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Department of Health

Draft Report on

Evaluation of the Community Health Volunteer (Mitanin) Programme

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Abbreviations

ANC : Ante-natal care
ANM : Auxiliary Nurse and Midwife
ASHA: Accredited Social Health Activist
AWW: Anganwadi Worker
BMO: Block Medical Officer
BPM: Block Programme Manager
CHW : Community Health Worker
CMHO: Chief Medical and Health Officer
DLHS: District Level Household Survey
DPM: District Programme Manager
DRP: District Resource Person
IMR: Infant Mortality Rate
MT: Mitanin Trainer
NFHS: National Family Health Survey
NGO: Non-Governmental Organization
NHSRC: National Health Systems Resource Centre
NREGA: National Rural Employment Guarantee Act
NRHM: National Rural Health Mission
PDS: Public Distribution System
PRI : Panchayati Raj Institution
RGI: Registrar General of India
SHRC: State Health Resource Centre
SPM: State Programme Manager
SPMU: State Programme Management Unit
SRS: Sample Registration System
VHSC: Village Health & Sanitation Committee

Executive Summary

Introduction: Objectives, Scope and Methodology

The *Mitanin* [a community health volunteer] Programme was conceptualized in 2001 as a way for facilitating people's access to health services at the village and habitation levels . It was part of a larger health sector reform initiative which included a series of interventions aimed at strengthening supply side interventions such as rational use of drugs, strengthening of logistics and supply chain management, enlarged role of the PRIs and deepening decentralization etc. A dedicated State Health Resource Centre (SHRC) was established to support the initiative.

The actual implementation of the Mitanin programme was taken up in a set of pilot blocks in May 2002 with the active involvement of leading NGOs who had partnered with the State in designing the programme, including articulation of reforms agenda. The programme quickly expanded to cover all blocks by the end of the year 2003. By the end of 2004, more than 50,000 Mitanins were in place.

An external evaluation of the programme was carried out in 2005. However, this was in the nature of examining the processes in place and recommending steps for further improvement of the programme. Also, the sample was too small to provide reasonably robust results. Therefore, in order to obtain more robust data / information about the impact of the programme, the State requested, in March 2010, the European Union Technical Assistance (EUTA) for EU-State Partnership Programme Chhattisgarh to organize a detailed evaluation of the Mitanin programme.

The evaluation was undertaken in two parts – a quantitative evaluation led by an independent expert engaged by the EUTA and a qualitative evaluation carried out by a two-member team deputed by the NHSRC. While the qualitative evaluation relied on in-depth interviews and focus group discussions with the stakeholders on provider side, the quantitative survey made use of sampling methodology structured questionnaires to gather information from beneficiaries of Mitanin work, the Mitanins themselves, the ANMs, AWWs and PRIs. The survey methodology targeted to reach 640 sample villages in 32 blocks of 8 sample districts, drawn @ 2 districts in each of the 4 revenue divisions of the State. In each sample village, 2 Mitanins, 8 beneficiaries [2 pregnant women, 2 women with children aged less than 6 months and 4 women with children aged 6-24 months], at least one AWW and PRI member were planned to be reached for interview. In addition, the ANMs serving the sample villages were also planned to be interviewed.

The field work for the quantitative evaluation was carried out during mid-September – early November, 2010 followed by data entry /cleaning, report generation and analysis which lasted until the end of January, 2011. The field work for the qualitative assessment was carried out by the NHSRC experts during 8-13 November, 2010.

Mitanin programme : evolution and outcomes

A well designed social mobilization drive was an essential ingredient of the Mitanin programme; the key component being the *kala jathas* (cultural troupes) which would visit the villages to create awareness around health issues on the one hand and facilitate community consultation to elect / select their Mitanin.

Among others, the Mitanins would provide preventive healthcare services and promote good practices. She is also to act as the main link between the community and the public health system; in particular, she would help her community to utilize the available health services.

The years 2003 and 2004 witnessed highest ever drop of 27 points in the infant mortality rate in the rural areas of the State where the Mitanins had been positioned. This reduction was seen to be due to promotion of good home based practices such as early initiation of breastfeeding.

Programme Management :assessment of changes

Until 2006-07, the SHRC was directly responsible for all aspects of the programme, including release of funds to partner organizations. While there was no major change to other aspects, the role of SHRC in funds flow started reducing. The changes to financial management systems do not appear to have brought any improvement; on the contrary, accountability lines appear to have become blurred.

The launch of NRHM in 2005 witnessed changes in the way the programme was managed. The task based incentives available to the ASHA were made available to the Mitanin as well. This is quite contrary to the original programme design which very clearly stated that any payment to the Mitanins must be made by the communities they serve.

Findings of the qualitative evaluation

The quantitative evaluation report notes that the programme has had the positive impact that was envisaged in promoting good practices and utilization of public health services. More importantly, they have effectively played the role of an activist in raising community awareness about their rights. However, the assessment has raised the potential risk that the introduction of task based incentives may have the ability of the Mitanins to play their activist role.

The key observations made by the team in their report are summarized below:

- Operational and field support issues from the SHRC side have increased in the last few years which is seen to have an effect on the quality of the programme at the field level. The mentoring and one to one interface of field staff with senior members of the team has reduced.

- Even in the state level meeting, the agenda is more often on reporting and management issues.
- The district Coordinators too appear to be preoccupied with routine tasks and they rarely undertake field visits.
- …the SHRC itself appears to be a willing partner in gradually bureaucratizing the Mitanin programme. Consequently, its focus seems to be more on establishing and enabling systems for ensuring fixity to systems and ensuring the accountability of Mitanins to the Health Department rather than to the community (which they represent)…
- (capacity building of the new Mitanins) does not appear to be done effectively…. In the FGD with newly nominated Mitanins, almost all of them were unable to answer questions like what does the term Mitanin mean …..
- The attempt to freeze the number / list would limit the ability of the communities to determine who they want as (their) Mitanins…
- The process of bureaucratization is also gaining strength owing to the need to adhere to the national guidelines on the ASHA program. The provision of incentives and the need to ensure that number of Mitanins adhere to the national norms are also issues that appear to be strengthening the process of bureaucratization…

Following recommendations have been made by the qualitative evaluation team:

- The SHRC needs to re- strengthen its relationship with its field staff and also be able to spend time on their problems in dealing with the system
- The balance between skill based and knowledge based training needs to be critically maintained.
- Future career ladders and remuneration issues need to be critically addressed and a strategy made on the same, else there will be deep cynicism on the field and repercussions for the programme.
- Build stronger links with the mission on different aspects of the Mitanins work and also rebuild the relationships and similar ideological ground with District level government

Findings of the quantitative evaluation

<u>Access to and utilization of services : feedback from pregnant women</u>

- Majority of pregnant women relied on the Mitanin for confirming the pregnancy; she is also the main source of advice during the pregnancy.
- The Mitanin advice is generally converted into action which is evident from high levels of utilization of services such as TT injection and IFA tablets and access to supplementary nutrition services.
- While most respondents felt that their Mitanins were active for issues related to health care; a large number also felt the Mitanin to be active for issues related to Anganwdi, Mid Day Meal, NREGA, pension and food security and women's participation in Gram Sabha.

Access to and utilization of services : feedback from women with children aged less than 6 months

- Proportion of respondents who reported having received various antenatal services has ranged from 40% (lower abdomen examination) to a high of more than 90% for IFA tablets and TT injection; weight measurement and pregnancy testing rates are also found to be high for this group of respondents.
- Mitanin has been the main source of advice and/or service for the respondents, particularly for IFA tablets, institutional delivery and weight and blood pressure measurement and TT injection.
- More than 40% of the respondents reported having one or symptoms requiring help during pregnancy; nearly half of the respondents sought help and assistance from their Mitanin.
- More than 80%respondents were advised / encouraged for institutional delivery, the PHC or CHC being the most frequently recommended place. However, 50% deliveries actually took place at home; the main reported reasons for opting not to go for institutional delivery are time (night) of delivery, unavailability of transport and distance of facility.
- In more than 80% cases of institutional delivery, the Mitanin accompanied the woman for institutional delivery (mostly in addition to husband and/or mother /mother-in-law); majority of respondents reported that the Mitanin helped them in various ways particularly in dealing with health workers / staff and getting the JSY benefits.
- In more than 70% cases the post partum visit was reported to have taken place within 12 hours of birth and immediate initiation of breastfeeding and colostrums has been the most important post partum advice by the Mitanin, followed by advice for immunization of the new born.
- Ninety percent respondents confirmed receiving supplementary nutrition on regular basis; nearly 3/4th were helped by the Mitanins for receiving the benefits.
- Most respondents were aware about the need to keep the baby warm, use of blanket being the main method for doing so.
- About 15% respondents reported newborn illness in first month after birth; Mitanin was reported as preferred source of help ahead of local doctor; however the main source of treatment is reported to be a private doctor.

Access to and utilization of services : feedback from the Women with children aged 6 – 24 months

- More than 60% of the children born to respondents were delivered at home while about 30% were born in government health facilities. In more than 90% cases breastfeeding was initiated within 4 hours and exclusive breastfeeding for 6 months was found to be very high at 87%.
- Similarly, more than 90% respondents confirmed having utilized immunization services and the person who helped in accessing services the most is the Mitanin.
- Overall, 85% respondents confirmed receiving supplementary food / ration on a regular basis and 81% reported Mitanin help in enrolling the child with the AWC.

Mitanins' activism: feedback from the women respondents

- The results indicate a near unanimity among the beneficiary groups about the Mitanin involvement in local issues which is not limited to health only, although that remains the main concern of the Mitanins.

Feedback from the Mitanins themselves

- Nearly 3/4th respondents have been working as a Mitanin for more than 5 years (at the time of survey in September / October, 2010).
- Close to 90% of the Mitanins spend, on an average, up to a maximum of 3 hours a day on their Mitanin related work.
- 4% of the respondents are holding a position in the PRI (in addition to being a Mitanin); close to one third are also involved with the self-help group work either as a member or as its President.
- Of the 58 respondents who are members of the Panchayat, 46 became so after they became Mitanin and 34 (feel that they were elected to the Panchayat because of their Mitanin work.
- For all Mitanins, 'to serve the community' has been the main reason for becoming a Mitanin; raising awareness about health issues in the village and 'to look after family and children better' was reported as other leading reasons. Expectation of money or government job were reported as less important a reason than getting recognition in the community and/or opportunity to learn.
- The respondents were asked to recall the main subjects taught to them during their training. They were also asked to mention their most favorite topic as well as the subjects where they would like more training. The responses revealed a consistent result which placed child nutrition and newborn care as not only most popular subject, but also the subject where more training should be given.
- Dai training or training in 'handling delivery' has emerged as the first priority in all sample districts, perhaps because the Mitanins feel that they could help their hamlet much better if they have these skills.
- What would be preferred place for delivery in case the JSY scheme was wound up? The vast majority of respondents would still recommend institutional delivery in a government facility, preferably in the CHC.
- The average incentive amount received by the respondents is estimated to be less than Rs 200/- per month.
- The part most appreciated by the respondents in their work is " being able to help others.
- Getting better training and training in additional areas have been given importance by the respondents to be more productive and effective than increase in incentive money.

Impact of the Mitanin programme : feedback from the ANMs

- According to respondent ANMs, promotion and coordination of immunization, accompanying women for delivery, counseling women on all aspects of pregnancy, providing medicines for minor illnesses and providing pills condoms and IFA tables are the main roles of the Mitanins.

- Almost all respondents acknowledged the help extended by the Mitanins in mobilising women and children for the VHND. Other areas where their help is acknowledged includes motivating women for family planning, identifying women from marginalized communities and providing beneficiary list for JSY, DOTS, family planning etc.
- Close to 90% respondents feel that Mitanins have helped increase institutional deliveries. Other impact areas identified include increasing immunization, increasing mother and child presence in the VHNDs, increase in the utilization of public health services and better hygiene in the community.

Impact of the Mitanin programme : feedback from the AWWs

- According to respondent AWWs, promotion and coordination of immunization, accompanying women for delivery, counseling women on all aspects of pregnancy, visiting new born for advice and care and providing pills condoms and IFA tables are the main roles of the Mitanins.
- Close to 90% respondents feel that Mitanins have helped increase immunization. Other impact areas identified include increasing institutional deliveries, increasing mother and child presence in the VHNDs and better hygiene in the community.

Impact of the Mitanin programme : feedback from the PRI members

- According to respondent PRI members, accompanying women for delivery, promotion and coordination of immunization programme, counseling women on all aspects of pregnancy, providing pills condoms and IFA tables and visiting new born for advice and care and are the main roles of the Mitanins.
- Increase in the immunization coverage is the main impact of the Mitanin programme according to 85% respondents. Other impact areas identified include increasing institutional deliveries, increasing mother and child presence in the VHNDs and better hygiene in the community.

Conclusions and recommendations

The evidence from SRS data and the feedback from quantitative and qualitative assessments indicate the effectiveness of the Mitanin programme as it was conceived in 2001. However, the inherent strengths of the programme may be under severe threat of breaking down due to the operational changes introduced after the launch of NRHM. In particular, the incentive system, as it is designed currently, is likely to change the Mitanins in to the lowest rung of the health system.

Therefore, there is utmost need to restore the programme structure and its management to its original design. The accountability of SHRC towards the programme also needs to be made more direct by giving it the authority and responsibility to implement all components of the programme.

The Nutrition Fellowship initiative should be expanded to include all blocks. At the same time, there is a need to find new themes around which a fresh round of social mobilization ought to be built. The Mitanins who have been elected to the PRIs should be considered to

contribute to the identification of issues (initially) and leading the fresh round(s) of social mobilization.

An autonomous entity – e.g. Mitanin Kalyan Foundation - may be established to manage the Mitanin Kalyan Kosh set up by the State and all task based incentives available to the ASHA under the various national programmes should be pooled with the Kosh and used to implement social / economic empowerment activities for the Mitanins.

Experiences with CHW programme in other countries may be studies to design a well structured career pathway for the Mitanins which may not be limited to health sector alone.

Mitanins' role in mobilizing communities on social determinants of health like poverty, gender, nutrition, sanitation etc. should continue be actively encouraged and they must continue to be treated as volunteers and no duties should be imposed upon them especially involving submission of written reports.

Forums for regular interaction between Mitanins of a cluster or block should be encouraged as it helps in maintaining higher motivation levels.

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Chapter 1 - Introduction : Objectives, Scope and Methodology

Background

1.1 The *Mitanin* Programme was conceptualized in 2001 and officially launched in early 2002. The *Mitanin* [a community health worker-CHW] was conceived as a way for facilitating people's access to health services at the village and habitation levels.

1.2 The programme was part of a larger health sector reform initiative which went beyond creating the cadre of CHWs in the State; a series of interventions aimed at strengthening supply side interventions such as rational use of drugs, strengthening of logistics and supply chain management, infrastructure and work force rationalization and strengthening, enlarged role of the PRIs and deepening decentralization within the health sector were foreseen as necessary elements to be pursued simultaneously to make the CHW initiative successful. Given the lack of capacity in the State Directorate at that time, a dedicated State Health Resource Centre (SHRC) was established in partnership with State branch of ActionAid India. The SHRC role was foreseen as two fold : leading the implementation of the CHW initiative on the one hand and supporting the State Government in the design and implementation of various reforms initiatives, on the other.

1.3 Since the inception of the programme in 2002, more than 60,000 Mitanins have been trained. The efforts at creating this community based network has been supplemented by strengthening the larger health system in the State.

1.4 An external evaluation of the SHRC and the Mitanin programme was carried out in 2005. This evaluation was in the nature of examining the processes in place and recommending steps for further improvement of the programme. The SHRC component of the evaluation relied primarily on documentation review, field observations and discussions with the stakeholders. The Mitaning component of the evaluation did include a sample survey. However, the sample was rather small; the quantitative data collection covered only 96 Mitanins, 495 villagers, 19 trainers (of Mitanins), 31 Anganwadi workers / ANMs and 8 doctors. Also, the evaluation focused on processes with a view to draw out areas which needed further strengthening, and, as such, did not seek to make an assessment of the impact of the programme. The evaluation, nevertheless did note the valuable contribution made by the SHRC and found that Mitanins are doing a valuable service in the health sector.

1.5 The programme was started in 2002 with a number of objectives related to behavior change and access to services which would, in turn, lead to reduction in morbidity and mortality levels. The evaluation carried out in 2005, as mentioned, focused on processes and could not have evaluated the impact of the programme on outcome indicators such as IMR / MMR. With the programme having been in place for almost 8 years now, this would be

the appropriate time to evaluate the impact of the programme in terms of behavior change and access to services as well as contribution of the programme to reduction in morbidity and mortality levels.

1.6 Although an assessment of the impact of the programme on outcome indicators can be made at the very broad level and the results are indeed available from the independent surveys such as NHFS-3, DLHS-3 and SRS etc which can be used for such an exercise. However, the impact in terms of reduction levels can not be ascribed entirely to the programme interventions.

1.7 Moreover, there is no documentation of the impact the programme may have made on the perception of the communities on the role that the Mitanins have played in terms of facilitating their access to knowledge and services or the perception of the Mitanins themselves about the extent to which they feel they are empowered by the training or supported by the health system at large. The progress made in strengthening the supply side aspects – a necessary concomitant for making the Mitanin initiative a success - also needs to be documented with a view to identify areas which need further strengthening or additional measures which need to be introduced.

1.8 It is in the above context that the Directorate of Health, Government of Chhattisgarh requested, in March 2010, the European Union Technical Assistance (EUTA) for EU-State Partnership Programme Chhattisgarh to organize a detailed evaluation of the Mitanin programme.

Objectives of the evaluation

1.9 The evaluation exercise was undertaken with a view to find answers to the following key questions:

- How effective is the Mitanin in performing her stated role and achieving her stated objectives ?
- What is the quality of the key processes and mechanisms constituting the Mitanin programme such as her training, monitoring and mentoring support structures and community ownership ?
- How effective has the SHRC been in providing the mentoring and monitoring support?
- How effective has been the supply side response to the increase in demand (for services) after the introduction of Mitanin programme ?
- What changes have occurred, if any, in the design of the Mitanin programme following the launch of the ASHA programme ?
- What measures can be recommended to the SHRC and the state programme managers to strengthen the Mitanin programme ?

- What measures can be recommended to enlarge the role of the Mitatins beyond her current role and how best other social sectors can involve her for enhancing the community reach and oversight of their programmes and interventions ?

1.10 Differently stated, the evaluation was undertaken with the following objectives:

A. Review effectiveness of Mitanin functioning based on an assessment of her knowledge and skills;
B. Review quality of key processes and mechanisms that constitute the programme in its wider context : those related to the Mitanin component as well as those related to health system strengthening;
C. Use the findings and recommendations of the evaluation to provide feedback for further strengthening of the programme.

Methodology

1.11 The evaluation was undertaken in two parts – a quantitative evaluation and a qualitative evaluation. The quantitative evaluation exercise was led by an independent expert engaged by the EUTA. The expert designed the survey instruments, trained the field staff, prepared the tabulation plan, analyzed the data and prepared a consolidated report. The field staff for the survey was mobilized by the SHRC. The agency for the data entry and generation of the tables (as per the tabulation plan provided by the lead expert) was also mobilized by them.

1.12 The Qualitative assessment was carried out by the National Health Systems Resource Centre and relied on in-depth interviews and focus group discussions with the stakeholders on provider side – SHRC staff, state programme managers, Mitanin trainers, District CMHOs, BMOs etc.

Quantitative evaluation: sample size and methodology for data collection

1.13 Quantitative evaluation made use of structured interviews from amongst a sample of Mitanins, households (those who may have accessed Mitanin support / services), ANMs, AWWs and PRI representatives. Following schedules were used for this purpose

- Beneficiary interview schedule –Type A [currently pregnant woman]
- Beneficiary interview schedule –Type B [woman with a child under 6 months of age]
- Beneficiary interview schedule –Type C [woman with a child aged more than 6 months but less than 2 years]
- Mitanin interview schedule
- ANM interview schedule
- AWW interview schedule
- PRI member interview schedule

1.14 The quantitative evaluation was undertaken in 2 randomly selected districts in each revenue division, i.e. a total of 8 districts. In each district, 4 blocks were selected on random basis and 20 villages were selected in each block implying a total sample size of 640 villages. The villages were selected following circular systematic sampling with a random start, after arranging them (the villages) in ascending order of population.

1.15 For every selected village, all Mitanins were be surveyed when the number was 1 or 2; in case the number was 3 or more, a random sample of 2 Mitanins was taken. For very small, single hamlet villages, where there was only 1 Mitanin, the survey teams identified the nearest hamlet to include the Mitanin from that hamlet.

1.16 Each selected Mitanin was asked to provide the details of the three categories of households served by her : those with a currently pregnant woman, those with a child under 6 months of age and those a child aged more than 6 months but less than 2 years. The survey team then selected 2, 2 and 4 households respectively from each category on a random basis for canvassing the beneficiary interview schedule. In addition, Anganwadi Workers, PRI members and the ANMs serving the sample villages were also interviewed. The target sample sizes underlying the methodology were as follows:

- Sample villages : 640
- Mitanins : 1280
- Currently pregnant women : 2560
- Women with a child aged less than 6 months : 2560
- Women with children aged 6-24 months : 5120
- ANMs : 640 (maximum possible, assuming every sample village was served by a different ANM)
- AWWs : 640
- PRI members : 640

1.17 The field work for the quantitative evaluation was carried out during 15th September – 2nd November, 2010 followed by data entry /cleaning, report generation and analysis which lasted until the end of January, 2011.

