Mitanin Programme, Chhattisgarh, India: Preparing a Volunteer Force of Sixty Thousand Women for Community Healthcare Needs

India
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Project Summary

Concise Summary: Help us pitch this solution! Provide an explanation within 3-4 short sentences.

The main focus of the innovation is the knowledge and capacity building of rural women for addressing the first level of community health care needs at hamlet level itself and then to generate demand for the public health entitlements of the community.

The primary beneficiaries of this innovation are children and mothers living in all 60092 rural habitations of the tribal state of Chhattisgarh.

As the Mitanins are from the community itself, the first level of care and services are brought at the doorstep of all rural families of the state. A unique drugkit with those critical drugs needed for first level curative care is available free of cost with all these Mitanins. Despite the fact that many of them are not formally educated, these women are thoroughly trained on dispensing these drugs using innovative symbols and colour codes, identifying danger/risk signs and to promptly referring them to the health care facilities and getting them proper treatment. Through proper orientation and awareness by these women community volunteers, the community is made willing to use the available health care facilities at its best and many times, even to pressurise the public health providers to improve the quality of service delivery.

The difference lies in the fact that this innovation is a transition from the existing structure of health services to community based health services. The knowledge level as well as social confidence of Mitanins are built in such a way that they are in a position to impart knowledge to
other members of the community, especially women. In other words the uniqueness of this large-scale programme that sets apart from other programmes lies in the fact that it lays stress on continuous training, support and organisation of rural, sometimes even uneducated, ordinary women to work for the healthcare needs of their remotest localities. The strategy of maintaining a huge cascade of support system is the next key difference.

**About You**

**Location**
- Project Street Address
- Project City
- Project Province/State
- Project Postal/Zip Code
- Project Country

**Your idea**

**Focus of activity**

**Policy/institutional change**

**Year the initiative began (yyyy)**

2002

**Positioning of your initiative on the mosaic diagram**

Which of these barriers is the primary focus of your work?

Patients not empowered

Which of the principles is the primary focus of your work?

Democratize access

If you believe some other barrier or principle should be included in the mosaic, please describe it and how it would affect the positioning of your initiative in the mosaic:

Barrier: The outreach of health care services were leaning towards the power structure of locality and the health needs of the weaker/distant habitations were unaddressed

Principle: widen the outreach up to all rural hamlets of the state

Barrier: marginalisation of women's health care issues in a patriarchal social set up

Principle: Select, train and organise women for addressing their own health care needs

Barrier: Lack of adequate health awareness among the community

Principle: Spread health awareness through self-convincing measures

Barrier: Limited role of rural local bodies in health & health care management

Principle: Placing Health into Panchayat's (local body in India) Agenda

Barrier: systematic solution for health care problems

Principle: plan based on local health

**Innovation**

**Define the innovation**

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**Context for Disruption:**

The most important and the key factor is the health seeking behaviour, which has contributed to transforming traditional health or related systems
in the short and long term. For instance, the breakthrough in the traditional popular belief and concept that high neonatal and infant mortality as normal is changing. Now there is a growing insistence that every single child death is unacceptable and it is preventable. Like wise the practice of exclusive breastfeeding for the first six months has also been reported to be more than 80%, which previously had been as low as 35.1%. Besides these there are other enumerable instances where the innovation has contributed to transforming traditional health or related systems.

Delivery Model

There is a cascade of training existent from the state level up to the hamlet level through whom the messages are communicated and continuous interactions follow. There are around 400 Mitanis in a given development block/sub-district, where one trainer is deployed for a group/cluster of 20 Mitanins. Every block is having 3 District Resource Persons. Between every 5 blocks, a state level trainer is placed called field coordinator. Then a State Training Team comprising of the programme coordinators and subject area experts. The State Health Resource Centre, the apex institute- a state civil society joint initiative- set up for the purpose of health sector reforms in the state is coordinating the entire ongoing activities. All trainers are women, more than half of the senior training team is also women. Adequate participation of government officials is also ensured. Also it is made sure that the information passed on to is practically implemented at the grass root level, through on-the-job training support.

The training contents and information on various health related issues are reached to the target communities through a wide range of training material- so far the programme has published books on health entitlements, tools to track the outreach of health services training material on child health, womens health, community control of communicable diseases, first level curative care of primary ailments, health & human development index based rural health planning, food & social security schemes, herbal remedies, neonatal and child survival measures etc.

Another major medium was a very popular radio programme called "Kahat Hai Mitanin". The penetration of the innovation is up to the last person of the society, especially women and children.

There are special indicators developed to monitor the programme from the state level down to the village level, collected through the training cascade itself, which also function as programme support system.

