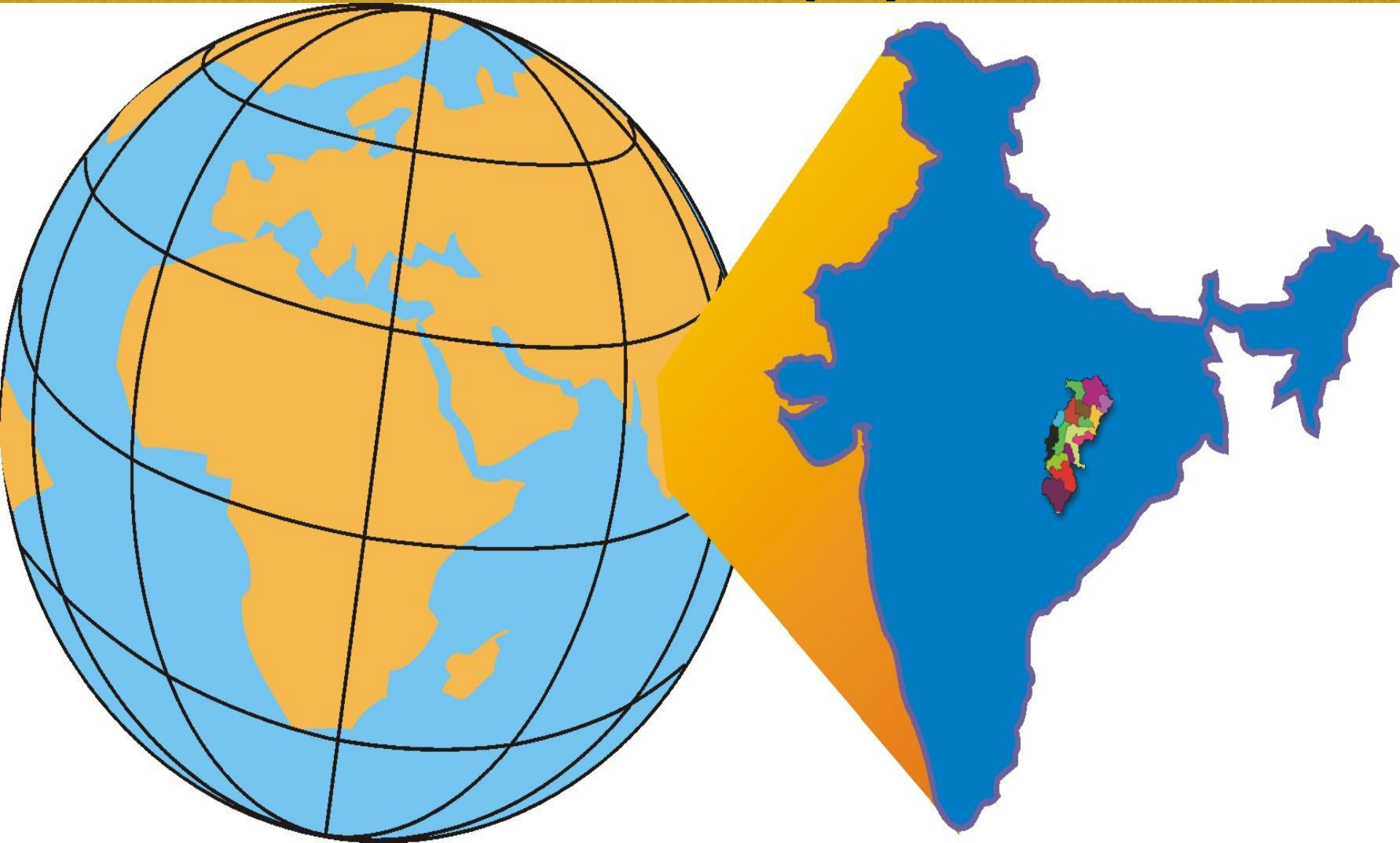


Chhattisgarh, ninth largest state of India - 24 million population



Lush green Forests-44% of land area- is our
asset and liability
with Mines -Tin,Coal,Iron



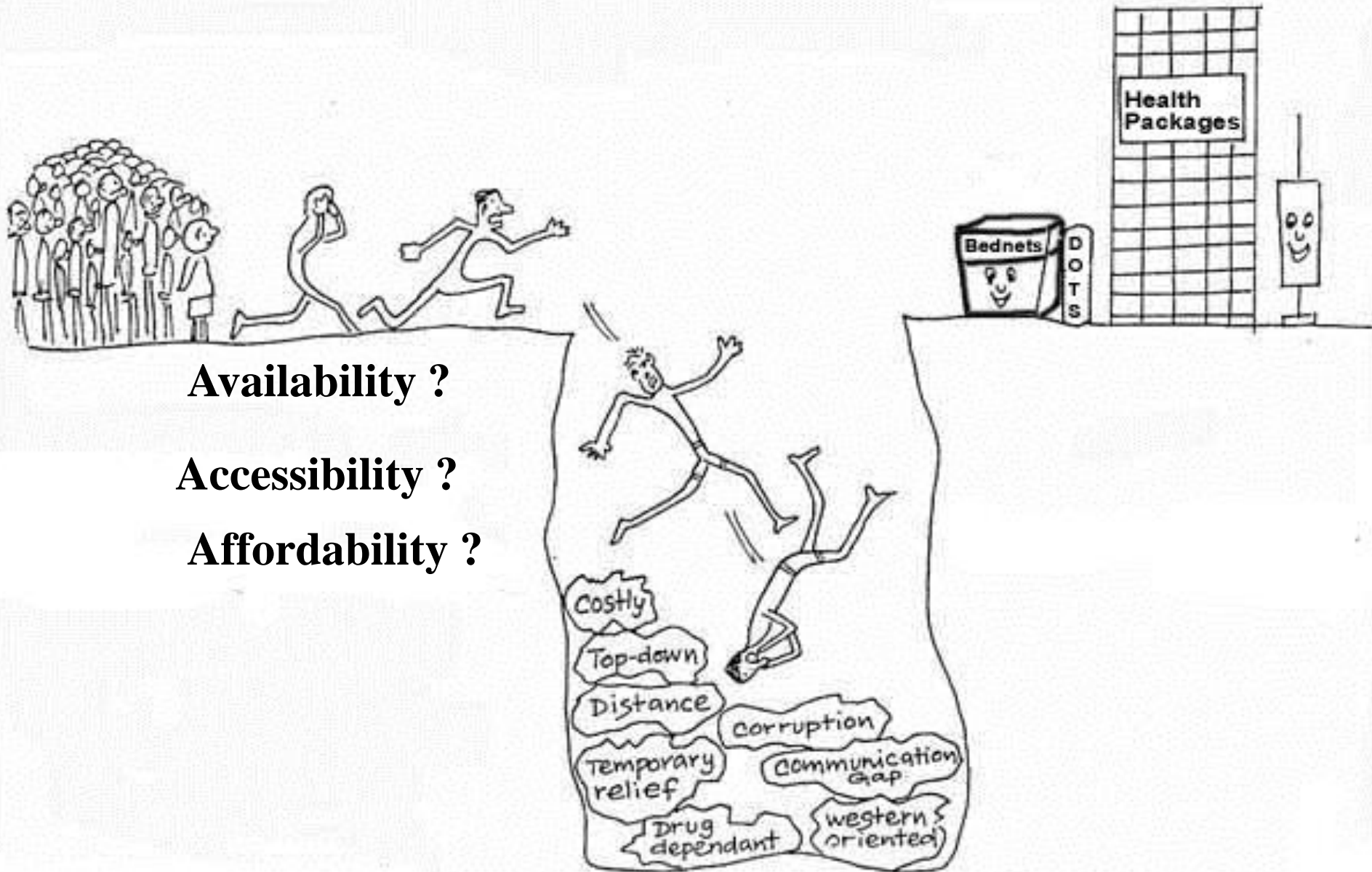
**80% of people living in villages/hamlets
32% of Population are Tribal- 7 of India's primitive tribal
groups live here**