1.18 The field work for the qualitative assessment was carried out by the NHSRC experts during 8-13 November, 2010.

Layout of the report

1.19 The subsequent chapters of this report are organized as follows:

- Chapter -2 outlines the evolution of the Mitanin programme and the impact / outcomes perceived to be due to the programme

- Chapter-3 outlines the role of SHRC in managing the Mitanin programme and the changes to programme structure and management after the launch of the National Rural Health Mission in 2005.
- Chapter-4 is the report of the qualitative evaluation carried out by the NHSRC experts
- Chapter-5 presents the findings from the quantitative evaluation
- Chapter-6 pools together the findings from the quantitative and qualitative evaluations and makes a set of recommendations for the consideration of the State Government.

1.20 There is an element of repetition of information among chapter 2, 3 and 4. This was unavoidable as the qualitative assessment report has been incorporated into the main report without any changes.

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Chapter 2 - The Mitanin programme : evolution and outcomes

Programme evolution

2.1 The Mitanin programme was formally announced on 1st November, 2001, on the occasion of first anniversary of the creation of the State. The letter number 4938/ 2001/ Swasthya dated 23rd November 2001 from the State Health Secretary **(Annex-1)** summarises the key features of the scheme. Briefly, the Mitanin would be the community's representative in dealing with the formal health system and while the State would take the responsibility for her training, she would be compensated for her services by the village community only; the State would not pay salary or honorarium to her. In other words, *the Mitanin was not foreseen as a pure volunteer; any compensation to her must however be determined by the community that she serves.*

2.2 The November letter was followed by an Order communicating cabinet approval to the scheme. The Order No. 5058/4519/2001/ Swasthya dated 28th November, 2001 (**Annex-2**) communicates the key features of the Rajiv Jeevan Rekha Yojana (RRY) which included, besides the Mitanin scheme, the other components such as effective decentralization and communitization of the health programmes / assets, which were included in the project titled "Improvement of Primary Health" referred to above. These were intended to complement the Mitanin initiative.

2.3 The actual implementation of the Mitanin programme started in May 2002 as a series of preparatory steps which were required to be completed before the process of selection of the Mitanins and their training could have been taken up. It may be noted that a structured social mobilization campaign was critical to ensure that the selection process was really community and civil society led. ***Design and implementation of (such) a social mobilization campaign is (also) a unique feature of the Mitanin programme which distinguishes it from any other government sponsored community health worker initiative in India[1].***

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[1] The SHRC publication titled " Giving Public Health a Chance" enumerates following 7 cardinal principles which governed the design of the Mitanin programme, developed on the basis of a detailed review of community health worker programmes in the past [see chapter-III : Design features of the Mitanin Programme] :

- Women as community health workers
- Well-planned social mobilization and selection process
- Training support to be a continuous activity
- No financial payments, at least in the first year and limited incentives later, while retaining mobilizational and community based character of the programme
- Supplementary and not central role for curative care
- Linkage to parallel public health strengthening initiatives
- State-civil society partnership at all levels of programme management.

2.4 The programme started with 14 pilot blocks involving the State Health Department and participating NGOs who had agreed to partner with the State to develop the specifics of the programme through experimenting alternative approaches to mobilization and selection.

2.5 The social mobilization campaign was launched in July 2002 followed by launch of the training programme in October, 2002. In November, 2002, another 66 blocks were taken up followed byinclusion of all remaining blocks in November, 2003.

2.6 By July 2003, about 30,000 Mitanins were in place in 70 blocks of the State and by December, 2004, more than 50,000 Mitanins were in place in all blocks of the State with at least one round of training.

Objectives of the Mitanin Programme and the role of Mitanin

2.7 The broad objectives of the Mitanin programme are as follows[2]:

- Health education and improved public awareness of health issues
- Improved utilization of existing public health care services
- Initiating collective community level action for health and related development sectors
- Provision of immediate relief for common health problems
- Organizing women for health action and building up the process as a process of women's empowerment
- Sensitizing panchayats and building up its understanding and capabilities in health planning and programme implementation

2.8 The Mitanins were assigned the following roles and responsibilities under the programme[3]:

- Provide preventive primary health care services to the community
- Promote health
- Treat minor ailments
- First aid
- Health education and referral service
- To act as the main link between the community and the public health system

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The social mobilization process was built around two themes – *Swasthya Hamar Adhikar Havay (*health is our right) and *Janata ka Swasthya, Janata ke Haath* (people's health in people's hands) – and were spread through songs and dramas, in the form of *kala jathas* (cultural troupes).

[2] Ibid, page 12

[3] Order dated November 2001

Outcomes : Reduction in the Infant Mortality Rate

2.9 The estimates of Sample Registration System (SRS) of the Registrar General of India (RGI) indicate a 40 point reduction in the infant mortality rate (IMR) in rural Chhattisgarh vis-à-vis 19 point reduction at all India level (rural) during the 9-year period 2000-2009. The reduction levels in the urban areas of the State has been just 2 points against 10 point reduction at all India level (See Table-1 below). It may be noted that the sharpest reductions have happened during the expansion phase of the Mitanin programme in the years 2003 and 2004, which was *before* introduction of Janani Suraksha Yojana[4].

Table 1 : IMR (Rural and Urban) : Chhattisgarh and all-India

Year	IMR Rural				IMR Urban				Source (SRS Bulletin)
	Level		Reduction in points		Level		Reduction in points		
	CG	India	CG	India	CG	India	CG	India	
2000	95	74			49	44			April 2002
2001	88	72	7	2	56	42	-7	2	Oct 2002
2003	77	66	11	6	55	38	1	4	April 2005
2004	61	64	16	2	52	40	3	-2	April 2006
2005	65	64	-4	0	52	40	0	0	October 2006
2006	62	62	3	2	50	39	2	1	October 2007
2007	61	61	1	1	49	37	1	2	October 2008
2008	59	58	2	3	48	36	1	1	October 2009
2009	55	55	4	3	47	34	1	2	January 2011
2000-2009			40	19			2	10	

2.10 The SHRC publication " Giving Public Health a Chance" notes that single biggest possible contributor in the change may be the change in breastfeeding practices. This is more likely to be so because the early part of the Mitanin training focused on addressing such issues like wastage of colostrums, late initiation of breastfeeding and accessing public health services etc[5]. The data from the coverage evaluation surveys conducted by Unicef do indicate significant increase in the rates of (a) early initiation of breastfeeding, (b) colostrums feeding and (c) exclusive breastfeeding. Similarly, the National Family Health Survey Phase-2 (1998-99) and Phase-3 (2007-08) results also indicate significant increase in the utilization of public health services. For example, full immunization of children increased to 48.7% from 21.8, an increase of 123%!

[4] The negative decline in 2005 may be on account of replacement of sample villages which happened in one go in the year 2004 instead of spread over a 3 three year period. This bunched replacement in one go also explains the 'zero' reduction in the levels in 2005 at the all-India level.

[5] The first round of training is on understanding health, health services and child health and nutrition.

Impact beyond health

2.11 More than the results specific to changes in health indicators, the Mitanin programme has also been about general social empowerment of women of the State. Indeed, the above SHRC publication is replete with examples where the Mitanins have taken up issues like agitation against tree-felling, corruption in the PDS and campaigns against untouchability, early age marriage and alcoholism etc[6].

2.12 This is very much along the lines anticipated in the State Health Secretary's letter dated November 2001 which clearly stated the following to be part of Mitanin's mandate:

- To work for (promote) other schemes of the Government,
- To work for addressing general issues of the community, specially the social issues,
- To work for any other issues which she and the local community consider necessary.

Cost effectiveness

2.13 Since inception till the end of 2009-10, the total expenditure on the Mitanin programme has been Rs 67.28 crore (see Table-2 below for details). This does not include cost of the drug kits supplied to them but includes every other expenditure item including education and equipment kits supplied in 2007-08.

Table 2 : Expenditure on Mitanin programme

	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10
SHRC Core Fund	1223059	1461137	2722660	3317763	3461767	5003955	4446052	6589261
Mitanin-HO level	2058655	6209299	9113625	7113223	8740661	46884950	43053591	24834873
Mitanin-PO level								
Expenses against SHRC releases	7253939	30990267	50301110	51841203	54557033	32905373	38519222	15394886
Expenses against SHS releases						117801901	15038665	82033283
Total	10535653	38660703	62137395	62272189	66759461	202596179	101057530	128852303

[6] See Chapter – VII : Mitanin Programme: Some Success Stories, and Chapter-VIII: Case Studies: Mitanins in Action in the SHRC Publication titled " Giving Public Health a Chance". A particularly noteworthy development that the programme has brought about is the so called Mitanin Sammelans / Mahasammelans [large gatherings]. They started happening from 2005 in different pockets. They were never part of the programe design but were seen positively by SHRC when they took place through local initiative. Koriya, for example, had Sammelans regularly from 2005 onwards. Mitanins locally displayed lot of enthusiasm for such events but such events happened in places where they were better organised and had some catalytic support. Replication of Koriya experience of large mobilization events was encouraged specifically in 23 blocks in 9 districts where programme could find strong leadership at the block level. SHRC never funded these Sammelans. The events required small expenditures (around 3-4 thousand each) and it was raised localy through voluntary donations. Mitanins also bore their travel expenses to participate in these events.

2.14 Considering the first 4 years as the investment phase, the per Mitanin investment cost works out to less than Rs 2900/- [Rs 17.36 crore spent in the first 4 years to put in place the network of 60000 Mitanins]. The annual maintenance cost is also impressively low at just about Rs 2000 per Mitanin per year even after including the occasional one time expenses on items like education kits.

Note: Data for Table-2 was obtained from the audited expenditure statements of AAI, SHRC and State Health Society

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Chapter 3 - Programme Management : Assessment of changes

Changes in Programme Management arrangements

3.1 During first three years – 2002-03 to 2004-05, the Mitanin programme was implemented as an Action Aid India (AAI) project. Thereafter, the programme has been implemented as a project of the SHRC, an autonomous entity registered under the Societies Registration Act.

3.2 The programme management structure has remained more or less the same since inception and involves the following levels:

- State level : SHRC at the State level with a dedicated unit for the Mitanin programme
- District level : The programme is looked after a District Nodal Officer nominated by the Chief Medical Officer. The Nodal Officer is assisted by District Coordinators (earlier called Field Coordinators) recruited from the open market with each District Coordinator looking after 4-5 blocks which means that large districts with many blocks have more than 2 or more District Coordinators (there are a total of 28 District Coordinators for 146 blocks). The District Coordinators' are the employees of the SHRC and their task is training, facilitation and monitoring.
- Block level: Every block has three District Resource Persons (DRPs) – one nominated by the Block Medical Officer and the remaining two recruited from the open market. The DRPs are responsible for training, facilitation and monitoring in the assigned areas within the block. The Govt nominated DRP has additional responsibility namely that of working as the interface between the BMO [who is overall in-charge of all health programmes in the block including the Mitanin programme] and the other two DRPs as well as the Mitanin Trainers.
- Cluster level: There is a Mitanin Trainer (MT) for every 20 Mitanins. The main task of the Mitanin Trainer is to train the Mitanin and provide supportive supervision to her.

[The compensation of the District Resource Persons and Mitanin Trainers (also called block resource persons) is paid by the concerned Block Medical Officer or the NGO in charge of the programme in a block.]

3.3 However, there have been significant changes in the funds flow system for the programme. Until 2006-07, funds for all activities under the programme [other than the drug kits which have been procured by the State Health Directorate] were being allocated and transferred to the SHRC [AAI for the first three years]. The SHRC would then transfer part of the allocation to its implementing partners which would be the participating NGOs or the District Health Societies. Starting from 2007-08, however, the SHRC agreed that the funds required to be transferred to the implementing partners may be directly released to the District Health Societies. This changeover, however, did not happen in one go; for 2007-08 and 2008-09, the State Health Society and the SHRC both transferred the funds to District Health Societies; covering different components of the programme budget. It is only in 2009-10 when funds for the implementing partners were directly transferred to the District Health Societies by the State Health Society (See Table 3 below).

Table 3 : Funds transferred to DHSs by SHS and SHRC for Mitanin programme

FY	Funds transferred by SHS to the DHSs		Funds transferred by SHRC to the DHSs	
	Amount	Purpose	Amount	Purpose
2007-08	13,44,43,875	Mitanin education and equipment kit	2,36,53,800	8 and 9th round of Mitanin training and Mitanin compensation during training period
2008-09	4,79,75,000	Mitanin training, Mitanin compensation during training period, district level contingencies, block level contingencies	5,85,60,000	Compensation to District Resource Persons and Mitanin Trainers
2009-10	14,27,13,840	Compensation to District Resource Persons and Mitanin Trainers Mitanin training, Mitanin compensation during training period, district level contingencies, block level contingencies	■	■

3.4 The above change in procedure achieves no clear advantages except that the SHRC would not have to chase the District Health Societies for obtaining audited statement of expenditure for the funds that it released to them. On the contrary, the accountability lines become relatively blurred and it becomes that much more difficult to get the programme related expenses in one place [it took 2 days to obtain the above details from the Accounts Unit of SHRC]. Since a part of the mandate of the SHRC was capacity building of the State and district level programme management units, it would have been more appropriate for the SHRC to organize technical assistance to the DHSs to improve their account management system. In the end, the SHRC appears to have taken the option of avoiding the problem than resolving it.

Involvement of NGOs

3.5 One of the stated 'cardinal principles' of the programme is state-civil society partnership at all levels of programme management. While this aspect received the due attention in the initial stage, particularly in the pilot blocks when 12 of the 15 blocks were assigned to partner NGOs, sufficient attention does not appear to have been given to institutionalize the partnership arrangement. As a result, the entry / exit of the NGOs [the number of NGO run/managed blocks reached 36 in 2008-09 but has steadily come down after that] has depended on personal initiative and wisdom of district level leadership.

Introduction of incentives[7]

3.6 After the launch of National Rural Health Mission, task based incentives were introduced. While the incentive per se is not a violation of the original programme design, the operational arrangements for making these payments are certainly against the explicit stipulation in the State Government Order dated November 2001 which clearly stated that "no honorarium or pay shall be paid to the Mitanin by the Government; however the village community itself can compensate her for her efforts by pooling money or grains"[8].

3.7 Any payment for which the Mitanin has to depend on the functionaries of the Health Department reduces her ability to play the activist role as it weaken the principle of "retaining the mobilisational and community based character of the programme". At the same time, Mitanin's attention is also bound to start getting restricted to only such activities which has the element of an incentive at the cost of other activities like promotion of breastfeeding, which is claimed to have contributed significantly to the IMR reduction.

Maintaining Social Mobilization focus of the programme

3.8 As noted, social mobilization (SM) was a key activity in the beginning of the programme. The initial focus of the SM interventions was to support the selection process to ensure that the right candidate was selected. Post selection, the focus of SM interventions should perhaps have shifted to operationalize the second most important construct of the programme, namely getting the village community to make specific commitments for compensating their Mitanin. However, there is no evidence if there was any structured process to assess whether all Mitanins were happy working as a volunteer or if there were certain Mitanins who expected to receive regular payment in return for the services they provided.

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[7] Please see chapter 4 for a more detailed discussion on the changing role of SHRC and implications of introduction of task based incentives.

[8] When asked whether a fresh cabinet directive was sought when introducing the incentives, Mr Samir Garg, Programme Coordinator (Mitanin) in the SHRC stated as follows: "Task based incentives were introduced once NRHM came in and Mitanin Programme started getting funded by it under ASHA head. SHRC or health deptt have not asked for any amendment on cabinet approved scheme. SHRC had proposed that community agencies like VHSC/PRI should pay Mitanins in its Visioning Workshop on 18th July 2009. But later the health department declined to go as per recommendation of the Workshop".

Chapter 4 - Findings of the qualitative evaluation

Background and Introduction

4.1 The state of Chhattisgarh is the 9th largest state of India and has a population of more than 20 million people. 34% of the population comprises indigenous tribal people. About 44% of the land mass is forested and much of the population of the State is settled in scattered forested habitations. The state of Chhattisgarh, formerly a part of Madhya Pradesh, was given an independent identity in November 2000. With a population of 20.6 million, the new state of Chhattisgarh inherited a low health status. With crude birth and death rates of 26.3 and 8.8 respectively, an infant mortality rate of 76 per 1000 live births, and a maternal mortality rate of 548 per 100,000 live births, the health status of Chhattisgarh was well below the national average.[9] The public health infrastructure in the state was also equally poor with only 3818 health sub centres for a population of over 20 million, a 79.8 percent of primary health centres lacking basic equipments and human resources, a low community health centre coverage of 21.9 percent, and only 9 out of 16 districts with functioning district hospitals.[10] In this context, the Government of Chhattisgarh felt the urgent need to initiate health sector reforms for adequate provision of quality health services to achieve better health outcomes for the population.

4.2 Past experiences (of CHW): Madhya Pradesh ran the Jan Swasthya Rakshak (JSR) scheme which also was implemented in Chhattisgarh. This scheme had majority male health workers, who were trained in aspects of curative care and medicine by doctors at the PHC level. An evaluation undertaken of the scheme showed irrational use of saline and drugs by the JSRs and also an affinity to becoming quacks and running illegal clinics. The issues and details of the JSR programme were carefully studied by the team which first suggested the blue print of the Mitanin programme, so as to not repeat the mistakes of the JSR programme in the Mitanin programme. The idea of emphasising a 'woman' health worker and also an initial and strong focus on preventive and promotive care were some of the key leanings.

4.3 Different NGOs such as Rupantar, RAHA and BGVS had run community health worker initiatives or community mobilisation initiatives in Chhattisgarh before and were a critical part of the early advisory group and also implementation teams of the Mitanin programme.

4.4 Subsequent to the European Commission and GoI committing support to the GoC under the Sector Investment Programme, the state government sought civil society participation for initiating a community health worker ('Mitanin' which means friend in

[9] Census of India, 2001.
[10] Ibid.

Chhattisgarhi) scheme in the state. The community health worker programme was an acknowledgement by the state government that:

- Health services do not reach the people who need them the most including poor and marginalised tribal communities inhabiting remote tribal areas;
- The solution lies not in merely strengthening existing systems and programmes, which are bureaucratized, vertical and based on a technical understanding of health, but in creating community based alternatives.

4.5 A process of consultation with the leading health activists, NGOs and state officials was initiated by the Department of Health & Family Welfare, GoC in collaboration with ActionAid to seek out ways to transform the existing health services in the state. A three-day workshop (January 2002) was organised by the GoC and ActionAid, which brought together leading health activists, and NGOs from across Chhattisgarh as well as other parts of India and representatives from the European Commission. The discussions in the workshop centered around the initial draft of the programme prepared by ActionAid and the Government of Chhattisgarh. There was consensus amongst participants, especially those from the leading NGOs of the state, that the 'Mitanin' programme, as it had been framed was unlikely to succeed unless wide-ranging structural reforms were also undertaken by the GoC to change the existing laws, policies, programmes and institutions of the state's public health delivery system. To achieve the vision of 'Health for All' there was need to make a transition from existing health services to community-based health services.

4.6 Taking on board these suggestions, the Department of Health & Family Welfare and ActionAid, in collaboration with the leading NGOs of the state including Rupantar, Jan Swasthya Sahayog, Zilla Saksharta Samiti (Durg) and Bharat Gyan Vigyan Samiti, identified a number of areas of the current health services provision which needed structural changes in state policy and practice in laws, programmes and institutions mainly by strengthening community health systems, primary and district level health delivery systems, health surveillance and epidemic control. A high-powered State Advisory Committee comprising representatives of NGOs and senior state health officials including the Health Secretary was formed to monitor the progress of the reform process as well as provide inputs for the community health worker programme. Simultaneously, the 'Mitanin' programme was designed in close consultation with NGOs and leading health activists who had been involved with every aspect of the programme from the conceptualisation stage and setting the objectives to determining the pace and detailing of training material.

4.7 The Mitanin Programme is a successor of other large scale CHW programmes initiated by the Government – the Village Health Guide (VHG) Scheme (1978) and the Jan Swasthya Rakshak Programme (1995) in Madhya Pradesh. These programmesdid not have the desired impact on health outcomes due to structural gaps in the system, issues in training and lack of linkages with the public health system, the lack of community based

support structures, and degeneration of the CHWs into quackery.[11] With this background, the SHRC adopted a systematic, decentralised and contextualised approach, oriented towards processes, innovations and community participation in the Mitanin Programme. The following components of the Mitanin Programme highlight this approach and differentiate the programme from previous large-scale CHW programmes..

4.8 The expected out come of the Mitanin Programme were envisaged as:

- Health Education and Improved public awareness of health issues
- Improved Utilisation of existing public health care services
- Provision of immediate relief for common health problems
- Organising community, especially women and weaker sections on health care issues
- Sensitising Panchayats and build up its understanding and capabilities in local health planning and programme implementation

4.9 Other than in health care, the Mitanin was also conceptualized to contribute to:

- Improve information about and access to other government programmes and facilities and on basic rights and entitlements of people.
- Assist in helping local communities organize.

4.10 The SHRC has been involved in each stage of designing, operationalising and implementing the Mitanin Programme, a state-wide community health worker (CHW) programme in Chhattisgarh, launched in November 2001 as a major component of the Rajiv Jeevan Rekha Programme. The programme aimed to place a trained voluntary health worker – the Mitanin – at the hamlet level in each of the 60,000 plus hamlets in 146 blocks of the state. This programme aims to provide better outreach for health education, health services and community based health programmes, as well as strengthen community health action and community level networks to counter the current under-utilisation of existing health services. The programme has succeeded to have 60,000 Mitanins reaching saturated coverage across the state. Given the impediments encountered by community health worker programmes at scale, the Mitanin Programme has been a pioneer, attempting to sculpt out its own approach by integrating fundamental changes in its design and operationalisation. It has built a strong base of understanding of the complex functioning of the health system in social and political life, and with that foundation, has formulated effective strategies to achieve better health outcomes.

