top down and bottom up approach was felt along with the block-wise feedback which could be further utilized for operational modifications. The training, supervision and community level health action suffered because of the rushed up-scaling of the programme leading to pressures to meet the promised goals with a view to expand the Mitanin programme. The programme was based on voluntary participation by underprivileged village women having little experience in health care who gave less importance to primary care. Promises were made regarding the allocation of future government jobs and payments, this lead to uncertainty and loss of confidence in programme. There is a need for the combination of the right-based and service based approach as the cornerstone of the programme with the health activist trying to improve governance and accountability of the health related systems. There needs to be a discussion about operationalizing the two approaches in a symbiotic manner.

Chapter 3
Methodology

Locale

Chapter 3
Methodology

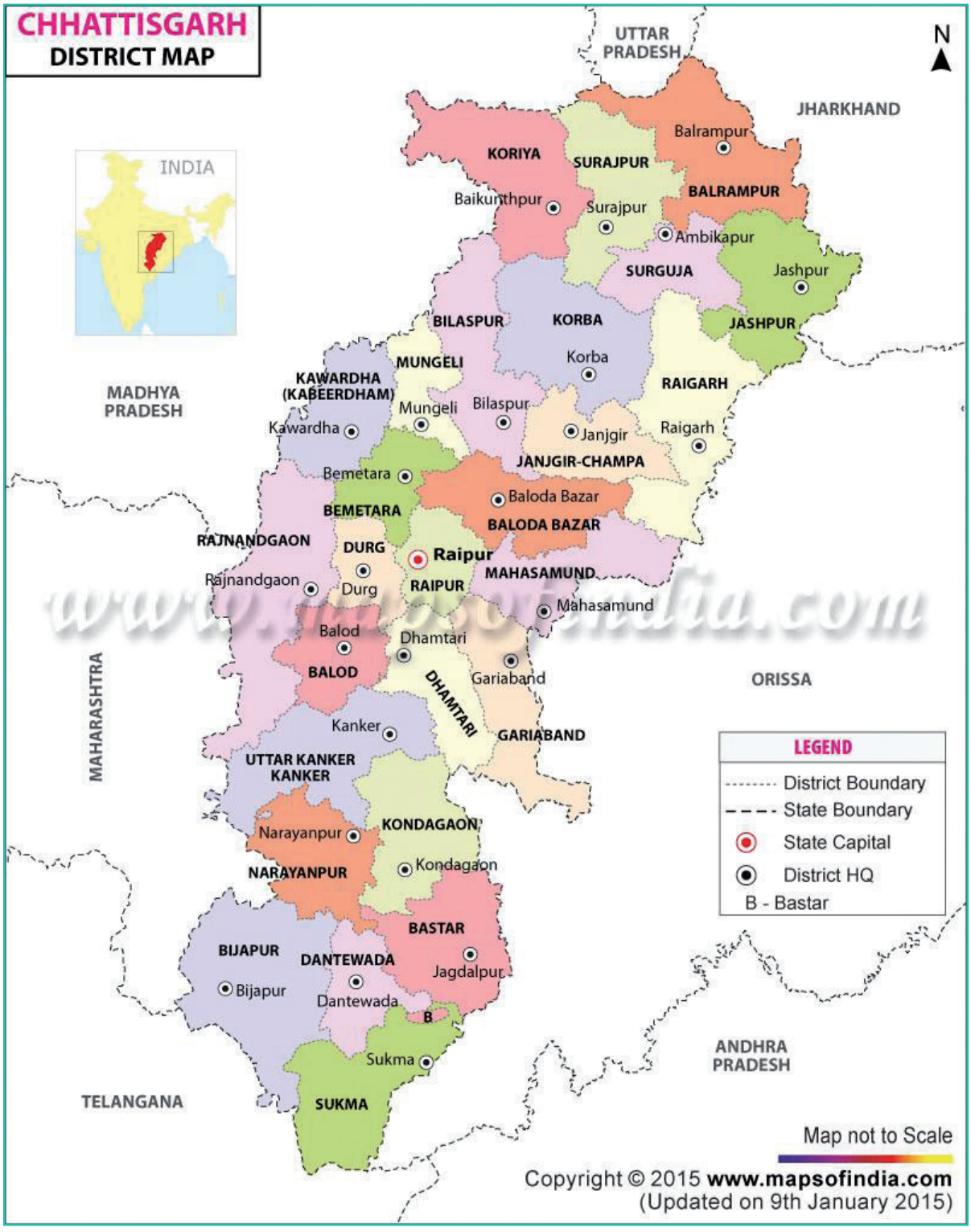
This chapter elucidates the methodological facets of this evaluative study and an attempt was made to document and analyze the reality of the rural health services as it exists in the context of mitanin programmes and the challenge it poses on them. The entire process had two specific phases; the primary stage comprising of extensive review of the published literature on several community health initiatives in national (with regards to India) and global context from 1970 to 2014, available either in printed form or electronically. This included studies largely identified through keywords and author searches in electronic databases such as PubMed, Sage, Springer Link, Scopus, Google scholar, Science Direct, JSTOR, Francis and Taylor and various other data sources. The second stage of the evaluative research was an exploration though primary data collected from different respondents such as Mitanin, ANM, AWW, and Households to understand the perceptions and experiences of women among different social groups and ANMs '& AWWs' about the roles and performances of Mitanins' in the state of Chhattisgarh, India.

3.1 The Research Setting

The research sites were located within the state of Chhattisgarh, one of the three recently formed states in India, came into being on November 1, 2000. The state has bigger milestones to achieve with respect to its development indicators as there are compounding challenges resulting from socio-demographic and health variables. Chhattisgarh has 16 districts, 96 tehsils, 146 blocks, and about 19,720 villages. At the time of its creation, the Total Infant Mortality Rate of the state, for example was 79 per 1000 and Rural Infant Mortality Rate was 95 per 1000 - which was the second highest in the country. In comparison the all India IMR was 68 per 1000 and the rural IMR was 74 per 1000. Infrastructural capability too, the state lacks the public health facilities to a large extent. As per national norms the state was short by 9 district hospitals, over 30 CHCs and over 200 primary health centers and over 874 sub-centers.

The respondents were selected from state of Chhattisgarh belonging to the different blocks and villages of the state. Consultative meetings were conducted before the initiation of research and pilot study. The study incorporated both quantitative and qualitative research methods for evaluating the health services provided by the Mitanin groups. The quantitative aspect included the structured inventories and interview schedules meant for the Mitanins, beneficiaries (households), Anganwadi workers and Auxiliary Nurse Midwives while the qualitative aspect included focus group discussions directed to the Mitanins and in-depth interviews directed towards the support system of the Mitanin groups

FIGURE 3.1 Chhattisgarh District Map



and state health authorities. The Standardized interview schedules that were well tested and amended according to the local circumstances and employed for the data collection necessary for the study. Data collection was subjected to a sample size of 4000 participants which included 1200 Mitanin, 1500 Households, 500 ANMs, 500 AWW and 300 participants from various stakeholders were included such as Mitanin trainers, District and Block medical officers, PRIs and programme managers in various districts and blocks. Ethical guidelines were strictly followed and informed consents were obtained before the interview of all participants.

3.2 Rationale of the Study

Chhattisgarh as one of the EAG state of India was lagging in socio demographic, economic and health indicators in comparison with other states in India. The biggest concern for these EAG states was the poor state of the MCH services (Dhillon and Yadav, 2013). The introduction of the Mitanin programme was to improve the condition of poor and marginalized women in the states of Chhattisgarh had been a major step towards inclusion of health deprived household in rural areas to the public health service delivery. The comprehensive development favoring large-scale interventions by the Community Health Workers (CHWs) known as Mitanin had generated encouraging results in Chhattisgarh. However, a study conducted by SOCHARA in 2005 had specified that the systems that support them often have greater scope of strengthening. The programmes often focused on training but other performance factors such as supportive supervision, clear performance expectations, motivation and recognitions were neglected. Contrary to that another study by EU-SPP in 2011 indicated that the CHWs called Mitanins along with substantial improvement in infant mortality rates of the state, reportedly achieved the goal of holistic development. The Mitanin programme proved to be a unique innovation in building knowledge and capacity of rural women for addressing first level of community health. The Mitanins workers delivered most of the critical public health services for the poor and remote areas in Chhattisgarh.

The newly formed state of Chhattisgarh faced difficult forms of social determinants of health causing increasing health inequity. Household level outreach health services, social mobilization and community coordination for improvement of health related determinants by involving the women volunteer in every habitation was the main idea behind the origin of the government led Mitanin Programme in the State of Chhattisgarh. The evidence and knowledge of Mitanin programme led to the origination of the CHW programme at the national level called ASHA (Accredited Social Health Activist) Programme.

Contemporary evaluation studies focusing on the Mitanin programme also indicated improvement in health and mortality indicators and increased utilization of the health serv-

ices chiefly by the women and children. The involvement of the Mitanins at the grass root level had effected on health equity, social and health determinants. While there were concerns that both ASHA and Mitanin programme were able to influence the health determinants like percentage of institutional deliveries, immunization coverage, breast feeding, IMR, under five mortality and MMR in a positive manner, however there was a large gap in terms of an systematic evaluation of such an influences and documentation of such actions in depth.

The data available at the national level clearly indicated that there is a gap in community outreach services as an important area in need of support for maximizing the impact of *"Janani Surkasha Yojana"* and thereby impacting the MMR & IMR. The Mitanins were the point of maximum influence among the community, who facilitated the implementation of services aimed towards the women in general and the mothers in particular. She was the fulcrum between the formal sector and the community with regards to the NRHM. These unexplored circumstances called for a comprehensive and objective investigation that may explore the performance of the programme on the desired pace and expectation of enhanced utilization of MCH services in the remote rural areas of the state.

Though, there were two preceding noteworthy studies, evaluation research carried out by Community Health Cell, Society for Community Health Awareness, Research and Action (SOCHARA), Bangalore in 2005 and the other by the EUTA for EU-State partnership Programme Chhattisgarh assisted by gtz International services in 2011, it was imperative to have an entirely etic perspective on a large scale. It was thus, crucial to explore the state of the CHW intervention, evaluate the efficiency of their performances and determine whether the burden of illness was reduced and positive health outcome achieved. To ascertain the current field realities, systematic and participatory appraisal of Mitanin programme employing in-depth and independent feedback from the community and other key field level stakeholders was essential. Data and evidences as critical ingredients in furthering and designing effective Mitanin health workforce policies and strategies were required. Review of literature strongly indicated policy-makers needed information on the size and distribution of the Mitanin health workforce, inflows and outflows, absolute and relative gains and motivation of Mitanins, effectiveness and acceptance of service delivery in the local communities, and so forth. It was thus imperative to understand Mitanin programme outcomes in tangible terms, which led to formulation of the different policies or reforms that would potentially impact the outcomes of interest. Moreover, periodic program evaluation was an essential organizational practice in public health.

The role and responsibilities of Mitanins affirm their significance in the achievement of the objectives set by NRHM. The Mitanin programme is not just a peripheral scheme, it is a socio-health phenomenon which has macro objectives of maternal and child care, prevention and long-term care in the communities by empowering communities. There are a number of interwoven factors which determine success of the programme that a stock check is an absolute necessity. Thus, an evaluation study which constructs the performance reality of Mitanin, gives input for improvement and addressing the challenges becomes inevitable. The processes which the study effectively deals with are that of selection, training, and honorarium, success in mobilizing the community, accessibility to healthcare services, and assessing the implementation of the programme.

The evaluation framework was comprised of various aspects in Mitanin program standards with the adherence to the roles and responsibilities that may allow a comprehensive understanding of the programme. Furthermore, the framework encourages an approach to evaluation that is integrated with routine program operations. The emphasis was on practical, ongoing evaluation strategies that involved all program stakeholders, not just evaluation experts. Understanding and applying the elements of this framework was driving force for planning effective research strategies; and ultimately the findings and recommendations was aimed potentially to improve the existing program implementation as well as demonstrate the results of resource investments.

Realizing the need for conducting a comprehensive evaluation of the Mitanin programme focusing on the community health profiles, this evaluation study was designed to analyze the current condition of core social factors and health indicators at the community level on unsafe motherhood, maternal and infant mortality and access to health care for these morbidities; and access to maternal, child health and family planning services provided by the Mitanin programme. By virtue of being an external evaluation, it had the potential to provide an even-handed understanding of the effect of the programme on the maternal and child health services in the community. The evaluation also enabled better understanding of the roles and responsibilities of the Mitanins and their communication with other healthcare providers and the health benefits to the community. Attempts were made to recognize the needed improvement in the strategies of the Mitanin programme.

3.3 The specific objectives

- To understand and analyze the different socio-demographic, economic and cultural aspects of the Mitanin programme corresponding to their entry procedures e.g. selection, recruitment, preparation, education and training.

- To explore the perceptions and experiences of women among different social groups, ANMs and AWWs' about the roles and performances of Mitanins' in providing health and ante-natal care in their respective communities.
- To study the various Mitanin performance factors such as organizational supportive supervision, clear performance expectations, distribution of the Mitanin health workforce, activities and functions, inflows and outflows, motivation, competence, effectiveness, acceptance and recognition in the local communities.
- To assess community awareness and responsiveness towards health related issues and utilization of public health services.
- To study the resources required for the implementation and sustenance of the Mitanin programme with an exploration of the training facilities and the incentive system for the Mitanins.
- To investigate the programmatic challenges and difficulties experienced by Mitanin in delivering health services as a community health worker with especial focus on attrition and exit.
- To examine the linkages and contribution of *"Gram Panchayat"* in Mitanin programme with special emphasis on community participation in planning and program implementation.
- To collate the findings to recommend effective strategies for strengthening and improving the implementation of the existing Mitanin programme in the state of Chhattisgarh.

3.4 Phase I: Literature Review

The objective of reviewing the existing literature was to study the numerous features and characteristics of different community health workers programmes in the global and national background. The literature review was conducted with the aim of converging details about historic evolution of vast community health initiatives in terms of their need, establishment, progress, abandonment and revival. A special attempt was made to study the community health workers programme in the south Asian region with an attempt to observe and compare the health needs of the marginalized communities in these regions. Literature was reviewed based on the various aspects of the Mitanin Programme in the state of Chhattisgarh. Attempts were made to understand the existing conceptual and operational information of Mitanin programme. It included exploration of recent research work undertaken by various groups and individuals both globally and at national level. The review of literature significantly contributed to lay down the conceptual map and designing tools for data collection. It facilitated the designing of the data collection tools to gather pertinent information from the Mitanins and other stakeholders. Various crucial reports on Mitanin programme published by government authorities, non-government agencies were also reviewed during the literature review.

The prime motive of conducting a detailed literature review was to provide a comprehensive

insight of the Mitanin programme from its conception to the recent implementation and progression. It was done with the aim to understand the organizational structure of the Mitanin programme, the personal and professional life experiences of the Mitanins, the support systems from the government, health department, civil bodies and communities. Several important and critical reports on community health workers programme in India and around the world published by various recognized agencies like National and State Health Services Resources Centre in India, Ministry of Health and Family Welfare, India, World Health Organization, World Bank, UNICEF, United Nations, USAID (United States Agency for International Development) were also reviewed in the light of Mitanin Programme. Many of the reports had set vital protocols and guidelines for the formation, execution and improvement of community health programmes. The literature and reports helped in developing in-depth understanding related to their conceptualization, operational arrangements, and current advancements in the Community Health Programme. The reports also aided the research team to understand the functional, vocational, and situational analysis of the Mitanins and their service users in the state of Chhattisgarh.

3.5 Phase II: Primary Data Collection

The secondary phase of this study comprised of a detailed investigation of the research objectives and collection of primary data in the state of Chhattisgarh using both quantitative and qualitative measures. It included preparation of data collection instruments, training and orientation of the field investigators, actual data collection form primary and secondary respondents, data entry, data analysis and report writing. The data collection instruments involved structured and semi-structured interviews; the instruments were pre-tested in the field with the help of translated version (Hindi) of the instruments.

The study employed stratified random sampling which allowed an expanded objectivity. Hence, depending on the Random Sample Calculator (RSC) with less than 3% acceptable level of error and with 95% of confidence level the sample size was calculated. This scientific representative sample calculation in this evaluation study reduced the cost and workload in a time bound rapid evaluation. Utmost care was taken to ensure that the respondents chosen were representative of the whole population and included respondents specifically hard to reach groups.

The Mitanins, ANMs, AWWs and the beneficiaries (Households) were interviewed mainly at different villages, Anganwadi Centers, offices or at meetings like gatherings or exhibitions. All interviews were conducted in proper environment with sufficient privacy. Average time required for each completed interview was 45 minutes in case of Mitanins and approximately 30 minutes for the beneficiaries, AWWs and

ANMs. The female field investigators were encouraged to interview female respondents for maintaining level of comfort and ease with the women respondents in the study.

3.6 Research Design

This exploratory design of the evaluation research was conducted to provide a better under-standing of the situation in the ground, thus employed both qualitative and quantitative methods. The qualitative methods encompassed semi-structured interviews, field observation, in-depth interviews, focus group discussion, review of documents and other materials and the quantitative methods comprised of structured interview schedules and standard inventories. The study also included examination and analysis of variables associated with Mitanins in relation to their entry in the programme, their performance, factors affecting their performance and issues related to their attrition and exit. The study aimed to focus on conducting comparative analysis of the variable with similar construct and characteristics, while variables with different backgrounds and features were analyzed for in-depth understanding of the programme. Predominantly a combined method of both quantitative and qualitative methods of data collection with various stakeholders was considered.

a. Quantitative approach generated organized experiential first-hand information on various processes of Mitanins activities, duties, performance, contentment, and beneficiary's formulation of perceived reality in association to the Mitanins and their functioning as highlighted in the conceptual framework.

b. Qualitative research design by utilizing procedures such as in-depth interviews, focus group discussions, semi-structure interviews intended to explore social, cultural and organizational understanding of the Mitanin and other's engagement in the community health care services and initiatives.

