Community Health Worker Training: Linking Pedagogy and Practice Report

A National Workshop Report

10th to 12th April 2006
Tata Management Training Center, Pune

organised by

The Foundation for Research in Community Health (FRCH)

in partnership with

The Early Child Health Team of the Social Initiatives Group (SIG), ICICI Bank

About this document

A National Workshop titled, "Community Health Worker Training: Linking Pedagogy and Practice" was organised by the Foundation for Research in Community Health (FRCH) in partnership with the Early Child Health Team of the Social Initiatives Group (SIG), ICICI Bank on April 10 – 12, 2006.

The broad objectives of the Workshop were:

1. To share and consolidate innovations and learnings in community health worker training across programmes over the last three decades.
2. To discuss and develop initiatives for mainstreaming these innovations and learnings towards extending coverage and enhancing quality of community health worker training.
3. To initiate dialogue and create networks between various health worker training programmes, and between civil society groups and the National Rural Health Mission.

The following is a detailed compilation of all the documents relevant to the workshop. These contain:

- A background paper titled, Training Community Health Worker – Where do we stand?
- The workshop Programme Schedule
- A comprehensive report on the capturing the minutes of the workshop
- A set of Reflections and Recommendations circulated to the Ministry of Health and Family Welfare
- An analytical article covering the thematic debates rose during the workshop. The article is titled, Community Health Worker: the scope and hopes from ASHA
- Handout prints of Power Point presentations made by all the participants
- Participant contact details

TRAINING COMMUNITY HEALTH WORKERS – WHERE DO WE STAND?

Back ground paper prepared for the Community Health Worker training workshop – April 10-12 2006.

INTRODUCTION

As noted in the report titled "Training Community Health Workers"[1], "Training is only one element in the implementation of primary health care, and much of its content and methods must reflect the programme as a whole. Some training designers become overly engrossed in tangible implementation details rather than in broad policy and resource questions – yet the latter are often more critical."

Further the report notes, "Planners must resolve training issues for themselves. They must understand how training fits into their program and decide how much effort to invest, given competing priorities. It is easy to be didactic about training ideals, but a more difficult task is to adapt ideals to field situations and to balance training with management and technical support, provision of supplies, and all the other elements which make primary health care effective."[1]

While Community Health Worker training has been going on at different scales and in different programmes over the last few decades, and has more recently started at the national level as part of the National Rural Health Mission, there is a need to look at certain issues that go beyond the traditionally discussed issues of content, methodology and human resources and indeed influence and shape these critical aspects of the training process. This paper attempts to raise some of these questions in the light of some accepted principles and guidelines and some potential new approaches and relationships.

LINKING TRAINING TO OVERALL PROGRAMMES

Post the 1960s "technology transfer" phase of development thinking, and learning from its failures, building up community participation and capacity have been central strategies for most programmes attempting to facilitate development. This move has been reflected in the health field as well with numerous community based projects mushrooming all over the world including India during the 1960s and 70s. The main aim of these programmes has been strengthening the people's capacity in planning and implementing development programmes.

As part of this overall strategy of increasing community involvement most programmes have adopted strategies that included the training of an individual from the community to act as a 'link worker' or 'extension worker'. This was done with the expectation that such workers would help in translating 'expert' knowledge and interventions into culturally and socially acceptable forms to increase community acceptance and thus increase community ownership of programmes. While the many programmes saw participation as merely one way of increasing the efficiency of systems, more radical interpretations saw

community involvement as a process that was essentially empowering and that ultimately led to a redistribution of power and control over resources.

In the health field numerous approaches to community health worker based programmes have been tried. While many projects have adopted an extension approach where health workers are trained in preventive and curative medicine to 'fill-the-gap' as it were, other programmes saw health workers as activists, who by challenging medical hierarchies and demystifying medicine and its interventions would facilitate mobilization and organization of communities to demand health as a human right.

The World Health Organization has defined Community Health workers as workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training, and are not necessarily attached to any formal institution (WHO Study Group, 1989).

Training of community health workers, regardless of the ultimate perspective of the programme is obviously a crucial aspect of any community based health programme and necessarily reflects the overall philosophy of the programme managers / initiators and also to a large extent defines the overall and ultimate outcomes and impacts of the project.

Given the complexity of such social processes and the status-quo challenging nature of most such programmes, most demonstration and learnings / innovations from such projects are necessarily context specific. Thus while such programmes have been extremely creative, the generalizability and scalability of many of these have always been questioned.

While the challenges of programmes attempting to create change agents have included the transference and sustenance of vision, social analysis, organizing capacity, leadership skills and negotiating skills to the health workers, the challenges of programmes that have conceptualised their workers largely as service providers are demystification of medicine, teaching diagnostic and therapeutic skills, standardizing approaches and maintenance of records, and quality control. Obviously the two approaches need not be exclusive. However the methodology for each of the knowledge, skill and attitude components are very different and require very different competencies on the part of the trainers and are very sensitive to the context within which they are taught. They obviously also require very different monitoring, support and evaluative skills.