4.11 The Mitanin programme was initiated in 14 blocks in the pilot phase followed by the first phase where 65 blocks were added after having developed the processes. The scale up witnessed a large scale social mobilisation campaign through 160 Kalajatha Troupes (cultural caravans) moving across 80 Blocks (out of 146) and generate awareness on the right to health campaign. The Programme now covers all the 146 blocks (approx 60,000

[11] Sundararaman, T. 2005. "Community Health Worker Programmes and the Public Health System" in *Review of Healthcare in India.* Gangolli, L.V., Duggal, R. & Shukla, A. (eds.). Mumbai: Centre for Enquiry into Health and Allied Themes.

Mitanins identified and trained). The SHRC has brought out a series of training material: text based ones for literate Mitanins and illustrated ones for non-literate ones. Manuals and Handbooks have already come out on Basic Health Awareness, Social Mobilisation, Health Care Entitlements, and Child Health where Training manuals on Women's Health, Community Control on Preventable diseases, First Level Curative Care etc.

4.12 The conceptualizers of the Mitanin programme explain that they are using this opportunity to create a cadre of dedicated health workers who understand health as a basic entitlement and are able to take communities to this realization using conscientisation methodologies and participatory techniques[12]. The challenge of this programme is to guide the process of grassroots social mobilisation and capacity building achieved for the Mitanin programme into a process of local planning and empowerment. An external evaluation of the SHRC and the Mitanin programme was carried out in 2005. This evaluation was in the nature of examining the processes in place and recommending steps for further improvement of the programme. The SHRC component of the evaluation relied primarily on documentation review, field observations and discussions with the stakeholders. The Mitanin component of the evaluation did include a sample survey. However, the sample was rather small; the quantitative data collection covered only 96 Mitanins, 495 villagers, 19 trainers (of Mitanins), 31 Anganwadi workers / ANMs and 8 doctors. Also, the evaluation focused on processes with a view to draw out areas which needed further strengthening, and, as such, did not seek to make an assessment of the impact of the programme. The evaluation, nevertheless did note the valuable contribution made by the SHRC and found that Mitanins are doing a valuable service in the health sector.

4.13 The current evaluation was conducted in two parts- an assessment of the impact of the programme based on a detailed survey of beneficiaries, Mitanins, ANMs, AWWs and PRI members and a qualitative evaluation. The two components were designed and carried out independent of each other; the quantitative evaluation was organized by the European Union Technical Assistance (EUTA) team for the State Partnership Project whereas the qualitative evaluation was organized by the National Health Systems Resource Centre (NHSRC).

4.14 This report is based on the qualitative assessment and was undertaken by Sarover Zaidi and S Ramanathan over a week with interactions at the state level and field visits to two districts between November 8, 2010 to November 13, 2010.

Ownership and Management of the programme AND Impact of governance and institutional environment on the programme

4.15 The State Health Resource Centre (SHRC) is a non-governmental organisation registered under the Registration of Societies Act, Madhya Pradesh, 1973 and the

[12] Mitanin Programme: Conceptual Issues, Operational Guidelines, SHRC, 2003.

Registration of Societies Ordinance, Chhattisgarh. Established in 2002, the SHRC was a joint initiative of ActionAid India (AAI) and the Government of Chhattisgarh (GoC) and was conceived as a functionally autonomous institution mandated to provide “additional technical capacity” to the Department of Health and Family Welfare in developing the state’s health sector reform programme.

4.16 The structure and role of the SHRC evolved within this context in which the state government was committed to undertaking a wide-ranging health sector reforms programme, but did not have adequate technical capacity within the government system to design and implement these major initiatives. The SHRC was therefore conceptualised as a supportive and facilitative institution that would infuse expertise and experience into the public health system on an ongoing basis, build state capacity, and create productive partnerships between civil society organisations and the government in the health sector. The goal of this institutional arrangement between an autonomous technical resource and the existing health department was articulated as follows: “to make structural changes in state policy and practice – to make health services more accessible to people who need them the most, including very poor and marginalized groups, tribal people inhabiting remote hamlets, women and other people at risk, mainly by strengthening community health systems, primary district level health delivery systems, health surveillance, epidemic control and comprehensive reforms in policies, laws, programmes and institutions for realising the vision of Health for All.”

4.17 Based in Raipur, the SHRC is staffed by a core team of individuals recruited from the open market and with complementary professional backgrounds. The SHRC has three Programme Coordinators with backgrounds in social mobilisation and community development, clinical expertise, and preventive and social medicine respectively to provide technical and management input to the SHRC’s various initiatives. Each district has its own field coordinator (now called District Coordinator) who works as the eyes and the ears of the SHRC and helps in organizing trainings of Mitanins, troubleshooting, solving problems at the district level , negotiating with the government functionaries etc.

4.18 The Mitanin Programme has integrated a rigorous process of monitoring and evaluation of each of its components on the basis of predetermined outcome and process indicators. The SHRC had conducted a detailed internal outcome evaluation of the programme.

4.19 The SHRC was headed by Dr T Sundararaman since inception until 2005 and is currently headed by Dr. K R Antony. He explained the role of the SHRC as a key facilitator in operationalisaing the Mitanin programme in Chhattisgarh. Especially in the context of the NRHM, post 2005, the SHRC plays a pivotal role in coordinating between the SPMU, the mission director and the Directorate to ensure smooth functioning of the programme on the ground. Besides coordinating on orders, to be pushed through at the district level, it continues to play a key role in training and monitoring of the programme at the field level. He also explained the key role still played by the SHRC District Coordinators, in trouble shooting issues in the programme, negotiating, managing and monitoring things related to the Mitanin

programme at the district and block levels and also their intense involvement in the ongoing trainings for the programme. His role is not only limited to the negotiations with the state and district levels on the Mitanin programme, but also in coordinating or providing special assistance to the directorate and the mission on other programmes that they may wish to start. The SHRC has activity been involved in drafting the Rogi Kalyan Samiti guidelines, EQUIP programme, monitoring and HMIS issues for the public health system etc.

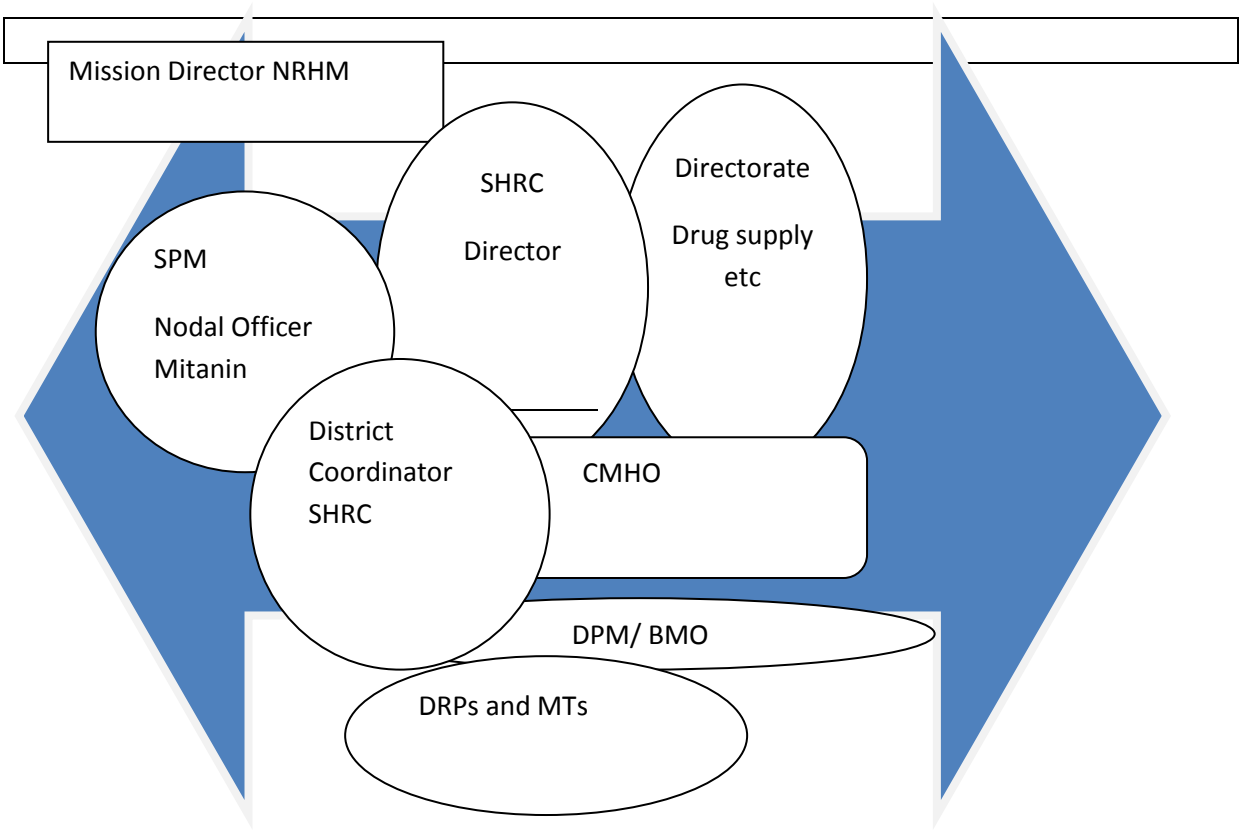
4.20 Mr. Anbalgan, Director Health Services, an IAS officer posted to the Health Department, explained that he had seen the Mitanin Programme for the past 5 years (he has been collector during the period when the programme unfolded on ground and has been actively associated in facilitating the Mitanin Programme. Since Directorate is responsible for the refilling or delivery of the drug kits of the Mitanins, he continues to be associated with the programme and works in close coordination with his department staff and also in a feedback loop from the SHRC on the issues with drug kits for the Mitanins.

4.21 He feels he has seen a range of Mitanins, namely those with high levels of knowledge and those who are Mitanins for name sake. Over all he explained that the Mitanin programme was good system and Mitanins have knowledge on many issues that are needed to address health concerns of the villages. The key aspect that he underlined about the Mitanin programme was that it was a volunteer based scheme, where the most a Mitanin would initially get was social recognition. He felt that the best evidence on this format of recognition can be seen in the number of Mitanins who have now become Panchs or elected as Panchayat members. A bribe value of about Rs. Ten Lakhs is ascribed for even receiving the ticket for the post of a Panch, while in the case of the Mitanins, they have been elected on the basis of the recognition of their work in last few years. He felt that the current trend or demand for regularising the Mitanin as a paid worker from the health system will eat into her independence and make her the lowest level functionary of the health system and also a mare assistance to the ANM. This would take away her independence as a community representative and also her ability to critique the public health system and raise demands from it for the people. Mr. Anbalgan believes that she should continue to be outside the health system and innovative methods of incentivising need to be explored, such as funding through Panchayats etc. He feels the current trend of Unionization have been initiated by the training cadres, as they themselves are in temporary jobs and are also pushing together the Mitanins into what seems to be more their agenda than that of the Mitanins. He concluded by explaining that the key innovation in the Mitanin programme has been her location at the hamlet level and a continuous training and on field learning programme for the Mitanins. He also mentioned the processes for accreditation that the Department has undertaken for the Mitanins, where, 457 Mitanins have been chosen to become ANMs and recruited through the Department to join private ANM schools.

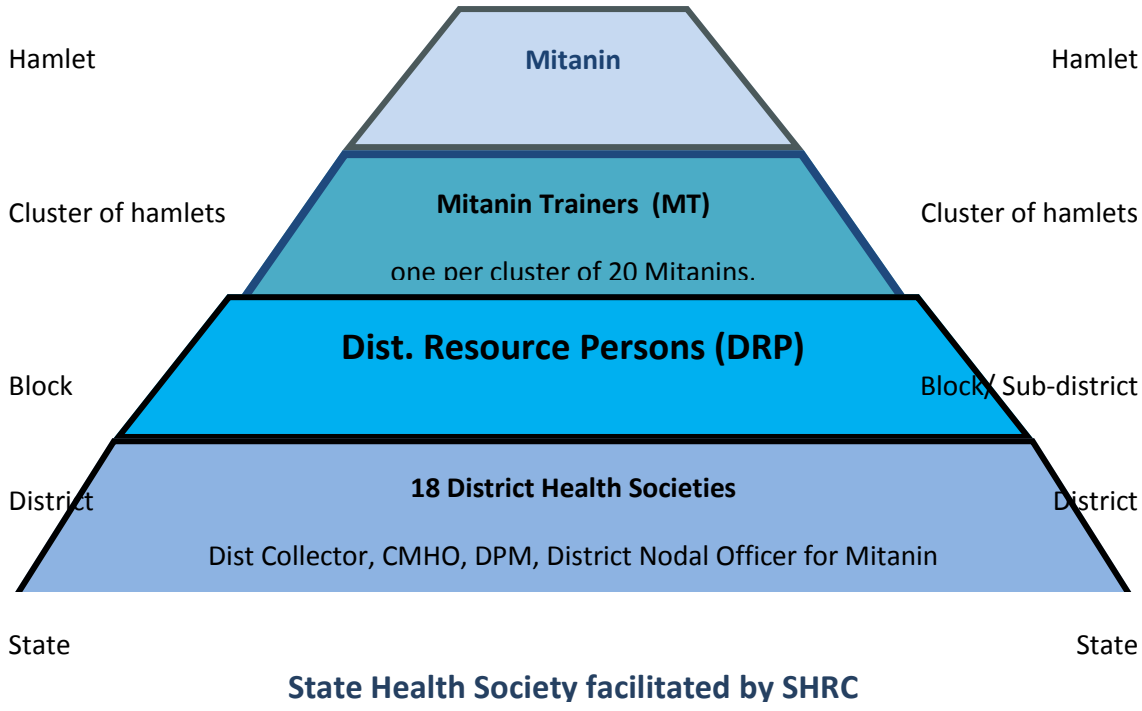
4.22 The programme at the SHRC level is led by Mr. Samir Garg, to whom the District Coordinaters report.

Workflows, Governance and Structures

4.23 The broad flows and relations between different official bodies can be broadly explained by the following diagram, the overlaps have been shown within different officiating bodies. They work in coordination with each other on different aspects of the Mitanin programme.



4.24 The structure of the SHRC's functioning within itself on the Mitanin programme can be represented in the following pyramid.



4.25 Fund Flow Structure

- Until 2006-07, the funds for the programme were being allocated to the SHRC. A part of these were retained at the HQ level for state level activities like production of training modules and training of trainers etc. The funds required at the field level were being transferred to the District Health Societies [RCH societies before NRHM was launched] from where these would be allocated either to the Block Medical Officer or to the partner NGO who are in charge of actual implementation of the programme. In other words, only the funds for District level meetings of district resource persons (DRPs) are directly spent by the District Health Society; rest of the funds in the field are managed by the BMO or the partner NGO.

- The funds flow system below district level has remained the same. However, starting from 2007-08, the involvement of SHRC in transfer of funds to District Health Soceities has been reduced as the part of funds are now directly sent by the State Health Society to the District Health Societies, although on the recommendation of the SHRC. To the extent the SHRC is no longer involved in providing funds to the DHSs, its ability monitor performance of the DHSs appears to have weakened.

- BMOs organise the logistics arrangements and make its payments for Mitanin Trainings with help of Govt DRP/non-govt DRP/BPM/BADA or directly

- BMOs make payments for MT, DRP Compensation based on verification done by District Coordinator

- BMOs make payments for fortnightly MT meetings, photocopies and other contingencies

- Note: In 20 Blocks, NGOs selected by District health societies are receiving funds for above three points instead of BMOs

4.26 Role of the SHRC: The SHRC plays the key role in the implementation and management of the Mitanin program. However, its involvement too, has been gradually evolving and changing over a period of time, with the emergence of the new institutional arrangements and the national guideline on the implementation of the NRHM program.

4.27 The SHRC's core mandate is to implement the Mitanin programme and all members of the SHRC will strongly reflect on this. There is a strong perception in the government system also, that since the programme was started at the initiative of the SHRC, they are responsible for it. The Nodal Officer for the Mitanin program at the state level is of the view that the health department does not have the human resource to manage the programme. The District Societies do not often follow up on the availability of the funds for the program. The SHRC plays a significant role in the management and implementation of the Mitanin program. The guidelines and various other documents required for the Mitanin Program are prepared by the SHRC and shared with the NRHM, which issues it either independently or jointly with the SHRC. Even though currently the except for the District Coordinator, the disbursement of the honorarium for the District Resource Persons (DRPs) and the Mitanin Trainers (MTs) is now undertaken by the Health Department.

4.28 At the district level each CMHO selects a district Nodal Officer, for the Mitanin programme, who then works closely with the DPM, district Coordinators of SHRC and is also responsible for release of funds to BMOs and DRPs at the time of Mitanin Trainings. In our interviews some CMHOs also suggested that the SHRC District Coordinator should also work under them and receive a salary through them. We got the perception that they are currently still seen as outsiders and somewhere a threat to the hegemony of the CMHO, at the district level. Their 'outsider-ness', also makes the Mitanin programme seem , like it is actually not run by the department.

4.29 The maintenance of a certain ambiguity along with a sharing of power and work in a many ways with the government functionaries, seems to have worked in the case of both the Mitanin programme and the SHRC. Many government functionaries, though critical about the idea that SHRC had been given certain powers in running the Mitanin programme, admitted that it would not have been possible to run the programme the way it did run, without the presence of the SHRC staff and field coordinators. At the level of the DPMs their seemed effective coordination and amicable relations between the work that needed to be undertaken on the Mitanin programme in the district. Data sharing is done adequately, so that there is no repetition of collecting data on the Mitanins and their work and fund flows.

4.30 Field level: At the field level, the hierarchy of the institutional arrangement for the Mitanin Program consists of the following:

- Field coordinator, who is now designated as District Coordinator. One person per district and s/he is engaged and directly reporting to the SHRC.

- District Resource Person (3 per block – 1 from the Government and the rest non-Government)
- Mitanin Trainers (MTs) (20 per block and they oversee 20 Mitanins)
- Mitanins (400 Mitanins per block)

4.31 Civil Society Involvement: Mr. Samir Garg, the Senior Programme Coordinator from SHRC for the Mitanin programme, has been associated with it, from its early days. Mr. Garg and Ms. Sulakshana Nandi, ran the programme and looked at nearly all aspects of it in Koriya District, since about 2003. Due to his in-depth knowledge of the issues of the programme in its workings on the field, Mr Garg is able to have many insights and also provide able guidance to the programme from the state level. Mr. Samir explained that the early phase of the programme, was initiated in a campaign mode and high focus was placed on community mobilisation and community awareness on health issues and the Mitanin programme, through Kala jathas etc. He also explained that in the initial phase, 14 blocks initiated the programme through NGOs and about 66 blocks were government led. There was not much difference in the quality of outcomes of these two types of blocks. Also most NGOs could not handle the scope of running a programme at the scale of a few blocks and were much more easily handle a few villages in the catchment areas of their hospitals. Most NGOs also shied away from working with the government and would even at times of malaria outbreaks, approach private donations for medicines than source chloroquine from the government. He explained that over the years, they have reduced the role of NGOs in the operationalisation of the Mitanin programme. His role is to coordinate with all the District Coordinators and also work closely with the government departments, to strengthen different aspects of the programme.

4.32 Role of NRHM: The Mission Director, NRHM is responsible for the overall implementation of the Mitanin Program. To support the MD, NRHM, there is a State Nodal Officer for the Mitanin Program. An officer of the Deputy Director level has been designated as the nodal officer. However, it appears that the Nodal Officer, is not very keen to take on the role. Hence, he does not get into the day to day management of the program. Another officer of the rank of Deputy Director level, is also responsible for the procurement of the drug kits for the Mitanin and ensuring their distribution. There is a State Program Manager (SPMU) for the NRHM. The District Program Manager at the District Levels coordinates the activities on behalf of the District CMHO. However, there appears to be a limited role for the NRHM in the day to day management of the Mitanin program.

4.33 We also got the continuous impression that the Health Department would like to have more control on the program rather than nurture it. This process of “control” appears to be emerging from the attempt to freeze the list of Mitanins and issue of identify cards etc to the Mitanins.

4.34 Evolving Institutional Arrangements: Over a period of time, the institutional arrangements of the NRHM program are stabilizing. The District Program Officer (DPM) plays a key role in supporting the CMHO in the implementation of the NRHM program. As

mentioned above, there is also a District Coordinator of the SHRC, who is responsible for the management of the Mitanin program. As the NRHM is now paying the honorarium for the MTs and other resource persons, save the District Coordinators, the district officials appear to be articulating a greater role for themselves in managing the personnel and the program.

4.35 There is a view that the presence of the District Coordinator of the SHRC is a parallel arrangement, which is not required. The issue of the parallel system is also articulated by the MD, NRHM who said that he is studying the issue to understand the roles and responsibilities of the various arrangements. The MD,NRHM said that he is not clear on what is the role of the various MTs and the Resource Persons in monitoring the functioning of the Mitanins and felt that this ought to be done by the Health Department, rather than by the resource persons/ MTs.

4.36 In the last few years, the operational and field support issues from the side of SHRC has increased and this is seen to have an effect on the quality of the programme at the field level. The mentoring and one to one interface with senior members of the team has reduced and there are concerns from field staff on this.

4.37 As mentioned elsewhere, while the SHRC provides the technical support for the training, the execution is done by the Health Department. Except for the District Coordinator, the rest of the personnel associated with the Mitanins are now paid honorarium through the District Health Administration. Consequently, the Health Administration, is of the view that they ought to be monitoring the functioning of these personnel. Consequently, the MTs and the resource persons are often made to undertake tasks for other vertical programs, which are considered more important by the Block Medical Officers. For instance, the MTs who sit on the Mitanin Help Desk at the PHC between 9 to 5 are often made to do other tasks than be a help desk.