3.7 Measures and Procedures

The trained research assistants/ investigators conducted the interviews with individual respondents using standard and structured interview schedules in the field, in the health facilities or in the communities. The study interview protocol contained standardized constructed inventories with respect to exploring the performance and effectiveness. The data was analyzed with the current version of SPSS 20.0 for Windows to establish linkages between variables and concepts. The qualitative data was analyzed using the Atlas.ti for large bodies of textual and audio data.

3.8 Locale of the Study and Study Population

Chhattisgarh as the 10th largest state in Central India with an area of 135,190 Sq km (52,200 sq mi) and a population of 2,

55, 45,198Crore, Chhattisgarh was the 16th most-populated state of the nation. The state was formed on 1st November 2000 by partitioning 16 Chhattisgarhi-speaking south-eastern districts of Madhya Pradesh with 27 districts. Chhattisgarh borders the states of Madhya Pradesh in the north-west, Maharashtra in the south-west, Andhra Pradesh in the south, Odisha in the east, Jharkhand in the north-east and Uttar Pradesh in the north.

TABLE 3.1: Demographic Particulars (Census, 2011)

Population	2,55,45,198 Crore
Males	1,28,32,895
Females	1,27,12,303
Rural	19607961 (76.8%)
Urban	5937237 (23.2%)
Literacy Rate	71.04% (Male 81.45%, Female 60.59%)
SC	12.82%
ST	30.62%

Source: Censusindia.gov.in/2011 Census

3.9 Sampling Frame and Data Collection

A major portion of the state's total population lived in the villages; approximately there were about 19,744 villages in Chhattisgarh that were rich in their social, cultural and religious diversity. Due to large geographical coverage and at time inaccessible areas, the 1200 required number of Mitanin were conveniently selected for the interviews by the field investigators. However, data was collected from the districts and Blocks as mentioned in the Table: 3.2. For better representation of samples from all the districts and blocks of the state five administrative divisions were considered. The field investigators visited respective villages under the blocks mentioned in the table and contacted the Mitanin in the villages for the interviews and informed consent was obtained before administering the interview schedule.

The study aimed to cover five representative divisions of Chhattisgarh state namely Bastar Division, Durg Division, Raipur Division, Bilaspur Division, Surguja Division. The following 15 districts both from the old and newly formed Districts were conveniently selected. Thereafter, 10 mitanins were purposively selected from each block and those were readily available and volunteered to participate in the interviews were included in the study. A list of the villages in each block was consulted for the selection of the villages.

TABLE 3.2: Geographical Distribution of Respondents

Divisions	Districts	Blocks/Villages	Total No of villages
Bastar Division	Bastar, Kanker (Uttar Bastar), Bijapur	Bastar (12 Blocks) Kanker (7 Blocks) Bijapur 4 (Blocks)	(120+70+ 40) = 230
Durg Division	Kabirdham (Kawardha), Durg, Rajnandgaon	Kabirdham (4 Blocks) Durg (11 Blocks) Rajnandgaon (9 Blocks)	(40+110+90) = 240
Raipur Division	Dhamtari, Raipur, Mahasamund	Dhamtari (4 Blocks) Raipur (13 Blocks) Mahasamund (5 Blocks)	(40+130+50) = 220
Bilaspur Division	Bilaspur, Korba, Janjgir-Champa,	Korba (4 Blocks) Janjgi-champa (8 Blocks), Bilaspur (8 Blocks)	(40+80+ 80) = 200
Surguja Division	Koriya, Surguja, Jashpur	Koriya (1 Block) Surguja (18 Blocks) Jashpur (10)	(10+180+120) = 310
			Total: 1200 Villages

Source: www.chhattisgarh.gov.in District wise report accessed on 12th August 2013

To increase the probability of inclusion of representative primary respondents according to known characteristics such as geographical spread, social class, caste and tribal categories, the researchers made sincere attempts to ensure that all sub-groups of the population relevant to the study were adequately represented.

Considering the complete six to seven months' duration of the research project, initially only two months were budgeted for the data collection, however, due to enormous hardships and inaccessible rural areas the data collection was extended to three and half months. The trained research staff comprised of 10 Research Investigators, 2 Research Scientists, and 1 Facilitator engaged in the data collection process and the team was provided with close supervision by the PI.

The proposed sampling size was –Structured interviews of:

1. Mitanins (1200 interviews)
2. Households (1500 Household interviews)
3. Auxiliary Nurse and Midwives (ANMs) (500 interviews)
4. Anganwadi Workers (AWWs) (500 interviews)
5. Block Medical Officer (BMO) (20 In-depth interviews)
6. Block Programme Manager (BPM) (20 In-depth Interviews)
7. District Programme Manager (DPM) (15 In-depth interviews and EI)
8. District Resource Person (DRP) (15 In-depth interviews)
9. Mitanin Trainer (MT) (20 In-depth interviews)
10. Key personnel of NGOs (20 In-depth interviews)
11. Significant Members of Panchayati Raj Institution (PRI) (15 In-depth interviews)
12. State Health Resource Centre (SHRC) (3 In-depth interviews)
13. State Programme Manager (SPM) (Key informant interview)

3.10 Ethical Considerations

The research team was exposed to and trained in highly ethical behavior during the course of research, prior to the initiation of the study the core research team was trained and explained to understand the ethical issues related to the Mitanin group and the people associated with this service. These ethical issues centering the research was discussed and detailed out. The following guidelines were followed to the core while collecting data and through the process of the research. All the respondents were selected for the interview only after obtaining informed consent. The categories of the respondents from the health systems and the community were approached through the credible organizations working in the rural districts of the state and the government health system.

The privacy of the participants during entire research was maintained appropriately. No identity of the participant was sought or recorded during the entire course of current study in order maintain anonymity. Participants were not forced to mention their name anytime during interview and even after that. All possible attempts were made to not disclose or violate privacy of the respondent in any way. A voluntarily agreed written consent was requested from the participants before interviewing them by adopting a culturally sensitive approach and in a language (local language) well understood by the participants. Participants were informed about their right to withdraw from the study at any time and during any stage of the study. In case of the participants being illiterate, a thumb impression was obtained from them to ensure their participation. The detailed Informed Consent form and instruments are produced in the appendix section at the end of the report.

3.11 Instruments for Data Collection

A detailed Semi-structured Interview Schedule was prepared for the Mitanin as they were the primary respondents of the study. Separate other semi-structured interview schedules were prepared for other respondents such as Households, ANMs, and AWWs. Simultaneously in-depth interview guides were prepared for the Block Medical Officers, Block Programme Managers, District Programme Managers, District Resource Persons, Mitanin Trainers, NGO Personnel, Significant Members of Panchayati Raj Institution, and State Health Resource Centre. The instruments were prepared after the meticulous review of literature and consultative meetings with the experts in the field. The variable of the study were sub divided into different subsections with pertinent questions related to the area such as a) Socio-Demographic profile, b) Mitanin Recruitment, c) Education/Training, d) Preparation and Deployment, e) Mitanin Performance, f) Availability of Resources, g) Perception/Experiences, h) Supervision/Support, i) Career Growth, j) Compensation, k) Attrition and Exit etc.

3.12 Translation of the Instruments in Regional Language

At the initial stage all instruments were prepared in English and then translated into Hindi regional language with the help of experts in the respective fields. The translated versions of instruments were then subjected to rigorous scrutiny by the technical experts to check the accuracy and those who were familiar with Hindi language.

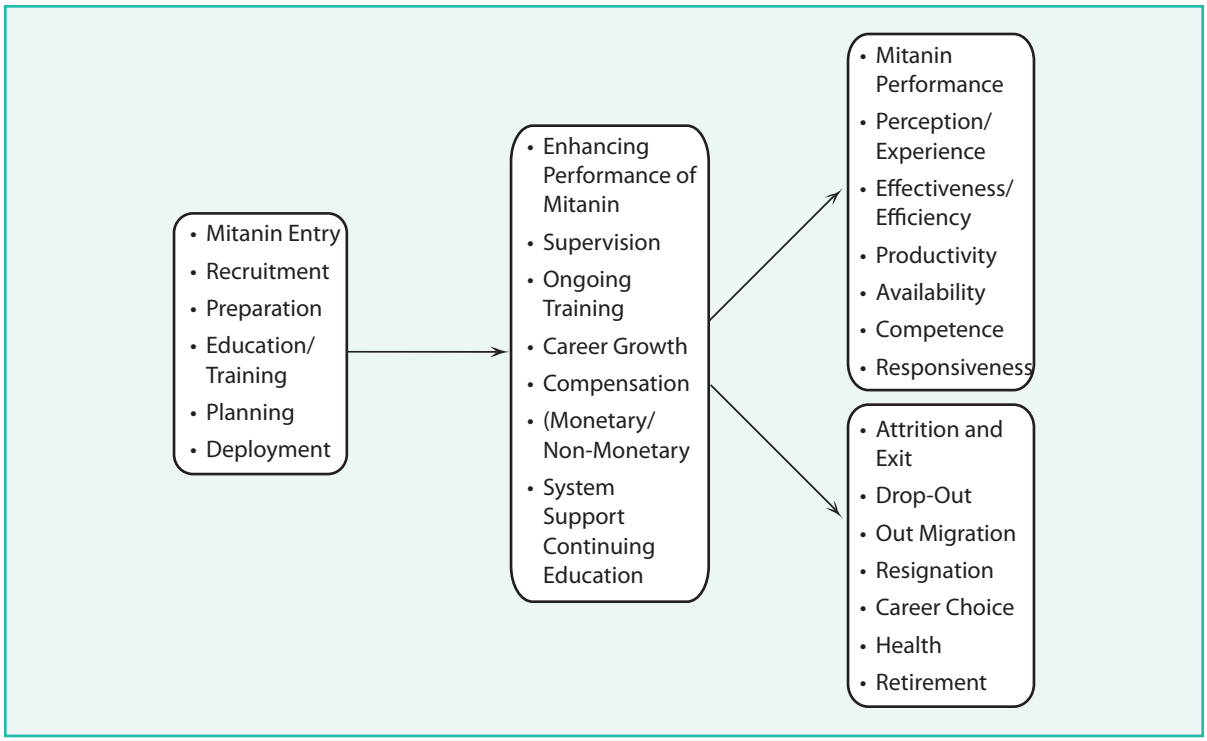
3.13 Pilot Testing of the Instruments

The structured interview schedule was tested in the field by administrating it to 15 Mitanin before finalizing it for actual data collection. The pilot testing gave an opportunity to sharpen the instrument by adding, deleting and modifying some questions according to the inputs of the respondents. It has also helped to modify the instrument in such a way that optimum information could be extracted from each respondent in a short span of time (40-45 min / per respondent) that too in one attempt. Qualitative instrument i.e. In-depth Interview Guides for secondary respondents as mentioned above were also pilot tested in the field by conducting face to face interviews (1 for each category) in the field. Moreover, interview guides for field investigators were prepared to guide them while conducting interviews so that personal biases and errors are avoided efficiently. Five training sessions of two day each were organized for the field investigators. Subsequent regular weekly meetings were held in the field to review and monitor the quality of the interviews, which helped in training and preparing the field investigators. They were able to successfully conduct the interviews in the field without much errors and personal biases.

3.14 Framework of analysis

In the proposed study, a conceptual framework was developed with a comprehensive focus

FIGURE 3.2: Mitanin Evaluation Framework



on life span evaluation model of Mitanin programme. The framework certainly provided a sharper focus into the inquiry; and was used in the research to outline all related and inter-related variables. The inter-relatedness of the variables (independent and dependent) and certain imperative courses of action as a result of interaction amongst the variables were identified to form the integrated part of the inquiry. Independent variables (presumed cause) such as socio-demographic variables like age, education, family income, religion, social origin etc. and the dependent variables (presumed effect) Mitanin Entry, enhancing performance, attrition and exit, and Mitanin performance were incorporated in the interactional model that supposedly had determining effects on the Mitanin performance and the overall impact on the programme. Thus, the enlisted variables were the frame of reference for formulating the areas of research questions.

In addition it is important to explore the reliability of support and supervisory mechanisms. Supervisory activities that ensured effective communication among the different level of health workers were also studied. Specific logistics and infrastructure support addressing the issues of reliable provision of transport, drug supplies and equipment were analyzed as well. Opportunities of professional development for the Mitanins and compensation available to the Mitanins were reviewed. Factors acting as incentives and disincentives for the Mitanins reflected in terms of financial remunerations

and possibilities of future employment opportunities were also researched. The attrition and exit of the Mitanins attributed to drop-outs, migration, career shift and retirement due to health reason were assessed. Mitanin Performance (Perception, experience, effectiveness/efficiency, productivity, availability, competence, responsiveness) were also assessed. The perception and experiences of the Mitanins while working in the community and with other health officials were considered. The appropriateness of the health services provided by the Mitanins to the health needs of the population they serve and effectiveness in creating self-reliance and enhancing local participation among the communities was investigated. The evaluation also aimed to assess the accessibility and acceptability of the Mitanins among the communities they operate and the means by which the Mitanins improved the coverage of the health services especially among the low income groups thereby ensuring equity.

3.15 Scope and the Limitations of the Study

Besides all possible attempts to make the research study as comprehensive and representative one, there may still some foreseeable limitations of the study. Reviewing and documenting the performance analysis of the Mitanins in the community reproductive health remained a neglected area. Thus the influence of the community health services provided by the Mitanins on MCH care, Family planning services utilization and chronic disease patterns remained invisible and was understood only partially. Besides all possible attempts to make this research study comprehensive and representative one, there were few limitations of this study as follows:

The evaluation was completed within a short period between 2013 and 2014. The research was time bound and there were limitation in terms of approaching all the Mitanins and beneficiaries associated with the programme due to the difficult geographical conditions and lack of transport facilities in the interior regions of the state. The field situation was complex as certain areas were affected due to the actions of the Left Wing Extremists. These factors also led to the delays in the data collection processes which were the major reason that made the research team realize that the evaluation task involved more than what was originally planned and decided. Approaching various state health authorities during their extremely busy schedules for the participation in the study required considerable amount of time for collecting data and information from these stakeholders.

Chapter 4

RESULTS AND DISCUSSION

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Chapter 4

RESULTS AND DISCUSSION

4.1 Socio-Economic and Demographic Profile

The primary respondents in the study comprised of the Mitanins - a cadre of trained female community health workers also knows as India's largest Community Health Volunteer Programme. This chapter briefly discussed the socio-economic and demographic characteristics of the Mitanins in relation to their age, gender, marital status, religion, social status and income. The findings of the study revealed various aspects of Mitanin programmes in the rural areas and their role performance in the state health programmes. The knowledge and skills of Mitanins in the areas of maternal and child health, family planning, sanitation and hygiene were assessed during the study. Other significant areas such as work experience and their interpersonal relationship and coordination with peers, ANMs, AWWs were also discussed with reference to their role, responsibilities and contribution in state reproductive and child health programme. The result also provided information on the evaluation indicators of Mitanin's education and trainings, recruitment process, deployment as well as preparation and planning. In addition, assessment of core indicators such as career growth, supervision and support from health care professional, head of the villages, monetary benefits and incentives allocated are also elucidated in this chapter. Further in order to maximize state's potential to achieve the health care goals through the NRHM, it is essential to investigate methods to improve Mitanin performance, specifically through the processes of recruitment, training, supervision, provision of incentives, and expansion to greater roles.

4.1.1 Age and Gender of the Respondents

The Table 4.1 illustrated the mean age of all the respondents such as Mitanins, ANMs, AWWs and Household respondents, it indicated the mean age of Mitanins in the study was 36 years (SD = ±8.1) with the range 19 to 70 years. This average was very close to mean age of AWWs 35 years (SD= ±8.2) with the range as 20 years to 61 years. Whereas, the mean age of ANMs was 32.4 years (SD= ±9.7) with the range of 21 years to 58 years. The mean age of the community health workers indicated that the young women were actively working in the field as main grass root level community health workers in the state of Chhattisgarh. However, the difference in the mean age of the household respondents was observed in the present study was as 25.3 years (SD= ±4.8) with the range 18 years to 73 years. Thus the household respondents who participated in the study were from lower mean age and where younger than the community health workers. The findings of nearly half the Mitanins belonged to the age group of 26-35 years was also in accordance to the SOCHARA evaluation that had also observed that half of their respondents belonged to almost the similar age group of 22 to 35 years.

TABLE 4.1: Age of the Respondents

Total No. of Respondents	Minimum (in Years)	Maximum (in Years)	Mean (± SD)
Mitanins (n=1200)	19	70	36.0 (±8.1)
AWW (n=500)	20	61	35.2 (±8.2)
ANM (n=500)	21	58	32.4 (±9.7)
Household (n=1500)	18	73	25.3 (±4.8)

The Table 4.2 illustrated the overall percentage of age distribution of Mitanins, a significant proportion of the Mitanins (47.4%) belonged to the younger age group of 26-35 years. This finding was in accordance with the national level finding of the ASHA evaluation (NHSRC, 2010-11) that reported the maximum number of ASHAs were between the age group of 25-35 years. The observation also corresponded with the selection criteria of the Mitanins as laid down in the operational guidelines of the Mitanins programme. The findings of nearly half the Mitanins belonged to the age group of 26-35 years was also in accordance to the SOCHARA evaluation that had also observed that half of their respondents belonged to almost the similar age group of 22 to 35 years.