SOME ISSUES

Three conceptual issues are raised here:

1. One of the crucial issues and one that need to be raised constantly is

regarding the approach to training taken by the programme managers / initiators. Is training seen as a charity doled out, or is it seen as an enabling process that helps redistribute power and control over resources and infuse confidence into communities? Even if it seen as an empowering process we need to look carefully at the definition of empowerment we are using. Are we defining empowerment as enabling people to negotiate the dominant system better (a so called status-quo non-challenging empowerment) or to challenge and transform the system?

2. George Foster notes, "The striking thing about these questions is that almost all assume that effective health care can be achieved only when members of traditional communities change their health behavior (so that they accept whatever is offered to them by health bureaucracies). Rarely, if ever, the question is asked: "How can anthropologists help to change bureaucratic behaviour that inhibits the design and operation of the best (people centered) health care system" [2] (brackets added).

   This is an important question for the approaches to all aspects of training including content, methodology and human power and logistics. The ultimate choice of each of these depends on whether we are trying to manipulate people and communities to change behaviors to suit the developed technologies or are we inviting communities to organize and demand technologies that are in line with their values and priorities?

3. There seems to be an underlying assumption that we are 'teaching' the people something new – something without which they can't 'develop'. Something that is crucial for their overall development. It is almost as though we are doing them a favor. However clearly 'training' is not a 'favour' to anybody by any stretch of the imagination (as is sometimes argued by those arguing for voluntary workers) – given the fact that it is the people who are subsidizing both training and research of / by professionals – it is their right that this knowledge / benefits of the knowledge reach them.

These questions are not merely theoretical exercises but will be the foundation upon which the whole approach to training is based.

PRINCIPLES AND LEARNINGS

While there have been many programmes training community health workers the following are some of the common lessons learnt / principles that are followed.

It has been well recognized that while training community health workers one has to follow the principles of adult learning. As per a recently published module by CEDPA[3] they are as follows:

Adult learning occurs best when it:

• *Is self-directed*

Adults can share responsibility for their own learning because they know their own needs.

• *Fills an immediate need*

Motivation to learn is highest when it meets the immediate needs of the learner.

• *Is participative*

Participation in the learning process is active, not passive.

• *Is experiential*

The most effective learning is from shared experience; learners learn from each other, and the trainer often learns from the learners.

• *Is reflective*

Maximum learning from a particular experience occurs when a person takes the time to reflect back upon it, draw conclusions, and derive principles for application to similar experiences in the future.

• *Provides feedback*

Effective learning requires feedback that is corrective but supportive.

• *Shows respect for the learner*

Mutual respect and trust between trainer and learner help the learning process.

• *Provides a safe atmosphere*

A cheerful, relaxed person learns more easily than one who is fearful, embarrassed, or angry.

• *Occurs in a comfortable environment*

A person who is hungry, tired, cold, ill, or otherwise physically uncomfortable cannot learn with maximum effectiveness.

Apart from the above, experiences in various other training programmes have come up with many accepted principles of teaching adults and especially teaching them to take on the roles of a change agent as well as a service provider. An example of such a set of principles is that developed by the SEARCH[4] programme,

1. Training is not only for "knowing more", but is also for "behaving differently". Our focus is not upon information, but is upon attitude and skills.
2. Training must be meaningful to trainees, it must start from where the trainees are, and must respond to their evolving needs, both as individuals and as a group.
3. Effective learning comes from personal experience.
4. To be effective as an agent of change, the individual should have experienced change himself.
5. The processes, the issues, the forces and the learning in the group under training are similar to those in other groups, in a community and in society at large.

Thus to sum up – methodology is experience based, open ended, individual and group centered and largely here and now."

Similarly in a review[5] of the various projects that have been reported in the Anubhav series the following has been noted as far as training is concerned.

- Aim not only to impart skills, but also to change attitudes, and do so through novel ways of communication, such as street theatre and use of symbols, so as to include even illiterate women in community participation.

- Acceptance of the need for local health workers brought with it need for 'innovative training methods.'
    - For a primarily illiterate group of trainees simplified systems of training, testing and monitoring had to be devised like in CHDP-Pachod.
    - Intensive and repeated training
    - Quality of training is a major factor for success.
    - Short, simple and imaginative training courses at various levels and varying intervals.
    - Pre-job, on-the-job training and refresher courses.

Some of the projects took over the existing government staff in an area retrained them.

- The worker is as good as his or her training.
    - In the 12 case studies of Anubhav series the workers have been trained in different aspects of maternal and child health, preventive and curative care, and their repeated in-service training.
    - Training is functional not didactic and in-service training and supportive supervision helps to further develop existing skills.