SHRC - Attenuation of Capacity to Nurture Mitanin

4.38 From the limited field visits and discussion with the field functionaries, it appears that over time there is an attenuation of the capacity of SHRC to nurture Mitanin program. The visit of the senior program persons from the SHRC at the state level to the field to meet the field functionaries and discuss the issues on the ground and provide supportive supervision appears to have declined. In both the districts, it was learnt that senior program persons from the state level have not visited the districts for many months. The spirit of nurturing capacity through discussion and interactions appears to have reduced over time. Consequently, the process has become one of “managing” the program and reporting on it by the District Coordinators. It was informed that even in the state level meeting of the District Coordinators, the agenda is more often on reporting and management issues rather than on discussing the issues on the ground and addressing them.

4.39 There have been some changes in the District Coordinators and it appears that some who were not involved in the Mitanin program have also become coordinators. it appears

that their own abilities on is not very adequate. Consequently, their ability to provide the support to the field personnel is an issue.

4.40 The District Coordinators too, appear to be preoccupied with routine tasks and they rarely undertake field visits. Most of their time appears to be spent on meetings and reporting that District Coordinators do not appear to be doing any field visits to meet the Mitanins and understand the issues on the ground. There is one perception that the SHRC is now overburdened with many other tasks that is losing its focus on the Mitanin program. Its attention is getting dissipated into providing episodic support to the NRHM on a regular basis.

4.41 In addition, the SHRC itself, appears to be a willing partner in gradually bureaucratizing the Mitanin program. Consequently, its focus seems to be more on establishing and enabling systems for ensuring fixity to the systems and ensuring the accountability of the Mitanins to the health administration rather than ensuring their accountability to the community. However, this observation is made based on field visits spread over a week and discussions with a sample of the persons involved in the program. This is an aspect that could be probed further and this is an issue on which SHRC could perhaps even do an internal discussion.

Mitanin Selection and Training

Selection

4.42 The Mitanins are selected by the community and there is a process of community consultation at the hamlet level to identify the Mitanin. The selection is habitation based and was done with in the community in the hamlet. Since the selection is habitation based, the Mitanin is one of the equal members of the community. Most Mitanins therefore are poor and nearly 700 are believed to be from the “primitive” tribal groups. The DRPs undertook initial visits to villages to explain and understand different habitations to discuss the issue with the community for the selection of the Mitanins.

4.43 Mitanins were initially selected in a “campaign mode” and Kala Jathas were used to spread the information and to ensure that the Mitanins were selected.

4.44 There are two differing perceptions on the issue of the Mitanin selection. There is one view that prior to NRHM, the Mitanins were motivated by social purpose and were of the best quality. Consequently, the community benefited in the process[13]. However, some of the field personnel were of the view that since there was a perception that Mitanins did not receive any benefits, it was difficult to motivate women to become Mitanins. However, it is also felt that post NRHM, with incentivisation and with some of the Mitanins becoming ANMs, many perceive this as an avenue to a career. Consequently, many educated young girls are now opting to become the Mitanins.

[13] Interview, Director, Health Services, November 8, 2010.

4.45 Though, the Mitanin is a volunteer identified by the community, the social recognition by the community is believed to be a key factor in enabling their selection. In addition, the provision of the drug kit, which enabled her to provide drugs to the neighbours, is also believed to have enhanced her standing and acceptance among the community. The Mitanins felt that they are now recognized and not viewed as some ones' wife or daughter and they have an individual identity. In addition, they said that the ability to dispense medicines has given them a standing in their community[14]. Also, their overall knowledge and awareness of the functioning of the public health systems, liasioning with the ANM and knowledge and mobilization for entitlements to different government schemes has added to their position in the villages.

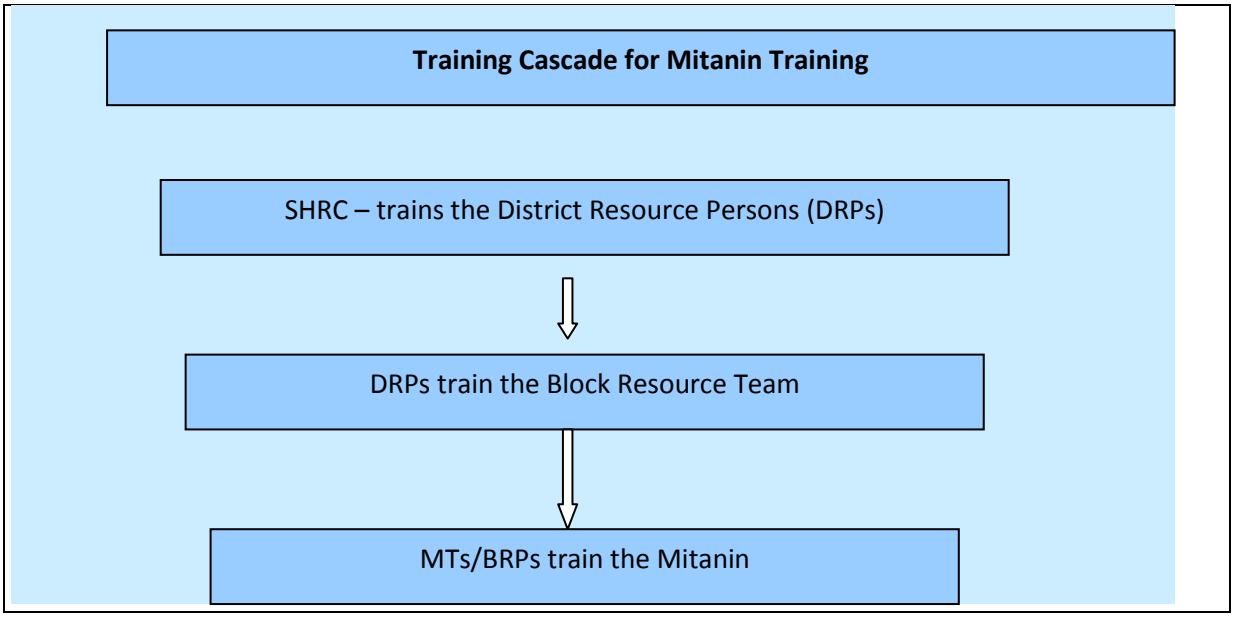
4.46 Involvement of NGOs Though the initial pilot phase was positive, it is held that the quality of implementation between the NGOs and the Government was not very different[15]. The other issue was the reluctance of the NGOs to engage with the Government to take it to scale and scaling up was also a major issue for the NGOs. Hence, the expansion phase of the Mitanin program occurred almost entirely under the aegis of the health department through the District Health Societies.

4.47 The coming of the NRHM: The norms of selection has only recently affected the Mitanin programme, though there is no effect on the norm of one Mitanin per hamlet. Education levels are being more seriously considered now than earlier.

Training:

4.48 One of the key and most critical aspects of the Mitanin programme has been its continuous, creative and on the field focus on training and capacity building of all its cadres with a core focus on the Mitanins themselves. There are four levels of cascade that is undertaken to build capacity. The SHRC trains the District Resource Persons (DRPs), who in turn train the Block Resource persons and they in turn Mitanin Trainers and they in turn train the Block Resource Persons who train the Mitanin. Refresher training is provided twice a year and currently 15th round of training is being organized.

[14] FGD with the Mitaninis in Talakura village, November 13, 2010.
[15] Interview Samir Garg, November 9, 2010.



4.49 The training modules for the Mitanin differ from ASHA modules. The former is more elaborate than the latter. The Mitanin modules number 15 compared to the 7 modules of ASHA. While the SHRC provides the technical support for the training the execution is done by the Health Department. However, the funding for the training is provided through the NRHM institutional arrangement.

4.50 However, for the 10th round of training, the SHRC decided to undertake the training directly. While this ensured quality in training, it strained the SHRC completely. It also led to some level of resentment within the health department, as it reflected on their ability to undertake the training.

4.51 The training was organised across a series of rounds and in a training cascade. The rounds and phases of training are as follows :

2003 to 2006

Round 1: Social Basis of Health, Introduction to the Programme, Healthcare services and entitlements, Preventive and Promotive Child Health

Round 2: Revision of Round 1, more pictorial

Round 3: Gender and Health, Preventive and Promotive Maternal Health

Round 4: Malaria (including community planning to fight malaria)

Round 5: Mitanin Drug Kit

Round 6: TB and Leprosy

Round 7: Panchayat and Health

2006 to 2009

Round 8: Food Security, addressing social exclusion

Round 9: Herbal remedies

Round 10: Neonatal Survival – Counselling, Screening, Referral

Round 11: Village Health Sanitation Committees and Village Health Planning

Round 12: Infant and Young Child Feeding – Counselling

Ongoing Training:

Round 13: BCC Kit

Planned for this Year (2011) :

Round 14: Malaria, Leprosy, TB, HIV-AIDS, Blindness Control, RSBY

Round 15: Neonatal care, screening and referral for neonatal Sepsis

Skill building and the 10th round of Mitanin training:

4.52 Across all cadres and in a majority of Mitanins we found great enthusiasm for the 10th round of training which was one of the first times the Mitanins gets to learn skills. It was for her, and for many others the first time that she was 'doing something'. The performative of the skill, has instilled her with pride, more curiosity, and a different social standing at the level of the community and also her family. We also got a strong impression from our interaction with the Mitanins that in this skill based training, they are also able to learn from each other and work together through its difficult aspects. The other critical discussion we have was regarding the attitude of some Mitanins who wanted to learn more skills, such as giving injections. They saw the only difference between themselves and the ANM/doctor as the ability to give an injection. They also explained practical reasons for the desire for this skill, where they have had to travel long distances with their patients just to get a single shot. Eventually they also mentioned that though they were able to handle most cases at the village level, through their drug kits and local remedies, it was only one in a ten case scenario that their patient had to be given injections. The focus on skill based training may have been the cause for such articulations. It is highly recommended to the SHRC to look into re-orienting Mitanins on the issues of curative care and preventive promotive care.

4.52 DRPS from Khadgaon explained that they found the training of the 10th round most interesting and also the most difficult to undertake. They also learnt and re-learnt as they taught the MTs. The training was repeated many times across cadres to reinstate the key messages and skills and this also helped the process of learning for both DRPs and MTs.

4.53 We were also explained that the MTs and DRPs meet on every 7th and 14th day of the month and share their workplans with the DRPs. These work plans could include a range of things, such as organising VHSC meetings, para baithaks, cluster meetings, or home visits, new born visits, or repetition of training on specific issues.

4.54 A curious fact was explained to us regarding the MTs, by a BMO in Koriya district. Many people approach the MTs at the time of delivery as they are located at a better social class than the Mitanins, and also because they are more likely to have mobile phones, if an ambulance needs to called in case of emergency etc. The MT- Mitanin tension could also be seen in issues of Mitanin selection for ANM schools, and MTs continue to remain MTs. These will be issues of concern in the future of the programme.

Building Capacity of New Mitanins:

4.55 There is attrition of the Mitanins for various reasons and this is expected too. However, the process of building capacity of the Mitanin who have joined midstream is a challenge, One of the process of building capacity for the new Mitanin is through discussions in the cluster meetings and by the home visits that the MTs undertake along with the Mitanins. But this does not appear to be done effectively. There is no special focus given on building capacity on knowledge and skills for the new Mitanins. In the FGD with the Mitanin undertaken in Gugra village, except one, all had recently joined. Almost all of them were unable to answer questions like what does the term Mitanin mean, what is her role and what are the issues that they are discuss with the community. This aspect of building capacity for the new Mitanins who join midstream has to be strengthened.

4.56 While most Mitanins do articulate the knowledge on many issues such as neonatal care or in teaching mothers how to breast feed, how they transmit these skills in the field appears to be rarely assessed. While the MTs do undertake cluster visits, the visits appear to be more preoccupied with planning and reporting rather than on assessing and strengthening the capacity and skills.

Role of Mitanins

4.57 The role of the Mitanin was at core conceptualized as village based preventive promotive worker, who 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. The emphasis on the health rights approach was also critically built into her role. The early years of the Mitanin programme saw this strongly reflected in the field. Since the Mitanin Programme preceded the ASHA programme, it would be critical to note the changes it has gone through in the NRHM years.

4.58 The Director Health services explained that he has closely watched the Mitanin programme since he was Collector in Dantewada. He feels that the Mitanin programme has been able to fulfil the role of the health worker as a empowerment agent and also as a people representative to raise health issues, and this is clearly reflected in the selection of

Mitanins in Pachanyats and also as panchs, This awareness and notion of her role as someone who is proactive in peoples health rights has been sufficiently met and was continuously articulated by all levels of government functionaries. In our interviews with the MD NRHM, the programme coordinator (SHRC) and also at the district levels with CMOs and DPMs, this we got the continuous sense of satisfaction that she has been able to effectively become a people's representative.

4.59 In understanding what the key roles of the Mitanin were, the roles envisaged in the early documents and also by those we interviewed ranged from the following list or inclusive of all the following:

- She is a representative of the community on health rights and issues to the public health system
- She will work on maternal and child health issues, which would include, counselling mothers through their pregnancy, ensuring child immunization , ensuring timely ANC< PNC and delivery care for the mother
- She will work on issues of malnutrition amongst children in her village, liaison wit the AWW
- She will be a link between the ANM and the community
- She will work for health and hygiene issues and notify in case of epidemics

4.60 The role of the Mitanin, as originally envisaged is comprehensive. She is responsible for 5 objectives and 6 tasks.

4.61 On commenting on her role, Mr. Samir Garg explained that the Mitanin programme has also looked at in a few blocks for a much more comprehensive role for the Mitanin. Here she is able to monitor different government programmes such as PDS, NREGA, MDMS, ICDS and issues of forest and sanitation departments. She has also been special training on food and nutritional counselling, on conducting social audits for NREGA and also to undertake negotiations with the Sarpanch on antodaya scheme etc. Her usage of drug kit and something as basic as ORS has proved very useful, and he can clearly say that maternal mortality of tribal districts has reduced. Though on the other hand, there are issues on reportage of malaria deaths, though diagnosis of malaria cases has gone up, official data claims to show hardly any malaria deaths. The recent Lancet article shows otherwise. The Mitanin has emerged as a care giver in the cases of malaria also. All Mitanins have been trained in IMNCI programme and have also received training on neonatal care based on the Gadchiroili model. Mitanins are also demanding trainings on delivery care and giving of injections as their experience with systemic functionaries had not been very good, or timely in these cases.

4.62 The Baikunthpur CMO informed us that one of the key roles the Mitanin has played is creating awareness amongst the communities and also informing the department at the time of epidemics. He feels that the Mitanin has now been empowered enough to call directly to

the District hospital or inform the BMO in case of an epidemic in her village. He felt that though the SHRC has done a thorough job in continuous and ongoing trainings for the Mitanins, these could also be distracting and burdening on her daily life. He also felt that too much knowledge can be damaging and the amount of information given to Mitanins needs to contained. It would be better to repeat the 13 rounds of training rather than introduce new ones. He also explained that maybe its better for them to get a fixed salary , as then they will be in the control of the department and more accountable to their work.

4.63 The Manendargarh BMO on the other hand explained that though the Mitanins are doing some great work, they have not been helping too much in mobilising for Family Planning operations. The number of deliveries though at his PHC have substantially gone up due to JSY and Mitanin referrals. He also felt they have a critical role in epidemic control, but also feels some Mitanins, have started 'doctary', but she should be aware, they can never run out the doctor. Even for malaria, he feels she should refer, rather than treat, as medicines are not her domain.

Changes in the role of Mitanin Post NRHM

4.64 The Mitanin programme underwent many changes especially with aspect to her role after the coming of the NRHM. This also affected certain monitoring structures and also financing structures and schemes for remuneration.

4.65 Her roles expanded to provided sure shot referral services for pregnant women at time of the delivery and also came to include more specific targets for family planning and other national health programmes, which she then got incentivised for. Her structure of incentives can be seen as the most contentious and most talked about aspect in our current evaluation visit. As she was envisaged as volunteer, and the reasons for that were related to the ; fair selection' the earlier experiences of the AWW which came to be seen as government job and also the notion that the Mitanin would be the community and villages representative and hence drawing a salary could shift this focus to being the lowest level functionary of the government system. The original selection process and conceptualization as a volunteer aimed to guard against such influences in her selection and her work overall. The volunteer idea was also pushed to not create too many bureaucratic hurdles in the taking off the Mitanin programme and but was aimed to encourage a voluntary spirit. Alternate forms of incentives like public recognition etc were also encouraged. With the coming of the JSY scheme and other national programmes that incentives, the situation on the ground has drastically changed.

4.66 The public health functionaries we met, a majority maintained that the voluntary or the incentive based format of payment should be continued and more innovative ways of encouraging Mitanins should be employed. Because the Mitanin programme has already gone though many years of its operationalistion on the ground, it has seen many phases of the volunteer based worker and also under the incentive based format. One can see that due to a proactive and stance to have Mitanins selected as panchayat members or even panchs , selection of Mitanins for ANM training the incentives and enthusiasm have varied.

4.67 Through our field evaluation we heard mixed responses on the Mitanins voluntary nature, the coming of incentives through the NRHM and also a high demand for making the Mitanin a salaried worker. We also understood form senior persons at the state level of the different types of unionization that has taken place a the level of the MTs and DRPs who are not permanent staff and how they have also pushed this idea onto Mitanins , so as to include them in their protests. But their has also been other spontaneous unionization on the same issue amongst Mitanins.

4.68 Overall at the field level, though we did see high levels of enthusiasm for their work, we also came across a strong articulation and demand amongst the Mitanins for getting a fixed payment or higher incentives. Because the early notion of a voluntary worker served the purpose of the selection of Mitanins, we would recommend that the state reviews this policy in the context of the NRHM and also the number of years these Mitanins have worked and aim to reprioritize focus on their recognition, with or without financial incentives. The state also needs to be guarded on ensuring that the Mitanins do not become cynical towards their work due to the issue of incentives and are motivated enough and protected from corruption in receiving their fixed incentives. The fact that many Mitanins have stuck out in the programme, from its initiation also needs to considered when looking at reviewing benefits, incentive structures and career ladder options.

Capacity of the Mitanins

4.69 Almost all vouch for the capacity of the majority of the Mitanins in the state. Most Mitanins are capable of identifying risk cases, support in pregnancy related issues and have become reasonably well versed. The ability of the Mitanins is evident from the reduction in maternal and infant deaths and in the sharp increase in the feeding practices- an aspect mentioned under the impact of the Mitanin program.

4.70 However, there is also a view that about 15 to 20 percent of the Mitanins are not capable and do not do any significant work. This appears to be a nearly universal view amongst most officials.[16]

4.71 It is also held that there is diversity in the performance of the Mitanins across the districts. In some districts, the Mitanins are good in enabling referral and in some blocks they take on more activist role.[17]

Support structures

4.72 Continuous support structures are provided to the Mitanin in the form of the Master trainers, who provide hand holding and on the field training to the Mitanins. Besides training issues, the Mitanins also seek them at times of crises, or in issues where the system has

[16] The nodal officer for the Mitanin however is of the view that nearly 40 percent of the Mitanins do not work, Interview, Dr Sonvani, Deputy Director, NRHM, Interview November 8, 2010.
[17] Interview Samir Garg, November 9, 2010.

been unresponsive. The MTs, hold cluster level meetings to understand the existing issues and also act as links between Mitanins, the system and the SHRC. Mitanin Help Desks have been set up and are manned by MTs and DRPs. This too provides support to the Mitanin, as she is able to see a familiar face when visiting the Hospital and able to seek help in case required.

Community processes, social mobilisation and addressing social exclusion

4.73 The SHRC has been key in the community mobilisation processes for the Mitanins programme. Early phase of the programme had longer and stronger community processes, especially at time of the selection of the Mitanin. Kala Jathas, were sent out to the blocks and villages where selection of the Mitanins was to take place, the need for a community representative, health rights issues etc were explained through the process of these street plays. The SHRC did continue some amount for social mobilisation activities over the years, though now the activities seem to have reduced.

4.74 Social exclusion was addressed critically at time of selection of the Mitanins, where Preraks, or facilitators, ensured the participation and also selection of Mitanins from socially excluded groups to be represented in the selection processes. Mitanins are continuously trained on issues of social exclusion. The preparation of food together by Mitanins also acted as way of combating social exclusion. Hamlet based workers also works as one strategy to reach socially excluded and marginalised groups.

Accountability, Budgetary provisions, remuneration issues

Accountability of the Mitanins

4.75 To whom the Mitanin is accountable, is still evolving. While there is one section which is of the strong view that the Mitanin is of the community and is accountable to them, there is also a view that since the funds of the Health Department have been spent on building their capacity, they are also accountable to the Health Department. This is also the view that was articulated by the current head of the SHRC. One view is that if any honorarium / incentive is paid, then the Mitanin ought to be accountable to the Health Department. If she does it voluntarily then, she can be accountable to the community.

4.76 Since the Mitanins only receive incentives under the NRHM and since the incentives are considered very meagre for the Mitanins, the district health administration does mention that they do not force responsibilities on them. Many officials said that since the Mitanins are volunteers they do not give any targets for them. However, since the administration does impose responsibilities on the resource persons and the MT, they in turn, tend to ask the Mitanins to deliver.

4.77 Mr. Samir Garg explained that the earlier fund flow of the programme was through the EU-SIP programme, which gave money to the central government, which forwarded it to the state government , which then gave it to the SHRC which forwarded the money to the District Health Society. This would then forward the money to the BMO or the NGO involved at the block level. Now the fund flow is through NRHM and also the state has the Mitanin programme as a budget head in the state budget. The Directorate Health services explained that the Mitanin needs to continue in the volunteer mode and also be paid for specific tasks.

4.78 At the field level the responses have been mixed, where a large number of Mitanins did feel they should receive a fixed honorarium for their work. Unionisation issues of the MTs and DRPs have also mixed agendas with those of the Mitanins understanding of their work and demands. Issues on ANMs stealing Mitanin FP cases, JSY delays have only added to their distress. Though we also heard from some Mitanins how the programme had given them a sense of freedom , which was both in their fears of travelling out of the house alone and also fears of authority like doctors etc. They have found a new voice and articulation to be able to speak fearlessly in front of those, they used to be scared of.