Among the selected Mitanins, less than 7% were below to the age of 25 years and more than one third of the Mitanins (34.3%) were between the age group of 36 to 45 years. Interestingly the data also revealed the fact that 1.7% of the Mitanins were older than 56 years. It was also desirable that these women would be supported by their families, as this age group of 26 to 35 are likely to be married and with children so that they are knowledgeable about child health and care. As prescribed all Mintanin in the study were female habitants of the respective villages prepared to form a cadre of trained female community health volunteers/workers.

4.1.2 Marital Status and Religion

The Table 4.2 indicated that the great majority of Mitanins (94.1%) those who had participated in the study were married. However, less than 5 per cent of the respondents were either widowed (3.3%) or unmarried (1.5%), at the same time the number of divorced or separated were negligible (only 1.1%). The state data on Mitanin showed that the largest proportion (96.8%) of respondents were from Hindu religious faith. Whereas, only a small proportion (3%) of the Mitanins belonging to other religions such as Islam and Christianity, 1.6% and 1.2% respectively. In addition it was also observed that less than 0.3% of the Mitanins belong to the Buddhist and Jain communities.

4.1.3 Educational Level

The level of education was not a strict criterion for the selection of the Mitanins, however neo-literacy level was encouraged amongst them as certain aspects of their roles and responsibilities required minimal level of literacy. The evaluation findings indicated that almost half (50.1 %) of the Mitanins had received education up to middle school. About one fifth (21%) of the respondents had completed Secondary School or Pre-degree college education. Around 13 per cent of the participants had no education, out of these 7.3 per cent were literate, but had no formal education. Only 17 (1.4 %) Mitanins had received education up to the graduation/post-graduation level as shown in the Table 4.2. However, better level of literacy among the Mitanins is always desirable as to ensure their level of comprehension for the training modules, programmes implementations and maintenance of records etc. The requirements of the community health workers vary, in some countries they typically have at least a high school diploma and must complete a brief period of on-the-job training. In some states of USA have certification programs for community health workers (BLS 2015). The qualitative data indicated that the Mitanins with no or low level of literacy experienced difficulty in understanding the trainer during the training sessions. These Mitanins were also found to have not maintained any kind of records of their work.

4.1.4 Individual and Household Income

The Table 4.2 indicated that a large majority of the Mitanins (61 per cent) reported to have received Rs. 200 to Rs. 900 as incentives and 27 percent of the Mitanins received less than Rs. 200 per month from the Mitanin Programme. However, a significant proportion (42%) of the families of the respondents earned only between Rs 2000 to Rs. 5000 per month. Although small proportion (2%) of Mintanin workers admitted that they did not receive any incentives, on the other hand almost 20% of the Mitanins also mentioned that incentives earned by Mitanins were the only source of income and they did not have any other source of earnings.

TABLE: 4.2 Socio-Economic and Demographic Profile of Mitanin

Variables (n =1200)	Frequency	Percentage
Age (in years)		
≤ 25	83	6.9
26-35	569	47.4
36-45	411	34.3
46-55	117	9.8
≥ 56	20	1.7
Marital Status		
Unmarried	18	1.5
Married	1129	94.1
Separated	10	0.8
Divorced	3	0.3
Widowed	40	3.3
Religion		
Hinduism	1164	97.0
Islam	19	1.6
Christian	14	1.2
Buddhism	2	0.2
Jainism	1	0.1
Level of Education		
No education	68	5.7
Literate, but no formal education	88	7.3
Primary school (up to 4 years)	174	14.5
Middle school (5 to 9 years)	601	50.1
Secondary School Certificate (SSC)	123	10.3
Pre-degree (XII Standard)	128	10.7
Diploma	1	0.1
Graduate/post graduate (Gen)	12	1.0
Graduate/post graduate (Pro.)	5	0.4

Variables (n =1200)	Frequency	Percentage
Individual Monthly Income as Incentives (in INR)		
≤ 200	324	27.0
201-500	555	46.3
501-900	173	14.4
901-1400	95	7.9
1401-2000	36	3.0
2001-2700	8	0.7
≥ 2701	9	0.8
Individual Monthly Income (Other Sources in INR)		
≤ 300	538	44.8
301-500	261	21.8
501-1000	242	20.2
1001-5000	153	12.8
5001-10000	5	0.4
≥ 10001	1	0.1
Monthly Household Income (All Sources in INR)		
≤ 1000	161	13.4
1001-2000	292	24.3
2001-5000	498	41.5
5001-10000	155	12.9
10001-20000	56	4.7
20001-50000	34	2.8
≥ 50001	4	0.3

4.1.5 Population Distribution

The Table 4.3 described the percentage distribution of the Mitanins by the population categories, almost half (47.2%) of the respondents belonged to the Other Backward Classes (OBC), nearly 30% belonged to the Schedule Tribes (ST), while 17% belonged to the Schedule Caste (SC). Only around 7 % of the participants were from the general category.

4.1.6 Type of Family and Household Size

The results showed that the leading numbers of the Mitanin belonged to the joint families (41.3%), equally a considerable proportion of respondents (39.6%) belong to nuclear families. With lowest representation of the Mitanins were from the extended families, there was also a substantial number of Mitanins almost 12 per cent that lived on their own.

Household size of the Mitanins revealed that a significant proportion (35.4%) had family size ranging between 5-6 members in the family. A comparison of the mean household size with the available state census 2011 figures indicated that the mean household size at the national level is slightly lower at 5 per household. Some Mitanins (26.3%) reported to have the household size of 3-4 members; on the other hand about 23.2 % had still larger household size with more than 7 members. Only a small proportion 15.2% of the Mitanin had 1-2 member household. The current study indicated that the mean score of the household was 5.3 members; this might be due to the fact that almost half of the respondents hailed from extended (6.8%) and joint family (41.3%) background.

TABLE: 4.3 Distributions of Mitanin as per Social Position, Type of Family, Household Size.

Variables (n =1200)	Frequency	Percentage
Social Position		
General	73	6.1
Schedule Caste	202	16.8
Schedule Tribe	359	29.9
Other Backward Class	566	47.2
Type of Family		
Single member	147	12.3
Nuclear family	475	39.6
Extended family	82	6.8
Joint family	496	41.3
Household Size		
1 to 2	182	15.2
3 to 4	315	26.3
5 to 6	425	35.4
≥ 7	278	23.2

4.1.7 Comparative Analysis of Social Profile of Mitanin, ANM, AWW and Household

The study of Mitanins programme also aimed at incorporating the significant feedback from the household respondents about the service provided by the Mitanins and tried to understand the awareness among the household participants about the functions of the Mitanins. The head of the family, 6-9 months pregnant women, mother with child less than 6 month age and women with child aged 7 to 24 months were the main respondent in household respondents. Among the household more than half of the respondents (61.6%) below 25 years and about 35.4 percent of the respondents were between the age group of 26 to 35 years. Whereas, small proportion (3%) of the household where between age group 36 to 45 years. Further analysis of age trend of ANM and AWW revealed significant proportion (44.6% and 44%) of ANM and AWW belonged to age group 26-35 and 36-45 years as compared to Mitanin 47.4% belonged to age between 26-35 years. A large majority of Mitanins, ANMs and AWWs were married and followed Hinduism as their main religion. A Substantial proportion (54.2 and 39.8 %) of ANM and AWW had the education up to Pre-degree (XII Standard), on the other hand 50.1 % of Mitanin had education till middle school level. However, significant proportion (42.7%) of house hold participants had no formal education and the data further revealed that majority of the participants in the study belonged to the OBC as compared to other social class.

TABLE 4.4: CHWs and Household Profile: Comparative Analysis

Social Profile	Mitanin (n=1200)		ANM (n=500)		AWW (n=500)		Household (1500)	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Age (in years)								
≤ 25	83	6.9	80	16.0	61	12.2	924	61.6
26-35	569	47.4	121	44.6	112	22.4	531	35.4
36-45	411	34.3	76	15.2	220	44.0	45	3.0
46-55	117	9.8	223	24.2	89	17.8	-	-
≥ 56	20	1.7	-	-	18	3.6	-	-
Marital Status								
Unmarried	18	1.5	75	15.0	48	9.6	-	-
Married	1129	94.1	415	83.0	416	83.2	-	-
Separated/Divorced	13	1.1	1	0.2	7	1.4	-	-
Widowed	40	3.3	9	1.8	29	5.8	-	-
Religion								
Hinduism	1164	97.0	440	88.0	475	95.0	1439	95.9
Islam	19	1.6	15	3.0	15	3.0	28	1.9
Christian	14	1.2	41	8.2	4	0.8	31	2.1
Buddhism	2	0.2	4	0.8	-	-	1	0.1
Jainism	1	0.1	-	-	-	-	-	-
Sikhism	-	-	-	-	6	1.2	1	0.1
Level of Education								
No education	68	5.7	-	-	1	0.2	641	42.7
Literate, but no formal education	88	7.3	-	-	1	0.2	138	9.2
Primary school (up to 4 years)	174	14.5	-	-	12	2.4	241	16.1
Middle school (5 to 9 years)	601	50.1	3	0.6	168	33.6	181	12.1
Secondary School Certificate (SSC)	123	10.3	27	5.4	67	13.4	128	8.5
Pre-degree (XII Standard)	128	10.7	271	54.2	199	39.8	129	8.6
Diploma	1	0.1	76	15.2	3	0.6	5	0.3
Graduate/post graduate (Gen)	12	1.0	105	21.0	37	7.4	27	1.8
Graduate/post graduate (Pro.)	5	0.4	18	3.6	12	2.4	10	0.7
Social Position								
General	73	6.1	120	24.0	57	11.4	76	5.1
Schedule Caste (SC)	202	16.8	72	14.4	83	16.6	266	17.7
Schedule Tribe (ST)	359	29.9	113	22.6	151	30.2	478	31.9
Other Backward Class (OBC)	566	47.2	195	39.0	209	41.8	673	44.9
Others	-	-	-	-	-	-	7	0.5

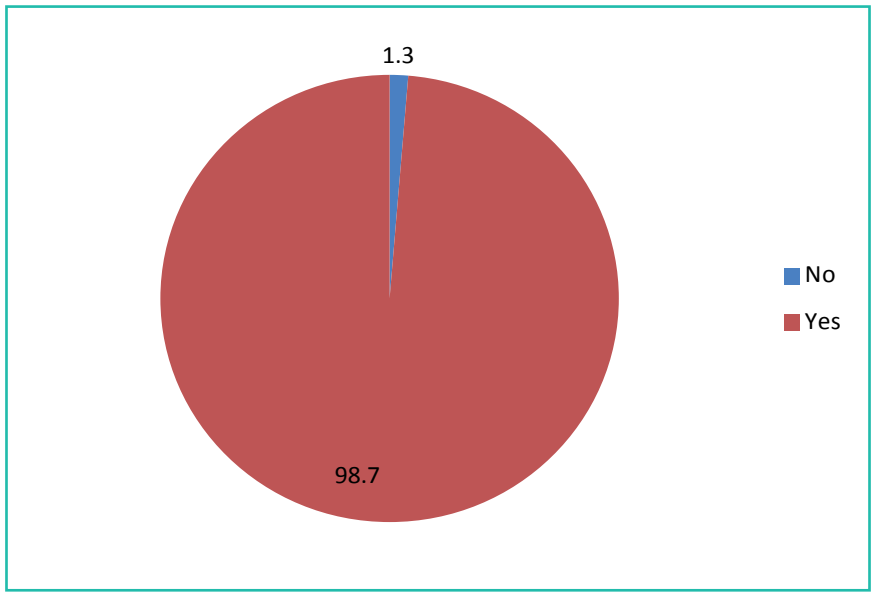
4.2 Selection and Recruitment Processes of Mitanins

The Mitanin programme clearly chalked out operational guidelines for the selection process during the initial phase. The facilitators ("*Preraks*") played a vital role in the selection of the Mitanins at the outset. The facilitators were people who were socially active with a strong will to bring a positive change in the community. They were selected by the members of the district training team comprising of the government employees as well as NGO partners. The facilitators conducted discussions with the local leaders, gram panchayat and communities including the women's group and explained the objectives and process of the programme to them to enable them to select the Mitanins. They achieved this through various activities like arranging events that aroused public interest in the Mitanin Programme.

4.3 Mitanin's Place of Inhabitation and Work

The CHWs serve as a bridge between health care providers and the community as well as they have accountability to both the groups. Therefore, a multi-step selection process is required to ensure the belongingness and cultural affinity with the households they serve and consequently receive acceptance and respect from them (Cepikua & Giordano, 2013). The study intended to find out the extent of the belongingness among the Mitanins towards their place of stay and people they served. The study explored that almost all the Mitanins (98.7%) were the inhabitants of the villages where they worked. However, a small proportion of the Mitanins (1.3%) did not belong to the villages where they functioned as community health workers (Figure 4.1).

FIGURE: 4.1: Belongingness of the Mitanins to their Villages (in %)



The Table 4.5 illustrated the native place/belongingness of Mitanins to their communities in selected districts of Chhattisgarh. The findings suggested that almost all Mitanin (98.7%) were the inhabitants of the same village where they worked however some districts namely Bastar, Janjgir-Champa, Durg, Jashpur, Kabirdham, Korba, Mahasamund, Raipur and Rajnandgaon had very negligible proportion of Mitanins (1.3%) from outside of their community. Lehmann & Sanders (2007) insisted that the most important factor in the selection of the CHWs was that the community health worker should be from the community he or she serves. During the qualitative interviews the researchers had also observed that method of selection influences the acceptability of CHWs in the community, commitment and accountability of the CHWs.

TABLE 4.5: Native Village/ Belongingness of Mitanin in the Districts

Districts	Belongingness to Native Village	
	Yes	No
Bastar	113	3
Bilaspur	103	0
Janjgir-Champa	64	2
Dhamtari	83	0
Durg	77	1
Jashpur	160	2
Kanker	62	0
Kawardha	20	1
Korba	72	2
Koriya	27	0
Mahasamund	29	1
Raipur	195	2
Rajnandgaon	99	2
Surguja	3	0
Surguja	77	0
Total	**1184**	**16**

4.4 Selection Procedure of the Mitanins

The following conclusions were derived about the selection process of the Mitanins - a combination of information collected from the structured interviews administered to the Mitanins, ANMs and AWWs and qualitative responses from the stakeholders. There have been several commentaries on the selections of the Mitanins and the different modes of their entry into the programme and formal methodologies employed for their recruitment. In most cases it was reported that the selection process involved active participation of the Mitanin trainers and the members of the *"Gram Panchayat"* especially the "*Sarpanch"* (Village head). These decisions were finalized only after a "*Gram Sabha*" (Village Meeting) involving the members of the communities was convened. Many experts like Rifkin (2009) contend that the CHWs need to be accountable to the community, specifically to the poor and vulnerable groups of the community and not the health authorities, thus the process of the selection of the community health workers should be by the community, of the community and for the community. The findings also testified the assistance offered by the facilitators, district resource personals and state health workers and authorities in the selection process were minimal.

Process of the selection of the Mitanins as informed by the District Programme Managers was usually expedited by the Mitanin Trainers, Block Medical Officers and later the Chief Medical Officers of the various districts who were informed about these selections. In the earlier phase as confirmed by the SHRC, a facilitator like ANM, ICDS worker, VHSC member, member of the *"Panchayat"* and NGO worker helped the communities understand the concept of the Mitanins and encourage them to select a Mitanin from their community. In recent times, the awareness levels have gone high resulting on saving of time and effort of facilitators and concerned workers. The SHRC reported an evolution with respect to the community participation level wherein the decision making capacities with respect to Mitanin selection had been heightened. In many places there was a formal meeting of the *"Gram Sabha"* (Village meeting) to select the Mitanins with harmonious agreement between the local community and the *"Gram Panchayats"* and the health department representatives were present at the meeting. Furthermore, many researchers have also recognized that in several CHW programs, the political favoritism promoted the selection of individuals who were not well-motivated or suited for the role. Therefore, in this connection probing of the several stakeholders elicited that there were at times minimal influence however those were covert local or regional political influences and dynamics on the selection processes. The staffs were of the opinion that in some places not all, decisions were politically influenced the selection.

Several District Health Officers expressed the fact that they were not directly involved in the selection of the Mitanins so their knowledge and understanding about the selection process of the Mitanins was very restricted and limited. But they shared few vital points which they reflected the current scenario of the system of the selection of the Mitanins. According to them the monetary compensations of the Mitanins had defeated the purpose of volunteerism. The introduction of the incentives has made the programme vulnerable to political influences in the selection of the Mitanins.

The DHOs were of the opinion that over the years the Mitanins have picked up skills and those near the urban districts were motivated to be become Mitanins because they were aware that they may be able to earn some monetary incentives. Some of these Mitanins also hoped to become a permanent government employee. It was reported that currently the Mitanins are well organized and are demanding for their rights and entitlements. They are making demands for the regularization and absorption as government employees. In addition, it was learnt that Mitanins had formed strong unions and now organizing for their demands.

4.5 Experience as a Requisite

The work of the Mitanin involves a constant interaction with the community environmental system; hence their prior work with communities is advantageous. However, experience is not a limiting factor at all, amongst the Mitanins a sizeable majority (89%) had no prior work experience before joining as a Mitanin. Out of the 11% experienced CHW workforce, nearly half had some experience of one year or less. The Table 4.6 illustrates the year of community work experience that the Mitanins had before joining the programme and it can be inferred that most Mitanins join the programme as fresher. Most Mitanins did not carry previous work experience which features as a preferable requirement as per the state guidelines for the programmes, however their retention in the programme found to be satisfactory. During the interviews a majority (53.1%) of Mitanins reported to have more than 10 years of work experience and around 18% of Mitanins mentioned that they had 4-6 years of work experience. Only a few Mitanin, less than 2% had less than one year experience suggestive of a fact that they were in the programme for substantial period.