Paddy cultivation is our main occupation

Population Density:154 /sq.km (National-324)
**Scattered habitations a challenge to provide
health services**





Chhattisgarh, a new state of India born on 1st November, 2000, has launched many initiatives to reform the Health Sector.

Health Sector Reforms

- **“Sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector” (Burman & Peter-1995)**
- **“A sustained process of fundamental change in policy and institutional arrangement of the health sector, usually guided by the government.” (WHO)**

The difference here is: The reform processes is guided by the peoples perspectives and public health experts.

Gaps in Health Service Provision

Supply Side Gaps:

- Infrastructure
- Human Resource/ Manpower
- Governance Issues
- Skills, capacities and Motivation
- Drugs, Supplies and Equipments
- Programme Design
- Referral arrangements

Demand Side Gaps:

- Inadequate awareness
- Poor utilisation of services
- Need for behavior changes
- Needs greater community participation

Other Critical issues:

- ANMs Workload and limitations in expanding the MPW force
- Anganwadi centre coverage limited to the nearby areas only- large number neighborhood villages left out.
- Limited connectivity - Most villages are not connected and even unapproachable in monsoon seasons.
- Weaker linkages of the panchayats with health system.

Factors that lead to the reforms...

- Limitations of a new state compelled to open newer avenues
- Political priorities towards popular and mass interventions
- The state-civil society engagements moved into effective negotiations, to shape a pro-poor health reforms agenda.
- Community basing was viewed as the central element of health sector reforms.
- Availability of Sector Invest Programme to support such a Health Sector Reform Agenda
- Determination of certain individuals in key positions too..
- *These together unfurled an era of new community role in health sector reforms, Which manifested in the form of Mitanins and other initiatives.*

Mitanin Programme:

60000 Women as Community level Health Volunteers to Support the Public Health System & Public Health Initiatives in Chhattisgarh



Mitanin is the community face of Health Sector Reforms; Serving the people as a bridge to health services at 60000 Hamlets and habitations.

It is the largest ongoing community health activist programme of the country now.

**State Health Resource Centre
and Department of Health, Chhattisgarh, India**

About Mitanin Programme

- Started in 2002 as a State-Civil Society joint Initiative as a result of a long consultation process.
- Mitanin- “the best friend”- derived from the emotional friendship bondage among indigenous communities
- Covering all 146 rural development blocks of the state, scaled up in 3 phases- during 2002 & 2003.
- About 60000 female CHVs- one per hamlet, covering about 250-300 population
- Selection through rigorous community mobilisation process and facilitation
- Trained on various community health areas, in 12 rounds
- Provided with a “Dawapeti”- a drug-kit with essential life-saving drugs
- Amongst the large-scale female CHW initiatives across the globe
- The “Hope” behind “ASHA”- instrumental in design of ASHA Scheme under National Rural Health Mission

Mitanin Programme:

