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Patient Revolution

A band of 60,000 voluntary healthcare workers were trained to counsel villagers and confront errant government doctors. The untold story of how they improved healthcare for 18 million people in the state, writes M Rajshekhar

FIGURE WATCH

2.08 cr	TOTAL POPULATION
721	TOTAL NUMBER OF PRIMARY HEALTH CENTRES
20 k	TOTAL NUMBER OF VILLAGES IN CHHATTISGARH
60 k	TOTAL NUMBER OF MITANINS

...AND MILES TO GO

	INDIA (2005-06)	CHHATTISGARH (2005-06)	CHHATTISGARH (1998-99)
Women between 15-19 years who were already mothers or pregnant at the time of the survey	16.0	14.6	NA
Mothers who had atleast three ante-natal visits for last birth	50.7	54.7	33.2
Children between 12 and 23 months who are fully immunised	43.5	48.7	21.8
Children with diarrhoea in last two weeks who received oral rehydrate	26.2	42.0	29.7
Children under three breastfed within 1 hour of birth	23.4	24.5	13.9
Children between 6-35 months who are anaemic	78.9	80.9	87.7
Married women between 15 and 49 years who are anaemic	56.2	57.6	68.7
Married men in the age group of 15-49 years who are anaemic	24.3	26.4	NA

SOURCE: National Family Health Survey 2 (1998-99) and NFHS 3 (2005-06) — **Figures in (%)**

HEART OF THE MATTER

- **Mitanins' efforts** have ensured that 500 of the 717 public health centres in Chhattisgarh now work 24X7
- **Mitanins perform** two functions: Work with villagers to bring about a behavioural change and play an activist role in helping them demand healthcare as a fundamental right
- **The Mitanin** programme was specifically designed to match the system's functioning with the people's expectations and extend healthcare deeper into the state, instead of opening more clinics
- **The state** has decided that only women can become Mitanins. They were chosen at the hamlet level to reduce the possibility of upper/lower caste barring their entry into their houses
- **In 2002**, the first Mitanin pilot began in 14 of Chhattisgarh's 146 blocks.
- **Importantly, the** Mitanin programme has been kept out of the health department's purview. A technical support group called SHRC has been set up
- **SHRC's activities** include churning out training programmes and monitoring implementation

MITANIN ON A MISSION A mitanin holds out hope for these deprived tribals of Chhattisgarh

The word 'Mitanin' was derived from a Chhattisgarhi custom, where a 'mitanin' is a girl bonded ceremoniously in her childhood to another girl as a lifelong friend

IT IS quite common for tractors in rural India to haul all kinds of unusual cargo. Even then, a late night emergency shuttle, from a small home in Narayanpaal village in the backward Bastar district of Chhattisgarh, to ferry a pregnant woman in the early throes of childbirth to the local primary health centre, is an uncommon sight. For Savitri Sahu, the woman who responded to the family's late-night distress call and hailed the tractor, it was just another day at work.

Now, Sahu didn't just happen to be around. She was deliberately positioned there by the state under a voluntary healthcare worker program called Mitanin. Simply put, this is an institutionalised 'good Samaritan' program. Only the samaritans also double up as fierce activists.

Mitanins like Sahu are trained by the government to respond to citizens' demand and get healthcare from the state as a matter of right. The baby was born that very night. Yet another baby born in a clinic…one more small victory for the Chhattisgarh government. The state has managed to increase clinical births as opposed to the traditional home births from 10% to 38% since 2000. And, yet another statistic to prove that the Mitanin program is indeed taking the state's healthcare services to the masses.

This birth was very different from typical deliveries in much of rural India. The family's decision to take the mother to the hospital itself was a breakthrough. The doctor and support staff being present at that time of the night was another achievement. In fact, 500 of the 717 public health centres in Chhattisgarh now work 24X7. Next, the mother breast fed her baby within two hours of the birth to ensure that the baby gets colostrum, the first liquid that comes out as a mother begins breast feeding. Age-old custom in Chhattisgarh holds this as unhealthy, and also rules that mother and newborn should not be given water for the 24 hours after delivery. Mitanins like Sahu played an instrumental role in making all three happen.

For urban dwellers, even poorer ones, such births are hardly a miracle. But in the tribal-dominated Chhattisgarh, pockets of which have once seen almost one out of every five infants die, this birth is nothing short of a healthcare revolution. Infant mortality in the state is down from 95 per 1000 in 2000 to 44 per 1000 in 2009.