TABLE 4.6: Experience of Mitanin as Community Health Worker

Variables	Frequency	%
Previously worked as CHW before joining Mitanin (n=1200)	128	10.7
(in Months) (n=128)		
0-12	59	46.2
13-24	19	14.8
25-36	11	8.6
37-48	11	8.6
49-60	10	7.8
61-200	3	2.3
No Response	15	11.7
Years of Experience as a Mitanin (n=1200)		
Less Than 1year	21	1.8
1-3	150	12.5
4-6	217	18.1
7-9	175	14.6
≥10	637	53.1

4.6 Motivating Factors

The evaluation research had identified 14 motivational factors there were associated with participants' motivation to work as a Mitanin. These factors were further measured as per the motivational level from **low** to **high** using a 'Likert Scale', the scoring of Scale was from 0 to 10; where "0" meant that the Mitanin was "not at all" motivated by that factor to highly motivated to a score of "10". There was also an option to name any 'other factors' other than the listed. However, no newer factors emerged during the interviews. The Figure 4.1 illustrated the motivational factors and their affinity among the respondents to become a Mitanin worker. The majority (70%) of respondents stated that improving the health care services in their village was the prime motivating factor to become a Mitanin. Nearly two third (63.5%) of the Mitanins were highly motivated by their aspiration to serve the community, whereas, 50-60% of the Mitanins agreed that they were motivated by the fact of becoming a Mitanin will provide an opportunity to get more exposure, a better social position/prestige, self-satisfaction, get trained as a health worker, and an avenue to become independent. Peer pressure or any other external pressures in 57% respondents was as another factor that minimally contributed to their motivation. Approximately 63% of Mitanins stated that getting a government job was a main reason that remained motivational factors for their work and engagement. In addition almost 35% of the Mitanins were of the opinion that they were highly motivated with a hope to secure a government job. Likewise two third of the respondents were either moderately or highly motivated to be a Mitanin with a view to earn a livelihood. Rahman et al., (2010) investigated the factors that motivated the CHWs in Sylhet District in northeastern Bangladesh and also found that the motivating factors that were most commonly cited were self-development (desire to improve skills) and the desire to improve community health. Other factors that motivated the women to serve as CHWs were the desire to use available time productively and less commonly, value and recog-

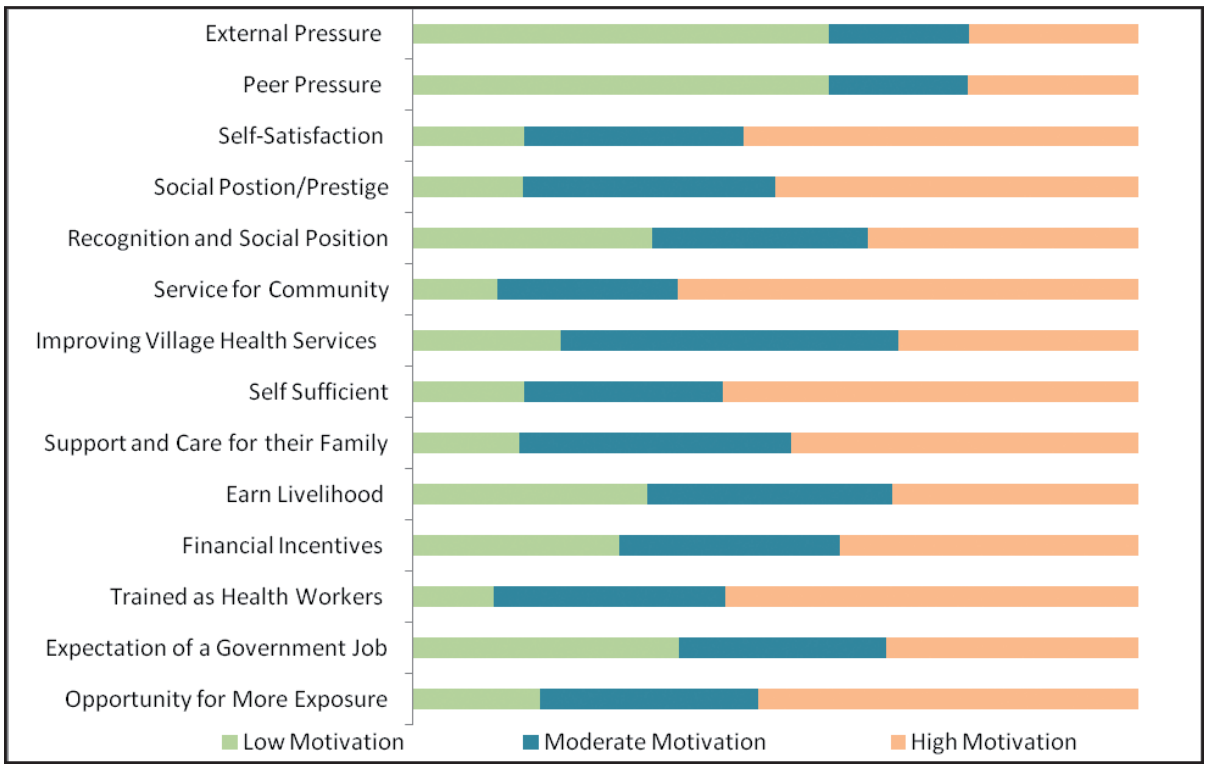
nition from the community and aspirations for financial independence.

There are evidences that suggest that the importance of extrinsic incentives, pressure from friends and family, desire to enhance development and earn a social position as motivation for becoming a CHW needs investigation, particularly the role of money in the context of the performance of CHWs in low economic settings cannot be undervalued.

The motivational factor that led to the majority of the Mitanin to join the programme according to the 2011 EUSPP evaluation of the Mitanin programme was the desire to serve the community, other important factors were raising awareness about health issues in the village, and 'to look after family and children better' were reported by the respondents. Monetary expectations or hope to get government employment were reported as less important as reasons than getting recognized in the community and/or opportunity to learn new things and develop skills.

However, most of the district programme managers, medical officers informed that nearly 30% of the inactive Mitanins were motivated by the financial incentives and those incentives were the prime reason behind their engagement as Mitanins. Thus, there is a greater need to enhance the motivation of the Mitanins towards higher end needs like self actualization.

FIGURE 4.2: Motivational Factors of Mitanin



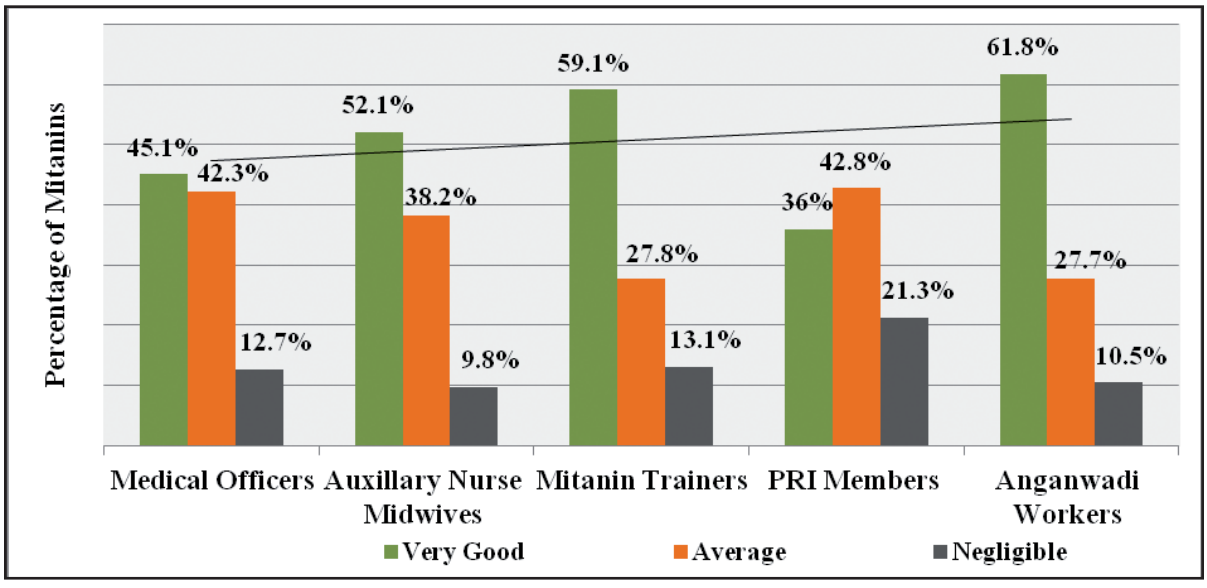
4.7 Evaluation of Training &Education of Mitanin's Programmes

In Chhattisgarh, Chhattisgarhi and Hindi language are the main spoken language in the rural areas. Mostly the Mitanins are working in the interior villages and districts of the state hence Chhattisgarhi is most spoken and understood language amongst the respondents. A large majority 96.5 % of the respondents agreed that they were comfortable with the language used by instructor or trainer during the training sessions shown in Table 4.7. The data indicated that trainers were sensitive and well versed with the communication needs of the trainees. Only a few Mitanins expressed their inability to understand training content due to language barrier. The Mitanins who were not comfortable with the language of the trainers attributed that their inefficiency to their low literacy levels. Interestingly, 91% of the Mitanin participants mentioned that the trainers were able to explain the training material clearly and the trainers' knowledge and competencies were enough to answer their queries. These findings again demonstrated the ability of the trainers to be more inclusive and it would be desirable that they formulate their training sessions on easily comprehensible principles.

4.8 Supervisory Support

The Figure 4.3 presented the level of support and cooperation received by the Mitanin from different health professional such as Medical Officers, ANMs, Mitanin Trainers, PRI members and Anganwadi Workers. About 51 % Mitanins reported that they had received very good support and cooperation from the above health care personnel, followed by 35.5 % received Average and 13.5% negligible support and cooperation. However, some Mitanins felt that the support services provided by supervisors were negligible and probably there is a need to reach out to all Mitanins for improving the sustainability and effectiveness of the programme.

FIGURE 4.3: Level of Support and Co-Operation Received from Health Professionals



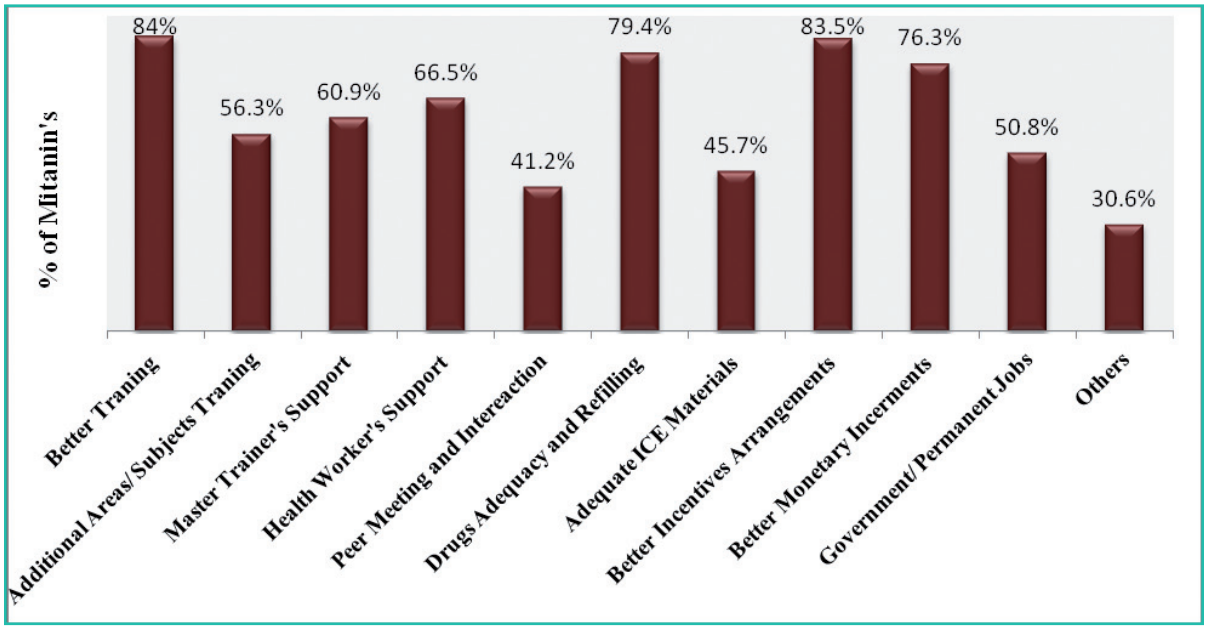
4.9 Career Growth of Mitanin

The Mitanins (57.8%) were reported to be actively involved with the activities of the Panchyati Raj Institutions (PRIs) such as the Village Health and Sanitation Committee (VHC) and the Rogi Kalyan Samiti (RKS) in their villages. The study revealed that one fourth of the Mitanins holds some or other position in the *Panchayati Raj* Institutions in addition to their role as a Mitanin. This different position included *"Sarpanch"*, Member of Self Help Group, President of Self Help Group and Member of *"Panchayat" etc.* Whereas, majority (67.3 percent) of the Mitanins hold the position of being member of a Self Help Group followed by President of Self Help Group (17.3 percent), Member of *"Panchayat"* (8.5 percent) and *"Sarpanch"* (8.2 percent).

One fourth of the respondents became as a Panchayati Raj Institution member after becoming a Mitanin, of which majority (63 percent) of the respondents believed that they could be a member of Panchayati Raj Institution because of their contribution as a Mitanin in their community. An opportunity to become the PRI member has served as a motivation for others. Researchers believe that the best supervisors in the CHW programmes or leaders in the village organizing committees were those who had progressed their way up and have the experience of being effective CHWs themselves (Bajpai & Dholakia, 2011; Lehmann & Sanders, 2007; Rowe et al., 2005). Similarly studies focusing on the CHWs in South Africa, Nepal, Pakistan and Bangladesh have reflected the fact that by selecting the better performing CHWs and appointing them to be the supervisors inspires other CHWs to work better (Bhutta et al., 2010).

The Figure 4.4 illustrated the Mitanins' perception regarding the supports required for increasing their effectiveness at work. It demonstrated that 84 percent of the respondents thought that better training and 83.5 percent of the respondents believe that better arrangement for payment of incentives could improve the chances to be an effective delivery of Mitanin programme. There were 79.4 percent of the Mitanins said that timely refilling of drug kit would help them to be more effective. Others reported better support from health worker (66.5 percent), better support from master trainers (60.9 percent), training in additional area or subject (56.8 percent), regular appointment in the government health system, (45.7 percent) more Information Education and Communication material and. Only 41.2 percent of the Mitanins felt that they needed more opportunities to meet and interact with friends to be more effective. Thus majority of the Mitanins revealed that better training opportunities, regular incentives payments and drug supplies should be the priority of the health authorities to help the Mitanins function effectively, followed by the improvement in the support systems in term of training opportunities and provision of IEC materials in adequate quantities.

FIGURE 4.4: Support Required for Increasing Effectiveness of Mitanin



4.10 Monthly Incentives of Mitanin

Regarding the monthly incentives of the Mitanins, almost (46.8%) responded that they earned incentives ranging from Rs. 200 to 500 per month. Nearly 30% of the Mitanins earned less than Rs. 200 as incentives. However, eight Mitanins out of the sample of 1200 did not earn any incentives. However 10% of the Mitanins earned more than Rs. 900 per month.

TABLE 4.7: Incentive of Mitanin: Year 2013-14

Programme	Incentives	Incentives for per Task (In Rupees)
Janani Suraksha Yojana (JSY)	Incentives for motivating institutional delivery	Rs. 200
	Travelling expense to accompanying to institution	Rs. 150
Home Based Newborn Care (HBNC)	6 or more visits by Mitanin to house of newly born child during first 42 days	Rs. 250
Nutrition Rehabilitation Center	Bringing severe malnourished child to Nutrition Rehabilitation Center	Rs. 50
	Regular advisory household visits to child returning home from Nutrition Rehabilitation Center	Rs. 150
Village Health and Nutrition Day	Participation of Mitanins in village health and nutrition day	Rs. 50 per Mitanin per session
Immunization	For ensuring complete immunization of the child	Rs. 100 per child
Family Planning	For successfully motivating Couple for family planning operation after having 1-2 living children	Rs. 1000 Per Couple
	For successfully motivating a female beneficiary for family planning operation after having 3 or more living children	Rs. 100
	For successfully motivating a male beneficiary for family planning operation after having 3 or more living children	Rs. 125
	For successfully motivating a couple for maintaining 3 years of birth gap after having first child	Rs. 500
	For successfully motivating a couple by the Mitanin for maintaining 2 years of birth gap after marriage	Rs. 500
Cataract	Beneficiary treated for cataract with the help of Mitanin	Rs. 175
NVBDCP	On providing Filariasis medicines to 50 patients	Rs. 125 per Mitanin
	Malaria diagnosis slides	Rs. 10 per slide
	On completion of treatment of leprosy patient	Rs. 450
T.B	Confirmation of TB patient and complete treatment with the help of Mitanin	Rs. 250

According to the Mitanins, sometimes the payments were severely delayed up to 6-9 months. The qualitative findings from the interviews with the Mitanins and the Mitanin Trainers in the month of June and July 2014 indicated that payments of the incentives were delayed profoundly. The Mitanins that were interviewed in Sukma and Bastar districts declared that although they were entitled for incentives for the tasks they performed they had not received the payments since October 2013. Delays in the payments of the incentives were reported in all the districts. Some Mitanins expressed that the delay in the payments was a serious and major de-motivating factor for them to carry out their regular work.