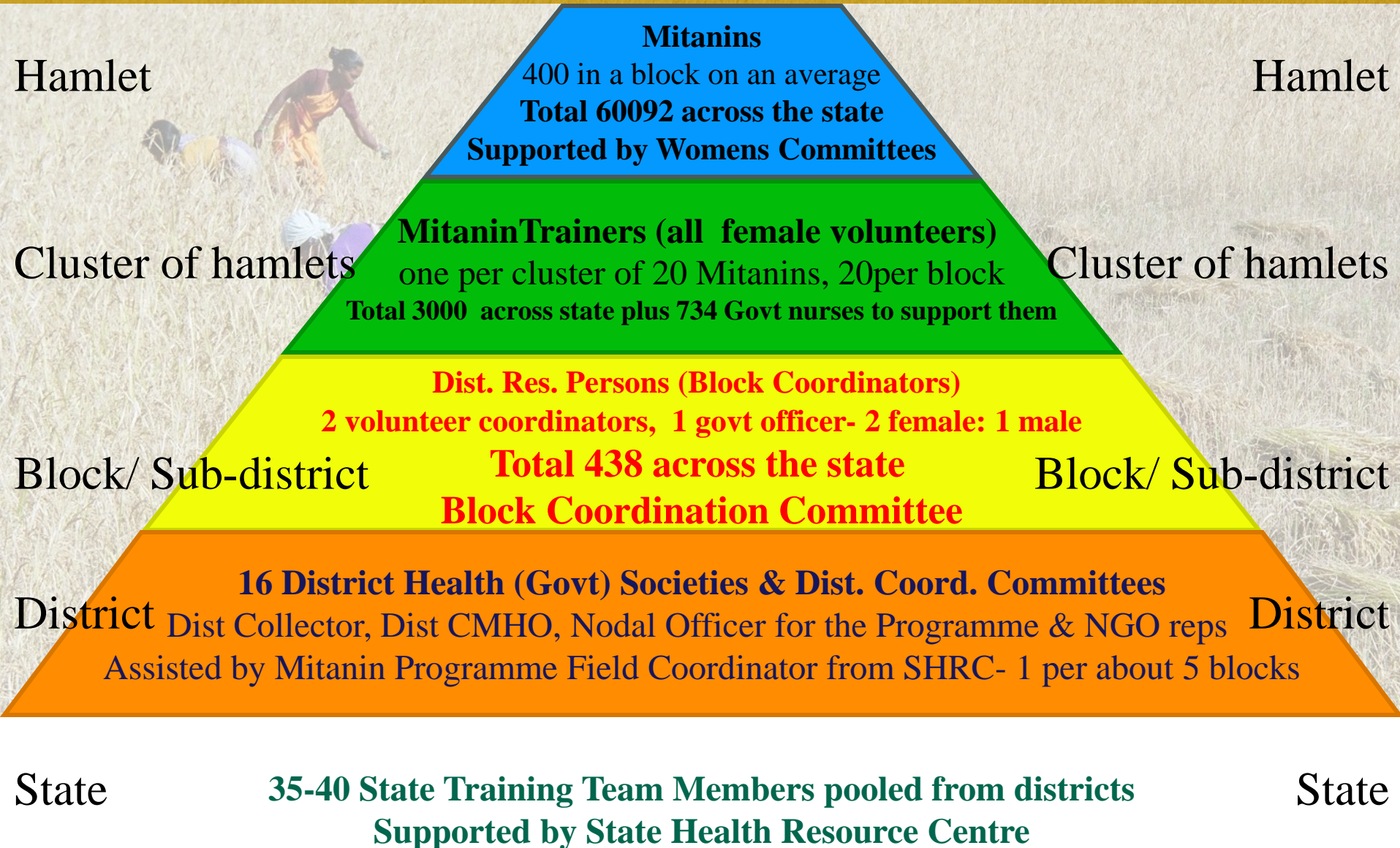
Key Objectives

- Improve awareness on health and spread health education
- Improve utilisation of existing public health care services and advocacy for equitable access and its effectiveness
- Provide local measures of immediate relief to health problems of weaker sections of society- curative and preventive
- Organise community ,especially women and weaker sections on health and health related issues
- Sensitize panchayats (the local self-governing institutions) and build up its capabilities in planning and imparting health- placing health on panchayat's agenda.

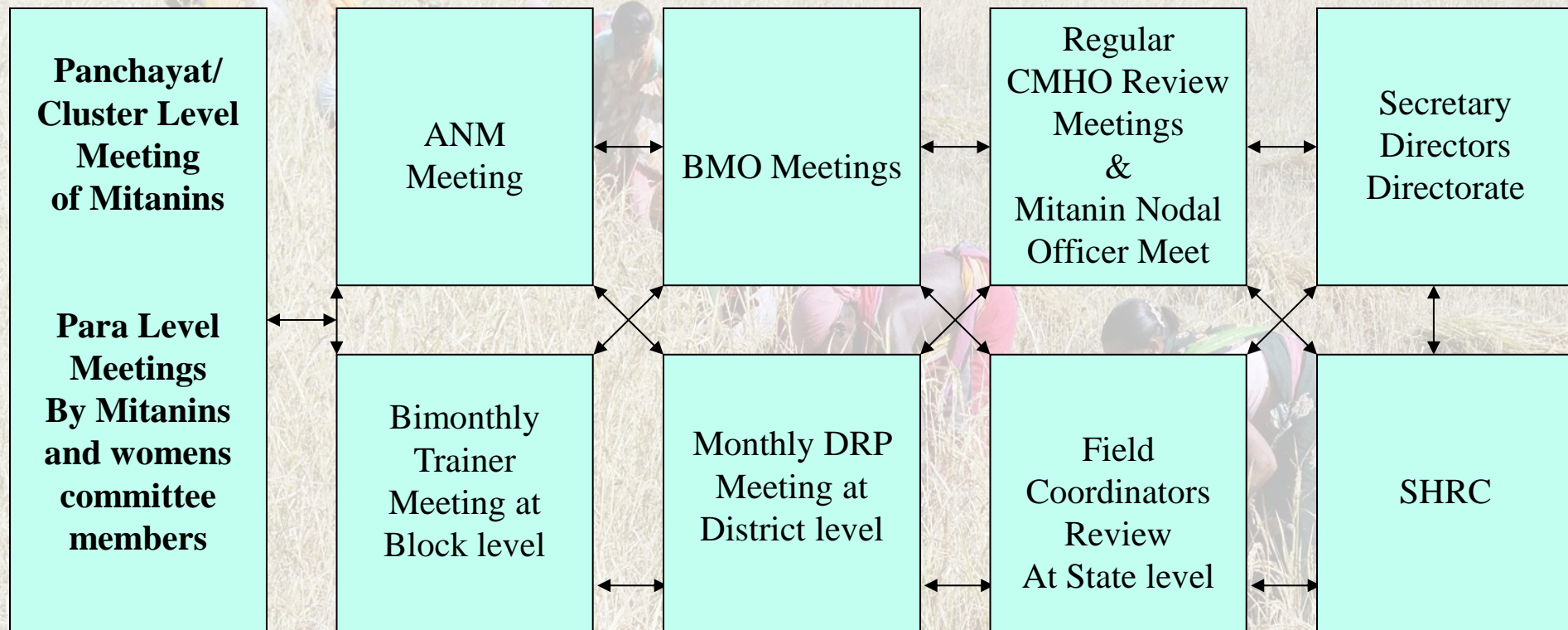
Operational Objectives

1. Select a Mitanin in every hamlet of the state- 60,000 in all.
2. Train all the Mitanins within the fixed campaign phase (18 months- 18 days of camp based training and 45 days of on the job/induction training at the village) Then 12 days of camp based and 30 days of on the job training every year.
3. Supportive Supervision to Mitanin in her work and closely coordinate with ANM and AWW for maximal effectiveness- on a regular basis
4. Setting up systems for community involvement, health department ownership, Panchayat participation.
5. Regular review and support mechanisms across the state.