4.79 JSY payments though fixed to Rs. 350 in Chhattisgarh, for the Mitanin, fluctuates vis a vis the component of the transport payment. In the PHC visited at Koriya, Rs. 50 had also been set aside for referral during delivery for the Dai, this was a directive by the District Collector.

Drug kits

4.80 Most Mitanins mentioned that they had received training on the drug kits. Newer Mitanins though did not seem to know this well, though they are specifically trained for it by the MTs.

4.81 Drug kit filling was an issue and some Mitanins mentioned intermittent supplies. This becomes especially problematic during the monsoons, where demand is higher and supply issues persist.

4.82 They also mentioned that mostly people come to them for fevers, cold coughs. According to the Study conducted to Assess the Mitanin Referral System in Chhattisgarh (Nandi, Mishra and Nundy, 2009), the most common conditions for which people seek their help are fever (34%), Cough/TB (23%), Cold (20%), Diarrhea (14%), Pregnancy (5%) and others like skin problem, headache and pains.

Future role of the Mitanins

Community representatives Vs Bureaucratization

4.83 The Mitanins emerged from the premise that there is a need to have more community participation in health to enable a greater involvement of the people in health

issues, to ensure an accountable and efficient public health system. The Mitanins are the link to enable this process. This approach to communitization is reflected significantly in the NRHM. However, the reviewers found that there is the jostling occurring between the need to ensure the community focus of the Mitanins versus the attempt to bureaucratize the entire process. The Director of SHRC is of the view that from an administrative perspective there is a need to list the Mitanins and ensure that they are accountable to the health administration.

4.84 The attempt to freeze the list of Mitanins, issue them identity numbers to track their performance and ensure their accountability to results and the gradual shift to an output focused reports rather than a process focused reporting in the various reporting formats, appear to indicate the process of bureaucratization. In our view, the attempt to freeze the list of the Mitanins would limit the ability of community to determine who they want as Mitanins. It would also limit the ability of a Mitanin to opt out in case she is not interested or unable to undertake the tasks for various reasons. Samir Garg explained that he feels the push from the government side to freeze the number of Mitanins/ ASHAs can be damaging to the programme. The push to create data bases and to governmentalise the programme will take away from the community aspects of the programme, as they reduce the possibility of actually asking the community if they are satisfied with the work of their health worker, if she has been working at all , or if a change is required at all. Another aspect to think of on this issue, was the situation created by Salwa Judum camps in southern districts of Chhattisgarh, where many Mitanins had been placed in the camps and hence were not available to their villages during a cholera outbreak. They might have proved useful within the camps, but their absence from the villages, would necessitate the selection of new Mitanins for future purposes.

4.85 The process of bureaucratization is also gaining strength owing to the need to adhere to the national guidelines on the ASHA program. The provision of incentives and the need to ensure that number of Mitanins adhere to the national norms are also issues that appear to be strengthening the process of bureaucratization. There was a range of emotions on the NRHM , from contempt to many of its rules to a strict need for adherence to its rules was seen across different levels. At the SHRC level, and the Directorate level, their was great comfort towards a home grown, state developed community health worker programmes, while from the Mission and from government functionaries at the district levels we got a sense that they would have preferred an adherence to national ASHA guidelines, as it reduces the number of Mitanins and hence the workload of the Department.

ASHA or Comprehensive Community based health worker

4.86 Again we heard a range of issues regarding here future role and involvement in health issues of Chhattisgarh. Most of the government staff though appreciative towards here role of a preventive promotive worker, also laid emphasis for her to work on the targets of National programmes such as FP, Cataract surgeries etc. Immunisation was also the key

space they felt her involvement would be necessary in community mobilisation. The Mission Director was extremely dismissive of her working on any issues besides health and was keen that she focused only on programmes of the health department.

4.87 The Mitanin plus initiative was launched in 2005 to develop capacity of Mitanins across 23 blocks on issues relating to the PDS, ICDS, MDM scheme and also NREGA. This project initiated a new cadre of trainers, who focused on teaching mitanins detailed nutrition counseling, undertaking an analysis of food practices and depravations in their village households and also linking strongly and mobilizing people to demand proper functioning of the government schemes mentioned above. The programme is now in the process of being scaled across 60 blocks. Though an interesting and difficult initiative to operationalise, we got the impression that this has been run directly by the SHRC , with less or minimal knowledge of it to the health department. Infact one of the reasons the current MD NRHM wanted more monitoring of the SHRC was to ensure that it does not run programmes such as these. The government wants to identify the programme as a health department programme only and sees no value addition and infact dilution of the Mitanins work in this case. On the field though, the Nutrition security initiative has mixed responses, we were informed by the field coordinator and some Mitanins that it was extremely useful for them to learn such detailed ways of nutritional counselling for both the mother and for her child and also have a keen awareness of their entitlements in the food schemes, NREGA. We did also though hear of the resentment in a few MTs vis, a vis this , as the trainer for nutrition security project got higher salaries than the regular MTs.

Public Health Vs Curative care

4.88 The programme seems to have shifted focus post the coming of the NRHM, as we did find a large number of Mitanins focusing on institutional delivery. It was interesting to note how, the Mitanins have suddenly taken onto the governments agenda of institutional delivery, the reasons for which they could not clearly explain. , The Mitanins though have been trained and provided the knowledge on many aspects of public health and community health, the focus of the programme could be set to be shifting towards national government programmes and targets. This may in itself not be a bad thing, but in the long run, it could seep away the essence of the Mitanin programme as it was originally conceptualized.

4.89 In Nara village in Kanker district, which the reviewers visited on November 13, 2010, there was an outbreak of diarrhea in August-September 2010. The Mitanins informed the ANMs who ensured that the health team reached the village. The Mitanins provided significant support to the Medical Team to contain the outbreak and to ensure that the deaths were minimal – only one old person died. However, when the Mitanins were asked about how they would ensure that this diarrhea does not recur again, almost all of the Mitanins in the group, were not clear about how to go about the process. They kept suggesting that they would meet the families and talk to them about it but the process of engaging the community and ensuring hygiene did not appear to be top of the mind responses of the group. The Mitanins seem more focused on individual level interactions,

and this is understandable, given the emphasis on maternal and child health that they pursue now. The reviewers are of the view that since there has been a significant impact on the maternal and child health, the process of Mitanins being involved in public health and in engaging the community to realize the larger public health objectives need to be prioritized.

Empowerment of Mitanins or Career Ladders

4.90 A proactive stance of ensuring that Mitanins were taken in to the process of being Panchayat members was initiated by the SHRC. Though some of it would also have more organically evolved, based on the knowledge of the Mitanins and the trust she would have gained from the community. Many of the Mitanins, have contested the elections and have become Panchayat representatives. The Chairperson of the Zilla Parishad in Nara village was a former Mitanin. Many others, have become Sarpanch and members of the Panchayat. This has been a significant empowering process.

4.91 Career Ladder: In addition, the Health Administration has opened the space for Mitanins to become ANMs. 457 Mitanins have been supported by the NRHM to join private nursing schools and ANM training institutions. This has opened a major career growth path for the Mitanins. Many are now keen to become Mitanins because they perceive this as a gateway to becoming an ANM/ nurse- an opportunity, which was not available to the rural poor educated women in the state. It is also held that the Mitanins perhaps would make a better ANM given that they have an understanding of the health system and the needs of the community[18]. We also spoke to many Mitanins who did not have the required educational background for even applying for this post. A response of cynicism and enthusiasm is what we could understand, as many Mitanins are also now part of study groups, trying to give their higher secondary exams and hence be able to eventually be eligible for such scheme. Besides this, many proactive Mitanins were also made or given the post of master trainers. One issue that did come up in our discussion with MTs was, regarding them not being able to apply for the ANM post. This will need to considered and given some thought in the future and could potentially also be valuable in creating a much larger ANM cadre, which has had a large amount of community based work.

Impact or Result of Mitanin Program

4.92 There is a significant impact that Mitanins have brought about in the status of maternal and child health in the state. Some of the key indicators of impact are:

- Colostrum feeding went from about 25 percent to about 80 percent in three years.
- There has been a significant reduction in IMR.
- Awareness of health rights

[18] Director Health Services, Interview on November 8, 2010, Chattisgarh.

- Awareness and access and improvement in quality of food at the ICDS and mid day meal scheme
- Higher institutional deliveries

Overall Suggestions/ Recommendations

- The SHRC needs to re- strengthen its relationship with its field staff and also be able to spend time on their problems in dealing with the system
- The balance between skill based and knowledge based training needs to be critically maintained.
- Future career ladders and remuneration issues need to be critically addressed and a strategy made on the same, else there will be deep cynicism on the field and repercussions for the programme.
- Build stronger links with the mission on different aspects of the Mitanins work and also rebuild the relationships and similar ideological ground with District level government functionaries. In a sense, reduce the communication gap and undertake workshops with district level functionaries on issues of the Mitanin programme etc.

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Chapter 5 - Findings from the Quantitative Evaluation

The Sample

5.1 As mentioned, the quantitative evaluation was carried out in 32 blocks in 8 of the 16 districts. Table -4 provides the list of sample districts and blocks.

Table 4: List of sample districts and blocks

Division	Sample district	Sample blocks
Raipur	Dhamtari	Dhamtari, Kurud, Nagloi, Magarlod
	Rajnandgaon	Dongargarh, Chauki, Mohla, Rajnandgaon
Surguja	Koriya	Baikunthpur, Sonhat, Khadgawan, Bharatpur
	Surguja	Surajpur, Shankargarh, Udaypur, Balrampur
Bilaspur	Bilaspur	Marwahi, Kota, Gaurela, Mungeli
	Raigarh	Gharghoda, Baramkela, Sarangarh, Lailoonga
Bastar	Kanker	Kanker, Narharpur, Bhanupratappur, Durgkondal
	Bastar	Bakavand, Nangoor, Kondagaon, Makdi

5.2 A total of 640 sample villages were selected for the survey. After the drawal of the sample, it was realized that the many small and very small villages may have only one Mitanin, particularly if they were single hamlet village. The survey teams were instructed, therefore, to include the nearest hamlet in such cases. As such, the number of sample villages actually covered in the survey was 659.

5.3 As will be observed from Table-5 below, more than half of the sample villages are small or very small and are more remote from civic facilities than others. It may be relevant to mention that lower population density and remoteness were some of the specific reasons underlying the design of the Mitanin programme. As such, conclusions drawn from a sample allowing higher representation to small and very small villages will be more reflective of the reach and effect of the programme.

Table 5: Sample villages and their average distance from civic facilities

Population Category	No. of Sample Villages	Average distance (in Km) from				
		Bus stop	Metalled road	SHC	PHC	CHC
Less than or equal to 500	364	3.37	3.12	4.86	9.21	18.04
501-1000	260	2.47	2.37	3.62	7.43	14.86
1001-1500	25	1.72	0.60	3.04	6.44	11.72
More than 1500	10	1.67	1.50	4.00	7.17	13.50
Total	**659**	**2.92**	**2.70**	**4.29**	**8.37**	**16.47**

5.4 The actual number of beneficiaries and other stakeholders interviewed under the survey also varies from the numbers anticipated by the sampling design. Mainly, this happened due to higher proportion of representation for small and very small villages. The actual and anticipated number of interviews are given in Table-6 below.

Table 6: Sample size for the quantitative evaluation

Form / Schedule No.	Used for	Planned sample size	Actual sample size
1	Selection of Mitanins and listing of beneficiaries	640	659
2	Interview of currently pregnant woman	2560	2037
3	Interview of women with a child under 6 months of age	2560	2228
4	Interview of women with a child aged more than 6 months but less than 2 years	5120	4610
5	Interview of Mitanins	1280	1230
6	Interview of ANMs	640 (maximum)	329
7	Interview of AWW	640	654
8	Interview of PRI members	640	625

Socio-economic characteristics of the beneficiaries and the Mitanins serving them

5.5 One of the key constructs of the Mitanin programme was representation at the hamlet level which would ensure that the Mitanins and beneficiaries would share similar socio-economic characteristics. The data presented below bears out the true representativeness of the Mitanins vis-à-vis the community they serve.

Table 7: Socio-economic characteristics of Mitanins and families served (by them)

	Pregnant women	Women with a child under 6 months of age	Women with a child aged 6-24 months	Mitanins
	Families of the %age of respondents belonging to the category			
Agriculture as the main source of income	60	62	61	66
Daily wage workers	32	30	32	23

	Pregnant women	Women with a child under 6 months of age	Women with a child aged 6-24 months	Mitanins
Income less than Rs 1000 per month	21	22	22	21
Income Rs 1000-3000 per month	65	63	64	59
Holding BPL card	56	54	54	60

Access to and utilization of services : feedback from the Pregnant Women

5.6 A total of 2037 pregnant women were interviewed to obtain information about the advice and services they received from (their) Mitanin and their views about the impact of the Mitanin programme. Close to 90% of the respondents were below the age of 30 years with a significant proportion being less than 20 years of age (Table-8).

Table 8: Age distribution of pregnant women surveyed

Age group	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
<20 years	7%	2%	8%	3%	6%	7%	7%	9%	11%
20 - 25	52%	48%	59%	52%	45%	55%	54%	57%	44%
25 - 30	29%	39%	24%	32%	28%	27%	25%	24%	33%
30 - 35	8%	8%	5%	8%	9%	7%	12%	6%	8%
35 - 40	2%	1%	1%	2%	2%	2%	1%	3%	3%
>40 years	0%	0%	0%	0%	0%	1%	0%	0%	0%
No Response	3%	1%	3%	2%	11%	1%	1%	1%	2%
Total Respon-dents	**2037**	**220**	**266**	**248**	**222**	**281**	**256**	**281**	**263**

5.7 The data revealed that majority of the respondents had relied on the Mitanin as their main source for confirming their pregnancy, other main sources being a doctor (not necessarily government doctor), the ANM or the Anganwadi Worker (AWW)c. Table-9 provides and district wise percentages for the main sources accessed for confirming the pregnancy.

Table 9: Sources accessed by respondents for confirming pregnancy

	State	Kanker	Dhamtari	Rajnandgaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
AWW	11%	11%	14%	4%	11%	15%	18%	10%	7%
ANM	10%	13%	15%	10%	15%	3%	6%	7%	14%
Doctor	11%	9%	15%	14%	12%	8%	5%	13%	14%
Mitanin	**57%**	**63%**	**49%**	**65%**	**41%**	**59%**	**60%**	**62%**	**54%**
Nurse	2%	2%	5%	3%	1%	0%	0%	2%	1%
Others	9%	3%	3%	4%	20%	14%	12%	6%	10%
Total Respondents dents	2037	220	266	248	222	281	256	281	263

5.8 The Mitanin is also the main source of advice during pregnancy. Overall, 85% of the respondents received at least one advice from the Mitanin during pregnancy; most frequent advice related to regular consumption of IFA (77%), weight and blood pressure measurement and advice for TT injection (62%) and advice for institutional delivery. Table-10 provides district level values which indicate significant variation across the districts.

Table 10: Pregnancy related advice by Mitanin (% of respondents)

District	Weight and blood pressure measurement and advice for TT injection	Advice on regular consumption of IFA tablets	Advice for institutional delivery	Information about JSY	Information about 5-cleans for home delivery	Advice on early breast feeding	Advice on diet and nutrition	At least one advice
KANKER	49%	80%	71%	42%	9%	38%	56%	89%
DHAMTARI	71%	78%	65%	51%	20%	46%	44%	85%
RAJNANDGOAN	67%	82%	61%	53%	25%	42%	52%	92%
KORIA	48%	68%	62%	45%	17%	29%	43%	80%
SURGUJA	73%	82%	63%	48%	32%	43%	49%	85%
BILASPUR	62%	74%	58%	45%	15%	36%	36%	78%
RAIGARH	76%	80%	71%	57%	31%	50%	51%	84%
BASTAR	48%	77%	70%	44%	10%	34%	41%	87%
State	**63%**	**78%**	**65%**	**48%**	**20%**	**40%**	**46%**	**85%**

5.9 The advice by the Mitanin is generally converted into action as 77% of the respondents reported having received TT injection, 76% received IFA tablets and 67% were monitored for weight gain (Table-11). However, the coverage for the services which involve visit to / by health workers (e.g. blood pressure measurement) are significantly lower.

Table 11: ANC services received by the pregnant women

	Weight measurement	Blood pressure	Urine testing	Blood testing	Lower abdomen examination	IFA tablets	TT injection	ANC card and registration
KANKER	86%	41%	70%	61%	50%	85%	84%	61%
DHAMTARI	82%	50%	70%	70%	58%	90%	91%	77%
RAJNANDGOAN	79%	42%	61%	64%	46%	82%	80%	54%
KORIA	34%	16%	27%	26%	18%	56%	55%	36%
SURGUJA	49%	23%	31%	31%	25%	71%	73%	41%
BILASPUR	63%	27%	47%	41%	37%	71%	79%	55%
RAIGARH	68%	32%	60%	53%	40%	75%	83%	69%
BASTAR	71%	31%	51%	43%	38%	74%	72%	49%
State	**67%**	**33%**	**52%**	**49%**	**39%**	**76%**	**77%**	**56%**

5.10 Registration of pregnant women with the AWCs is 94% on overall basis with the district level coverage being 90-96% in the districts. Of those registered, more than 90% have reported receiving supplementary nutrition on a regular basis. This implies 86-94% effective coverage (i.e. all respondents). The district wise details are given in Table-12 below.

Table 12: Access to supplementary nutrition for pregnant women

	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
%age respondents registered with AWC	94	96	96	92	96	93	94	90	94
%age respondents (of those registered) receiving supplementary nutrition	96	94	98	94	97	98	95	97	94
%age respondents registered AND receiving supplementary nutrition	90	90	94	86	93	91	89	87	88

5.11 Although only 65% of respondents were advised for institutional Almost 80% respondents were planning to go for institutional delivery. However, however only 28% (of those who were planning to go for institutional delivery) were actually registered with the ANM for JSY. This appears to be due to supply side weaknesses as the registration levels vary significantly across the sample districts (Table -13).

Table 13: ANC / JSY registration of pregnant women

	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
%age respondents planning for institutional delivery	80	87	86	80	75	77	72	80	81
%age respondents (of those planning for institutional delivery) who were actually registered by the ANM for JSY	28	14	49	30	17	20	40	35	14
Effective rate of registration for ANC / JSY	22	12	42	24	13	15	29	28	11

Access to and utilization of services : feedback from the women with a child aged less than 6 months

5.12 A total of 2228 women with a child aged less than 6 months were interviewed to obtain information about the advice and services they received from (their) Mitanin and their views about the impact of the Mitanin programme. Close to 90% of the respondents were below the age of 30 years with nearly half of them in the age group 20-25 years (Table-14).

Table 14: Age distribution of women with young infants surveyed

	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Less than 20 years	4%	4%	7%	2%	4%	3%	2%	1%	4%
20 - 25	50%	43%	57%	47%	49%	56%	50%	56%	40%
25 - 30	31%	38%	24%	30%	26%	27%	32%	30%	39%
30 - 35	9%	11%	5%	5%	8%	10%	11%	7%	12%
35 - 40	2%	3%	2%	3%	1%	2%	2%	4%	1%
>40 years	1%	0%	0%	0%	1%	1%	1%	1%	1%
No Response cases	4%	0%	5%	12%	11%	2%	2%	1%	2%
Total Respon-dents	**2228**	**256**	**285**	**276**	**272**	**298**	**289**	**272**	**280**

5.13 Proportion of respondents who reported having received various antenatal services has ranged from 40% (blood pressure measurement) to a high of more than 86% for TT injection. Weight measurement (73%) and pregnancy testing (72%) rates are also found to be high for this group of respondents (Table 15).

Table 15: ANC services accessed by women with young infants

	Pregnancy testing	Weight measure-ment	Blood pressure	Urine testing	Blood testing	Lower abdomen examination	IFA tablets	TT injection	ANC card and regis-tration
KANKER	80%	93%	53%	79%	75%	63%	94%	92%	77%
DHAMTARI	86%	88%	53%	78%	82%	73%	95%	96%	88%
R'GOAN	67%	71%	49%	59%	63%	46%	73%	71%	52%
KORIA	35%	40%	22%	31%	33%	27%	62%	62%	45%
SURGUJA	65%	57%	24%	34%	40%	32%	86%	91%	54%
BILASPUR	79%	73%	36%	62%	51%	50%	83%	90%	73%
RAIGARH	89%	78%	42%	66%	62%	50%	86%	94%	86%
BASTAR	78%	83%	41%	69%	61%	54%	90%	90%	63%
State	**72%**	**73%**	**40%**	**59%**	**58%**	**49%**	**84%**	**86%**	**67%**

5.14 The Mitanin was reported to be the main source of advice and/or service for the respondents, particularly for IFA tablets (77%), institutional delivery (65%) and weight and blood pressure measurement and TT injection (57%). About 70% respondents reported having receive advise / services on at least 3 aspects of pregnancy /ANC. However, only 38% reported having received advice / service on all aspects of pregnancy / ANC. Significant variations across the districts are also observed (Table-16).