4.11 Training and Capacity Building of Mitanin

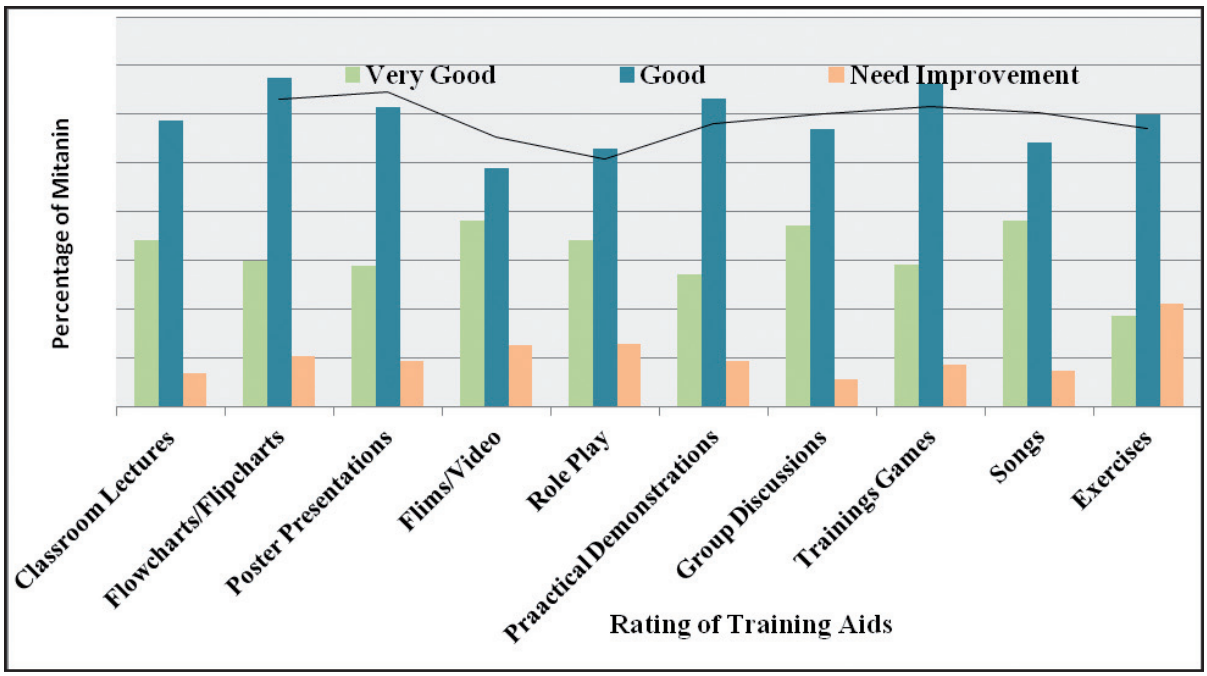
The feedbacks from the stakeholders about the Mitanin training were summarized in the following discussion - District and Block Programme Managers from central zone of Chhattisgarh reported that the trainings were very regular and efficient. But they felt that training pertaining to life-style disorders and non-communicable diseases became an over burden for the Mitanins. The training should be focused on Immunization, Maternal and Child health, and Reproductive health only. Moreover, they also stated that the Mitanins were trained on herbal and Ayurvedic medicines. The DPMs were also expressed discontent as the Mitanins were asked to focus on substance abuse like alcohol and tobacco addictions while the Mitanins had very little knowledge to deal with substance abuse and were not trained to deal with harmful consequences of alcohol and tobacco addiction.

4.12 Use of Different Training Aids and their Ratings

The process of training - learning depends upon the different type of training aids available in the training room. There are many aids available these days like, audio, visual and audio- visual aids; they have very much importance in Training and learning process. Different training aids were used during the training programme of the Mitanins to equip them with basic to advanced skills in health care services in the community. The methods that were used effectively by the trainers were Classroom Lectures, Flowcharts/Flipcharts, Poster Presentations, Films/ Videos, Role Plays, Practical Demonstrations, Group Discussions, Training Games and songs. While the training aids were being frequently used, it was reported that practical training sessions were less in number.

The Mitanins were largely satisfied with the training methods. As represented in the Figure- 4.5 nearly 40% of the Mitanins felt that the films, videos and songs used during the training were 'very good' and effective. However, 50-70% of the Mitanins rated the training aids were to be 'good' and less than 10 % of the Mitanins suggested that almost all the training aids needed improvement. Trend line on the graph suggested that majority of the Mitanin workers rated the training materials 'good' for their skills and knowledge development.

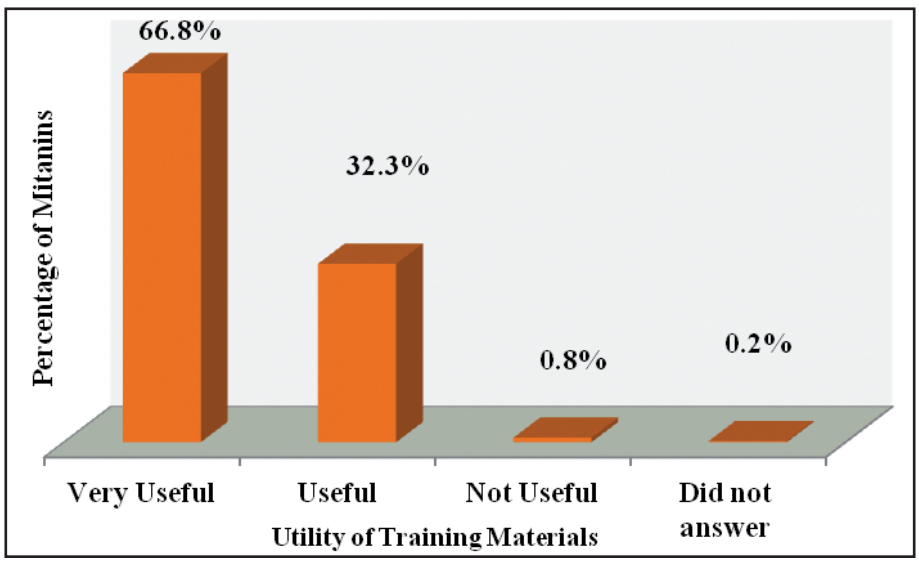
FIGURE: 4.5: Ratings of Training Aids by Mitanin



4.13 Training and Reading Materials Received

Figure 4.6 illustrated percentage distribution of utility of the training materials given to the Mitanin. More than half (57.8 %) of the Mitanins mentioned that they had received the various training materials and the Mitanins rated the usefulness of the training material as high.

FIGURE: 4.6: Useful of Training and Reading Materials



4.14 Theoretical Knowledge and Skills

Here the focus was to elucidate how the Mitanins felt with respect to their knowledge and skills gain. The Table 4.8 enlisted about 60 % of Mitanins concluded that their theoretical knowledge and skills in the content areas described in the interview schedule were **good** or **very good**. Significantly higher proportion (57.8 and 55.2 %) of the Mitanins reported that the theoretical knowledge imparted by the trainers was '**very good'** in terms of explaining the importance of breast feeding practices and benefits of the "*Janani Suraksha Yojana*". These were followed by the assessment of knowledge and skills regarding the water and sanitary advices and assistance provided in family planning measures that were recommended to be '**very good'** by 51 and 52 % of the Mitanins respectively. The area where Mitanins were not quite confident were giving injections and basic medications and 21% of the Mitanins rated their knowledge level to be '**poor'** and around 17% of the Mitanins found it to be average thus an aggregate amounting to nearly more than one third of the participants stating that the theoretical knowledge and skills in this area were not good. Around one third of the participants also felt that the theoretical knowledge and skills were poor or average in relation to control of Tuberculosis and Leprosy, Sexually Transmitted infections, HIV AIDS and Reproductive Tract infections. Hence, in most of the areas like malnutrition, government health services and schemes, child health and nutrition, drug kit related advices, community mobilization and behavioral change, immunization and prevention of non-communicable diseases the theoretical knowledge and skills, Mitanins claimed proficiency barring a few who required rigorous trainings for knowledge and skill development.

TABLE 4.8: Rating of Theoretical Knowledge and Skills of Different Training Contents

Theoretical – Rate knowledge and skills (n=1200)	Poor		Average		Good		Very Good	
	F	P	F	P	F	P	F	P
Government health services and schemes	27	2.3	240	20.0	517	43.1	416	34.7
Child health and nutrition	27	2.3	124	10.3	535	44.6	514	42.8
Women health and their rights	31	2.6	142	11.8	483	40.3	544	45.3
Malaria and waterborne diseases	36	3.0	186	15.5	520	43.3	458	38.2
Maintenance of drug kit	44	3.7	142	11.8	462	38.5	552	46.0
TB and Leprosy control	68	5.7	274	22.8	442	36.8	416	34.7
Social mobilization efforts for community action	70	5.8	244	20.3	562	46.8	324	27.0
Home based herbal remedies	79	6.6	257	21.4	452	37.7	412	34.3
Breast feeding	36	3.0	97	8.1	374	31.2	693	57.8
Introduction of a Behaviour Change Communication	62	5.2	160	13.3	584	48.7	394	32.8
Malnutrition	53	4.4	135	11.3	516	43.0	496	41.3
Non communicable diseases	113	9.4	223	18.6	559	46.6	305	25.4
First Aid for injuries (Treatment for dog/ snake bite)	139	11.6	195	16.3	426	35.5	440	36.7
Water and sanitation	54	4.5	90	7.5	447	37.3	609	50.8
Family planning	47	3.9	124	10.3	406	33.8	623	51.9
HIV/AIDS	99	8.3	271	22.6	466	38.8	364	30.3
STI/RTI	129	10.8	265	22.1	527	43.9	279	23.3
Immunization	96	8.0	172	14.3	430	35.8	502	41.8
Janani SurakshaYojana (JSY)	37	3.1	93	7.8	408	34.0	662	55.2
Handling deliveries	52	4.3	115	9.6	492	41.0	541	45.1
Giving injections & basic medication	253	21.1	198	16.5	408	34.0	341	28.4

4.15 Practical Knowledge and Skills

The job of Mitanins requires a thorough practical knowledge and skills. The Mitanins reported that the practical skills in the areas dealing with breast feeding and "*Janani Suraksha Yojna*" were **very good**. Following these fields according to 40-50% of the Mitanins also reported that their practical knowledge and skills were also **very good** in the field of demonstrating the techniques, practices and advices related to maintenance of drug kit, water and sanitation facilities, family planning services, immunization and handling normal delivery procedures. Less than 10% of the Mitanins included in this study testified that the areas for their practical skills and knowledge were **poor** in the field of government health services & schemes, child health and nutrition, women health & their rights, malaria and waterborne diseases, maintenance of the drug kit, Tuberculosis and Leprosy control, home based herbal remedies, breast-feeding, introduction of behavior changing communications, malnutrition, water and sanitation, family planning, immunization, "*Janani Suraksha Yojana*" (JSY), and handling deliveries. In the rest of the categories the respondent percentage was between 10 to 20% with a proportion (20.3%) of participants reporting that the practical knowledge and skills were poor as regards to the training provided to the Mitanins for giving injections & basic medications.

Home Visit

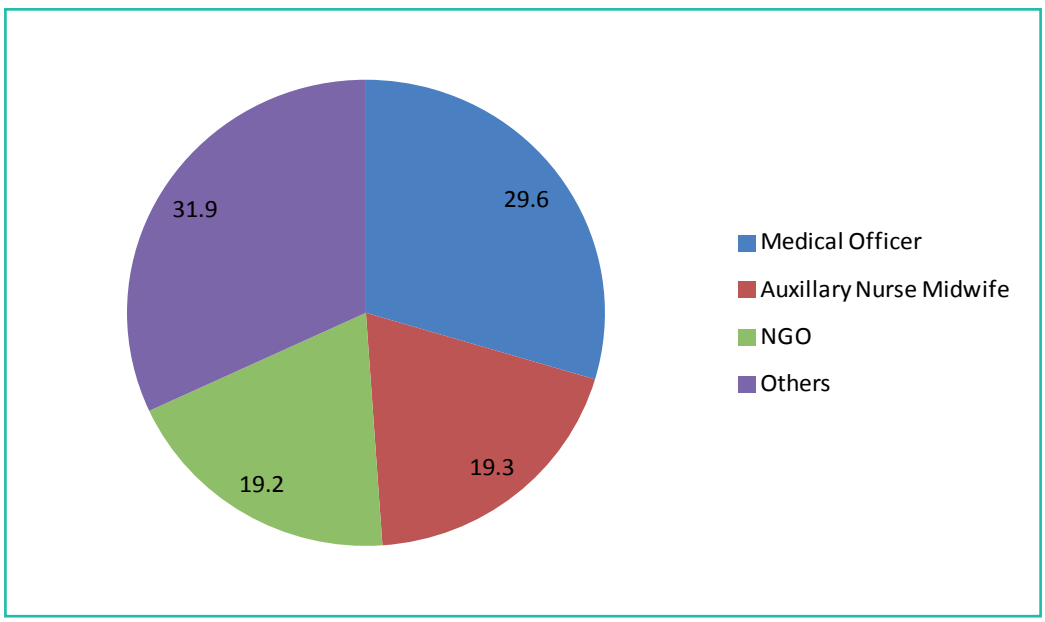
TABLE: 4.9: Rating of Practical Knowledge and Skills of Different Training Contents

Practical – Rate knowledge and skills (n=1200)	Poor		Average		Good		Very Good	
	F	P	F	P	F	P	F	P
Government health services and schemes	79	6.6	181	15.1	556	46.3	384	32.0
Child health and nutrition	68	5.7	164	13.7	524	43.7	444	37.0
Women health and their rights	70	5.8	147	12.3	541	45.1	442	36.8
Malaria and waterborne diseases	60	5.0	171	14.3	581	48.4	388	32.3
Maintenance of drug kit	79	6.6	146	12.2	472	39.3	503	41.9
TB and Leprosy control	108	9.0	224	18.7	516	43.0	352	29.3
Social mobilization efforts for community action	118	9.8	213	17.8	552	46.0	317	26.4
Home based herbal remedies	96	8.0	249	20.8	439	36.6	416	34.7
Breast feeding	62	5.2	139	11.6	352	29.3	647	53.9
Introduction of a Behaviour Change Communication	99	8.3	188	15.7	561	46.8	352	29.3
Malnutrition	67	5.6	150	12.5	512	42.7	471	39.3
Non communicable diseases	136	11.3	244	20.3	541	45.1	279	23.3
First Aid for injuries (Treatment for dog/snake bite)	182	15.2	214	17.8	428	35.7	376	31.3
Water and sanitation	75	6.3	126	10.5	440	36.7	559	46.6
Family planning	77	6.4	155	12.9	450	37.5	518	43.2
HIV/AIDS	149	12.4	248	20.7	514	42.8	289	24.1
STI/RTI	174	14.5	261	21.8	485	40.4	280	23.3
Immunization	111	9.3	157	13.1	456	38.0	476	39.7
Janani Suraksha Yojana (JSY)	63	5.3	102	8.5	402	33.5	633	52.8
Handling deliveries	88	7.3	124	10.3	464	38.7	524	43.7
Giving injections & basic medication	244	20.3	213	17.8	416	34.7	327	27.3

4.16 Refresher and On-Job Supervision

The provision of refreshing training was investigated from the study participants. With respect to the provision, only 54.7% Mitanins reported that they received the refresher training. However there were 142 Mitanins for whom this question was not applicable as they had not completed their 6 months working as a Mitanin and therefore would have not received any refresher training. Of the 1200 Mitanins interviewed, 1138 Mitanins (84.8%) testified that they received regular supervision. Although nearly one third (29.6%) of the Mitanins informed that they were regularly supervised by the Medical Officer from the respective districts, however the highest percentage (31.9%) of the Mitanins selected the option of any other as their response as shown in figure 4.7. The analysis of the responses included in the any other section indicated that the Mitanin Trainers and the District Resource Personals were health professionals that provided the on job supervision to the Mitanins.

FIGURE: 4.7: On Job Training of Health Professionals



4.17 Mode of Receiving the Incentives

Most Mitanins those earned the incentives usually received their incentives from the *"Sarpach"* (Village Head). Very small number of the Mitanins received from the Public Health Centre Accountant and lastly very few reported to have received the payments directly from the ANMs. The SHRC staffs that were interviewed regarding the incentives and its distribution presented a common theme of understanding for involvement of the *"Panchayat"* village self-governing body in the disbursement of the incentives. They informed about the

earlier system of incentives disbursement to the Mitanins through the district hospitals (health authorities) led to misconceptions among the communities that doubted the Mitanins. The community members believed that the Mitanins received the payments from the hospitals and those they were hospital staffs and not the representatives or social agents of the community.

4.17.1 Satisfaction with Monthly Incentives

Most of the Mitanins included in the study mentioned that if they received a fixed incentive as salary then they would have performed even better. A proportion of the Mitanins described that the "*Sachiv*" (Secretary) delayed their payment of their incentives and paid them very late. They express high level of dissatisfaction with the amount and regularity of the incentives. From the global and country case study reviews it was reported that the CHW programs that pay their CHWs either a salary or an honorarium regularly and appropriately, they function effectively to accomplish the set goals and objectives and achieve the short and long term goals. However, almost no examples existed of sustained community financing of CHWs (WHO, 2007; Bhutta et al.2010).

4.18 Expected Amount of Incentives

The expectation levels of the Mitanins in terms of fixed amount of incentive to be paid as honorarium/salary every month was discussed in several districts. A large majority (71.2%) opined that they may be provided with a fixed monthly payment of approximately Rs. 2000 or more and another group felt considering the important work they do they may be paid Rs. 4000-7000 per month.