The Programme Cascade



Regular Programme Review and Trouble Shooting Structure



The Training inputs so far

- Round 1 (3 days): Understanding of Health, Health services as entitlements and Management of Child Health Issues.
 - Follow up: Family level counseling begins, Womens Committees formed or strengthened.
- Round 2 (2 days): Reinforcement of Child Health Issues and Introduction of watching and accounting health services through a tool of Village Health Register.
 - Follow up: Village Health Register in place, Health Education through Cluster meetings starts. Flow of Monitoring forms to start.
- Round 3 (3 days): Women's Health & Women's lives
 - Follow up: Meeting of Adolescence girls begin, Family counselling further strengthened, attention on ANC, Delivery related issues and Register complete..
- Round 4 (2 days): Community Based Malaria Control
 - Follow up: Panchayat Level Initiatives begin especially on Malaria control, efforts to ensure measures on malaria control and cure.

The Training Inputs so far-2

- Round 5 (5 days): Provision of First level contact care and management of minor ailments.
 - Follow up: Day 1 visit and counseling on common diseases and birth, provision of 10 essential drugs, referrals.
- Round 6 (2 days): Revision of Round 5, Introduction of TB & Leprosy Control.
 - Mitanin would start to dispense doctor initiated drugs. And she has been constantly supported to become active so as to bring the desired programmatic outcomes.
- Round 7 (2 days): Panchayat Interlinkages and Coordination- Swasth Panchayat.
 - Health-centred human development index and ranking of panchayats according to health status segregated at hamlet levels- Mitanins to support and to be supported by local structures.

The Training Inputs so far-3

- Round 8 (2 days): Food & Social Security Entitlements
 - Follow up: social mobilisation efforts to ensure community action for streamlining of food/social security schemes as well as to identify vulnerable families/individuals in the community.
- Round 9 (2 days): Home based herbal remedies
 - Mitanins to understand the preparation and use of locally available herbal remedies .
- Round 10 (8 days): Neonatal and Child Survival- based on IMNCI and Home Based care (UNICEF supported).
 - Support on initiating home based care and prompt referral on neonatal/childhood diseases- aiming to impact IMR to the extent possible.
- Round 11 (2 days): Role of Mitanins in Village Health & Sanitation Committees-
 - Special village general body meet followed by Village Health Planning based on HHDI

Further Training Planned

- 12 days camp based training and 30 days on the job training per annum
- Round 12 (3 days): Infant and Young Child Feeding- to focus on the gaps identified by a special survey.
 - Follow up: joint action by Mitanins, ICDS staff and PRIs.
- Round 13(5 days): BCC-introduction of a specially designed BCC tool kit(UNICEF supported), to address critical behavior change areas -Campaign based interventions.
- Round 14 (2 days): Re-orientation on Malaria & Leprosy.
- Round 15 (2 days): Re-orientation on T.B & HIV/AIDS.

Key Activities By Mitanins

- Day 1,3,7-10 Visit to mother-baby pair and delivering essential neonatal care messages
- Birth Planning, facilitate ANCs; Prompt referral for complications and promote institutional delivery
- Regular Health Education, awareness generation and initiatives for health entitlements through women's groups: 75 messages
- Identification of malnourished children- refer the severe cases and counseling for common cases
- Mobilize community for public health services- find out gaps and help the health worker to fill them -Biannual immunization, de-worming & Vitamin-A drives
- Early detection, first contact care and referral- focus on common but critical childhood illnesses-fever, cough-colds, diarrhea
- To act as community interfaces for health & related interventions-national health programmes-malaria, T.B, Leprosy & epidemic control, primary education, food security, water & sanitation etc.
- To lead the hamlet level initiatives under Panchayat Health Planning & health related development. 18571 VHSC formed & 943 Village Plans developed

What do Mitanins Get?

- No salaries envisaged- she has been positioned as the leader at demand generation side
- Wages against loss of livelihood on training days- 75 INR a day
- Performance based incentives: 50 INR for mobilising people for immunisation/ANC, 200 INR for motivating for family planning, 200 INR for institutional delivery referral, 150 INR for hospital stay with pregnant women, 175 INR to work as a TB DoTS provider- some other national programmes too are introducing such incentives: *But these payments have also not made promptly, due to systemic weaknesses- hence the average income of Mitanins are negligible*
- But huge Social recognition: More than 5000 Mitanins were elected to local panchayat bodies- in varying capacities from village to district level bodies- they have been made the convenors of Village Health Committees as well