Key Operational Partnerships

The key partnerships established for this innovation is the convergence of the programme with that of the government, the State Health Resource Centre (SHRC), District/sub-district level NGOs and CBOs, the civil society groups and most importantly the Gram Panchayats- the rural local bodies, who has to take this community participation forward in the form of rural health development. These partners are equally involved in the coordination, collaboration, evaluation and implementation of the innovation. Every partner has to fulfill a certain part of the programme hence their roles are central- for example, the state and district governments are actually leading the programme, the SHRC to plan, provide continuous programmatic support, the NGOs and CBOs to organise the programme at the grassroots level, Panchayats to link it up with local health improvements.

The contributions by these partners has made the leveraging of change possible in the health services delivery.

Impact

Financial Model

This is a programme run by the government for enhancing the health rights of the people, hence the programme costs are covered by the government. Still, the human inputs of sixty thousand Mitanins, the women community health volunteers, are totally been voluntary and free of cost- if they are added, that will come to more than 300% percentage of the total budget provided by the state.

Also it is important to note to the volunteer training force is not working on remuneration, but on a minimal day compensation.

What is your annual operating budget?

269.5 million INR

What are your current sources of revenue? (please list any sources that are foundation grants)

The Key sources as of today for the mainstream programme is funding support from National Rural Health Mission, Government of India (NRHM) and the state health budget of Chhattisgarh state.

The NRHM for the last year has given 119.7 million INR and the state has given 11.5 million INR for the programme and 50 million INR for the drug kit provisions.

Effectiveness

The most significant achievement to date has been the decline in the rural infant mortality rate from 85 in the year 2002 to 85 by the latest figures available – a drop of 20 points over just three years. While there has been little change in the utilization of hospital based services during this period, household and community-level health care practices have changed dramatically- especially a huge increase in the percent of mothers initiating breastfeeding in the first 24 hours after birth, a 61% increase in three years by the independent externally conducted UNICEF coverage evaluation survey, and in exclusive breastfeeding – now the highest amongst all states – and the largest positive change among states reported in the latest round of National Family Health Survey. ORS use and health-seeking behavior for Acute Respiratory Infections (ARI) has also registered significant, although less dramatic changes, that could have contributed to this remarkable decline in IMR. It is worth noting that the urban areas, which had no such intervention, showed a static IMR. This achievement is not only due to the work of the Mitanins but also to the over all improvement of all outreach services as a consequence of large scale social mobilization and health sector strengthening. Most importantly, it has brought back credibility to the role of community participation in health sector reform and has given the whole health sector reform process a renewed confidence and dynamism and public visibility and grassroots support.

One another significant offshoot, though not a planned outcome, is that more than 4000 of these volunteers got elected by the people to rural local bodies, which is a major recognition to the work rendered by them and to the programme.

Which element of the program proved itself most effective?

The Mitanin initiative is designed to transform the health sector so as to address the health needs of the entire population, with special
emphasis on reaching the poor and the marginalized. Until now, however, we have been working only with the rural population, which constitutes 78% of the states 22 million population. The state has considerable inequities in health care. 81 blocks of the 146 blocks in the state are predominantly tribal and 33% of the population of the state as a whole is tribal. The health conditions of this section of the population living these blocks are relatively poorer. Within every village, more so in non-tribal areas there are some communities called scheduled castes, who are economically weak and socially marginalized. However, each habitation within a village is more homogenous based on caste and vulnerability. By insisting on a health worker per habitation instead of one for every village and by insisting on a transparent process of selection one was able to provide a greater access for the poorest. Employing trained facilitators further ensured this concern for equity in selection of the health workers. By designing the programme to select only women at the community level, ensuring over 90% women at the trainer’s level, and insisting on at least half of the management level positions are occupied by women, the programme has proactively and consciously addressed gender equity concerns. The content of the training materials also addressed the multiple dimensions of health inequities, with one book being exclusively devoted to helping Mitanins identify different forms of social exclusion and increased vulnerabilities even within homogenous communities. Further, the Mitanin, not as a stand-alone service provider, but as a community leader organizing for collective action to secure health care entitlements. Another element was the focus and advanced training on identification, management and referral for neonatal and childhood illnesses.

Number of clients in the last year?

The exact numbers are not populated as the programme is supposed to serve the entire rural population of the state of Chhattisgarh, ie, about 18 million people, whoever is in need. However, if one parameter of the provision of drugs through Mitanin Drug kit is considered, a minimum of 6 million people are benefitted of this programme. They include care for common but life-threatening childhood illnesses like acute respiratory infections, malaria and Diarrhea. The important highlight here is that the care and drugs that are provided by Mitanins are totally free of cost-care by her self motivation and drugs provided by the state government. Other than this, the adults are also provided first level curative care for common ailments- like fever, ARIIs, diarrhoea, UTIs etc. Children and parents are mobilised towards government services like immunisation etc also. Nextly, The members of womens health committees in all hamlets also shall form the direct beneficiaries- they are regularly been involved in health education meetings. In number the total of such people shall exceed a million population. Then comes those pregnant women who got referred by Mitanins for institutional delivery or been motivated for prompt ANCs- this shall exceed twenty thousand in number.