4.19 Mitigation & Management Core Public Health Issues by the Mitanin

The research found that nearly 95% of the respondents interviewed were assertive that they could identify pregnant women and register them for ante-natal care services. While around 5% of the Mitanins were unable to identify and register pregnant women for ANC. Few reasons were stated by these Mitanins who could not identify pregnant women and register them for ANC. Lack of knowledge about performing the examination to identify pregnant women and inadequate information about the procedures for their registration to access ANC and was one of the prime reasons highlighted by these Mitanins. Another group who were unable to identify and register pregnant women for ANC were having a perception that these were the responsibilities of the Anganwadi Workers and they therefore often referred women suspecting pregnancy to the Anganwadi Workers for confirmation and registration for ANC. However, the qualitative analysis also indicated that a small fraction of Mitanins were considered incapable and incompetent by the communities they served and therefore were expressed reluctance to consult Mitanins for pregnancy identification and registration for ANC. The 126 respondents

mentioned about the inadequacy of the IFA tablet for the pregnant women in their field areas. The data suggested that 93% of the Mitanins could identify children with malnourishment. The participants were also enquired about the means and ways employed by them to identify malnourished children. The qualitative information gathered from the Mitanins provided an insight about the observations that the Mitanins utilise to differentiate normal children from those having malnourishment. The following observation were used by most of the respondents, children with enlarged head and abdominal size, eye balls sunken deep in the eye socket, extremities were lean and thin. After observation, the Mitanins also reported use of examination techniques like weighing the children that revealed low weight as compared to the average weight required for its age, the children with poor muscle masses and palpable bones, low circumference of arms and legs and enlarged circumference of head and abdomen were considered by the respondents to measure the extent of malnourishment. Measuring the height of the children was another criteria used by the Mitanins to diagnose malnourishment who observed stunted height among malnourished children as compared to the average height required for that age. The respondents also mentioned about the other parameters that they had included identifying a child with malnourishment like lack of physical activity, general debility and lethargy, poor appetite, poor consumption of milk, frequent illnesses and fevering bouts.

4.20 Care of Sick Newborn

The study attempted to explore about the care of any sickness of the newborn during the first month of birth (Table 4.10). Analysis of the data revealed that 68.7% of the baby had suffered from some kind of sickness during first month of the birth. However, a large proportion (51.7%) of the mothers informed that it was their own family members who helped maximum during the time of seeking medical care of the newborn, followed by 31.4% mothers informed about the help from Mitanins while seeking care of the baby and another 16.9% indicated that ANM were helping them during the baby's health care (Table 4.11). Further, it also explored if the baby had received any kind of medical treatment, 66.5% informed about the treatment, of which 71.3% of them went to the Primary Health Center for the treatment. Another 12% informed that they went to the ANM for treatment of the infant. Those who did not sought for any treatment during the child's sickness; almost 16.7% of them told that they didn't go as the institution are quite far and sought help from the local healers.

TABLE 4.10: Care of Sick Newborn

Did your Newborn suffer any sickness? N=1500	Yes	No
Frequency Percentage	1030 (68.7%)	470 (31.3%)
Did you seek medical help for your infant? N=1030	**YES**	**NO**
Frequency Percentage	685 (66.5%)	345 (33.5%)

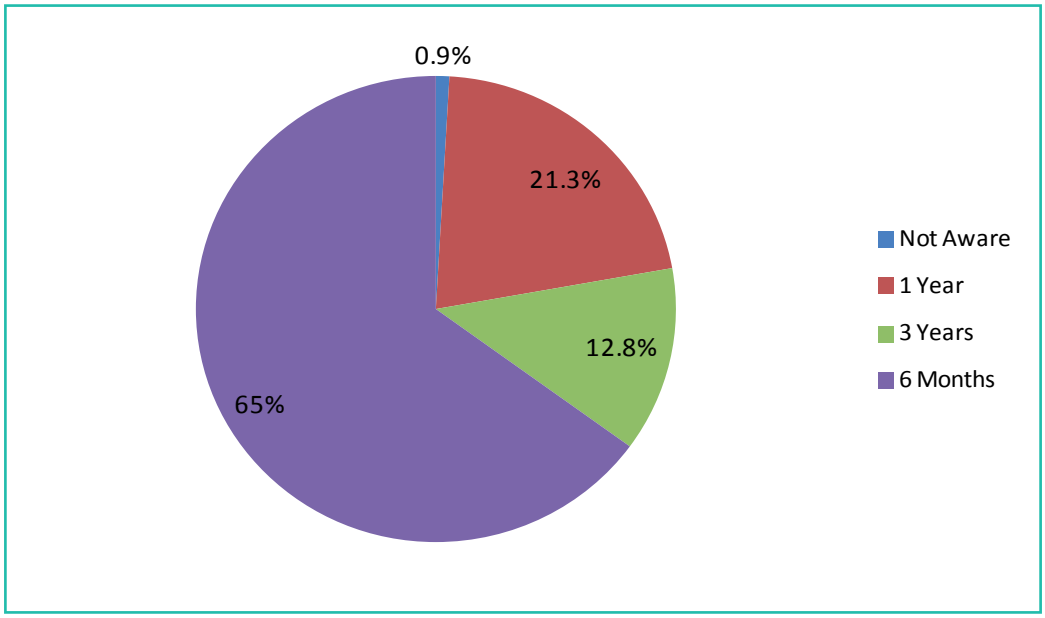
TABLE 4.11: Sources of Treatment

Whom did they approach for Treatment? N=685	PHC	ANM	Local Healer
Frequency Percentage	488 (71.3%)	82 (12%)	115 (16.7%)
Who provided help during medical treatment? N=685	**Own Family Members**	**Mitanins**	**ANM**
Frequency Percentage	354 (51.7%)	215 (31.4%)	116 (16.9%)

4.21 Knowledge about Breastfeeding

The Mitanins included in the evaluation were enquired about the age of the child when the mother should stop breast feeding. The Figure 4.8 illustrated that nearly two third of the respondents (65%) were of the view that the mother should halt the breastfeeding when age of the child is about 6 months. Some (21.3 %) of the Mitanins were of the impression that by one year of age the mother should discontinue the practice of breastfeeding. Negligible percentage of participants belonged to the group that stated that they were not aware of any facts related to stopping of breastfeeding and the age of the child. However, about 12.8% percentage Mitanins mentioned that the age of the child for stopping breastfeeding to be 3 years.

FIGURE 4.8: Breastfeeding Age for the Child



4.22 Immunization

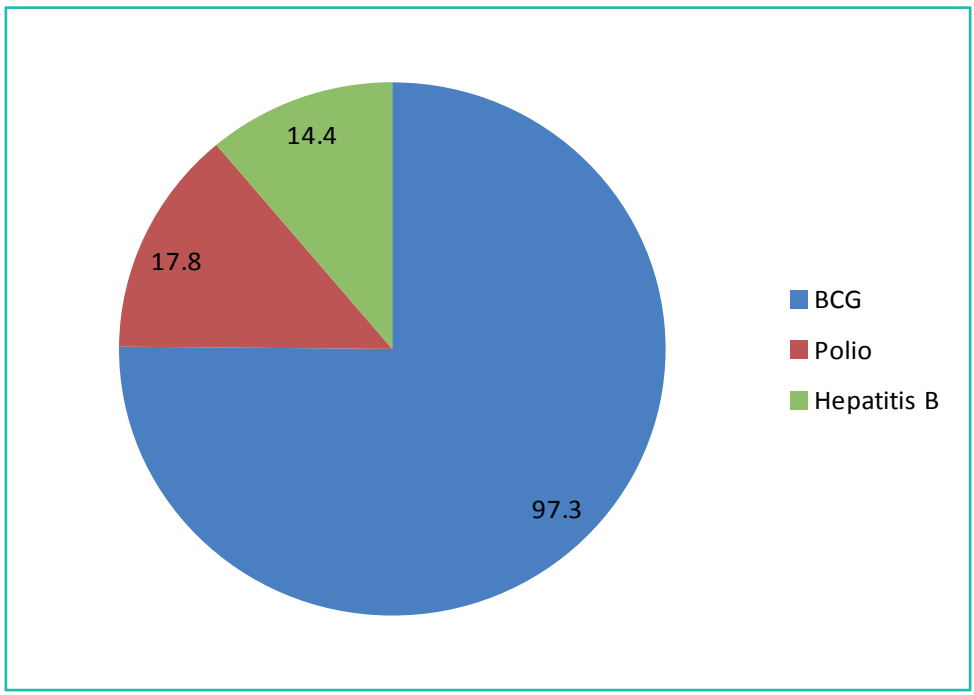
The Figure 4.9 represented the percentage wise distribution of the responses from the Mitanin trying to answer question associated with the vaccine to be given at birth. Three vaccines to be given at birth were considered in the interview schedule – BCG, Polio and Hepatitis B. Almost 97% of the Mitanins responded positively and stated that the BCG vaccine was needed to be given at birth. However the percentage of Mitanins who mentioned that Polio and Hepatitis B vaccine should be given at birth was very low. More than 80% of the Mitanins did not feel the need for immunization against Polio and Hep B to be prescribed at birth. These finding indicated the lack of understanding of the Mitanins about the immunization to be given at birth.

The DPM, BPM and PRI members of several districts were of the opinion that the Mitanins were responsible for increasing immunization coverage in the state thereby facilitating the process of immunization. The EUSPP evaluation in 2011 observed that knowledge of Mitanins on immunization schedule was also found to be adequate, moreover the evaluation considered the primary immunization vaccines namely BCG, DPT and measles. However the findings of current evaluation that focused on primary vaccines like BCG, Polio and also considered Hep B and disclosed the inaccuracies in the knowledge about the specific vaccines needed by the newborn.

On questioning about the role and effectiveness of the Mitanins in immunization the SHRC

staff informed that they will focus on training the Mitanins who would be taught new things associated with public health issues especially the preventive aspect of the diseases so that a vital role can be played by the Mitanins in reducing the impact of preventable diseases through effective immunization.

FIGURE 4.9: Immunization at Birth for the New-born



4.23 Influence of Evil Spirits on Child Health

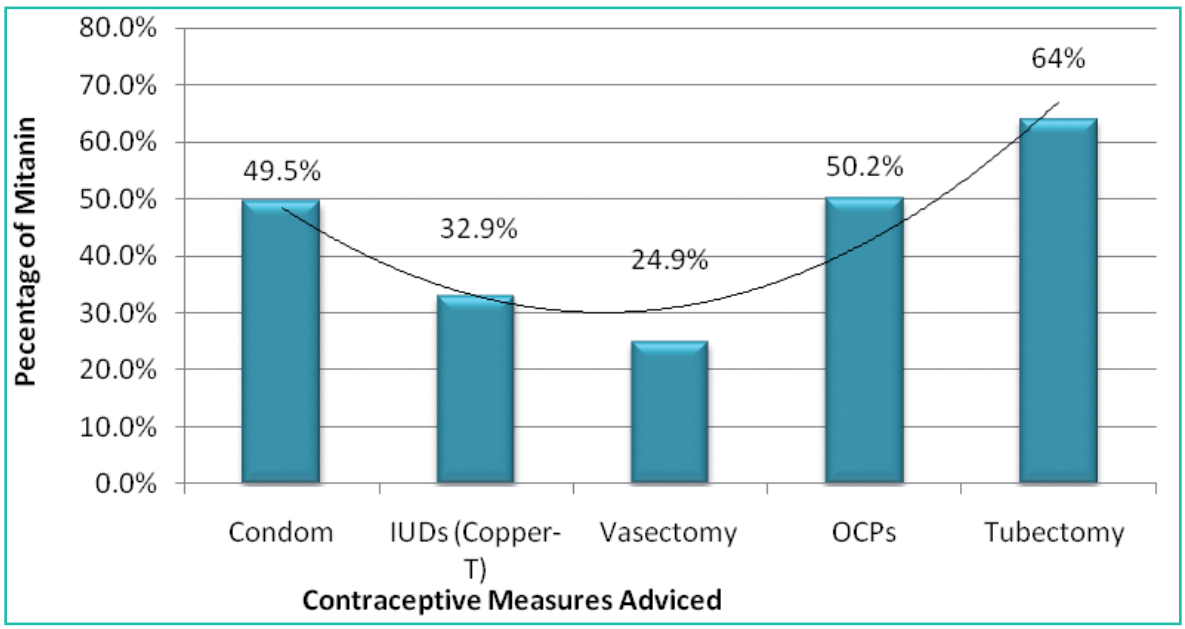
Almost 18 per cent of the respondents believed that evil spirits influence the health of the child. The readings in the northern zone matched with those of the overall state and the results in the central zone discovered that only 6.8% of the Mitanins believed that evil spirits influenced child health. However, analysis showed a huge variation in the southern zone with 31% of the respondents stated that evil spirits had influence on the health of the child; especially the Mitanins from the Bastar district had highest percentage in favour of evil spirits influencing the child health.

4.24 Family Planning and Management: Contraceptive Measures

The participants were inquired about the contraceptives that they advised frequently in the community. The options included a variety of barrier, medical and surgical contraceptives suitable for both men and women. Further the Mitanins were also given a choice to include any contraceptive that they prescribed and was not present in the options offered. The following ta-

ble showed the preferences of the Mitanins that were interviewed for the various contraceptives advised in the community. The Figure 4.11 illustrated that nearly half (49.5%) of the Mitanins preferred condom to be advised as a contraceptive in the community. Similarly 50.2% of the respondents also preferred contraceptive pills to be advised as contraceptive in their respective communities. However, the highest proportion of the Mitanins (64%) selected Tubectomy as a preferred contraceptive in the community. Not more than one third of the Mitanins (32.9%) reported their preferences for IUCD like Copper T, furthermore the lowest preference was observed for vasectomy with only 24.9% of the Mitanins advising it in their community.

FIGURE 4.10: Contraceptive Measures Suggested by Mitanin



4.25 Anganwadi Services

Analysis of the data on Anganwadi services showed that almost 77.9% of the children were availing services from Anganwadi centres. Out of which 57.7% of the mothers informed that initially the Mitanins had assisted them in getting in touch with the services in the Anganwadi centre. Of all the mothers interviewed as regards to the Anganwadi services for the child (supplementary food), 42% mothers reported that they were availing the services regularly and 30.8% reported availing it occasionally, whereas, significant proportion 27.2% reported that they had never availed any services from Anganwadi Centre.

4.26 Abortion or Medical Termination of Pregnancy

Consultation about the MTP services was one of the prescribed role and responsibilities of the Mitanin laid down in the operational guide-

lines. However, previous research studies and evaluation of the Mitanin programme in Chhattisgarh overlooked this aspect of the Mitanins' role in this area of intervention. This research study attempted to analyse the approach of the Mitanins while educating about the MTP services and their understanding about needs of the pregnant women in time of MTP services.

The Mitanins interviewed for the study were asked about their responses when they were approached by a pregnant woman asking for their help and advice in relation to MTP. The following were the qualitative responses that were recorded and analysed. Most of the participants replied that they would not advice the pregnant women anything and would refuse to give any suggestion. Even larger proportions of the Mitanin respondents cited that they would stop the pregnant woman from going for MTP. The participants also mentioned that they would not advice abortion as the woman would become weak affecting her health so they would refuse her to go for an abortion. Mitanin also responded maintaining that they would refer such women to either the ANMs or Doctors and would ask them to seek medical advice before taking any decision. Many of the respondents also declared that they had not come across any such incident in their respective field areas. Few respondents also mentioned that they would ask the pregnant women about the number of children she had and if she just had one child, then they would ask the woman to continue with the pregnancy or else would ask her to seek medical advice and also advise her to go for Tubectomy following the delivery or abortion. In cases when the pregnant women had more than two children and if it were to be an unplanned pregnancy then the Mitanins would refer the women to the doctor for medical advice. Some of the Mitanins also reported that they would advise the pregnant woman not to go for abortion to avoid feticide and advise the couple to maintain physical distance between them to prevent unwanted pregnancies or use contraceptives to prevent abortion.

Following are few of the verbatim of the responses by the Mitanins in relation to their advices for abortion-

*"**Saf manakar doongi,Usse kamjori aati hain toh yeh nahi karna chhahiye" (*** I will straight away refuse her to go for abortion as it causes weakness so it should not be done)" (A Mitanin from Abhanpur Block, Raipur)

*"**Mat kharaab karo apne sharirko, bacche ko ane do"** (*Do not spoil your body, let the baby be born). (A Mitanin from Charama Block, Kanker).

4.27 Management of Public Health Issues by the Mitanin

Diarrheal Epidemic: Precautions Advised & Management

Diarrhoea as a major public health problem in Chhattisgarh was projected by the SOCHARA

report 2005 and also reported inadequate access to safe water and sanitation that lead to high transmission of water borne diseases. The evaluation of the Mitanin programme by the EU SPP in the 2011 revealed that the effectiveness of Mitanin in terms of diarrheal management was markedly higher than that of ASHAs in other states. However during a community visit by the researchers in Lakhanpuri, Kanker district, a group of Mitanins were asked about the prevention strategies for reoccurrence of diarrheal epidemic, they were not clear about how to go about the process.

4.28 Maintenance of the Record Books

Record keeping of the activities of the Mitanins as a system of simple clinical records facilitates monitoring and on-going evaluation of their work by the health staff and BRP-DRPs as laid down in the operational guideline. Thus, the *"Gram Swasthya"* Register (Village Health Register) as a pictorial record book for family health facts was to be maintained by the Mitanins. The previous evaluation studies reported that the quality of recording in the *"Gram Swasthya"* record books by the Mitanins was not satisfactory. *"Gram Swasthya"* record books lacked the ability to record output, outcome and impact data essential for programme monitoring and evaluations, thus weakening the record keeping systems.