Mitanin Drug kit

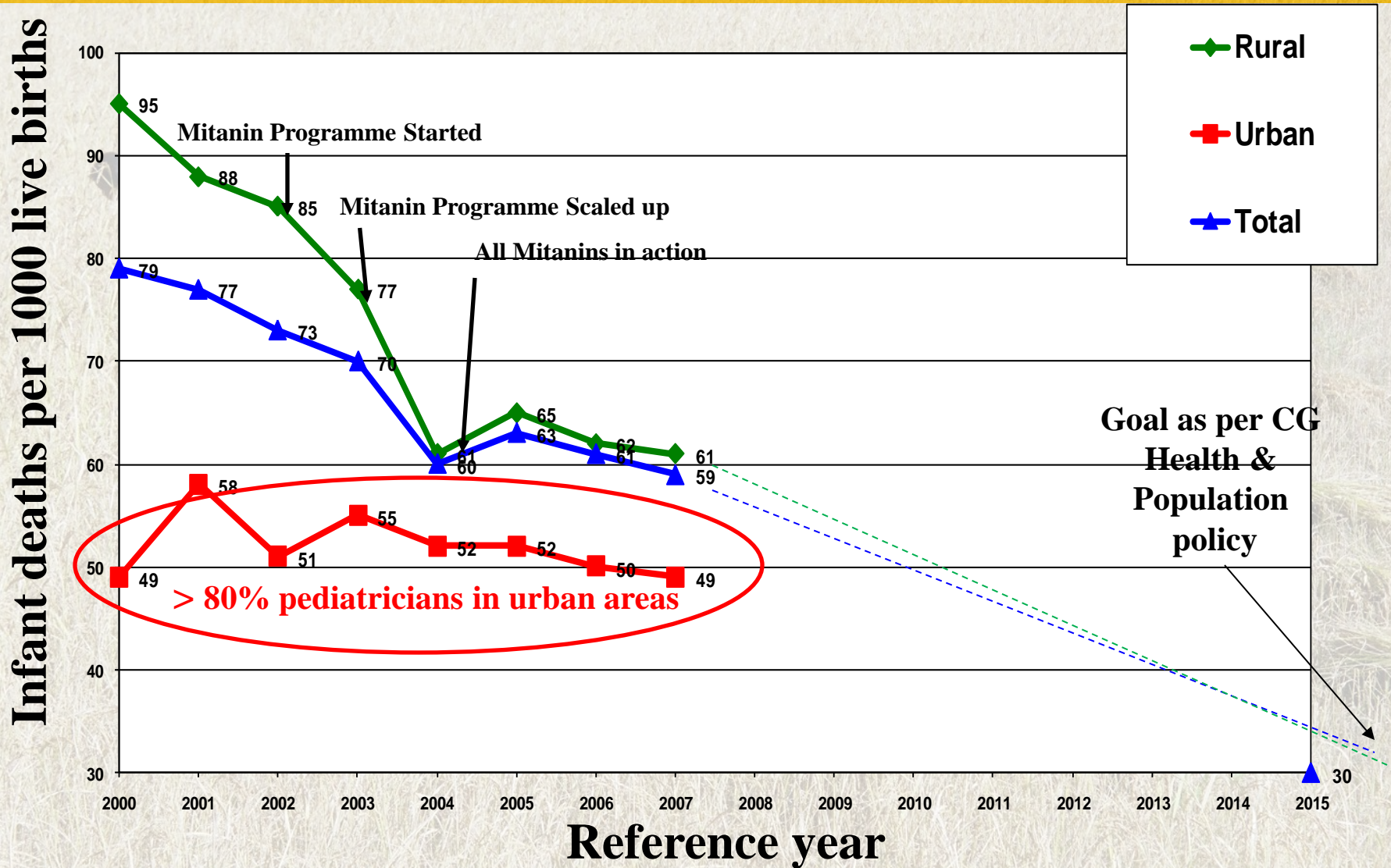
Provided to all Mitanins under a special

scheme by Chief Minister of the State, 50 million Rs per year Paracetamol, Chloroquine, Co-trimoxazole, ORS, Metronidazole, Antacid, Albendazole, Iron-folic acid, Gention Violet, Gamma BHC, Blood slides, cotton, spirit, lancets, pregnancy detection kit, Rapid Diagnostic Kit for Malaria, Condoms, and Doctor initiated Drugs like MDT for TB.

- Specially designed kitbag and containers and unique drug identification system: logo for each drug, color nicknames- to help less-educated Mitanins
- Efficient usage recorded of the drugkit- special inventory system introduced for refills
- Sometimes the refills are delayed