Table 16: Mitanin as the source of various ANC services to women with young infants

	Weight and blood pressure measure-ment and advice for TT injection	Advice on regular consumption of IFA tablets	Advice for institutional delivery	Information about JSY	Information about 5-cleans for home delivery	Advice on early breast feeding	Advice on diet and nutrition	Advice on 3 or more aspects	Advice on 5 or more aspects
KANKER	48%	90%	80%	54%	19%	46%	62%	81%	39%
DHAMTARI	68%	80%	66%	52%	21%	49%	50%	75%	42%
R'GOAN	50%	70%	55%	45%	30%	44%	48%	63%	39%
KORIA	36%	55%	49%	34%	15%	29%	37%	48%	25%
SURGUJA	71%	83%	64%	47%	31%	43%	46%	71%	41%
BILASPUR	59%	72%	58%	46%	25%	43%	33%	65%	39%
RAIGARH	75%	83%	67%	50%	32%	53%	44%	77%	46%
BASTAR	49%	87%	80%	46%	11%	39%	47%	79%	28%
State	**57%**	**77%**	**65%**	**47%**	**23%**	**43%**	**46%**	**70%**	**38%**

5.15 About 42% of the respondents [942 out of 2228] have reported that they had one or more symptoms their pregnancy where they sought help. The Mitanin was the main source for seeking help for more than 42% of the respondents; the ANM and AWW being other sources for help. A wide variation across the districts is also observed (Table-17).

Table 17: Source of advice / help for complications during pregnancy

	No. of respondents who had one or more symptoms during pregnancy	Source of advice / help						
		Mitanin	ANM	Dai	AWW	Local doctor / healer	None	Others
KANKER	128	70%	49%	5%	20%	2%	6%	7%
DHAMTARI	154	50%	40%	5%	17%	3%	10%	11%
R' GOAN	153	44%	18%	7%	17%	1%	3%	8%
KORIA	145	17%	8%	1%	4%	3%	8%	13%
SURGUJA	60	10%	12%	5%	2%	30%	7%	28%
BILASPUR	116	40%	17%	8%	10%	15%	9%	12%
RAIGARH	64	34%	9%	14%	5%	31%	5%	25%
BASTAR	122	55%	48%	1%	13%	7%	7%	15%
State	**942**	**42%**	**27%**	**5%**	**12%**	**8%**	**7%**	**13%**

5.16 More than 80%respondents were advised / encouraged for institutional delivery, the PHC or CHC being the most frequently recommended place (Table-18). However, 50% deliveries actually took place at home (Table-19). The main reported reasons for opting for not going for institutional delivery were time (night) of delivery and /or unavailability of transport and distance of facility or both (Table-20). It may be noted that lack of faith in the nurse (of the government facility) or the facility is not the issue.

Table 18: Place recommended by the Mitanin for the delivery

Place recommended by Mitanin for delivery	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Sub Health Centre	31	31	42	36	20	17	27	34	36
PHC/CHC	47	52	29	44	41	65	50	50	41
District hospital	8	10	12	9	18	7	0	1	10
Other / no suggestion	14	7	17	11	21	11	23	15	13

Table 19: Actual place of delivery for the children aged 0-6 months

	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Home	50	33	36	42	59	61	62	58	50
Sub-centre	14	17	23	17	10	7	12	7	17
PHC/CHC	25	33	23	31	15	24	24	23	25
District hospital	7	11	9	7	15	5	2	3	7

Table 20: Leading reasons for opting home delivery

	Birth happened at night	Lack of transport facility	Family tradition/ pressure	No escort	Do not trust nurse or facility	Faith in local dai and family members
KANKER	49%	49%	9%	7%	0%	21%
DHAMTARI	48%	29%	8%	5%	0%	32%
RAJNANDGOAN	55%	31%	3%	15%	2%	19%
KORIA	43%	59%	18%	22%	3%	7%
SURGUJA	60%	45%	11%	26%	2%	30%
BILASPUR	64%	43%	18%	9%	2%	31%
RAIGARH	58%	39%	11%	20%	1%	30%
BASTAR	57%	61%	15%	7%	1%	13%
State	**56%**	**45%**	**12%**	**15%**	**1%**	**24%**

5.17 In cases where the respondents did go for institutional delivery, most did so because of the Mitanin advice (Table 21). The JSY incentive money was relatively less important perhaps because institutional delivery entails out of pocket expenses; the data indicates that 56% of the respondents (who did go for institutional delivery) incurred out of pocket expenditure (Table-22).

Table 21: Leading reasons for opting institutional delivery

	Referral by Mitanin	Money available from JSY scheme	Good Doctor / Nurse	Good facility	Timely transport available	Self motivated	Family pressure	Due to complications during pregnancy
KANKER	82%	21%	38%	56%	13%	27%	1%	14%
DHAMTARI	69%	29%	43%	50%	13%	34%	3%	41%
RAJNANDGOAN	84%	41%	35%	59%	27%	18%	0%	15%
KORIA	80%	23%	43%	64%	4%	36%	3%	23%
SURGUJA	79%	30%	55%	61%	27%	38%	1%	40%
BILASPUR	75%	29%	56%	46%	18%	37%	2%	44%
RAIGARH	80%	36%	48%	56%	34%	35%	2%	39%
BASTAR	86%	31%	24%	56%	9%	27%	0%	11%
State	**79%**	**30%**	**42%**	**55%**	**18%**	**31%**	**1%**	**28%**

Table 22: Out of pocket expenditure related to institutional delivery

	State	Kanker	Dhamtari	Rajnand gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
%age of respondents who actually went for institutional delivery	49	67	64	58	41	38	38	39	50
%age respondents (of those who went for institutional delivery) who reported out of pocket expense	60	59	66	61	74	58	50	55	55
Average out of pocket expenditure per case (Rupees)	1271	717	2320	1125	1055	1485	1400	1150	634

5.18 In more than 80% cases of institutional deliveries, the Mitanin accompanied the woman for institutional delivery, which was mostly in addition to the husband and/or mother /mother-in-law (Table 23). The majority of respondents reported that the Mitanin helped them in various ways particularly in dealing with health workers / staff and in getting the JSY benefits (Table 24).

Table 23: Persons who accompanied the respondents for institutional delivery

	Mitanin	ANM	Husband	Mother / mother-in-law	(other) Relatives	Others	None
KANKER	89%	13%	83%	88%	45%	11%	1%
DHAMTARI	72%	10%	85%	82%	29%	9%	1%
RAJNANDGOAN	83%	28%	88%	89%	36%	10%	1%
KORIA	86%	14%	79%	88%	59%	0%	0%
SURGUJA	82%	13%	89%	81%	30%	13%	0%
BILASPUR	82%	0%	84%	81%	23%	3%	0%
RAIGARH	74%	14%	110%	97%	28%	3%	0%
BASTAR	88%	23%	92%	84%	47%	3%	1%
State	**82%**	**14%**	**88%**	**86%**	**37%**	**7%**	**1%**

Table 24: Mitanin role in institutional delivery

	Spoke to the medical personnel	Helped in expediting registration and other administrative activities	Helped in getting the JSY cash incentive	Provided psychological and moral support	Arranged for the medicines required
KANKER	50%	26%	52%	75%	22%
DHAMTARI	65%	68%	69%	55%	29%
RAJNANDGOAN	70%	53%	87%	61%	45%
KORIA	55%	36%	55%	80%	4%
SURGUJA	64%	65%	59%	64%	22%
BILASPUR	58%	65%	71%	49%	19%
RAIGARH	47%	72%	61%	59%	22%
BASTAR	41%	42%	63%	79%	10%
State	**56%**	**52%**	**65%**	**66%**	**22%**

5.19 In 70% cases the post partum visit was reported to have taken place within 12 hours of birth (Table-25). Immediate initiation of breastfeeding and colostrums has been the most important post partum advice by the Mitanin followed by advice for immunization of the new born (Tables 26, 27).

Table 25: Time taken by Mitanin in making first post partum visit

	Within 12 hours	More than 12 hours but within 24 hours	More than 24 hours but within 2 days	After more than 2 days	Never came
KANKER	78%	4%	4%	6%	9%
DHAMTARI	67%	2%	5%	11%	15%
RAJNANDGOAN	83%	3%	3%	7%	5%
KORIA	65%	4%	5%	6%	20%
SURGUJA	66%	4%	8%	9%	12%
BILASPUR	67%	3%	2%	6%	21%
RAIGARH	66%	6%	4%	9%	16%
BASTAR	67%	7%	5%	11%	10%
State	**70%**	**4%**	**4%**	**8%**	**14%**

Table 26: Type of post partum advise from the Mitanin

	Imme-diate initiation of breast feeding	Advice for not bathing the child imme-diately	Giving food to mother	Advise for registr ation of birth	Signs of post partum bleed-ing	Use of contracep tion	Exclu-sive breast feeding	New born immu-nisation	Keep baby warm	No advice
KANKER	80%	47%	49%	43%	5%	16%	54%	58%	52%	9%
DHAMTARI	78%	50%	56%	57%	14%	39%	53%	63%	46%	16%
R'GOAN	88%	59%	64%	61%	14%	31%	58%	72%	54%	6%
KORIA	63%	53%	45%	27%	3%	12%	50%	59%	45%	21%
SURGUJA	74%	39%	43%	28%	16%	23%	70%	67%	64%	17%
BILASPUR	70%	40%	51%	45%	18%	32%	56%	62%	43%	20%
RAIGARH	73%	44%	48%	44%	15%	29%	64%	64%	51%	20%
BASTAR	76%	52%	45%	32%	4%	8%	49%	65%	45%	12%
State	**75%**	**47%**	**50%**	**42%**	**12%**	**24%**	**57%**	**64%**	**50%**	**15%**

Table 27: Mitanin role in colostrums feeding

	Gave advice to feed the child within first hour	Was physically present and helped the mother	Was willing to do even more help
KANKER	56%	49%	12%
DHAMTARI	55%	42%	20%
RAJNANDGOAN	70%	48%	12%
KORIA	53%	22%	27%
SURGUJA	56%	32%	12%
BILASPUR	56%	32%	20%
RAIGARH	43%	29%	18%
BASTAR	53%	33%	18%
State	**55%**	**36%**	**17%**

5.20 More than 80% respondents confirmed having got their child immunized. More than 85% confirmed some role of Mitanin in the immunization such as reminding or accompanying her for the immunization of the child (Table -28).

Table 28: Mitanin role in Child immunization

	Number of respondents confirming immunization of the child	Mitanin role – none	Mitanin role – informed /reminded about the service	Mitanin role – accompanied the mother and child to immunization session	Mitanin role – other help	Mitanin Played Some Role
KANKER	89%	10%	67%	36%	1%	90%
DHAMTARI	89%	13%	67%	41%	2%	87%
RAJNANDGOAN	87%	12%	59%	58%	4%	88%
KORIA	77%	20%	55%	8%	1%	80%
SURGUJA	77%	8%	54%	32%	1%	92%
BILASPUR	77%	18%	51%	30%	1%	82%
RAIGARH	84%	15%	47%	35%	0%	85%
BASTAR	84%	9%	69%	28%	1%	91%
State	**83%**	**13%**	**59%**	**34%**	**1%**	**87%**

5.21 Ninety percent of the respondents reported receiving Anganwadi services. Of those accessing the services, nearly three –fourth were helped by the Mitanin in accessing the services (Table- 29).

Table 29: Mitanin role in access of nutrition services for lactating mothers

	%age of respondents who received Anganwadi services	%age of respondents who reported receiving help from Mitanin in accessing Anganwadi services
KANKER	96%	88%
DHAMTARI	92%	76%
RAJNANDGOAN	79%	69%
KORIA	82%	63%
SURGUJA	95%	77%
BILASPUR	93%	69%
RAIGARH	90%	72%
BASTAR	93%	81%
State	**90%**	**74%**

5.22 Most (94%) respondents were aware about the need to keep the baby warm, use of blanket being the main method for doing so (Table-30).

Table 30: Lactating mothers' knowledge about the need to keep the newborn warm

	Blanket	Kangaroo care	Baby warmer	Not aware about any of the three
KANKER	91%	28%	1%	3%
DHAMTARI	88%	37%	7%	5%
RAJNANDGOAN	90%	32%	2%	2%
KORIA	96%	12%	1%	2%
SURGUJA	96%	34%	2%	2%
BILASPUR	96%	26%	2%	2%
RAIGARH	96%	25%	3%	1%
BASTAR	91%	22%	1%	2%
State	**93%**	**27%**	**2%**	**3%**

5.23 About 15% of the respondents [342 of 2228] reported newborn illness in first month after the birth of the child. The Mitanin was reported as preferred source of help ahead of local doctor (Table-31) while government facilities were the main source of treatment (Table-32).

Table 31: Illness episode and source of help

	Number of respondents who reported newborn illness in the first month	Source of help					
		Mitanin	ANM	VHSC	Local doctor	AWW	No one
KANKER	66	67%	35%	2%	24%	6%	5%
DHAMTARI	37	27%	24%	3%	43%	5%	8%
RAJNANDGOAN	38	47%	24%	0%	37%	13%	0%
KORIA	24	29%	13%	0%	29%	8%	17%
SURGUJA	19	32%	0%	0%	26%	11%	26%
BILASPUR	46	17%	2%	0%	43%	4%	24%
RAIGARH	30	23%	13%	0%	43%	0%	13%
BASTAR	82	38%	28%	0%	38%	6%	6%
State	**342**	**38%**	**21%**	**1%**	**36%**	**6%**	**10%**

Table 32: Illness episodes among young infant and source of treatment

	Source of treatment									
	SHC	PHC	CHC	SDH	DH	All Govt Facilities	Private qualified Doctor	Private unqualified Doctor	Mitanin	Others
KANKER	32%	12%	14%	0%	6%	64%	21%	0%	32%	5%
DHAMTARI	16%	8%	16%	3%	19%	62%	35%	3%	0%	3%
RAJNANDGOAN	13%	13%	18%	3%	3%	50%	24%	5%	16%	5%
KORIA	8%	8%	13%	0%	33%	63%	21%	0%	8%	8%
SURGUJA	0%	5%	37%	0%	0%	42%	11%	26%	16%	5%
BILASPUR	7%	4%	11%	0%	7%	28%	39%	15%	2%	7%
RAIGARH	17%	3%	17%	0%	7%	43%	40%	3%	0%	7%
BASTAR	22%	7%	4%	1%	6%	40%	26%	7%	21%	11%
State	**18%**	**8%**	**13%**	**1%**	**9%**	**49%**	**27%**	**6%**	**15%**	**7%**

Access to and utilization of services: feedback from the women with children aged 6 – 24 months

5.24 A total of 4610 women with a child aged 6-24 months were interviewed to obtain information about the advice and services they received from (their) Mitanin. Close to 80% of the respondents were below the age of 30 years with nearly half of them in the age group 20-25 years (Table-33).

Table 33: Age distribution of women with children aged 6-24 months surveyed

Age group	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
<20 years	1%	1%	1%	1%	3%	1%	1%	1%	2%
20 - 25	42%	36%	49%	34%	43%	46%	43%	48%	38%
25 - 30	37%	41%	33%	37%	34%	36%	39%	35%	40%
30 - 35	11%	13%	11%	10%	12%	10%	11%	10%	14%
35 - 40	4%	4%	3%	4%	3%	6%	3%	4%	3%
>40 years	1%	2%	0%	0%	1%	0%	0%	0%	1%
No Response	4%	3%	3%	13%	4%	1%	2%	1%	2%
Total	**4610**	**546**	**574**	**561**	**535**	**614**	**604**	**601**	**575**

5.25 The proportion of sample children aged 6-12 months, those aged 12-18 months and those aged 18-24 months was 36%, 36% and 27% respectively with significant variation across the sample districts. The sex ratio (male : female) of the sample children was 52:48 on an overall basis and this also varied across districts (Table 34).

Table 34: Distribution of sample children according to gender and age groups

	Proportion of male children	Proportion of female children	Proportion between 6-12 months of age	Proportion between 12-18 months of age	Proportion more than 18 months of age
KANKER	49%	51%	30%	41%	29%
DHAMTARI	55%	45%	33%	41%	26%
RAJNANDGOAN	53%	47%	38%	38%	25%
KORIA	51%	49%	32%	38%	30%
SURGUJA	54%	46%	29%	33%	38%
BILASPUR	52%	48%	36%	39%	25%
RAIGARH	50%	50%	44%	32%	24%
BASTAR	51%	49%	44%	32%	24%
State	**52%**	**48%**	**36%**	**36%**	**27%**

5.26 More than 60% of the sample children were born at home while about 32% were born in government health facilities (the rest were born in private facilities). The share of home deliveries was more than 70% in Surguja and Bilaspur (Table-35).

Table 35: Place of birth of sample children

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Home delivery	59.6 %	50.0%	51.2%	52.6%	54.8%	72.6%	71.7%	61.6%	59.8%
SHC	10.0 %	10.4%	18.8%	9.6%	4.5%	4.7%	7.8%	10.8%	13.2%
PHC/CHC	16.5 %	25.8%	15.9%	11.1%	10.3%	15.0%	15.9%	19.6%	18.4%
District hosp.	5.1%	6.4%	8.0%	4.8%	6.7%	4.2%	1.5%	3.3%	6.1%

5.27 Regardless of place of birth, the breastfeeding initiation was done within 4 hours of birth and less than 6% reported supplementary feeding (other than breast milk) during 3 days after birth. The exclusive breastfeeding for 6 month was also found to be high at 87% as only 13% respondents reported having initiated supplementary foods within 6 months of the birth (Table-36).

Table 36: Exclusive breastfeeding and supplementary feeding

	Total number of Respondents	%age respondents who reported supplementary feeding (other than breast milk) within 3 days of birth	%age respondents who reported supplementary food within 6 months of birth	%age respondents who reported supplementary foods after6 months but before 9 months of birth	%age respondents who reported supplementary foods after 9 months of birth
KANKER	546	4.2	7	87	6
DHAMTARI	574	4.4	10	84	6
RAJNANDGOAN	561	2.3	29	67	4
KORIA	535	5.0	27	72	2
SURGUJA	614	6.8	8	90	3
BILASPUR	604	6.3	8	88	3
RAIGARH	601	15.6	5	90	4
BASTAR	575	1.4	9	83	7
State	**4610**	**5.9**	**13**	**83**	**4**

5.28 All but 7% of the respondents confirmed having utilized immunization services for the new born. The person who helped in accessing services the most was reported to be the Mitanin by 87% of the respondents (Table-37).

Table 37: Utilization of immunization services

	%age respondents who reported child immunization	Person who helped in accessing services					
		Mitanin	ANM	MPW	AWW	Doctor	Others
KANKER	99%	91%	36%	2%	47%	0%	0%
DHAMTARI	99%	85%	28%	5%	56%	3%	1%
R'GOAN	79%	87%	48%	3%	49%	8%	1%
KORIA	73%	84%	12%	6%	41%	1%	1%
SURGUJA	97%	90%	27%	5%	68%	1%	8%
BILASPUR	96%	79%	11%	7%	68%	3%	6%
RAIGARH	99%	89%	20%	7%	68%	4%	4%
BASTAR	98%	91%	31%	2%	35%	0%	0%
State	**93%**	**87%**	**27%**	**4%**	**55%**	**3%**	**3%**

5.29 Overall, 85% of the respondents confirmed receiving supplementary food / ration on a regular basis and 81% reported Mitanin help in enrolling the child with the AWC (Table-38).

Table 38: Utilization of Anganwadi services

	%age of respondents reporting			
	Receiving supplementary food / ration on a regular basis	Receiving supplementary food / ration but NOT on a regular basis	Not receiving supplementary food / ration	That Mitanin helped in enrolment of child with the AWC
KANKER	89%	8%	2%	89%
DHAMTARI	91%	5%	3%	87%
RAJNANDGOAN	74%	2%	2%	69%
KORIA	69%	8%	1%	62%
SURGUJA	81%	15%	2%	78%
BILASPUR	85%	8%	5%	72%
RAIGARH	93%	4%	2%	74%
BASTAR	92%	4%	3%	86%
State	**85%**	**7%**	**3%**	**77%**

5.30 Nearly one third of the respondents [1329 of 4610] reported a diarrhea episode in the last one month (prior to survey). More than 90% respondents reported seeking help from any source and 35% reported seeking help from Mitanin. Of those who sought help from the Mitanin, 35% were given ORS and 23% were given medicine (Table -39).

Table 39: Mitanin role in treatment of diarrhea among young children

	Number of respondents who reported a diarrhea episode in last one month (preceding the survey)	Those who sought advice and treatment		Mitanin role in treatment [responses are not mutually exclusive]			
		From any source	From Mitanin	Gave ORS	Gave medicine	Referred to AWW /ANM / hospital / others	Did not do anything
Kanker	241	95%	35%	46%	27%	37%	21%
Dhamtari	228	90%	19%	33%	25%	24%	38%
Rajnandgaon	131	93%	32%	45%	35%	26%	30%
Koria	102	89%	32%	37%	19%	12%	36%
Surguja	125	88%	9%	20%	18%	11%	20%
Bilaspur	178	91%	3%	17%	13%	8%	43%
Raigarh	115	89%	12%	21%	19%	10%	19%
Bastar	209	91%	38%	45%	25%	37%	26%
State	**1329**	**91%**	**24%**	**35%**	**23%**	**25%**	**29%**

5.31 As against only one third sample children had a diarrhea episode, the incidence of fever was found to be significantly more. Nearly 50% of the respondents reported a fever episode in the last one month (prior to survey). More than 90% sought help from any source

and 32% respondents reported seeking help from the Mitanin. Of those who sought help from the Mitanin, 45% were given medicine (Table -40).

Table 40: Fever episodes among young children and Mitanin role in their treatment

	Number of respondents who reported a fever episode in last one month (preceding the survey)	Those who sought advice and treatment		Mitanin role in treatment [responses are not mutually exclusive]		
		From any source (number of respondents)	From Mitanin (% of those who sought advice from any source)	Gave medicine	Referred	Did not do anything
Kanker	364	94%	42%	56%	44%	26%
Dhamtari	292	92%	36%	34%	38%	50%
Rajnandgaon	208	92%	38%	47%	43%	35%
Koria	230	94%	32%	40%	26%	42%
Surguja	232	88%	22%	46%	23%	20%
Bilaspur	285	95%	22%	44%	23%	33%
Raigarh	261	96%	21%	35%	19%	30%
Bastar	331	93%	45%	55%	44%	29%
State	**2203**	**93%**	**32%**	**45%**	**34%**	**33%**

Mitanins' activism : feedback from the women respondents

5.32 The survey results indicate a near unanimity among the beneficiary groups about the Mitanin involvement in local issues which is not limited to health only, although that remains the main concern of the Mitanins (Table-41).