The SOCHARA 2005 reported that neither the Mitanins kept any monthly records of their activities nor did the public health facilities have any subjective recordings of Mitanins' performance of activities. The available data was just summary reports by BRPs / DRPs creating inadequacy of hard data for programme evaluation.

Thus, studying the record keeping remained a pertinent variable of this study out of the 1200 Mitanins interviewed 1027 Mitanins revealed that they maintained the record books regularly. Close to 15% of the Mitanins that maintained that they could not record their activities attributed their incapability of record keeping to their low literacy levels.

The data revealed that most of the Mitanins predominantly recorded about immunization facilities, medical treatment, services regarding malnutrition, maternal and child health.

Greater section of the Mitanins recorded about the immunization services provided to the children, *"Kishori Balika"* (teenage girls) and pregnant women. Immunization facilities against diseases like BCG, DPT, Polio, Measles, and records of the provision of booster doses were also reported by the Mitanins.

The Mitanins also recorded information related to Tuberculosis and Malnutrition and early signs for diagnosis of diseases. During the rainy season the Mitanins recorded about the number of patients suffering from seasonal disorders like Malaria, their identification and their treatment. Few Mitanins also

reported to have recorded information about parasitic and pathogenic infections and their management especially about Malaria. Mitanins recorded information about the medicines and treatment given to the patients suffering from diarrhoea, they also mentioned about the blood tests and the hospital visits that they performed for the patients suffering from tuberculosis. Some Mitanin participants also mentioned that they recorded about addictions in the communities and measures employed by them to curb the addiction practices. Records about medicine dispensed and village health visits that were conducted by the Mitanins were also recorded. The Mitanins also included list of people affected and treated for fever, cold and about dreadful diseases. Mentioning about *"Upaay Jo Jaan Bachhaye"*– (remedies that save life) and about herbal medicines in detail the Mitanins also declared that they maintained records of the modern drugs available in their Drug Kits.

Majority of the Mitanins recorded registrations of pregnant women for ANC, PNC and immunization. However few of the Mitanins reported to have recorded information about updates and registration cards provided to the communities about 'Janani Suraksha Yojna'. The aspects related to the newborn care and care pregnant women as mentioned in "Mitanin Tor MorGoth" was also mentioned in the record books. A small proportion of the Mitanins also mentioned that they recorded the births and deaths in the register. The Family planning procedures were also mentioned by large percentage of Mitanin respondents. Apart from the above responses few Mitanins also mentioned that they recorded the details about what they explained to the communities such as health programs, various public health practices like sanitation, water purification and methods to combat communicable diseases and help provided to the people living with HIV AIDS.

Record keeping is a time consuming process and thus sometimes de-motivates a worker to record all minute details of their work. They record part of their work details but certainly fail to view it as a powerful tool to clarify their doubts and concerns which arise on an everyday basis. The skills of record keeping are essential for Mitanins which must be imparted at the initial training and could be strengthened in subsequent regular training.

4.29 Field Activities of the Mitanins

Most often one Mitanin attended to one hamlet, only a few Mitanins (just above 1%) of them covered two hamlets as her field area. The population size that most of the Mitanin served ranged from 150-300 people (See Table 4.11). Almost one fourth of the study sample of the Mitanins (26.2%) served less than 150 members of their community. However it was also recorded that around 3% of the Mitanins served a population size of more than 1000. The average hours most of the Mitanin were engaged in their work were

2-5 hours per day (see Table 4.11). There were 4% of the Mitanin who reported to have dedicated more than 6 hours per day to hamlet or community health services.

The Mitanins are individuals who multi-task and most of them have other occupational roles as well. Group discussions are effective tools for community involvement and an indispensable part of the Mitanin work. It was reported that half the Mitanin conducted 1-3 group discussions in a span of three months. The average number of the community meetings the Mitanins conducted was around one group discussion per month.

The Table 4.11 illustrated variations in the number of household visits conducted by the respondents on a daily basis. Majority of the respondents (59.2%) visited 1-3 houses on a daily basis. With 30% of the Mitanins visiting the 4-6 houses per day, there were a few Mitanins (2.4%) that did not conduct any household visits. While a small proportion of Mitanins also reported that they attended to the health care needs of 10 or more houses daily.

TABLE 4.11: Mitanin's Field Activities

Variables (n= 1200)	Sub-Categories	Frequency	Percentage
Population Size Served	≤150	314	26.2
(Number of Villagers)	151-300	560	46.7
	301-450	157	13.1
	451-600	63	5.3
	601-1000	63	5.3
	≥ 1000	43	3.4
Daily Time Spent for Health Related Services	No Time Spent	8	0.6
	1 hours	242	20.2
	2 hours	500	42.7
	3-5 hours	390	32.5
	≥ 6 hours	60	4.1
Average Household Visited on a Daily	Did not Visit	29	2.4
	1-3	710	59.2
	4-6	363	30.3
	7-9	59	4.9
	≥10	40	3.3

4.30 Mitanins' Group Discussions in the Community

One of the major areas of discussion remains the sanitation needs and services. The maintenance of general cleanliness and hygiene to prevent spread of diseases was the health promotional message the Mitanins conveyed and discussed with the communities especially at the onset of monsoon. Along with cleanliness of the environment, purification of water also formed an important part of their discussions including the cleanliness of the hand-pumps, drains and wells. Another area of community awareness programmes is nutrition.

The community discussion groups provided the Mitanins an opportunity to convey the knowledge about the nutritional needs of the pregnant and lactating mothers, children and of *"Kishori Balikas"* (teenage girls). Educating the community members about the importance of balanced diet for children, pregnant women the Mitanins explained the community member the benefit of eating healthy balanced diet. Breast feeding advices to lactating mothers for at-least 8 times a day were also included in their group discussion. With regards to maternal and child nutritional and medical care the Mitanins discussed and explained to the community along-with the AWW about the nutritional requirements of the mother and childThrough these discussions the Mitanin also informed the recently delivered mothers about the nutritional diet and breast feeding activities and trained them for checking the weight of the children regularly and subsequently prevent malnourishment. Discussion also included advice about the use methods of contraception like contraceptive pills. Advising the lactating mothers about nutritional diet and breast feeding and the pregnant women about regular ANC examination and birth preparedness were common activities during the discussion meetings. Guiding the women for registration at Anganwadi immediately after getting pregnant and ensuring their health protection and safety of mother and child were also discussed at such meetings. Care of children suffering from diarrhoeal disorders and pyrexia were few of the topics that were discussed at the meetings.

4.31 Common Health Ailments

The Mitanins discussed about the care of people with Tuberculosis and Leprosy and conveyed the message of completing the full course of the treatment for such long standing illnesses. The Mitanins also spread message about non-communicable diseases by conducting home visits regularly. Apart from the above mentioned topics the Mitanins also spread awareness about the epidemics in the villages and the measures to prevent it. The Mitanins discussed about the cleaning of stagnant water so that diseases and epidemics like malaria due to the vectors breeding in the waters are prevented and advice and discuss the precautions to be taken during diarrheal epidemic. The problems of alcohol addiction and domestic violence in

alcoholic households were also addressed. The Mitanins were links of communication between ANMs, AWWs and the communities.

4.32 Role in Reproductive Maternal Health Care Services

The Table 4.12 represented the actual percentage distribution of the respondents based on the number of pregnant women registered for ANC in past six months. Almost half the Mitanins (49.8%) reported that 1-3 pregnant women were registered by them for ANC in the past six months. Nearly one third (27.6%) of the respondents stated that 4-6 pregnant women were registered by them for ANC in the past six months. On follow-up services for women who had deliveries, 49.8% of the Mitanins responded that none of the pregnant women whom they had followed up opted for home delivery. Some of the Mitanins (35.8%) mentioned that 1-3 pregnant women opted for home delivery. Similar trends were observed while analysing the number of home deliveries attended by the Mitanins. The results indicated highest proportion (50%) of the Mitanins not attending the home deliveries followed by nearly 40% of the Mitanins attended 1-3 home deliveries. The majority (43.3%) of Mitanins referred 1-3 pregnant women to government institutions for delivery, followed by 23.8% of the Mitanins that referred 4-6 women and more than 20% of Mitanins referred more than 7 pregnant women for institutional deliveries, thus nearly 89% of the Mitanins had at least referred one pregnant woman for institutional delivery. In this context the effectiveness of Mitanins can be corroborated for promoting institutional delivery.

TABLE 4.12: Evaluation of Child Health Care Services Provided by Mitanin

RCH Services Delivered by Mitanin (n=1200)	Sub-categories	Frequency	Percentage
No. of Pregnant Women Registered for ANC in 6 Months	No Registration	104	8.7
	1-4	747	62.3
	5-8	278	23.2
	9-12	51	4.3
	≥13	20	1.5
No. of Pregnant Women Registered within First Trimester	No Registration	134	11.2
	1-4	890	74.2
	5-8	130	10.9
	9-12	42	3.5
	≥13	4	0.2
No. of Pregnant Women who completed full ANC check-ups	Did not Completed	175	14.6
	1	213	17.8
	2	325	27.1
	3	199	16.6
	4	22	9.1
	More than 4	266	14.8
No. of Home deliveries attended in Past 1 Year	Not attended	597	49.8
	≤5	558	46.5
	6-10	30	2.5
	≥11	15	1.2
No. of Pregnant Women followed up that had Home Deliveries	No Home deliveries	597	49.8
	1-3	429	35.8
	4-6	126	10.5
	7-9	21	1.8
	≥ 10	27	2.1
No. of Govt. Institutional Deliveries Referred in Past 1 Year	Not Referred		11.4
	≤5		60.9
	6-10		20.9
	≥11		6.8
Mitanin Accompanied Pregnant Women to the Hospitals for Delivery	Not Accompanied		12.7
	1-3		44.8
	3-6		24.8
	7-9		12
	≥10		5.8

4.33 Availability and Refilling of Drug Kit

During the key informant interviews few respondents in some districts stated that the drug supply to the Drug Kit was irregular. The supply of the drugs to the Mitanins was supposed to be in 6 months but some of the Mitanins liberally distributed the medicines in the communities. Because of such liberal distribution of the medicines the supplies got exhausted within 2 months and then the Mitanins did not have any drugs to for the rest of the months. The field observations also revealed that none of the Mitanin interviewed in the study maintained any records related to drug refilling information of their Drug Kits. Almost 96.2% of the respondents that were interviewed about the availability of the drug kit informed that they had drug kits whereas only 3.8 percent of the Mitanins reported not having the drug kit. Those Mitanins who had drug kits, of which 41.7 percent of the Mitanins got a refilling of their drug kit in every six months and 30.3 percent respondents' drug kits got refilled only once a year. Whereas only 15.8 percent of the Mitanins said their drug kits were refilled every month.

During the Key Informant interview a few respondents described several problems encountered by the Mitanins. Of the problems enlisted were the deficiency of drug kits and adequate supply of drugs was the prime difficulty. They informed that the Mitanins were supposed to receive replenishment of the medicines in every four weeks. They reported that the administrative issues caused unwarranted delays in distribution of essential drugs to the Mitanin. They further suggested that the drugs should be provided in bulk quantities but the packing should be done by the Mitanins Trainers and Block resource person with help and coordination from the Block coordinators and then handed over to the Mitanins. They believed this process would also provide an opportunity to the Mitanins to refresh their knowledge about the drug dosage and distribution. During the key informants interviews many of the key programme managers asserted that due to unavailability of drugs in the drug kit was major factor threatening the sustainability of the Mitanin Programme and was a major issue for the SHRC as well in implementing the Mitanin Programme effectively since the Programme aimed at blending health promotion and disease prevention with curative processes.

The key informants those were responsible for training of Mitanin opined that even if they trained the Mitanins to provide essential medications to the patients and if the medications were not available with the Mitanins then the purpose of the training sessions got defeated. Moreover, these observations are also supported by the 2013 Updates of the ASHA Programme, which stated that Chhattisgarh with its comprehensive support structure and extensive spending above 90% on training. But it showed negligible expenditures on the pro-

curement of Drug Kits and Incentives for the Mitanins. Gilson, et al., 1989 also articulated that the amalgamation of poor supervisory support and irregularly available supplies lowered the morale of the CHWs, and less valued by the community members who are interested in first aid for emergency medical condition and treatment for diseases. Moreover, the researchers also observed that when regular drug availability was accompanied by irregular supervision of the Mitanin and the period mainly spent on dispensing drugs and neglecting health promotional or disease preventive tasks. In certain places it was reported that when drugs were not available Mitanins' importance and activity were usually low in the community since the people did not greatly value the health promotion and information as useful.

4.34 Challenges of Mitanin

In some of the communities the Mitanins had a positive image and their work was appreciated by the villagers. However, in certain villages changing the perceptions and misbelieves of the community members were the difficult challenge. The Mitanins found it difficult to convince the pregnant women in the communities to opt for the institutional delivery due to the presence of the "*Zholachap Doctors*" (Quacks). They were at loggerheads with the Mitanins, at times these fake doctors did not allow the Mitanins to refer the pregnant women to the hospitals for delivery. This rivalry and community practices upsets the rhythm of Mitanin's work. A large proportion of Mitanins also reported that the community members insisted on home deliveries over institutional delivery, even after the Mitanins explained them the benefits of institutional delivery. Many a times when the Mitanins had strongly promoted the institutional delivery, the community members viewed them with suspicion about their motivation as they believed the ulterior motive of earning money by referring the women to institutional delivery and care. Even sometimes when the pregnant women were convinced about the institutional delivery but their families were not in agreement. Many of the Mitanins reported that they got distress calls for the deliveries and other infant related health issues at an unusually non-working hour at nights. Then due to lack of transportation and support mechanisms in the villages the Mitanins found it very difficult to commute at night and attend to the patients at a distant location. In addition, dealing with the inebriated community members were another major challenge reported by the Mitanins and their trainer. Many a times they met with rude and rough behaviour of the drunken men in the villages.

Another most difficult situation described by the Mitanins was that several families in the community still believed in black magic, superstitions and tribal medicine. Hence, it was difficult to convince such members of the community to practice the modern system of medicine.

Further, the Mitanins found it difficult to perform health promotion drives and campaigns

among the illiterate people in the communities. They revealed that when people in the community did not understand health related information then they had to explain such community members repeatedly. The respondents observed that it became very difficult to explain health related information to the people who had low literacy. There were some communities as reported by a few respondents who wanted Mitanins only from their own communities to attend to their health problems.

4.35 Suggestions of Mitanin for Strengthening the System

The Mitanins elucidated various challenges in the field and suggested that the following changes may strengthen the system. The ongoing guidance and support to the Mitanins by the Senior Health Officials of the department may be of crucial help towards mitigating the challenges that they face in the field. The training sessions must encompass enough practical training and demonstration for the Mitanins to feel confident about their knowledge and skills.

The Mitanins felt discouraged and de-motivated at times as they were not able to provide successful medical services to their own village people due to the lack of adequate drug supply. They strongly suggested that they should be given timely and sufficient supply of the medicines for the drug kit.

Most Mitanins stated that during the training sessions the standards of boarding and lodging facilities for the participants should be improved. The Mitanins also proposed that they should get decent and better allowances for attending the training sessions. In addition many Mitanins suggested that the complete logistics should be improved during the training programme.

The Mitanins articulated that there is necessity for a once a month meetings where all the health authorities and officials including the BMOs, CMOs, DPMs, BPMs, Mitanin trainers and Mitanins should come together to share and discuss their experiences and difficulties. This practice would certainly improve the working relationships and required communications amongst the Mitanins and other important health care officials. A large majority of the Mitanins preferred conducting health visits together with their supervisors in the respective hamlets with an idea of improving the confidence and legitimacy of their role in the community. The Mitanins expected that they should be provided with regular support from the supervisors in registering women for ANC, PNC etc., and resolving any unforeseen difficulties and problems in the field. The Mitanins also opined that they should work together with the supervisors to mobilize the community and expected better and close coordination with the Supervisors. The Mitanins all most all districts suggested that there should be some measures taken that will ensure us that we get salary of atleast Rs 3200/- per month.

4.36 Capacity Building and Engagement

During the interviews a large numbers of Mitanins suggested that they should be trained methodically by their supervisors to conduct deliveries so that they could conduct deliveries on time without any delay and in case of complication can refer effectively.

More than 66 % of the Mitanin respondents felt satisfied working as a Mitanin (see Table 4.13), 53% Mitanins were inspired and motivated by their senior workers and 62% reported that they felt proud to tell people about their work. It was interesting to observe that about 61 % of them felt they had right qualification and tools for effectively working in their communities and slightly higher proportion 64% of them perceived that people in their life value of the work they do. However, certain aggregate of the respondents scored negatively on the engagement inventory, where almost 26% respondents were not satisfied working as a Mitanin, 43% of them indicated that their senior workers neither inspired not motivated them in their work. Still 35% Mitanins never felt proud about their work and 30% of them did not perceive that they possess qualifications and tools to work effectively.