This revolution, which has impacted 18 million people in the state, has been possible only because both patients and doctors are now more responsive to health issues. The patient is willing to go to the health centre. And the doctor, unlike elsewhere, is actually available at the centre.

And the credit for making patients and doctors more responsive goes to Mitanins like Sahu. — there are 60,000 of them in the state. The word Mitanin was derived from a Chhattisgarhi custom, where a 'mitanin' is a girl bonded ceremoniously in her childhood to another girl as a lifelong friend.

Each Mitanin has been trained by the government to perform two roles. First, work with villagers to bring about a behaviourial change and train them in preventive health practices. Second, play an activist role in helping villagers demand healthcare as nothing less than a fundamental right.

For example, feedback passed by the Mitanins back to the trainers has helped crack down on errant doctors. In fact, some criticise Mitanins for taking the activism a bit too far. Sahu says she and other Mitanins make it a point to be present when the PDS shop is giving out rations to ensure that all households get their full 35 kgs. Some bureaucrats are complaining, but this could also be seen as evidence that the Mitanin approach is working.

There is a reason the nation should take note of Chhatisgarh's healthcare army. At a time when debate is raging on whether the Indian state can deliver social services well, the Mitanin programme illustrates that, with a little reform, the state can indeed deliver.

This is why two successive chief ministers have ignored political differences to back the Mitanin program. Former Congress chief minister Ajit Jogi started it 18 months before the state election of 2003. When he saw that the initial pilots were working, he wanted it steamrolled all across the state. But Jogi lost and the BJP's Raman Singh took over. Worried that the BJP might discontinue what was a Congress programme, Shukla and T Sunderaraman, who had joined to head the SHRC, sought and got an appointment with the new CM to build a case to continue the program. Raman Singh interrupted the session mid way to say that Mitanin was working extremely well in the villages. He knew that it was doing a lot of good work. The program has since got his full backing.

ALOK Shukla remembers how horrifying the numbers were. Ninety five out of every 1000 children born in Chhattisgarh were dying — the second highest in all India. This was in 2000, when Shukla was the state's health secretary. He has since become India's deputy election commissioner. Sitting in his office at Nirvachan Sadan, he recalls that diarrhoea, malaria, leprosy and tuberculosis were huge problems. Ten of its 16 districts did not have a district hospital. The state had 146 blocks but just 114 community health centers (there should be one in each block). Its 3,818 health sub-centres, each with one auxillary nurse and midwife had to cover 18 million people across 54,000 hamlets.

Worse, the existing infrastructure was not fully used. For one, the clinics rarely had doctors or medical supplies. Two, as one of the villagers in Sarguja, a district in northern Chhattisgarh, said: "Villagers were apprehensive of the hospital. We did not know where to go, whom to talk to." Three, in Chhattisgarh, much of the state's population lives in scattered forested habitations. Health workers found it hard to reach the villages, and villagers found it difficult to access the health centres.

These, says Shukla, are the larger realities of public health delivery. The treatment of diseases takes precedence over prevention of diseases. And there is a strong urban bias: the availability of doctors, health infrastructure drop as one moves from cities to villages.

Now, community health workers are not a new concept. But, till Mitanin came along, most such initiatives flopped.

In the first approach, doctors moved from cities to the hinterland to create an alternative to the public health system. They set up hospitals and trained locals to offer simple healthcare in their villages. These models, like the one started by Raj and Mabelle Arole in Jamkhed, Maharashtra, delivered very good results. For instance, between 1972 and 1992, the Aroles brought infant mortality down from 176/1000 to 20/1000. But such models, built around the charisma of their founders, have struggled to scale up. After all these years, Jamkhed covers only 60 villages directly, and 300 indirectly. Chhattisgargh has 20,000 villages.

Then, the health bureaucracy has been running its own CHW experiments to extend curative healthcare by grooming locals into quasi-paramedics and by getting them to bring more complicated cases to clinics. For instance, Madhya Pradesh's Jan Swasthya Rakshak programme, launched in the nineties, trained local men at primary health centres for six months. The programme bombed. Most of the training was curative, creating an incentive for the men to make money from patients. They rapidly became quacks.