Table 41: Views (of women served) about Mitanin involvement in local issues

	Pregnant women	Women with a child aged less than 6 months	Women with a child aged 6-24 months
	%age of respondents		
Issues related to anganwadi centre, med day meal and NREGA etc.	40	40	37
Issues related to health care	79	79	81
Issues related to Gram Sabha	32	30	28
Issues related to all concerns of the community	21	19	17

Findings from the survey of the Mitanins

5.33 The survey included a total of 1230 Mitanins. More than 50% of the Mitanins surveyed are less than 35 years of age (Table-42). Overall, 18% respondents were illiterate with higher illiteracy rate among the respondents from Koriya and Bastar districts. Of those who are literate, about 40% are 5th pass and more than 40% 8th pass (Table 43).

Table 42: Age distribution of Mitanins surveyed

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Less than 35 years	55%	60%	53%	52%	52%	62%	54%	51%	56%
35-40 years	19%	18%	18%	20%	15%	18%	17%	22%	21%
40-45 years	11%	8%	14%	15%	13%	10%	11%	12%	10%
45-50 years	8%	7%	9%	6%	12%	7%	8%	7%	8%
50-55 years	3%	2%	2%	2%	5%	1%	7%	5%	3%
More than 55 years	2%	2%	3%	3%	2%	1%	4%	3%	1%
No / missing Responses	1%	3%	1%	2%	2%	1%	0%	1%	2%
Total Respondents	**1230**	**153**	**153**	**148**	**155**	**157**	**157**	**152**	**155**

Table 43: Literacy and education status of Mitanins surveyed

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Illiterate	18%	16%	14%	16%	28%	15%	13%	13%	26%
Educational status of the literate respondents									
Less than 5th pass	4.5%	2.3%	3.0%	3.3%	0.9%	4.5%	12.0%	3.8%	5.5%
5th pass	39.6%	32.0%	42.4%	20.8%	55.9%	35.8%	45.9%	41.2%	44.5%
8th pass	43.0%	50.0%	34.8%	57.5%	36.0%	48.5%	32.3%	42.0%	43.6%
10th pass	7.6%	8.6%	9.1%	13.3%	3.6%	8.2%	3.8%	9.2%	4.5%
12th pass	4.3%	3.9%	9.1%	5.0%	2.7%	2.2%	5.3%	3.8%	1.8%
Graduate degree / diploma	0.8%	3.1%	1.5%	0.0%	0.9%	0.0%	0.8%	0.0%	0.0%
Post graduate degree / diploma	0.1%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%

5.34 Nearly 3/4th respondents had been working as a Mitanin for more than 5 years at the time of survey in September / October, 2010 (Table-44).

Table 44: Period of involvement in Mitanin work

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Less than 1 year	2%	0%	7%	3%	3%	1%	1%	1%	0%
01-02 years	8%	7%	3%	11%	9%	18%	3%	7%	6%
02-03 years	3%	5%	1%	4%	1%	3%	3%	3%	3%
03-04 years	7%	9%	5%	3%	6%	8%	6%	2%	15%
04-05 years	6%	14%	4%	5%	5%	4%	6%	5%	6%
More than 5 years	74%	65%	80%	74%	75%	67%	82%	82%	69%

5.35 Close to 90% of the respondents reported spending, on an average, up to a maximum of 3 hours a day on their Mitanin related work (Table45).

Table 45: Average time spent on Mitanin work in a day

	Less than 1 hour	1-2 hours daily	2-3 hours daily	3-4 hours daily	4-5 hours daily	More than 5 hours
KANKER	39%	29%	24%	4%	1%	3%
DHAMTARI	20%	38%	23%	7%	2%	10%
RAJNANDGOAN	40%	25%	14%	9%	6%	2%
KORIA	39%	25%	19%	5%	0%	3%
SURGUJA	12%	57%	19%	10%	1%	1%
BILASPUR	11%	51%	29%	6%	0%	1%
RAIGARH	20%	58%	17%	5%	0%	0%
BASTAR	44%	25%	22%	6%	1%	3%
State	**28%**	**39%**	**21%**	**7%**	**1%**	**3%**

5.36 About 4% of the respondents are holding a position in the PRI, in addition to being a Mitanin. About one-fourth respondents are also involved with the self-help group work either as a member or as its President (Table-46).

Table 46: Other positions held by the Mitanins surveyed

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Panch	3%	1%	7%	2%	3%	3%	2%	2%	6%
Sarpanch	1%	0%	1%	1%	1%	1%	1%	1%	1%
Member, Janpad Panchayat	0%	0%	0%	1%	0%	0%	0%	1%	0%
Member, SHG	17%	16%	24%	11%	7%	14%	22%	19%	18%
President SHG	9%	7%	7%	10%	3%	10%	8%	18%	14%

5.37 Of the 58 respondents who are members of the Panchayat, 46 became so after they became Mitanin and 34 (of the 46) – 75% or so - feel that they were elected to the Panchayat because of their Mitanin work (Table-47).

Table 47: Mitanins' participation in Panchayat

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Number who are members	58	5	12	8	7	5	8	5	8
Number who became PRI member after becoming Mitanin	46	4	11	4	6	4	7	3	7
Number who feel they became PRI member due to their Mitanin work	34	3	6	3	6	3	4	2	7

5.38 Motivation to become Mitanin: All respondents mentioned "to serve the community" as the main reason for becoming a Mitanin. Raising awareness about health issues in the village, and 'to look after family and children better' were also reported as a key reason by the respondents. Expectation of money or government job were reported as less important a reason than getting recognition in the community and/or opportunity to learn (Table-48)

Table 48: Motivating factors to become Mitanin

	To serve the community	To raise awareness about health issues in the village	In expectation of getting govt job	In expecta-tion of getting money	To get recog-nition in the commu-nity	To look after family and children better	To learn	To become indepen dent	Due to lack of health service in village
KANKER	100%	56%	4%	10%	16%	20%	31%	2%	28%
DHAMTARI	100%	65%	27%	24%	51%	39%	37%	17%	32%
R' GOAN	100%	52%	8%	12%	28%	20%	19%	2%	29%
KORIA	100%	56%	5%	21%	7%	25%	41%	3%	39%
SURGUJA	100%	78%	16%	11%	54%	73%	44%	10%	48%
BILASPUR	100%	66%	13%	10%	44%	44%	32%	5%	30%
RAIGARH	100%	80%	11%	11%	50%	63%	47%	9%	38%
BASTAR	100%	73%	5%	15%	14%	17%	22%	0%	30%
State	**100%**	**66%**	**12%**	**14%**	**34%**	**39%**	**35%**	**6%**	**34%**

5.39 Given the motivating factors as mentioned above, it would be reasonable to expect that 'helping others' part of their work would be most appreciated by the Mitanins in their work. This is indeed so as close to 80% respondents mention this as the most appreciated part of their Mitanin work. Opportunity to learn new skills and recognition and respect in the family and community are more important to her than the chance of getting a job in future (Table-49).

Table 49: Most liked / appreciated part of their job for the Mitanins

	Being able to help others	Respect in family	Recognition and respect in community	Independence	Opportunity to learn new skills	Opportunity to look after own children better	Ability to extend financial help to household	Making friends	Chances of a job in future
KANKER	67%	20%	35%	1%	48%	16%	10%	3%	1%
DHAMTARI	93%	50%	50%	17%	48%	31%	15%	14%	11%
R'GOAN	66%	29%	28%	1%	22%	3%	4%	1%	1%
KORIA	71%	16%	30%	3%	46%	15%	8%	2%	3%
SURGUJA	85%	60%	48%	15%	55%	55%	17%	11%	1%
BILASPUR	82%	41%	46%	4%	41%	32%	5%	5%	1%
RAIGARH	80%	51%	44%	7%	39%	37%	9%	13%	0%
BASTAR	82%	14%	32%	2%	37%	15%	8%	4%	1%
State	**78%**	**35%**	**39%**	**6%**	**42%**	**26%**	**10%**	**7%**	**3%**

5.40 Training: There is a high degree of attendance in the training courses which is consistent with the 'interest to learn new skills'. The data indicates that 75% of the respondents have not missed any of the 13 rounds of training held so far (Table-50).

Table 50: Number of Mitanins who missed any training

	Number of respondents who		% who did not miss any training
	MISSED any training round	DID NOT missed any round of training	
KANKER	61	92	60
DHAMTARI	51	102	67
RAJNANDGOAN	14	134	91
KORIA	34	121	78
SURGUJA	36	121	77
BILASPUR	47	110	70
RAIGARH	26	126	83
BASTAR	44	111	72
State	**313**	917	75

5.41 The respondents were asked to recall the main subjects taught to them during their training. They were also asked to mention their most favorite topic as well as the subjects where they would like more training. The %age distribution of the responses presented in Table-51 indicates a consistent pattern:

- child nutrition (44%), newborn care (10%), maternal care (10%) and food security (15%) were more readily recalled subjects than others;
- these, along with first aid for injuries and herbs are the most popular / useful subjects covered in the training as per the respondents;
- these are also the subjects where the respondents want more training; need for more training in herbs has been identified by 13% respondents

Table 51: Recalled and most popular subjects; subjects where re-training is sought

	%age of responses		
	Recall as a subject covered in training	Most popular subject	Subject where re-training is needed /sought
Government health services	2		
Water and sanitation	3		
Child nutrition	44	17	11
Family planning			
HIV/AIDS			
STI/RTI			
Maternal care	10	14	8
Newborn care	10	22	17
Childhood illnesses			4
Immunization			4
Malaria			2
TB			
First aid for injuries		7	3
Home remedies			
Treatment for dog / snake bite			2
Herbs		7	13
JSY			2
Mitanin Dawa Peti			4
VHSC and Village Health Plan	2		3
Leprosy			
Food security	15		4
Women's health and their rights			2
Use of thermometer and weighing machine /scale			
Handling deliveries			5
Giving injections			5
Other subjects			
Total	**100**		

5.42 As will be observed, handling deliveries received a score of 5% when included along with other subjects. However, when asked to prioritise, emerged as the first priority in all sample districts, perhaps because the Mitanins feel that they could help their hamlet much better if they have these skills. Giving injections and home remedies have also appeared as 2nd or third priority subject in many districts (Table-52).

Table 52: Three priorities for training identified by Mitanins

	Suggestion-1	Suggestion-2	Suggestion-3
KANKER	Dai training / Delivery	Giving injection	Newborn care
DHAMTARI	Dai training / Delivery	Home remedies / herbs	Giving injection
RAJNANDGOAN	Dai training / Delivery	Family planning	ANC checkup
KORIA	Dai training / Delivery	Giving injection	Family planning
SURGUJA	Dai training / Delivery	Giving injection	Home remedies / herbs
BILASPUR	Dai training / Delivery	Newborn care	Giving injection
RAIGARH	Dai training / Delivery	Giving injection	Home remedies / herbs
BASTAR	Dai training / Delivery	Giving injection	Home remedies / herbs

5.43 About one-fifth of the respondents [225 out of 1230] reported encountering pregnancies with complications; referring these to the CHC or district hospital was reported as the main course of action adopted (Table 53).

Table 53: Complicated pregnancies encountered and action taken

	Number of respondents who reported encountering pregnancies with complications	% of cases				
		Referred to CHC /district hospital	Referred to private hospital	Accompanied the woman to ANM	Referred but the woman did not go	Referred to PHC
KANKER	32	50%	19%	3%	3%	13%
DHAMTARI	25	68%	24%	4%	0%	8%
RAJNANDGOAN	24	63%	4%	4%	4%	17%
KORIA	30	73%	0%	0%	7%	7%
SURGUJA	17	71%	12%	0%	0%	0%
BILASPUR	27	93%	0%	4%	7%	4%
RAIGARH	31	81%	10%	0%	0%	0%
BASTAR	39	77%	5%	0%	0%	8%
State	**225**	**72%**	**9%**	**2%**	**3%**	**7%**

5.44 On an average, about 12 cases of illnesses are seen and managed by a Mitanin in a month. In more than 80% cases, she treats them with drugs from the Mitanin Dawa Peti, besides giving advice (Table-54).

Table 54: Illnesses cases encountered and action taken

	Total number of cases seen and managed	% of cases			
		% given advice and counseling	% treated with home remedies / herbs	% treated with medicine from Mitanin Dawa Peti	% referred
KANKER	17.90	86%	8%	86%	5%
DHAMTARI	9.21	53%	12%	75%	16%
RAJNANDGOAN	10.63	88%	13%	89%	19%
KORIA	14.83	90%	6%	86%	5%
SURGUJA	11.22	55%	0%	87%	6%
BILASPUR	8.50	46%	12%	86%	4%
RAIGARH	9.14	50%	3%	91%	6%
BASTAR	15.55	79%	6%	78%	6%
State	**12.12**	**72%**	**7%**	**84%**	**8%**

5.45 The respondents were asked to suggest the preferred place that they would recommend for delivery, should the JSY scheme be wound up. The vast majority of respondents would still recommend institutional delivery in a government facility, preferably in the CHC (Table 55).

Table 55: Preferred place for delivery, if there were no JSY

	Home	SHC	PHC	CHC	District hospital	Private hospital	Other places
KANKER	1%	33%	43%	57%	21%	2%	1%
DHAMTARI	6%	50%	46%	50%	44%	12%	1%
RAJNANDGOAN	4%	16%	32%	44%	9%	1%	1%
KORIA	2%	26%	56%	55%	39%	1%	1%
SURGUJA	10%	47%	46%	93%	29%	1%	0%
BILASPUR	10%	42%	56%	80%	27%	6%	0%
RAIGARH	7%	62%	46%	80%	28%	13%	1%
BASTAR	6%	43%	61%	63%	26%	1%	0%
State	**6%**	**40%**	**49%**	**65%**	**28%**	**5%**	**1%**

5.46 More than 70% respondents [853 out of 1230] confirmed that they are associated with the Village Health & Sanitation Committee (VHSC). Most of them are either the convener or a member of the VHSC (Table 56). About a third of the respondents also reported to be associated with the implementation of Swasth Gram Panchayat scheme (Table-57).

Table 56: Mitanins' participation in the VHSC

	State	Kanker	Dhamtari	R'gaon	Koria	Surguja	Bilaspur	Raigarh	Bastar
Convener	41.0%	33.1%	50.0%	46.9%	33.1%	34.5%	53.8%	55.8%	32.5%
Member	58.0%	64.7%	48.8%	50.6%	66.9%	64.7%	46.3%	44.2%	66.7%
Member secretary	0.6%	0.7%	0.0%	2.5%	0.0%	0.9%	0.0%	0.0%	0.8%
Other office bearer	0.4%	1.5%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Table 57: Mitanins' participation in the Swasth Gram Panchayat scheme

	% respondents who are involved in Swasth Gram Panchayat Scheme in…				Total Responses
	In Survey work	Training / orienting the Panchayat	Organize / participate in SGP 'sammelan'	Other	
KANKER	29%	1%	35%	15%	127
DHAMTARI	58%	30%	19%	17%	142
RAJNANDGOAN	30%	6%	31%	17%	100
KORIA	30%	1%	6%	21%	111
SURGUJA	63%	34%	16%	23%	133
BILASPUR	47%	27%	24%	23%	136
RAIGARH	51%	31%	19%	23%	123
BASTAR	19%	1%	15%	34%	125
State	**42%**	**17%**	**21%**	**22%**	**997**

5.47 The respondents were asked to rate the level of support they enjoyed from various sources into three categories – very good, average or negligible. The results indicate that the Mitanin receives maximum support from her trainer, followed by the AWW reported and the ANM (Table 58).

Table 58: Support received by Mitanin

	ANM- very good	Mitanin trainer – very good	PHC doctor –very good	Sarpanch – very good	Panch from own habitation – very good	AWW – very good	Total Respondents
KANKER	84%	92%	41%	47%	54%	86%	153
DHAMTARI	91%	89%	71%	71%	73%	87%	153
RAJNANDGOAN	57%	61%	42%	43%	49%	61%	148
KORIA	67%	81%	49%	48%	52%	75%	155
SURGUJA	68%	76%	38%	47%	50%	76%	157
BILASPUR	71%	81%	44%	52%	55%	78%	157
RAIGARH	75%	77%	28%	51%	55%	78%	152
BASTAR	76%	84%	45%	44%	51%	88%	155
State	**74%**	**80%**	**45%**	**50%**	**55%**	**79%**	**1230**

5.48 Drug kit: Close to 90% of the respondents had their drug kit available with them when they were interviewed (Table-59). More than 50% respondents reported having received replenishment in the last three monhs (Table 60). However, most respondents are satisfied with the quality of drugs in the Mitanin drug kit (Table-61).

Table 59: Availability of drug kit with Mitanins

	Number of Mitanins having drug kit	Total Respondents	%age of sample Mitanins having drug kit
KANKER	151	153	99%
DHAMTARI	135	153	88%
RAJNANDGOAN	98	148	66%
KORIA	136	155	88%
SURGUJA	149	157	95%
BILASPUR	145	157	92%
RAIGARH	138	152	91%
BASTAR	148	155	95%
State	**1100**	**1230**	**89%**

Table 60: Replenishment of drug kit

	Within last 3 months	3-6 months before	6-9 months before	9-12 months before
KANKER	54%	20%	12%	2%
DHAMTARI	48%	20%	0%	10%
RAJNANDGOAN	42%	4%	1%	3%
KORIA	55%	14%	10%	1%
SURGUJA	57%	6%	3%	29%
BILASPUR	55%	18%	6%	10%
RAIGARH	44%	10%	8%	28%
BASTAR	57%	22%	10%	5%
Total	**52%**	**14%**	**6%**	**11%**

Table 61: Satisfaction with quality of drugs in ‘dawa peti’

	Total Respondents	Satisfied with the quality of drugs
KANKER	153	93%
DHAMTARI	153	86%
RAJNANDGOAN	148	64%
KORIA	155	82%
SURGUJA	157	84%
BILASPUR	157	83%
RAIGARH	152	74%
BASTAR	155	92%
State	**1230**	**82%**

5.49 Incentive money: The average incentive amount received by the respondents during the last 3 months (prior to the survey) translates to less than Rs 200/- per month (Table 62). Only 20% of the respondents are reported to be fully satisfied with the incentive amount (Table 63).

Table 62: Incentive amount received during last three months

	Average amount (Rs)	Highest amount reported	Lowest amount reported	Total Respondents
KANKER	561.17	2200	50	153
DHAMTARI	543.46	3050	0	153
RAJNANDGOAN	596.72	4000	0	148
KORIA	646.72	3150	0	155
SURGUJA	617.42	2180	50	157
BILASPUR	520.11	2600	100	157
RAIGARH	407.20	1050	0	152
BASTAR	561.63	1550	0	155
State	**556.8**	**4000**	**0**	**1230**

Table 63: Mode of payment and satisfaction with incentive amount

	Mode of payment			Satisfaction level with incentive amount		
	Cheque	Cash	Direct credit to bank account	Fully satisfied	Half satisfied	Dissatisfied
KANKER	24%	87%	1%	8%	33%	56%
DHAMTARI	56%	46%	1%	33%	35%	29%
RAJNANDGOAN	59%	16%	0%	22%	34%	12%
KORIA	19%	83%	0%	14%	43%	32%
SURGUJA	71%	54%	0%	20%	61%	17%
BILASPUR	63%	41%	0%	22%	47%	18%
RAIGARH	47%	56%	1%	23%	51%	15%
BASTAR	10%	95%	0%	15%	40%	44%
State	**44%**	**60%**	**0%**	**20%**	**43%**	**28%**

5.50 Getting better training and training in additional areas have been given more importance by the respondents to be more productive and effective than increase in incentive money (Table 64).

Table 64: Help sought to be more effective Mitanin

	Better training	Training in additional areas / subjects	Better support from Master Trainer	Better support from Health Workers	Timely refilling of drug kit	More IEC material	Better arrangements for payment of incentive money	Increase in incentive money	More opportunities to meet and interact with friends
KANKER	50%	63%	5%	5%	50%	19%	46%	49%	2%
DHAMTARI	79%	65%	44%	25%	67%	18%	50%	53%	16%
R' GOAN	53%	35%	22%	10%	28%	3%	22%	20%	1%
KORIA	37%	66%	21%	19%	57%	23%	43%	48%	4%
SURGUJA	94%	94%	59%	6%	76%	14%	31%	52%	6%
BILASPUR	79%	80%	44%	6%	48%	11%	32%	42%	8%
RAIGARH	91%	90%	55%	10%	59%	14%	42%	43%	7%
BASTAR	47%	72%	20%	10%	58%	12%	59%	53%	3%
State	**67%**	**71%**	**34%**	**11%**	**56%**	**14%**	**41%**	**45%**	**6%**

ANMs' perception about the Mitanin programme

5.51 According to respondent ANMs, promotion and coordination of immunization, accompanying women for delivery, counseling women on all aspects of pregnancy, providing medicines for minor illnesses and providing pills condoms and IFA tables are the main roles of the Mitanins (Table 65).