TABLE 4.13: Mitanins' Engagement in Programme

Engagement Variables N=1200		Agree		Can't say		Disagree	
		F	P	F	P	F	P
1.	I do feel satisfied working as a Mitanin.	794	66.2	100	8.3	306	25.5
2.	My senior workers inspire/motivate me a lot.	636	53.0	54	4.5	510	42.5
3.	I feel proud to tell people about my work.	743	62.0	40	3.3	417	35
4.	I have the qualification & tools that I need to do my job effectively.	733	61.1	102	8.5	365	30.4
5.	My people value the work I do.	770	64.2	94	7.8	336	28

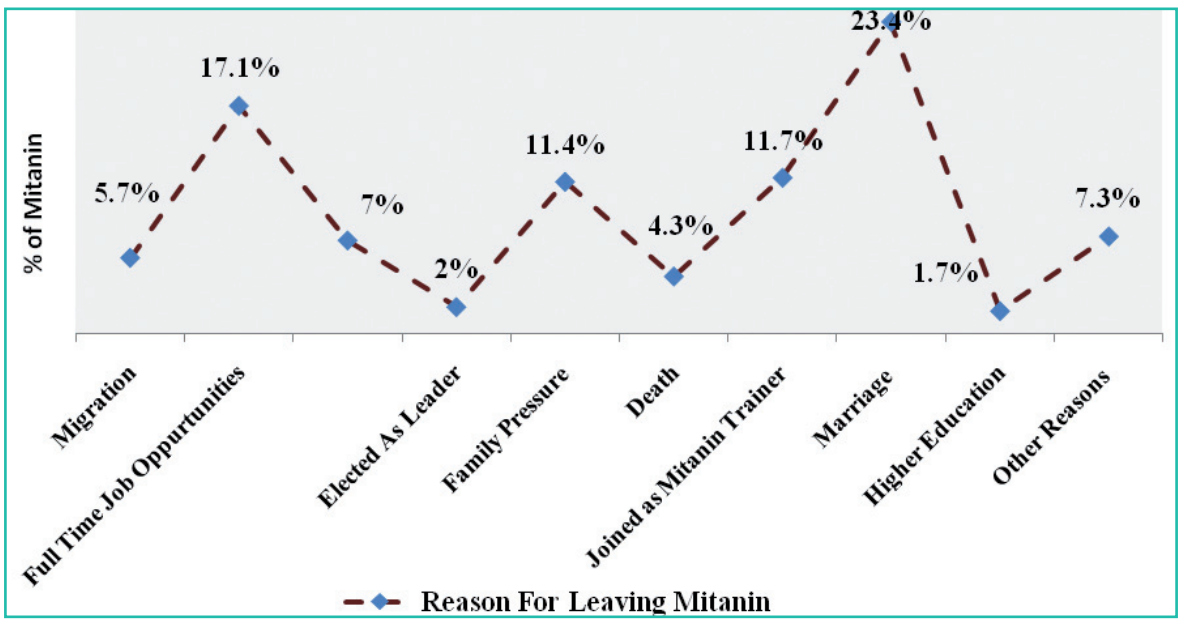
4.37 Attrition and Exit Mitanin

A significant number of Mitanins (75.1%) those recruited initially from various villages and hamlets were continuing their work. The previous evaluation study by EU-SPP in 2011 indicated that 82% of the Mitanins were found to be the 'original recruits' and only 18% had changed their jobs over an average period of 7 years thus indicated low attrition rates. However, the present study elucidated the reasons for 25% attrition rate, the Mitanins were asked the reasons for the same. Figure 4.11 indicated that the highest 23.4 percent of the Mitanins resigned from the post as they got married and migrated from their hamlets, where as

17.1 % of the Mitanins stopped functioning as a Mitanin and joined a full time job. These findings were in conformity with the studies conducted on the CHWs that presented the fact that around the world the attrition rates are high among the young community health workers as they are likely to get married or migrate away from the villages in search of better permanent jobs.

The study also found various other reasons for leaving the job such as family pressure, lower socio-economic conditions, travelling long distances for work, irregular and inadequate drug supplies, insufficient incentives or stipends and lack career opportunities. Only 2 percent of the Mitanin discontinued functioning as a Mitanin as they got elected to "*Panchayat*" or "*Janpad Panchayat*" and another 1.7% resorted to higher education.

FIGURE 4.11: Reason for Leaving Mitanin Work



4.38 Roles and Responsibilities of Mitanin Programme: Anganwadi Workers

Many AWWs reported that Mitanins provided medicines, iron tablets to the pregnant women and lactating mothers every month, they also provided necessary injections, vaccinations against preventable diseases and tried to provide health services by visiting households. Every Tuesday in a month the AWWs administered vitamin drops to the children and informed them and their parents or guardians about nutritional needs of the children, conducted weight examinations and also provided iron tablets. Some responded reported that Mitanins attended the malnourished children at home and referred the malnourished children to the health centers. The AWWs also maintained records about

the malnourished children in their working areas. Majority of the AWWs mentioned that they tried their level best to immunize every child. While caring for children the AWWs focused specially on children between the age group of 0-5 years, immunization of pregnant mother, take care of lactating mother and provide education with the help of Mitanins. The AWWs also informed that they helped the Auxiliary Nurse Midwives and Mitanins in the immunization drives, provided nutrition on nutrition day, provided necessary health information among community members. Guided and helped the Mitanins to increase converge of immunization, breast feeding and institutional deliveries. A large majority of AWWs reported providing right information, by conducting house visits with the Mitanins so that people can get benefit of services like the provision of nutritional food, registration of pregnant women and malnourished children and regular immunization.

4.39 Strengths of Mitanins Programme: The AWWs and ANMs

The AWWs stated that the collaborative attitude of the Mitanins to work together with the community, different sections of the health and sanitation departments and authorities is one of the major strengths of the Mitanins. The Mitanins being in regular contact with community brought everyone for meetings, planning and thus excelled in building good relations with the rural population. The Mitanins by conducting the household visits provided information about health, government schemes to the rural people as it was not possible for the AWWs to conduct house visits. The AWWs also reported that the provision of services by the Mitanins such as health education, immunization, medication and nutritional food to children and pregnant women and motivation for institutional delivery were the hallmark of the Mitanin programme. The advices and treatments offered by the Mitanins helped the health department to prevent the maternal and child mortality. The Mitanins strive hard to educate people to keep the village surroundings clean, provide health education, and cooperate with communities to understand their health needs and empower them to take decision about their health needs.

According to ANMs the strength of Mitanins was their ability to reach out to each and every household and provide health services to the underprivileged communities. With their considerate behavior towards the people some Mitanins could very effectively created health awareness, immunization, registration of pregnant mother and their examination. A large majority of the ANMs (63%) also attributed the increase in the percentage of the institutional deliveries across the state was due to the Mitanin programme. The ANMs also informed that the Mitanins regularly advised the community members especially the pregnant and newly delivered mothers about nutritional food and cleanliness. A substantial number of ANMs (55%) indicated that the Mitanin programme

had improved the community health status especially in reducing cases of malnutrition, providing first aid services, preventing diseases like jaundice and polio, advising about water purification methods, motivating for sterilization and providing information on menstrual cycle to adolescent girls. With the help of the Mitanins ANMs could engage the community members in the provision of health education on various diseases. They were able to report serious illnesses to the health officials, many ANMs also reported that they periodically informed the Mitanins about the National Health Programmes so that they could disseminate appropriate health awareness in the *"padas"*. Thus generally the ANMs felt that it was their duty to the help the Mitanins to motivate the community for institutional delivery, conduct camps for health examinations and family planning drives for propagation of population control.

4.40 Weakness of Mitanin Programme According to AWWs and ANMs

Both the group of the respondents informed that as many Mitanins had low level of education and did not complete trainings programmes, therefore, were unable to provide accurate and all information related to health issues and programmes to the people. Some of them were also unable to inform about schemes on time to the community members. A few Mitanins that were inactive did not take interest in work and did not call pregnant women. Most important drawback of the Mitanin programme was appointment of illiterate or semi literate Mitanins, as they were ineffective and were not able to provide health services to people. Another major issue reported that the delay in the payment of incentives and low amount of incentives given to the Mitanins and the ANMs/AWWs also informed that because of not receiving incentives on time, Mitanins got de-motivated. They also mentioned about the illiteracy among the Mitanins led to lack of respect, trust and support from the community. Lack of co-ordination among the Mitanins and from the doctors and nurses and lack of medicines further weakened the Mitanins programme. Poor economical condition of some Mitanins also negatively impacted on their health, less and irregular of incentives also affect on their work. Moreover, they did not have power to independent decisions.

4.41 Challenges and Limitations of Mitanin Programme

While enumerating the challenges of the Mitanin programme the ANMs and AWWs informed that the Mitanins being voluntary workers thus were not accountable in the system. Most of the Mitanins as per the AWWs faced the several problems as they had to go on the field visits alone, often had to encounter lack of resources, fear of unknown people and to build rapport with people believing in superstitious practices. Some key health professionals also felt that the need to update the Mitanins with current and recent health information as any wrong and obsolete information would have

serious effects on the health of the population. Deficiency of essential medicines was the most cited challenge by the key informants as the situation make it difficult for the Mitanins to build trust among the communities. Many people in community being illiterate fail to understand the health advices given by the Mitanins and even if they understand they do not abide by them and thus the Mitanin programme is not able to deliver in regions of extreme illiteracy. During the qualitative interviews the respondents also mentioned that due to illiteracy and lack of skills in some of the Mitanins who lack proper knowledge of medicines may therefore prove to be incompetent in treating even the minor complaints in the community.

4.42 Performance Evaluation of Mitanin as per ANM and AWW

The Table 4.14 illustrated the rating of Mitanins in their abilities in the areas of communication skills, community participation and involvement. The data revealed that in the given areas the AWWs had rated higher than the ANMs. More than 65% ANMs respondents stated that communication and interpersonal relation of Mitanin in community was good and almost 30 percent of the respondents specified it was poor. Whereas more than 72% AWWs had rated that the Mitanins as good in the areas of communication and interpersonal relationships. Again in the areas of Community participation and involvement almost 69% ANMs rated the Mitanins as good and more than 24% rated poor. On the other hand a large majority of the AWWs (74%) respondents mentioned Mitanins' were good in relation to their contribution in the areas of community participation and community involvement. And almost 23% respondents rated the Mitanins as poor.

TABLE 4.14 Performance Evaluation of Mitanin by ANM and AWW

Variables	ANM (n=500)		AWW (n=500)	
	Frequency	Percengate	Frequency	Percentage
Communication Skills & Interpersonal Relationships				
Good	327	65.4	362	72.3
Poor	147	29.5	132	26.4
Can't Say	26	5.1	07	1.3
Community Participation & Involvement				
Good	344	68.7	370	74
Poor	119	23.8	113	22.6
Can't Say	37	7.5	03	2.8

4.43 Guidance and Suggestions Provided to Mitanins by ANM and AWW

The majority of the ANMs cited that they had regularly advised the Mitanins to be present on the immunization day and mobilize the community to ensure good coverage. The ANMs also mentioned that they supported the Mitanins in providing health services to beneficiaries especially in the hard to reach populations so that no one was exempted from the benefits of the programme. The Mitanins were regularly advised by the ANMs to be punctual and regular while attending the patient and making visits to the households. The ANMs helped the Mitanins to motivate people for institutional delivery, spacing of pregnancies, sterilization and use of copper-T. The ANMs also reiterated that the Mitanins were advised regularly to monitor the treatment of the tuberculosis patient on continuity, follow up and completion. The ANMs also made the Mitanins realize that they should be accountable for their role and responsibilities, build trust in the communities, develop strategies so that the community members themselves seek various health services and for this the ANMs also helped the Mitanins to conduct "*pada*" level meetings every week.

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Chapter 5
CONCLUSION AND RECOMMENDATIONS

Health Education

Chapter 5

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Over the decades, the intervention of community health workers in healthcare delivery has increasingly widened as they are inevitable to meet the universal healthcare provision and the millennium development goals. The rural women in the state of Chhattisgarh consider becoming a Mitanin as a good prospect to be empowered individually, socially and more significantly financially. In this context empowering rural women as Mitanins who do not have alternate job opportunities can be a replicable and sustainable model for community health care at a larger level.

The programme had largely motivated and empowered the local women on community health based on internal locus of control and motivation. This implies that with proper selection, orientation and training, the lay women can be organized for community health activities.

The inner motivation to gain social recognition, earn knowledge in the areas of health, a sense of social responsibility and self-efficacy motivated them to become Mitanin. On the other hand due to their poor socioeconomic circumstances it was also a prime concern of large section of Mitanin to be driven by the external reinforces such as a government job and a monthly income. The state healthcare delivery system improvements might further motivate and enable them to gain the community trust. The Mitanin management and administration needs amendments to ensure adequate supportive supervision, skill and knowledge enhancement and enabling working modalities and a rewarding working model for large and heterogeneous section of Mitanin those who hails from the poor socioeconomic strata of the society.

Originally the Mitanin programme was conceived with impressive vision of an innovative community health care model which considerably contributed to the health and development in the state of Chhattisgarh. Given the array of findings in various studies that contains both positive and negative observations of Mitanin programme; on the other hand programme is necessary for the health system in Chhattisgarh to strengthen its foundation in the community. It certainly needs alterations by reinforcing and integrating strengthens and achievements that paved the way to good health, on the other hand correcting the drawbacks to increase its effectiveness and role. Without corrective measures at this crucial juncture the programme may lose further credibility despite the good impact it made so far. Generally most successful Community Health Programmes learn and mature biologically from practical experiences and the realities. There is enough in the world literature

about what works and what does not work. The case of Mitanin Programme in health sector of the state has grown organically and further may develop more responsive to people's health needs.

5.2 Recommendations

The recommendations are drawn based on the broader findings from study, overall observations, experience and learning from this field study. The following recommendations are written in anticipation that it may facilitate the future planning and development of the programme.

The community health programme and the health systems of the state require to be scaled up on the edifice of multidimensional health and development concept. Tackling multiple social determinants and economic development of rural communities may require greater attention in the state. Engaging collaborative work with various departments such as Panchayati Raj Institutions, Women and Child Development, Rural Development and Education is essential. Currently a state level review exercise to clarify the Mitanins' roles, responsibilities and expectations of various key stakeholders including the Mitanins may provide sharper directions and solutions to the programme. A Comprehensive analysis of the evidence may guide the policy responses and can be aligned with the expectations and needs of Mitanins. A proper system may be put in place to obtain regular feedback and suggestions for improvement and innovation from the Mitanins, community members, ANMs, AWW and other significant stakeholders from the health system.

Any shortage of Mitanins and other community health workers may prevent basic access to health services and may be a barrier to universal coverage. The budgetary allocation and personnel inputs into the Mitanin programme must be increased based on the expansion and a longer term estimation of diverse areas. Regular and better incentives would add a programmatic advantage in lowering the attrition rate and increasing the motivation among the Mitanins.

The most critical problems for the Mitanin program would be to reduce the rate of attrition which leads to a lack of continuity in the work and rapport between Mitanin and community, and increased costs in selecting and training new Mitanins. There were evidences that suggested that control on attrition and improve on motivation can be achieved through provision of regular and performance based financial incentives and appointing CHW as full time employees rather than part time volunteers. The underlying idea of incentives is that the money is the most significant motivating factor. These measures would ensure retention of the Mitanins in the programme and would also create a sense of professional accountability towards the programme. Recognition and non-monetary incentives

Simultaneously non-monetary incentives in the Mitanin Programme may be strengthened as they satisfy their social and psychological satisfaction. Such incentives include job security, recognition, participation in decision making, sincere interest in superiors, pride on the job, promotion, training facilities, welfare and social security measures; these mechanisms collectively may brought greater changes on the ground level. The Health Department must recognize the mitanins through a formal mechanism and provide them with some formal identity.

As regards to the Mitanin programme they were experiencing serious difficulties and hardship in carrying out the field related work due to chronic shortage and irregular supply of essential drugs. There should be a better managed mechanism that would ensure a regular supply for these drugs and first aid resources.

The capacity building procedures of the Mitanin Programmes should also focus on developing income generating activities for the Mitanins at the village level to sustain them in the Programme. During the work of Mitanin it should prove to be an economically viable option. The career growth and promotion opportunities should be available for the Mitanins in the Programme, which may include various opportunities such as Mitanin trainers, AWWs or ANMs. Exploring distance education and support programs for Mitanins along with career enhancement opportunities should be offered on completion of minimum qualification level and work experience. Such growth opportunities are required to reach the next level and may be utilized as incentive for career development.

Greater emphasis should be given in preparing the Mitanin trainers, the training of trainers needs strengthening as the quality of the trainers' knowledge, attitude and capacity bear greater value in the programme. An independent expert training institute may be deployed for conducting all regular trainings programmes and they may work in consultation with key state health system. The other ongoing regular orientation for the other health care providers such as MOs, ANMs, AWWs, key personal of the state health systems may be organised to impart advance management and administration skills in both technical and soft skills. A different participatory and experiential training technology is required for the non-literates and the team of trainers needs to be fluent in the different languages including the local adivashi language.

Community involvement and ownership of the health planning and implementation should be the fulcrum of any community based health programme. Thus effectively engaging and involving the gram panchayats members in the Mitanin Programme must be guaranteed. The community members too have to be engaged in reviewing and strengthening the Mitanin Programme. Community organisation programmes with ad-

equate financial and human resources would be required for effective and efficient delivery of the programme in future.

Originally the Mitanin programme was conceived with impressive vision of an innovative community health care model which considerably contributed to the health and development in the state of Chhattisgarh. Given the array of findings in various studies that contains both positive and negative observations of Mitanin programme; however programme is necessary for the health system in Chhattisgarh to further strengthen its foundation in the community. It certainly needs alterations by reinforcing and integrating strengthens and achievements that paved the way to good health, on the other hand correcting the drawbacks to increase its effectiveness and role. Without corrective measures at this crucial juncture the programme may lose further credibility despite the good impact it made so far. Generally most successful Community Health Programmes learn and mature biologically from the practical experiences and the ground realities. Globally and nationally there is adequate literature about what works and what do not work. The case of Mitanin Programme in health sector of the state has grown organically and it should further develop more responsive to people's health needs.

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