There have been two major community health worker trainers' conferences in the past in India; the more recent one in 1990 ended with the following 'Statement of shared concern and evolving collectivity'[i] from which the following sections are quoted[6]:

"GOALS – considering the goal of health for ALL the policy for education for health must

- See health as a constituent part of human development and as an integral instrument of building a just and equitable society.
- Aim at building up and sustaining a health system that,
    - is people oriented, helping the people to cope with their problems in health;
    - is available and accessible preferentially to the poorest sector;
    - strives to enable and empower them to participate in their own health care by sharing in decision making, control, financing and evaluation with regard to their choice of health system;
    - is in consonance with the culture and traditional practices, when these are constructive and beneficial;
    - uses the resources better, with appropriate technology which serves the people.
    -

"TRAINING STRATEGIES – Education for health should be community -oriented and people-based so that the health professional / worker is able to equip and enable the people to cope with their health problems.

Competence based learning. The health personnel at different levels should be trained with appropriate skills attitudes and knowledge to function effectively in the area of work, encouraging competence based learning.

Opportunities should be provided for learning outside the training institution or organisation in the health care delivery system at various levels. One way of achieving these objectives will be through the greater use of electives in the community with government and voluntary health and development projects.

Value Orientation. The training programmes at all levels should lay emphasis on values and ethics including conduct and relationships at the personal level and right to health and distributive justice at the social level.

Health and Culture. All training programmes should take into consideration the way of life of the people and their practices, learn from it and build on it. Both trainers and trainees must approach this area with an attitude of learning.

Governmental and Non-governmental programmes. It is the primary responsibility of the government to provide health care services, while the NGO sector also has its increasing role. To achieve the optimum mix, with respect to numbers, types and qualities of health workers and effective training programmes, all efforts should be made to have interaction between governmental and non-governmental sectors, learning from and supportive of each others efforts.

Systems of Health care and Medicine. All training programmes must take into consideration peoples' health culture.

What ever be the focus of the system of health care and medicine, in a training programme, there is need for generating awareness of the plurality of health systems and traditions in the country and encourage a healthy respect for all systems.

Evaluation. All training programmes should be evaluated for their effectiveness to achieve their goals, including their cost effectiveness. The process of evaluation should encourage evaluation by the trainees and the people

themselves.

Training of Trainers. There is a need for improving training of trainers for community based, people-oriented health care. The trainers should be role models for the trainees. For all formal courses, the trainers should devote their full-time for the training.

Methodologies of training. Different methodologies of learning and training, appropriate to the situation should be used. To the extent possible, all training should be more experiential.

Innovative programmes. To meet the requirements of health for all, innovative training programmes should be encouraged and supported, whether in the governmental or voluntary sectors. National institutes set up to function as torch bearers of innovation should be accountable to the people in this role.

Networking of individuals / institutions involved in promoting relevant innovations in training should be encouraged and strengthened.

The very process of training and gaining knowledge and perspectives that are usually beyond the reach of the average rural woman is itself a very transforming process. It greatly increases the recognition of inequities, social analysis and aspiration and confidence. In fact one of the common refrains that is heard from programmes all over the country is that, "if nothing else, at least we have 'x' number of confident and transformed women".

Thus the content and methodology of training as well as the very fact of going outside the home to learn new knowledge and skills are great transforming events. However in terms of overall goals of training, the ultimate impact is aimed at the community that the health worker serves and not only the individual and the family.

This translation of individual transformation into community level empowerment is dependent not only on a set of unique skills that the health worker may have, but also on certain systemic and community wide processes. Merely giving inputs to a particular individual, without any systemic and community level facilitation will be totally non-productive and community mobilization, organization and empowerment will be left to random events to trigger off. Moreover this sort of individual training can lead to the creation of new centers of power, rather than facilitating the redistribution of power as originally intended. This risk is well reflected by Paulo Friere when he says[7], "As soon as they complete the course and return to the community with resources they did not formerly possess, they either use these resources to control the submerged and dominated consciousness of their comrades, or they become strangers in their own communities and their former leadership position is thus threatened. In order not to lose their leadership status, they will probably tend to continue manipulating the community, but in more efficient ways."

TRAINING AND THE LARGER CONTEXT

Apart from these there are several issues regarding the changing context within

which training programmes are now being implemented that have a bearing on the overall approach chosen and the effectiveness of the training imparted. A few are highlighted here:

1. The changing context of the community health field. These include changes in the local level and national level like increasing urbanization, increased industrialization, a marketization of the economy, fracturing of the community along newer faultlines, fluctuating political will, and internationally by the move towards increasing globalization, increasing powers of the multinational corporations and homogenization of economies and cultures.
2. The pressure towards sustainability and scalability as crucial components of any programme.
3. Renewed interest shown by governments to start statewide / nationwide community health worker programmes.

As noted above the context within which training occurs has changed quite radically since the early programmes of the 70's. It is very important to re-look at our approaches and experiences in the light of these changes.