Mitanin chose a middle path. It was decided that only women could be Mitanins. They would be chosen at a hamlet level. Since hamlets are more homogenous than villages, this would reduce the likelihood of the Mitanin not entering the house of an upper/lower caste. To ensure local elite didn't capture these positions, the women would not be paid for their work — having one woman per hamlet (about 40-60 households) also ensured the workload would not eat into her livelihood. To emphasise the public health role of the Mitanin, curative would play second fiddle to preventive and promotive healthcare. And the Mitanin would be selected by the community, not the health bureaucracy.

It was also decided to keep the Mitanin program out of the purview of the health department. A technical support group called SHRC, State Health Resource Centre, was set up instead. This accentuated the activist aspect of the Mitanin and enabled her to challenge the government healthcare machinery. There was another reason for this. The Mitanin initiative called for skills the health department lacked — mobilising communities before choosing mitanins, collaborating with civil society groups for training, etc.

HEALTH FIRST

The spirit of the programme has been communicated through songs and kalajathas (skits) — an idea that came from their use by people movements

In May 2002, the first Mitanin pilot began in 14 of Chhattisgarh's 146 blocks. This was scaled up to 40 more blocks in July 2003. By June 2004, there was a Mitanin in every one of Chhattisgarh's all 54,000 hamlets.

This pursuit of scale has resulted in heated debates. For instance, in the programme's emphasis on scaling up, purists feel the CHW model has been diluted. Arole, the co-founder of the Comprehensive Rural Health Project, Jamkhed, feels Mitanin has struggled to find enough good trainers, and that the women have not been monitored regularly. "At Jamkhed," he said, "women speak most freely in the evenings and the evaluators spend a night in the village. On the other hand, at Mitanin, the trainers visit once every two weeks and most of the time goes into collecting data."

SUNDARARAMAN joined SHRC in October 2002, with a unique set of qualifications: he was a doctor, he had helped scale up the total literacy mission, and was known for his attention to details, all useful skills for someone who had to train lots of women about healthcare. "As one scales up," he says, "there is a loss of motivated leadership. There is greater transmission loss in training. Also lost is the tradition of working with the local community."

"So, what are the priniciples for reducing transmission loss? You have high voltage at the starting point, a clear channel for transmission, step-up boosters at different points, and you have to measure transmission at different points," he adds.

He did two things. First, he re-conceptualised some aspects of the programme. For instance, the women would be trained every four months for as long as the programme ran (the Jan Swasthya Rakshaks had been trained only for the first six months). To ensure trainers and managers did not forget the ground realities, it was decided that only people living at a block level would be hired to supervise the Mitanins, and that trainers would double as field coordinators. Second, he laid down elaborate, standardised processes for everything — selection, training, on-the-job support, skill development, motivation, supply of drugs, monitoring learning outcomes, the spirit of the programme.

On the whole, SHRC was the high-voltage starting point, churning out training programmes, monitoring implementation, etc. The adherence to processes reduced transmission loss. The multiple trainings were the step-up boosters. A set of process indicators (visits to newborns, number of village meetings held, etc) were used to measure transmission. (Sundararaman moved to Delhi to head the National Health Systems Resource Centre, a technical body advising the National Rural Health Mission, in 2007.)

Take training. SHRC had created books on child health, maternal health, etc. Trainers had to go through these line by line with the Mitanins. Says Sundararaman. "You are not allowed to give a speech on the book even if you can give a better speech. Whatever happens, the minimum gets conveyed."

Or take the spirit of the programme. That was communicated through songs and kalajathas (skits) — an idea that came from their use by people movements to build and retain a sense of mutual solidarity. The songs, written in workshops by Chhattisgarhi folk singers and writers, paint a popular image of the Mitanin in the local idiom — 'Sukh mein sabei saath, dukh mein Mitan'.

ONCE training began, Mitanins were told to refer patients to the government clinics. In the early days, villagers who went there found the clinics locked. The Mitanins reported these failed trips to trainers who passed the information on to block medical officers. Slowly, the doctors began coming on time. Similarly, the Mitanins also gradually forced the ANMs to adhere to their prescribed work schedules.

It is hard to quantify the precise contribution of Mitanin to indices like child mortality — there are too many other variables around poverty and disease at work. But the dramatic improvements in childcare practices and improvements in healthcare delivery by the state can be traced back to Mitanin's emphasis on preventive care and activism.

That said, the rate of improvement in health indices is slowing. This suggests that the low-hanging improvement have been made. The question is whether a health programme can improve the state's health numbers on its own. Says Arole, "Health is also about ensuring nutrition, clean water, a healthy local environment and education. We need to have a good implementation of all these programmes." Mitanin on its own is not a panacea.