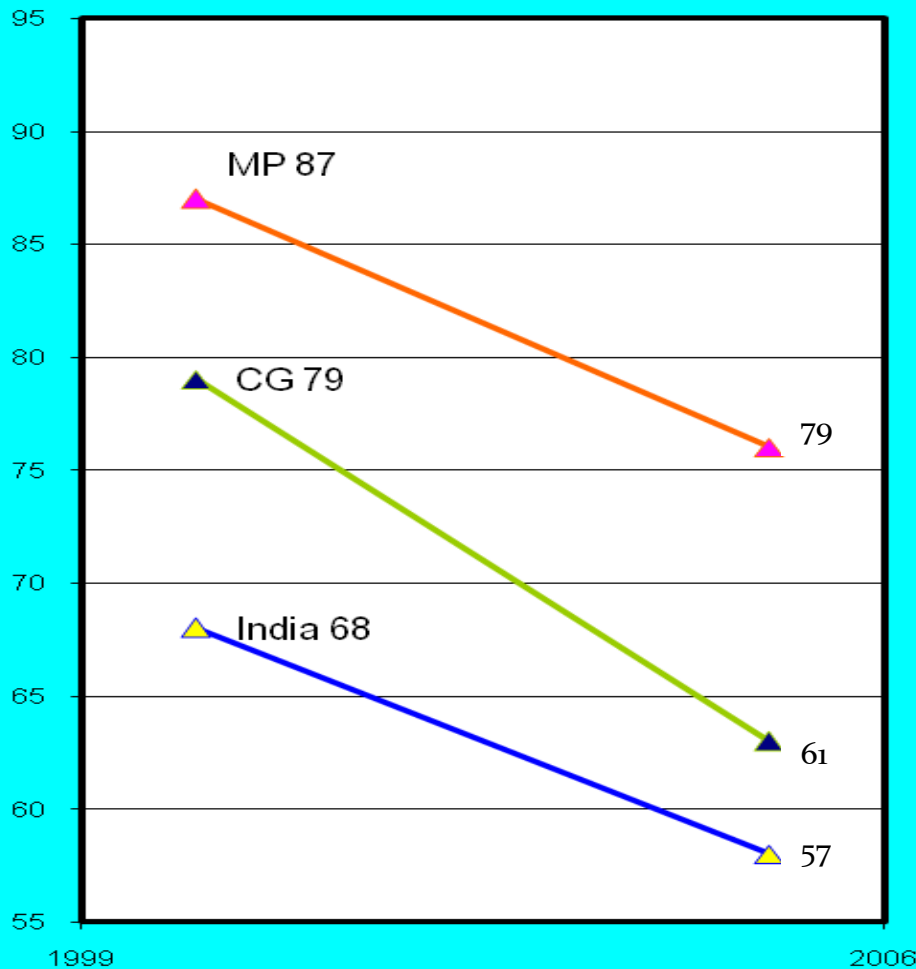


Trend of IMR in Chhattisgarh

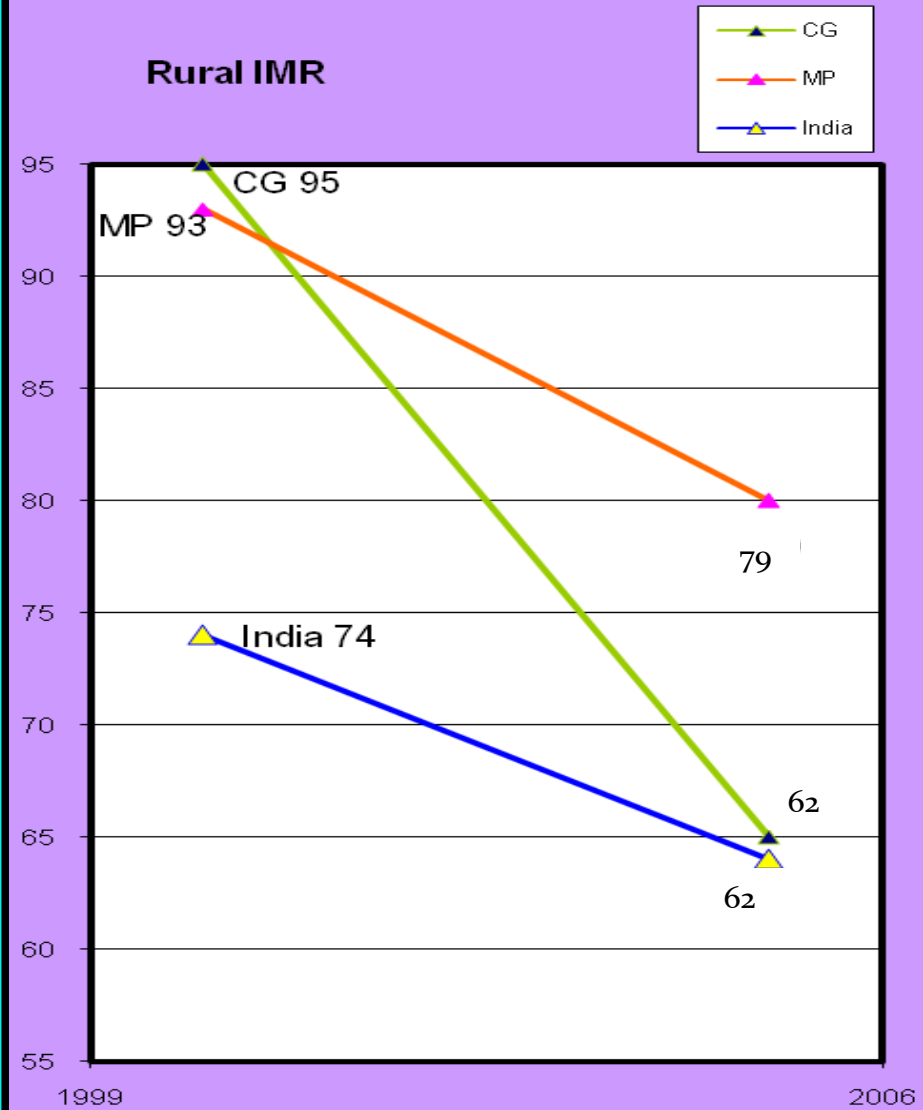


The IMR scene : Growth in Chhattisgarh 2000-2006: A comparison with Madhya Pradesh-the mother state, and India