CHW TRAINING: DEVELOPING INNOVATIVE WAYS TO WORK ON AND AT SCALE

Training is well recognized as a crucial input into any programme, while the principles of training and approach to training are broadly accepted, the actual translation of these inputs into content, and linked to this, methodologies has till now been, and is of necessity extremely context and programme specific. With the initiating of the NRHM and large-scale national and state-wide programmes, there is an urgent need to reflect on past experiences and critically develop ways to improve the design and implementation of such programmes. In this context, some of the important questions that need to be asked include:

- Is there a possibility of coming up with guidelines and processes for development of content, methodology and the planning of human power?
    - What can we adapt based on learnings from past experiences and in what ways can we develop new methodologies for training CHWs in large-scale programmes?
    - How can a large-scale programme ensure the creation of high quality and sensitively contextualized training content?
    - In large-scale programmes, who are the trainers and how should they be selected, trained, mentored and supported in their critical roles as facilitators and participants in processes of health empowerment?

- Is there potential to come up with methods to make the program learn as it is implemented and to incorporate these learnings as we move along?

- Is there a method by which the different stakeholders can create new

paradigms of engagement and partnership and together focus clearly on facilitating a people's movement?

THIS WORKSHOP

This workshop is an attempt to initiate a dialogue between the various stakeholders who are deeply engaged in developing and implementing CHW programmes across India. It aims to bring together representatives from NGOs, national and state governments, funding agencies, and researchers to share various experiences as well as re-examine them from both the specific perspectives of scaled programmes, as well as in the changing context of the 21st century. In doing so, the workshop attempts to go beyond the dichotomy of innovation and upscaling, towards evolving instead a process of "innovating at scale," in which the creativity and sensitivity of a rich history of community-based health experiences is combined with the historic imperative and opportunity to ensure access to health across the vast geographies and social contexts of India.

We also hope that this dialogue, in the context of the evolving National Rural Health Mission will provide a space to begin to forge new paradigms of engagement between the various stakeholders in the field of health.

REFERENCES

1. Training Community Health Workers. Information for action issue paper. UNICEF. 1983
2. George Foster. 1982. Applied anthropology and international health: Retrospect and prospect. Human Organization. Vol. 41, 3, 189-97. As quoted in Banerji D. 1986. Social sciences and health service development in India. Lok Paksh. New Delhi.
3. Training Trainers for Development. The CEDPA Training manuals series. Volume 1. CEDPA. Washington USA.
4. Staley John 1982. People in development. A trainers manual for groups. SEARCH Bangalore.
5. Pachauri Saroj, Reaching India's Poor: Non-Governmental Approaches to Community Health, Sage Publications, 1994
6. Community Health Cell, Community Health Trainers Dialogue – Towards an Education Policy for Health Sciences, Bangalore, October 1991, mimeographed report.
7. Friere Paulo. Pedagogy of the Oppressed. Harmondsworth: Penguin, 1972

Community Health Worker Training: Linking Pedagogy and Practice
A National Workshop
April 10 – 12, 2006
Tata Management Training Centre, Pune

Day I (April 10, 2006) **Community Health Worker Training: An Introduction**	
12:00 – 12:30	Arrival & registration of participants
12:30 – 13:00	Welcome Address by Dr. N.H. Antia, Director, Foundation for Research in Community Health, Pune
Lunch	
14:00 – 14:30	Introductory Key Note: Historical overview of CHW programmes internationally Speaker: Prof. David Sanders, University of Western Cape, South Africa
14:30 – 15:00	Introductory Key Note: The Community Health Workers of India – Training Extension Workers or Activists? Speaker: Dr. Ravi Narayan, Community Health Cell, Bangalore
Tea	
15:15 – 15:30	The National Rural Health Mission: an overview Speaker: Mr. Amarjeet Sinha, Director, NRHM, MoHFW, Government of India
15:30 – 15:45	Presentation by Health Workers
15:45 – 16:30	Film on 'Life of a CHW:Reflections on training programmes and policies' followed by discussion Director: Dr. Parvez Imam, f20 Communications, Delhi
16:30 – 17:00	Setting the agenda of the Workshop Speaker: Dr. Rakhal Gaitonde, Foundation for Research in Community, Health, Pune