Table 65: ANM's perception about Mitanin role

	Counselling women on all aspects of pregnancy	Accompanying women for delivery	Visiting new born for advice/care	Promotion and coordination for immunization programme	Provides medicines for minor illnesses	Providing pills and condom and IFA tablets
KANKER	71%	71%	42%	102%	27%	46%
DHAMTARI	85%	85%	48%	88%	80%	58%
RAJNANDGOAN	65%	70%	46%	80%	41%	59%
KORIA	40%	80%	6%	84%	80%	48%
SURGUJA	74%	74%	47%	93%	79%	70%
BILASPUR	90%	100%	62%	100%	86%	71%
RAIGARH	83%	80%	57%	93%	80%	57%
BASTAR	46%	96%	30%	91%	54%	43%
State	**66%**	**81%**	**39%**	**91%**	**63%**	**55%**

5.52 Almost all respondents acknowledged the help extended by the Mitanins in mobilising women and children for the VHND. Other areas where their help is acknowledged includes motivating women for family planning, identifying women from marginalized communities and providing beneficiary list for JSY, DOTS, family planning etc. (Table 66).

Table 66: Help received by ANM from the Mitanin

	Help received from Mitanin						
	Mobilises women and children to VHND	Provides beneficiary list (eg-immunisation, JSY, DOTS, family planning etc)	Identifies women in marginalised community (eg:immunisation, JSY, DOTS, family planning etc)	Brings to my notice cases of Malaria and TB	Informs me about any other disease outbreak	Motivates women for Family Planning	Other help
KANKER	100%	40%	40%	17%	15%	56%	17%
DHAMTARI	95%	68%	60%	45%	43%	80%	5%
RAJNANDGOAN	89%	37%	57%	30%	24%	54%	2%
KORIA	96%	12%	46%	22%	52%	50%	10%
SURGUJA	93%	60%	44%	42%	35%	56%	2%
BILASPUR	105%	67%	62%	48%	33%	62%	5%
RAIGARH	93%	60%	47%	47%	23%	53%	3%
BASTAR	93%	33%	46%	26%	48%	74%	9%
State	**95%**	**44%**	**49%**	**32%**	**35%**	**60%**	**7%**

5.53 Increase in institutional deliveries is seen to be the main impact of Mitanin programme by the ANMs. Other impact areas identified include increasing immunization, increasing mother and child presence in the VHNDs, increase in the utilization of public health services and better hygiene in the community (Table-67).

Table 67: ANM's perception of impact of Mitanin programme

	Increasing immunization	Increasing institutional delivery	Increase in utilization of public health services	Better hygiene in the community	Increased utilization of public health services by the marginalised	Increasing mother and children's attendance in VHND	Increased awareness of rights
KANKER	81%	92%	38%	35%	19%	56%	4%
DHAMTARI	83%	88%	53%	48%	23%	63%	18%
RAJNANDGOAN	89%	91%	37%	46%	7%	52%	9%
KORIA	82%	88%	48%	14%	8%	72%	8%
SURGUJA	91%	91%	42%	44%	33%	65%	16%
BILASPUR	95%	100%	52%	38%	19%	71%	29%
RAIGARH	93%	90%	50%	40%	33%	73%	23%
BASTAR	89%	83%	48%	41%	17%	76%	9%
State	**87%**	**90%**	**45%**	**38%**	**19%**	**65%**	**13%**

5.54 Nevertheless, the ANMs also recognize some of the social mobilization work of the Mitanins such as picketing of alcohol shops and adolescent education (Table 68).

Table 68: ANM's perception about social mobilization by Mitanin

	The social mobilization activities of Mitanin							
	Picketing of Alcohol shops	Ensuring participation in ICDS food production, PDS shop regulation and demand generation	Water and sanitation facilities	Forest rights and environmental issues	Mobilisation women against domestic violence	Adolescent and women education	Any Other	None
KANKER	21%	6%	19%	0%	2%	6%	10%	54%
DHAMTARI	15%	13%	58%	13%	13%	50%	5%	23%
RAJNANDGOAN	17%	30%	52%	2%	13%	13%	9%	26%
KORIA	26%	4%	26%	2%	4%	10%	8%	40%
SURGUJA	42%	35%	51%	9%	7%	33%	5%	26%
BILASPUR	29%	24%	57%	10%	19%	29%	10%	38%
RAIGARH	20%	30%	47%	13%	10%	23%	0%	40%
BASTAR	50%	13%	39%	0%	2%	4%	2%	30%
State	**28%**	**18%**	**42%**	**5%**	**8%**	**19%**	**6%**	**35%**

AWWs' perception about the Mitanin programme

5.55 According to respondent AWWs, promotion and coordination of immunization, accompanying women for delivery, counseling women on all aspects of pregnancy, visiting new born for advice and care and providing pills condoms and IFA tables are the main roles of the Mitanins (Table 69).

Table 69: AWW perception about Mitanin role

	Counselling women on all aspects of pregnancy	Accompanying women for delivery	Visiting new born for advice /care	Promotion and coordination for immunization program	Provides medicines for minor illnesses	Providing pills and condom and IFA tablets	Any tuberculosis related work (DOTS provider)	Getting Panchayat to take action on health related issues
KANKER	66%	79%	44%	100%	57%	45%	7%	7%
DHAMTARI	80%	86%	69%	91%	74%	72%	33%	41%
R' GOAN	65%	60%	45%	71%	58%	54%	14%	15%
KORIA	63%	79%	48%	76%	75%	43%	8%	6%
SURGUJA	94%	96%	86%	100%	75%	65%	14%	23%
BILASPUR	90%	85%	70%	100%	82%	79%	23%	25%
RAIGARH	94%	92%	84%	95%	80%	70%	18%	28%
BASTAR	66%	89%	43%	95%	64%	43%	8%	5%
State	**78%**	**84%**	**62%**	**92%**	**71%**	**60%**	**16%**	**20%**

5.56 However, unlike the ANMs, all of whom acknowledged Mitanin's help in mobilising women and children for the VHND, less than half of respondent AWWs recognized this role of the Mitanins, perhaps because this is part of their own tasks (Table 70). However, most

respondents do feel that Mitanins have helped increase immunization. Other impact areas identified include increasing institutional deliveries, increasing mother and child presence in the VHNDs, and better hygiene in the community (table 71).

Table 70: Help received by AWW from the Mitanin

	Mobilises women and children to VHND	Provides beneficiary list (eg-immunisation, JSY, DOTS, family planning etc)	Identifies women in marginalised community (eg:immunisation, JSY, DOTS, family planning etc)	Brings to my notice cases of Malaria and TB	Informs me about any other disease outbreak	Motivates women for Family Planning	Other help
KANKER	59%	23%	23%	10%	9%	33%	10%
DHAMTARI	45%	32%	28%	21%	20%	38%	2%
RAJNANDGOAN	53%	22%	33%	18%	14%	32%	1%
KORIA	76%	10%	37%	17%	41%	40%	8%
SURGUJA	48%	31%	23%	22%	18%	29%	1%
BILASPUR	25%	16%	15%	11%	8%	15%	1%
RAIGARH	32%	20%	16%	16%	8%	18%	1%
BASTAR	57%	20%	28%	16%	29%	45%	5%
State	**48%**	**22%**	**25%**	**16%**	**17%**	**31%**	**4%**

Table 71: AWW perception about impact of Mitanin programme

	Increasing immunization	Increasing institutional delivery	Increase in utilization of public health services	Better hygiene in the community	Increased utilization of public health services by the marginalised	Increasing mother and children's attendance in VHND	Increased awareness of rights
KANKER	87%	84%	32%	57%	15%	56%	13%
DHAMTARI	80%	92%	59%	58%	35%	61%	38%
RAJNANDGOAN	67%	65%	28%	49%	18%	58%	13%
KORIA	75%	70%	25%	35%	10%	44%	13%
SURGUJA	98%	92%	43%	65%	37%	86%	19%
BILASPUR	99%	94%	33%	60%	25%	76%	23%
RAIGARH	97%	89%	45%	60%	39%	88%	31%
BASTAR	87%	86%	20%	45%	12%	53%	17%
State	**87%**	**85%**	**36%**	**54%**	**25%**	**66%**	**21%**

5.57 The social mobilization activities of the Mitanin are acknowledged by significant number of respondents, particularly those relating to water and sanitation, picketing of alcohol shops and adolescent and adult education (Table-72).

Table 72: AWW perception of social mobilization by Mitanin

	Picketing of Alcohol shops	Demanding ICDS, PDS entitlements be given properly	Water and sanitation facilities	Forest rights and environmental issues	Mobilisation women against domestic violence	Adolescent and women education	None
KANKER	45%	12%	49%	10%	21%	34%	28%
DHAMTARI	34%	45%	60%	26%	29%	53%	16%
RAJNANDGOAN	35%	29%	51%	8%	27%	31%	12%
KORIA	40%	6%	32%	16%	16%	16%	40%
SURGUJA	55%	35%	71%	12%	37%	58%	18%
BILASPUR	41%	31%	63%	15%	40%	63%	14%
RAIGARH	57%	34%	60%	8%	25%	57%	20%
BASTAR	59%	11%	41%	7%	17%	24%	24%
State	**46%**	**26%**	**54%**	**13%**	**27%**	**43%**	**21%**

PRI representatives' perception about the Mitanin programme

5.58 According to respondent PRI members, accompanying women for delivery, promotion and coordination of immunization programme, counseling women on all aspects of pregnancy, providing pills condoms and IFA tables and visiting new born for advice and care and are the main roles of the Mitanins (Table 73).

Table 73: PRIs' perception about Mitanin role

	Counselling women on all aspects of pregnancy	Accompanying women for delivery	Visiting new born for advice /care	Promotion and coordination for immunization program	Provides medicines for minor illnesses	Providing pills and condom and IFA tablets	Any tuberculosis related work (DOTS provider)	Getting Panchayat to take action on health related issues
KANKER	73%	82%	45%	73%	73%	58%	10%	9%
DHAMTARI	86%	86%	66%	83%	80%	71%	25%	42%
R' GOAN	62%	60%	40%	62%	48%	58%	17%	23%
KORIA	46%	64%	26%	61%	65%	34%	1%	1%
SURGUJA	88%	90%	75%	88%	88%	66%	17%	22%
BILASPUR	86%	89%	55%	86%	70%	78%	14%	28%
RAIGARH	81%	88%	72%	89%	91%	72%	15%	27%
BASTAR	73%	88%	43%	84%	76%	46%	5%	4%
State	**75%**	**81%**	**53%**	**78%**	**74%**	**61%**	**13%**	**20%**

5.59 Increase in the immunization coverage is the main impact of the Mitanin programme according to the majority respondents. Other impact areas identified include increasing

institutional deliveries, increasing mother and child presence in the VHNDs and better hygiene in the community (Table 74).

Table 74: PRI perception of impact of Mitanin programme

	Increasing immunization	Increasing institutional delivery	Increase in utilization of public health services	Better hygiene in the community	Increased utilization of public health services by the marginalised	Increasing mother and children's attendance in VHND	Increased awareness of rights
KANKER	87%	86%	29%	59%	21%	59%	8%
DHAMTARI	88%	91%	54%	67%	42%	83%	49%
RAJNANDGOAN	62%	62%	30%	57%	31%	49%	10%
KORIA	68%	61%	23%	27%	7%	43%	5%
SURGUJA	96%	90%	43%	58%	38%	91%	27%
BILASPUR	95%	94%	28%	54%	28%	85%	19%
RAIGARH	96%	90%	43%	69%	36%	84%	21%
BASTAR	89%	89%	15%	50%	15%	65%	5%
State	**85%**	**83%**	**33%**	**55%**	**27%**	**70%**	**18%**

5.60 The social mobilization activities of the Mitanin are acknowledged by significant number of PRI respondents as well, particularly those relating to water and sanitation, picketing of alcohol shops and adolescent and adult education (Table 75).

Table 75: PRI perception of social mobilization work of Mitanins

	Picketing of Alcohol shops	Demanding ICDS, PDS entitlements be given properly	Water and sanitation facilities	Forest rights and environmental issues	Mobilisation women against domestic violence	Adolescent and women education	None
KANKER	45%	12%	49%	10%	21%	34%	28%
DHAMTARI	34%	45%	60%	26%	29%	53%	16%
RAJNANDGOAN	35%	29%	51%	8%	27%	31%	12%
KORIA	40%	6%	32%	16%	16%	16%	40%
SURGUJA	55%	35%	71%	12%	37%	58%	18%
BILASPUR	41%	31%	63%	15%	40%	63%	14%
RAIGARH	57%	34%	60%	8%	25%	57%	20%
BASTAR	59%	11%	41%	7%	17%	24%	24%
State	**46%**	**26%**	**54%**	**13%**	**27%**	**43%**	**21%**

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Chapter 6 - Conclusions and recommendations

Conclusions

6.1 The qualitative / quantitative assessments provide an un-ambiguous message, namely that the Mitanin programme was well designed and has had the desired impact in terms of improved utilization of services [e.g. immunization, supplementary nutrition] and health promotion. The 'activist' role, well structured into the Mitanin training strategy, has, at the same time, enabled them to mobilize the community for better participation in ICDS programme and promotion of hygiene. That 'serving the community' emerges as the key motivator from the quantitative evaluation validates the original design on the one hand and speaks volumes about the quality of social mobilization which preceded the selection of the Mitanins.

6.2 The qualitative assessment, however, underlines the fact that the inherent strengths of the programme may be under severe threat of breaking down unless urgent steps are taken to restore the original programme design.

The original 'design' of the programme : some remarks

6.3 In the context of the formulation of the 9th Plan, the Planning Commission had reviewed the results of more than 2400 evaluation studies conducted in the past. The review led to the following conclusions which ought to govern programme design[19]:

- in all success stories, people's participation has been a critical factor.
- this (people's participation), however, can not come about automatically; involvement of facilitators / animators is needed to remove the constraints and inertia of the people.
- development of the disadvantaged groups is not possible with focus on a single activity; without addressing the problem of illiteracy, ill-health, poverty and the forward and backward linkages of their primary activities simultaneously, the people could not be motivated to participate in the development process.

6.4 It would be interesting to note how well the original programme design of the Mitanin programme had responded to the above conclusions: the overall the aim of the programme was to enhance people's participation in health; the SHRC itself was designed to provide the facilitator / animator inputs and the programme did envisage going beyond a single activity. In fact, the Nutrition Security Fellowship Initiative was a step in the direction of going beyond "single activity" namely to provided added focus to malnutrition among children under 3 years of age. Taken up in 23 blocks with the financial assistance from ICICI Centre for Child Health and Nutrition (ICCHN), the project is reported to have already started making an

[19] See paragraphs 5.26 to 5.40, Volume-I, 9th Plan document, Planning Commission, Government of India.

impact on under-3 child mortality[20]. It may be noted that the project does not use any financial incentives and focuses on social mobilization which under-pinned the entire Mitanin roll-out.

6.5 That the task based financial incentives introduced after the launch of the NRHM is more than likely to damage the positive impact of the programme during the pre-NRHM period has been very well articulated by Mr Anbalagan, the then Director of Health Services:

> " The key aspect that he underlined about the Mitanin programme was that it was a volunteer based scheme, where the most a Mitanin would initially get was social recognition. He felt that the best evidence on this format of recognition can be seen in the number of Mitanins who have now become Panchs or elected as Panchayat members…. He felt that the current trend or demand for regularising the Mitanin as a paid worker from the health system will eat into her independence and make her the lowest level functionary of the health system and also a mere assistance to the ANM. This would take away her independence as a community representative and also her ability to critique the public health system and raise demands from it for the people. Mr. Anbalgan believes that she should continue to be outside the health system and innovative methods of incentivising need to be explored, such as funding through Panchayats etc. He feels the current trend of unionization (may) have been initiated by the training cadres, as they themselves are in temporary jobs and are also pushing together the Mitanins into what seems to be more their agenda than that of the Mitanins. He concluded by explaining that the key innovation in the Mitanin programme has been her location at the hamlet level and a continuous training and on field learning programme for the Mitanins"[21].

6.6 The key innovations referred to above were not by an accident; they were carefully built into the programme design based on a detailed review of what worked and what didn't. On the issue of incentives, for example, it was not the case that the Mitanin must be a volunteer; the key point of the design was that any compensation to the Mitanin must be determined by the community that she serves.

6.7 On the question of incentives per se, it may be relevant to refer to the lessons learned documented by Unicef as extracted below from its report titled *What Works for Children in South Asia : Community Health Workers* (2004):

> " Except India, all countries reviewed did not pay salaries or provide any kind of monetary incentives to CHWs, because the governments did not consider the salaries to be sustainable. Although Nepal started with a provision of small allowance per month (less than $2), it was discontinued after the first year as this could not be sustained. However, they were paid nominal allowances during the training period in all countries.
>
> Contrarily, countries are encouraging communities and local governments for providing them either monetary or non-monetary incentives such as bicycles, radios or community recognition and public appreciation for the contribution of volunteers in the

[20] The project MIS indicates a 4 point reduction [from 66 to 62] in under-3 child mortality during 2 years [2006-2008].

[21] Please see Section, II, qualitative evaluation report (Annex-5).

form of awards, certificates etc. And, some countries have even set up special funds for supporting the CHWs.

Ideally speaking, it is said that service to the community is the primary motivation factor for volunteering. However, it is reported that training stipend, earning an income through selling medicines and possibility of future employment opportunities are the motivational factors for many CHWs. But, evidence has shown that monetary incentives often bring a host of problems: money may not be enough, may not be paid regularly or may stop altogether. Hence, non-monetary incentives are critical to the success of any CHW programmes."

6.8 The latest documentation on the subject of CHWs, brought out by the WHO and Global Health Workforce Alliance, reconfirms the above[22]. The case studies (see **Annex-3**) include purely voluntary to contracted, paid CHWs. The key point, however, is that the selection and incentivisation is by the communities themselves, the formal health system's role being consciously limited to that of facilitation. This is exactly how the Mitanin programme was rolled out and this is why one finds the evidence of effectiveness [e.g. drop in IMR].

6.9 The case studies also indicate that the emerging trend is where the equivalent of the ANM is also identified from within the community. For example, Lady Health Worker in Pakistan is a woman residing in the same community where she resides; is a contractual employee who is required to organize community by developing women groups and health committees in her area. Similarly, the Health Extension Worker (HEW) in Ethiopia, which is a new cadre, is also recruited for training from the community in which she lives and would serve after completing her training[23]. The case studies thus indicate a move towards the situation where even the extension worker – the equivalent of the ANM - is also drawn from the community and put back into the same community after training.

Recommendations

6.10 There is compelling evidence that the original programme design has produced the intended results. Therefore, there is utmost need to restore the programme structure and its management to its original design. This would mean, inter alia, that:

- the principle of having one Mitanin per para (habitation) is preserved[24];
- the current system of task based incentives be stopped forthwith and a community led/owned compensation system be evolved, if necessary[25]; and

[22] *Global experiences of community health workers: A systematic review, country case studies and recommendations*, published by WHO and Global Health Workforce Alliance (GHWA); 2010.

[23] There are 2 HEWs for every 5000 population; similar to the 2-ANM per Sub-centre norm under the NRHM. The HEWs are supported by a number of volunteer CHWs selected by the community with ratio of one VCHW for every 250 population, roughly the same as the habitation based norm under the Mitanin programme.

[24] It is the habitation based approach which has helped in a) Mitanin being able to work as a volunteer as she has to work for a small area consisting of her own neighborhood, mostly her kins or friends b) achieving greater coverage of important target groups like pregnant women, newborn children, sick or malnourished children etc. and c) having closer accountability towards community.

- selection of new Mitanins must follow the elaborate social mobilization approach to selection that has been the hallmark of the original design.

6.11 It would be crucial, therefore, to restore the accountability of SHRC towards the programme and its mandate to provide technical assistance to the Department. As such, the role and mandate of the SHRC also needs to be re-emphasized to include the following:

- implementing the Mitanin programme (excluding procurement of Mitanin Drug kit)[26] and scaling up the Mitanin Nutrition Fellowship initiative;
- work with the Department of Panchayati Raj to design and implement a programme for communitization of health; and
- provide technical assistance to the Department of Health & Family Welfare in the areas enlisted in the MoU between the Department and the SHRC.

6.12 The Nutrition Fellowship initiative should be expanded to include all blocks. At the same time, there is a need to find new themes around which a fresh round of social mobilization ought to be built. The Mitanins who have been elected to the PRIs should be considered to contribute to the identification of issues (initially) and leading the fresh round(s) of social mobilization.

6.13 The State has set up a Mitanin Kalyan Kosh. The task based incentives available to the ASHA under the various national programmes should be pooled with the Kosh and used to implement such possible range of social / economic empowerment activities as may be designed through consultation meetings with the Mitanins[27].

6.14 An autonomous entity – e.g. Mitanin Kalyan Foundation - may be established to manage the Kosh and tax exemption for donations made to the Kosh may be sought in order to attract donations to the Kosh.

6.15 The WHO-GHWA Global review of the CHWs may be examined in detail for refining the programme, for example, for developing a career pathway for the Mitanins. Developing their skills in handling deliveries needs special attention as this has emerged as the leading desired skill in the quantitative assessment.

6.16 Mitanins' role in mobilizing communities on social determinants of health like poverty, gender, nutrition, sanitation etc. should be actively encouraged.

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[25] The overwhelming evidence is that the Mitanins take pride in volunteering. At the same time, original scheme design carefully placed the question of compensation in the hands of the community she serves. Therefore, incentives, if any, should be channelized through a community agency like VHSC with recommending authority being the Gram Panchayat/Gram Sabha. At the same time, non-monetary incentives in terms of recognition to Mitanins on occasions like health camps, Independence day etc. should be actively encouraged.

[26] Procurement of drug kits may be entrusted to the dedicated procurement agency being created; however, the budget for the drug kits should be reflected in the SHRC budget.

[27] A structured consultation process is suggested to identify empowerment / capacity building interventions which may well vary from area to area. For example, the Mitanins in one part of a district may be interested in organic farming of herbs while in other areas they may well be interested in other areas.

6.17 Mitanins must continue to be treated as volunteers and no duties should be imposed upon them especially involving submission of written reports.

6.18 Forums for regular interaction between Mitanins of a cluster or block should be encouraged as it helps in maintaining higher motivation levels.

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