Total IMR

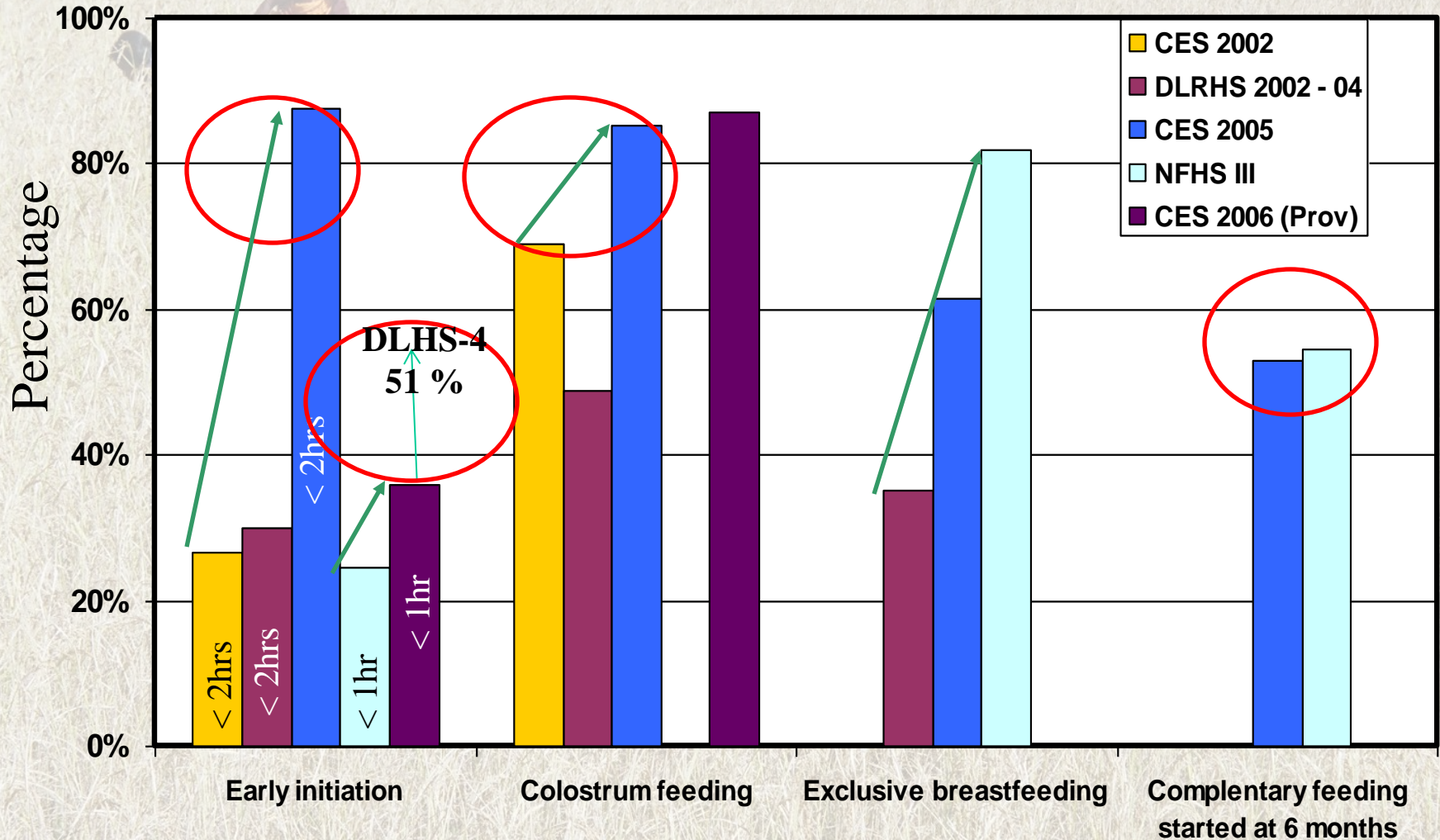


Rural IMR



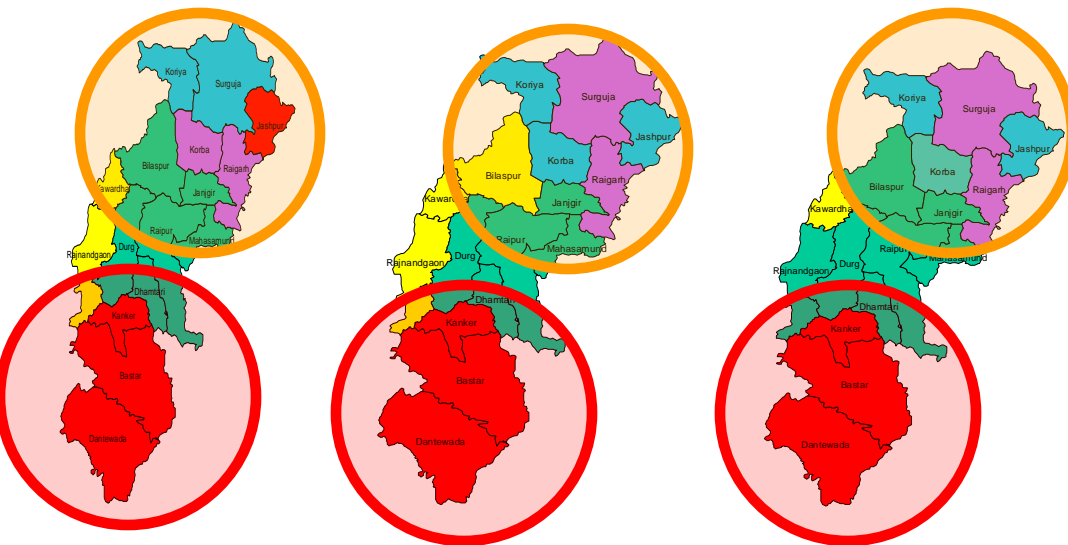
Breast feeding trends in CG

Efficient handling can reduce IMR by 13%



API and Pf proportion status reported data – Chhattisgarh-Malaria

API



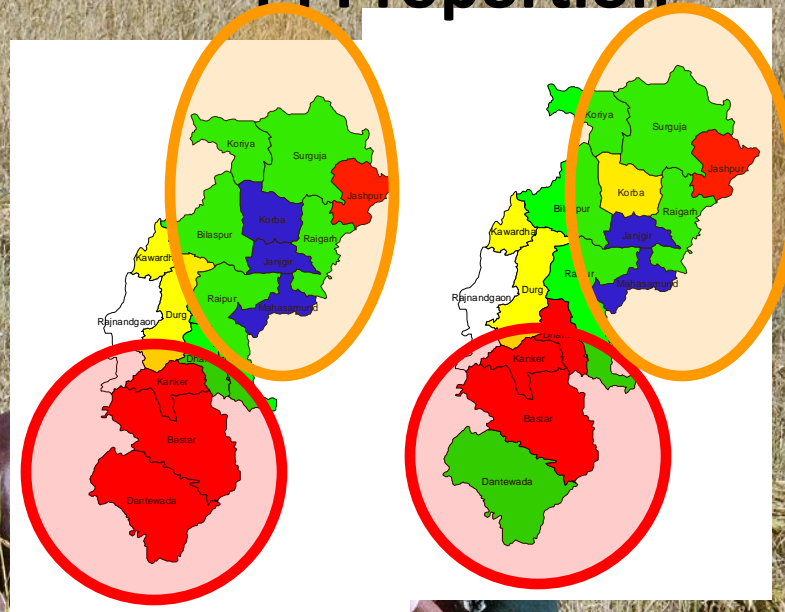
2005
(8.01)

2006
(7.53)

2007
(5.96)

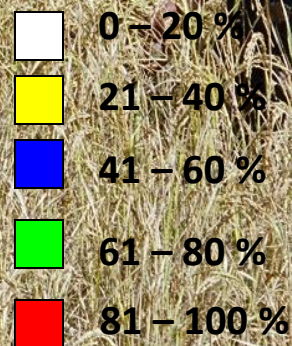


Pf Proportion



2006
(77%)

2006
(74%)