Day II (April 11, 2006)	
Innovations in Training Content & Methodologies in Community Health Worker Programmes	
09:00 – 09:30	Key Note: Adult learning principles – How community health workers learn Speaker: Dr. K. Balasubramanium, Commonwealth of Learning
Session I: Panel Discussion	
09:30 – 10:30	**Approaches to training: Focus on content, methodology and human resources for training** Speakers: Dr. R. Arole, Comprehensive Rural Health Project, Jamkhed Mr. V.R. Raman, Mitanin Programme, State Health Resource Centre, Chhattisgarh Dr. N. Mistry, Foundation for Research in Community Health, Pune
10:30 – 11:30	Discussion Discussants: Dr. Abhay Shukla, SATHI - CEHAT, Pune Dr. D.C. Jain, Deputy Commissioner, Child Welfare & Training, MoHFW, Government of India Dr. Shyam Ashtekar, Yeshwantrao Chavan Memorial Open University, Nasik
Tea	
Session II: Presentation of Case Studies	
A. Teaching Skills to Community Health Workers	
11:45 – 12:00	Teaching clinical skills to CHWs Speaker: Dr. Shyam Ashtekar, Yeshwantrao Chavan Memorial Open University, Nasik
12:00 – 12:15	Training CHWs for behaviour change communication Speaker: Maj. S. Menon, Kripa Foundation, Mumbai
12:15 – 13:00	Discussion Discussants: Dr. Yogesh Jain, Jan Swasthya Sahyog, Chhattisgarh Dr. S.C. Mathur, SIHFW, Rajasthan
Lunch	
B. Community Health Worker Training in Varied Contexts	
14:00 – 14:15	Gender & social exclusion in CHW training Speaker: Dr. Lindsay Barnes, Jan Chetna Manch, Jharkhand
14:15 – 14:30	Training CHWs with low literacy levels Speaker: Dr. Abhay Shukla/ Dr. Anant Phadke, SATHI-CEHAT, Pune
14:30 – 14:45	Training CHWs in the context of political strife Speaker: Dr. Sunil Kaul, Action Northeast Trust, Assam
14:45 – 15:45	Discussion Discussants: Dr. Narendra Gupta, Prayas, Rajasthan Ms. Arzoo Dutta, State Facilitator, NRHM, Nagaland

Day II (April 11, 2006) Innovations in Training Content & Methodologies in Community Health Worker Programmes	
C. Partnerships for Community Health Worker Training	
15:45 – 16:00	Partnerships for innovations in training CHWs in state programmes Speakers: Dr. Alok Shukla, Secretary of School Education, Chhattisgarh & former Secretary of Health, Chhattisgarh Mr. Biraj Patnaik, Principal Advisor, Office of the Commissioners of the Supreme Court, Delhi
16:00 – 16:30	Discussion Discussants: Mr. Amarjeet Sinha, Director, NRHM, MoHFW, Government of India Dr. Peter Berman, The World Bank, New Delhi
Tea	
Session III: Evaluating Training	
16:45 – 17:15	Evaluation and monitoring of the training process Speaker: Ms. S. Deodhar, Foundation for Research in Community Health Pune
17:15 – 17:45	Discussion Discussant: Dr. Nandita Kapadia, Institute of Health Management, Pune
17:45 – 18:15	Pedagogy and Social Context of Empowerment - a Peoples' Health Movement Reflection Speaker: Dr. Ravi Narayan, Community Health Cell, Bangalore

Day III (April 12, 2006)	
Training Content & Methodologies for Community Health Workers at Scale	
09:00 – 09:30	**Key Note: Approaches to achieving scale: Missions and Movements** Speaker: Dr. T. Sundararaman, State Health Resource Centre, Chhattisgarh
Session I: Group Discussions	
09:30 – 09:45	**Introduction to group processes** by Mekhala Krishnamurthy, Social Initiatives Group, ICICI Bank, Mumbai
09:45 – 11:15	**Group Discussions on aspects of CHW training at scale** Chair: Prof. David Sanders, University of Western Cape, South Africa
Topics:	**Content, methodology & human resources for CHW training at scale**
	Partnerships at scale – focus on training CHWs
	Support structures for CHW programs at scale
	Monitoring training processes & outcomes at scale
Tea	
11:30 – 13:00	**Presentation by Groups**
Lunch	
Session II: Panel Discussion	
14:00 – 15:00	**Discussion on group presentations** Discussants: Dr. T. Sundararaman, State Health Resource Centre, Chhattisgarh Mr. J.P. Mishra, European Commission Technical Assistance, Delhi Dr. Abhay Shukla, SATHI - CEHAT, Pune
15:00 – 15:30	**Open Discussion**
Session III: Reflections and Future Directions	
15:30 – 15:45	**Open House: Participants' suggestions for future directions**
15:45 – 16:15	**Discussion** Chair: Dr. N. Mistry, Foundation for Research in Community Health, Pune Dr. Narendra Gupta, Prayas, Chittorgarh
Tea	
16:30 – 16:45	**Reflections on the Workshop** Speaker: Prof. David Sanders, University of Western Cape, South Africa
16:45 – 17:00	**Concluding remarks**

TRAINING COMMUNITY HEALTH WORKERS – WHERE DO WE STAND?
Workshop on Community Health Worker Training: Linking Pedagogy and Practice
April 10-12 2006, Pune

INTRODUCTION

As noted in the report titled "Training Community Health Workers"[1], "Training is only one element in the implementation of primary health care, and much of its content and methods must reflect the programme as a whole. Some training designers become overly engrossed in tangible implementation details rather than in broad policy and resource questions – yet the latter are often more critical."