What is the potential demand?

The Potential demand for sustaining the programme is extremely high. The politicians, officials, health department functionaries, local leaders etc have testified the very important roles that are been played by these women volunteers. The success of the programme has influenced the national government as well, wherein the Mitanin Programme was the major inspiration behind the Accredited Social Health Activist (ASHA), a countrywide initiative under National Rural Health Mission. In Chhattisgarh, the urban population is also demanding such a programme to be launched for urban areas.

Scaling up Strategy

The Programme, though started as a pilot programme covering 16 sub-districts (blocks), this has already been scaled up to the entire 146 rural blocks of the state. Now the scaling up is envisaged for urban area where it is awaiting urban health systems to be in place first. Though the area wise coverage is already scaled up, the issue wise coverage needs to be scaled up. Focus for the ongoing year is to achieve a further halving of IMR through integrated neonatal and child survival measures. In coming years, it need to critically look at social exclusion issues, further demand creation for better running of public health services, Panchayat planning on health, and a larger women organisation to stand for betterment of the society.

Stage of the initiative:

2

Expansion plan:

The Programme, as mentioned above, going to be expanded to cover urban areas as well. The urban area population’s health needs and life style are different, hence the strategy also is going to be different. Presently, the rural Mitanin cover a hamlet whereas in Urban area she may cover a thousand population. The cascade training setup for this area also shall be different whereas these Mitanins shall be attached to Urban health centres and to the nurse working in that centre.

Origin of the Initiative

The first origin was political – then ruling state government in 2002 wanted to show quick results in turning around a dismal health situation and looked to the Mitanin Programme as one of the quickest and most visible ways of achieving this. The second origin was from the rights-based non-government organizations who came into the dialogue and insisted that they would assist the programme and participate only if the ambit of the programme was expanded into a full-fledged programme of strengthening public health systems as a whole. The third root was from a group of professionals in community development and public health who saw the need for an institutional structure like the SHRC to be created which could respond to the political mandate and the concerns of the rights-based organisations through technically and managerially sound programme design and implementation.

Sustainability

What are your two main challenges to finance the growth of your initiative

1) The major challenge is that even today, though the programme is being run in full-scale without any disturbance, it is given inadequate financial provisions. No financial year was there where the SHRC (the implementing agency) could receive total buget required. As a result, the initial seven training camps that were actually planned within first 18 months did scatter to more than 36 months. What we could provide regularly during this period was just the day-compensation for trainers as the on the job support and regular meetings were necessary to be maintained. Still, the programme could sustain because of the motivation of the volunteers and their training team. What we need annually is 328 million INR, what actually been provisioned under various budget heads is 247 million INR this year. While actual releases, this sometimes become 80% of this. Hence, the programme has been provided almost 10 to 12 million INR less to the actual requirement every year. If this could be 100% allocation, it can perform miracles for Chhattisgarh health scenario within a very short span. Another challenge is to build up capacities of the district level team
to timely spend the allocation.

How did you hear about this contest and what is your main incentive to participate?

Ms. Kalpana, who is the Asia Director and Managing Editor of Changemakers did know about our programme, its vast outreach and objectives. She informed us about the competition and encouraged us to enroll ourselves. Seeing the details, we were convinced that ours like programmes should come on board.

The Story

Do you have an annual financial statement?

Yes, The Mitanin Programme has published regular annual financial statements since financial year 2002-03. It has been internally and externally audited promptly by very experienced as well as reputed Chartered Accountants of the state. Being the funds are coming from government it is subject to financial audit of Controller & Auditor General of India as well- so far, we have completed two such audits. The state legislative assembly also looks at this programme as this is one of the major health initiatives of the state. Last year, we received a grant of 80 million INR and spend 73.18 million.

Do you currently have an annual financial statement that tracks profit/loss?

Being this is a programme welfare based not profit-based, what we keep track of is the income and expenditure statement of the activities conducted. These statements are been prepared and audited every year by the same mechanism mentioned above.

Please describe the amount (and/or type) of funding you need to implement your initiative, at year 1 and at year 5.

A support of 80 Million INR shall be needed to fill the gaps in 2007-08 and this shall be about 120 million INR in 2012. This can be even in the form of kinds- printing of training material, treatment aids for Mitanins etc.

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