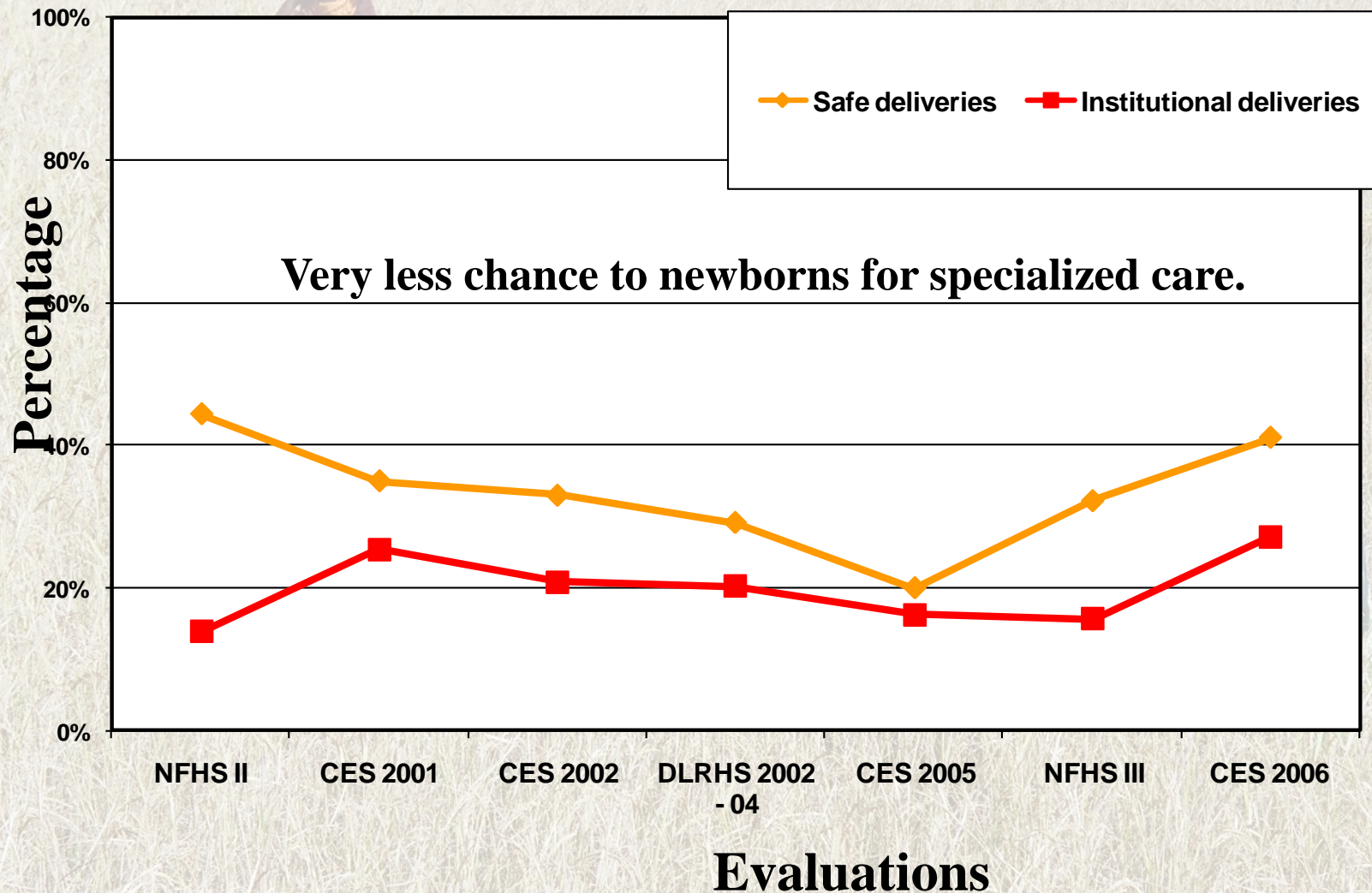
4th round of training- Chalbo Mitanin Sang

- Different methods to stop mosquito biting.
 - Mosquito control.
 - Role of Mitanin (ASHA)- making slide, giving primary treatment etc.
 - Role of Villagers (PRIs, SHGs etc.)-
 1. In primary and immediate treatment.
 2. To promote use of net etc.
 3. Controlling reproduction of mosquitoes.
- And then Village level Malaria Planning on above points.

Support and ongoing activities

- Supply of lancets in Mitanins (ASHA) drug kit.
 - Supply of chloroquine in Mitanins (ASHA) drug kit.
- Linkage with ANM for collection of slides and its test results.
 - Regular cluster meeting, Trainers meeting etc.
- Introduction of RDK/ Artesunate in endemic districts.
 - Strengthening skill of Mitanins in making blood slide.
- Introduction of incentive for making blood slide (which is yet to start).

Institutional deliveries and institutional care: clean deliveries can prevent 4% of IMR



NCSP
Training
and
HBNCC
Scaling
up

Anti-tree felling demonstrations

- Mobilized Village Assemblies and Forest Protection Committees



When resolutions and demonstrations did not stop felling, they snatched the axes and saws



They chased the timber contractors away.

Opposed felling of
40,000 hectares of
dense natural forests
by mobilizing women

Deforestation-
threatens livelihoods
and nutrition
security of tribal
(indigenous)
communities
especially women



In a nutshell: Cardinal Principles

- Women as Community Health Workers
- Well planned and facilitated selection process
- Adequate and continuous training and support
- No honorariums at least during the initial phase (compensation against loss of livelihood)
- Supplementary and not central role for curative care
- Not parallel or a substitute to the public health systems, but a form of strengthening them
- Linkages with health sector reforms: Policy interventions and programmes like Multiskilling, Referral linkages, Improved drug & supplies scenario, capacity building through Standard Drug Formulary & treatment protocols, workforce development etc.
- State-Civil society partnership in all levels and Institutional Mechanism like SHRC to support

Further Strengthening Indicated

- Supply side response and systemic inputs to be improved and streamlined
- Problems and delays in monetary incentive provisions to be addressed
- Civil Society Group inputs on socio-organisational aspects so as to sustain the movement character
- Strengthened Panchayat (local body) linkage and role of Mitanins in Local Planning
- Linkages with inter-sectoral issues such as food security, education, water-sanitation towards strengthening holistic health approach
- Economic empowerment and sustainability strategies



Thank You, On Behalf of all Mitanin

State Health Resource Centre and Department of Health, Chhattisgarh