Further the report notes, "Planners must resolve training issues for themselves. They must understand how training fits into their programme and decide how much effort to invest, given competing priorities. It is easy to be didactic about training ideals, but a more difficult task is to adapt ideals to field situations and to balance training with management and technical support, provision of supplies, and all the other elements which make primary health care effective."[1]

While Community Health Worker training has been going on at different scales and in different programmes over the last few decades, and has more recently started at the national level as part of the National Rural Health Mission, there is a need to look at certain issues that go beyond the traditionally discussed issues of content, methodology and human resources and indeed influence and shape these critical aspects of the training process. This paper attempts to raise some of these questions in the light of some accepted principles and guidelines and some potential new approaches and relationships.

LINKING TRAINING TO OVERALL PROGRAMMES

Post the 1960s "technology transfer" phase of development thinking, and learning from its failures, building up community participation and capacity have been central strategies for most programmes attempting to facilitate development. This move has been reflected in the health field as well with numerous community based projects mushrooming all over the world including India during the 1960s and 70s. The main aim of these programmes has been strengthening the people's capacity in planning and implementing development programmes.

As part of this overall strategy of increasing community involvement most programmes have adopted strategies that included the training of an individual from the community to act as a 'link worker' or 'extension worker'. This was done with the expectation that such workers would help in translating 'expert' knowledge and interventions into culturally and socially acceptable forms to increase community acceptance and thus increase community ownership of programmes. While the many programmes saw participation as merely one way of increasing the efficiency of systems, more radical interpretations saw community involvement as a process that was essentially empowering and that ultimately led to a redistribution of power and control over resources.

In the health field numerous approaches to community health worker based programmes have been tried. While many projects have adopted an extension approach where health workers are trained in preventive and curative medicine to 'fill-the-gap' as it were, other programmes saw health workers as activists, who by challenging medical hierarchies and demystifying medicine and its interventions would facilitate mobilization and organization of communities to demand health as a human right.

The World Health Organization has defined Community Health workers as workers who live in the community they serve, are selected by that community, are accountable to the community they work within, receive a short, defined training, and are not necessarily attached to any formal institution (WHO Study Group, 1989).

Training of community health workers, regardless of the ultimate perspective of the programme is obviously a crucial aspect of any community based health programme and necessarily reflects the overall philosophy of the programme managers / initiators and also to a large extent defines the overall and ultimate outcomes and impacts of the project.

Given the complexity of such social processes and the status-quo challenging nature of most such programmes, most demonstration and learnings / innovations from such projects are necessarily context specific. Thus while such programmes have been extremely creative, the generalizability and scalability of many of these have always been questioned.

While the challenges of programmes attempting to create change agents have included the transference and sustenance of vision, social analysis, organizing capacity, leadership skills and negotiating skills to the health workers, the challenges of programmes that have conceptualised their workers largely as service providers are demystification of medicine, teaching diagnostic and therapeutic skills, standardizing approaches and maintenance of records, and quality control. Obviously the two approaches need not be exclusive. However the methodology for each of the knowledge, skill and attitude components are very different and require very different competencies on the part of the trainers and are very sensitive to the context within which they are taught. They obviously also require very different monitoring, support and evaluative skills.

SOME ISSUES

Three conceptual issues are raised here:

1. One of the crucial issues and one that need to be raised constantly is regarding the approach to training taken by the programme managers / initiators. Is training seen as a charity doled out, or is it seen as an enabling process that helps redistribute power and control over resources and infuse confidence into communities? Even if it seen as an empowering process we need to look carefully at the definition of empowerment we are using. Are we defining empowerment as enabling people to negotiate the dominant system better (a so called status-quo non-challenging empowerment) or to challenge and transform the system?

2. George Foster notes, "The striking thing about these questions is that almost all assume that effective health care can be achieved only when members of

traditional communities change their health behavior (so that they accept whatever is offered to them by health bureaucracies). Rarely, if ever, the question is asked: "How can anthropologists help to change bureaucratic behaviour that inhibits the design and operation of the best (people centered) health care system" [2] (brackets added).

This is an important question for the approaches to all aspects of training including content, methodology and human power and logistics. The ultimate choice of each of these depends on whether we are trying to manipulate people and communities to change behaviors to suit the developed technologies or are we inviting communities to organize and demand technologies that are in line with their values and priorities?

3. There seems to be an underlying assumption that we are 'teaching' the people something new – something without which they can't 'develop'. Something that is crucial for their overall development. It is almost as though we are doing them a favor. However clearly 'training' is not a 'favour' to anybody by any stretch of the imagination (as is sometimes argued by those arguing for voluntary workers) – given the fact that it is the people who are subsidizing both training and research of / by professionals – it is their right that this knowledge / benefits of the knowledge reach them.

These questions are not merely theoretical exercises but will be the foundation upon which the whole approach to training is based.

PRINCIPLES AND LEARNINGS

While there have been many programmes training community health workers the following are some of the common lessons learnt / principles that are followed.

It has been well recognized that while training community health workers one has to follow the principles of adult learning. As per a recently published module by CEDPA[3] they are as follows:

Adult learning occurs best when it:

- *Is self-directed*

Adults can share responsibility for their own learning because they know their own needs.

- *Fills an immediate need*

Motivation to learn is highest when it meets the immediate needs of the learner.

- *Is participative*

Participation in the learning process is active, not passive.

- *Is experiential*

The most effective learning is from shared experience; learners learn from each other, and the trainer often learns from the learners.

- *Is reflective*

Maximum learning from a particular experience occurs when a person takes the time to reflect back upon it, draw conclusions, and derive principles for application to similar experiences in the future.

• *Provides feedback*
Effective learning requires feedback that is corrective but supportive.
• *Shows respect for the learner*
Mutual respect and trust between trainer and learner help the learning process.
• *Provides a safe atmosphere*
A cheerful, relaxed person learns more easily than one who is fearful, embarrassed, or angry.
• *Occurs in a comfortable environment*
A person who is hungry, tired, cold, ill, or otherwise physically uncomfortable cannot learn with maximum effectiveness.

Apart from the above, experiences in various other training programmes have come up with many accepted principles of teaching adults and especially teaching them to take on the roles of a change agent as well as a service provider. An example of such a set of principles is that developed by the SEARCH[4] programme,

1. Training is not only for "knowing more", but is also for "behaving differently". Our focus is not upon information, but is upon attitude and skills.
2. Training must be meaningful to trainees, it must start from where the trainees are, and must respond to their evolving needs, both as individuals and as a group.
3. Effective learning comes from personal experience.
4. To be effective as an agent of change, the individual should have experienced change himself.
5. The processes, the issues, the forces and the learning in the group under training are similar to those in other groups, in a community and in society at large.

Thus to sum up – methodology is experience based, open ended, individual and group centered and largely here and now."

Similarly in a review[5] of the various projects that have been reported in the Anubhav series the following has been noted as far as training is concerned.

- Aim not only to impart skills, but also to change attitudes, and do so through novel ways of communication, such as street theatre and use of symbols, so as to include even illiterate women in community participation.

- Acceptance of the need for local health workers brought with it need for 'innovative training methods.'
    - For a primarily illiterate group of trainees simplified systems of training, testing and monitoring had to be devised like in CHDP-Pachod.
    - Intensive and repeated training
    - Quality of training is a major factor for success.
    - Short, simple and imaginative training courses at various levels and varying intervals.
    - Pre-job, on-the-job training and refresher courses.

Some of the projects took over the existing government staff in an area retrained them.

- The worker is as good as his or her training.
    - In the 12 case studies of Anubhav series the workers have been trained in

different aspects of maternal and child health, preventive and curative care, and their repeated in-service training.

- Training is functional not didactic and in-service training and supportive supervision helps to further develop existing skills.

There have been two major community health worker trainers' conferences in the past in India; the more recent one in 1990 ended with the following 'Statement of shared concern and evolving collectivity" from which the following sections are quoted[6]:

"GOALS – considering the goal of health for ALL the policy for education for health must

- See health as a constituent part of human development and as an integral instrument of building a just and equitable society.
- Aim at building up and sustaining a health system that,
  - is people oriented, helping the people to cope with their problems in health;
  - is available and accessible preferentially to the poorest sector;
  - strives to enable and empower them to participate in their own health care by sharing in decision making, control, financing and evaluation with regard to their choice of health system;
  - is in consonance with the culture and traditional practices, when these are constructive and beneficial;
  - uses the resources better, with appropriate technology which serves the people.
  -

"TRAINING STRATEGIES – Education for health should be community -oriented and people-based so that the health professional / worker is able to equip and enable the people to cope with their health problems.

Competence based learning. The health personnel at different levels should be trained with appropriate skills attitudes and knowledge to function effectively in the area of work, encouraging competence based learning.

Opportunities should be provided for learning outside the training institution or organisation in the health care delivery system at various levels. One way of achieving these objectives will be through the greater use of electives in the community with government and voluntary health and development projects.

Value Orientation. The training programmes at all levels should lay emphasis on values and ethics including conduct and relationships at the personal level and right to health and distributive justice at the social level.

Health and Culture. All training programmes should take into consideration the way of life of the people and their practices, learn from it and build on it. Both trainers and trainees must approach this area with an attitude of learning.

Governmental and Non-governmental programmes. It is the primary responsibility of the government to provide health care services, while the NGO sector also has its increasing role. To achieve the optimum mix, with respect to numbers, types and qualities of health workers and effective training programmes, all efforts should be made to have interaction between governmental and non-governmental sectors, learning from and supportive of each others efforts.

Systems of Health care and Medicine. All training programmes must take into consideration peoples' health culture.

What ever be the focus of the system of health care and medicine, in a training programme, there is need for generating awareness of the plurality of health systems and traditions in the country and encourage a healthy respect for all systems.

Evaluation. All training programmes should be evaluated for their effectiveness to achieve their goals, including their cost effectiveness. The process of evaluation should encourage evaluation by the trainees and the people themselves.

Training of Trainers. There is a need for improving training of trainers for community based, people-oriented health care. The trainers should be role models for the trainees. For all formal courses, the trainers should devote their full-time for the training.

Methodologies of training. Different methodologies of learning and training, appropriate to the situation should be used. To the extent possible, all training should be more experiential.

Innovative programmes. To meet the requirements of health for all, innovative training programmes should be encouraged and supported, whether in the governmental or voluntary sectors. National institutes set up to function as torch bearers of innovation should be accountable to the people in this role.

Networking of individuals / institutions involved in promoting relevant innovations in training should be encouraged and strengthened.

The very process of training and gaining knowledge and perspectives that are usually beyond the reach of the average rural woman is itself a very transforming process. It greatly increases the recognition of inequities, social analysis and aspiration and confidence. In fact one of the common refrains that is heard from programmes all over the country is that, "if nothing else, at least we have 'x' number of confident and transformed women".

Thus the content and methodology of training as well as the very fact of going outside the home to learn new knowledge and skills are great transforming events. However in terms of overall goals of training, the ultimate impact is aimed at the community that the health worker serves and not only the individual and the family.

This translation of individual transformation into community level empowerment is dependent not only on a set of unique skills that the health worker may have, but also on certain systemic and community wide processes. Merely giving inputs to a particular individual, without any systemic and community level facilitation will be totally non-productive and community mobilization, organization and empowerment will be left to random events to trigger off. Moreover this sort of individual training can lead to the creation of new centers of power, rather than facilitating the redistribution of power as originally intended. This risk is well reflected by Paulo Friere when he says[7], "As soon as they complete the course and return to the community with resources they did not formerly possess, they either use these resources to control the submerged and

dominated consciousness of their comrades, or they become strangers in their own communities and their former leadership position is thus threatened. In order not to lose their leadership status, they will probably tend to continue manipulating the community, but in more efficient ways."

TRAINING AND THE LARGER CONTEXT

Apart from these there are several issues regarding the changing context within which training programmes are now being implemented that have a bearing on the overall approach chosen and the effectiveness of the training imparted. A few are highlighted here:

1. The changing context of the community health field. These include changes in the local level and national level like increasing urbanization, increased industrialization, a marketization of the economy, fracturing of the community along newer faultlines, fluctuating political will, and internationally by the move towards increasing globalization, increasing powers of the multinational corporations and homogenization of economies and cultures.
2. The pressure towards sustainability and scalability as crucial components of any programme.
3. Renewed interest shown by governments to start statewide / nationwide community health worker programmes.

As noted above the context within which training occurs has changed quite radically since the early programmes of the 70's. It is very important to re-look at our approaches and experiences in the light of these changes.

CHW TRAINING: DEVELOPING INNOVATIVE WAYS TO WORK ON AND AT SCALE

Training is well recognized as a crucial input into any programme, while the principles of training and approach to training are broadly accepted, the actual translation of these inputs into content, and linked to this, methodologies has till now been, and is of necessity extremely context and programme specific. With the initiating of the NRHM and large-scale national and state-wide programmes, there is an urgent need to reflect on past experiences and critically develop ways to improve the design and implementation of such programmes. In this context, some of the important questions that need to be asked include:

- Is there a possibility of coming up with guidelines and processes for development of content, methodology and the planning of human power?
    - What can we adapt based on learnings from past experiences and in what ways can we develop new methodologies for training CHWs in large-scale programmes?
    - How can a large-scale programme ensure the creation of high quality and sensitively contextualized training content?
    - In large-scale programmes, who are the trainers and how should they be selected, trained, mentored and supported in their critical roles as facilitators and participants in processes of health empowerment?

- Is there potential to come up with methods to make the programme learn as it is implemented and to incorporate these learnings as we move along?

- Is there a method by which the different stakeholders can create new paradigms of engagement and partnership and together focus clearly on facilitating a people's movement?

THIS WORKSHOP

This workshop is an attempt to initiate a dialogue between the various stakeholders who are deeply engaged in developing and implementing CHW programmes across India. It aims to bring together representatives from NGOs, national and state governments, funding agencies, and researchers to share various experiences as well as re-examine them from both the specific perspectives of scaled programmes, as well as in the changing context of the 21st century. In doing so, the workshop attempts to go beyond the dichotomy of innovation and up-scaling, towards evolving instead a process of "innovating at scale," in which the creativity and sensitivity of a rich history of community-based health experiences is combined with the historic imperative and opportunity to ensure access to health across the vast geographies and social contexts of India.

We also hope that this dialogue, in the context of the evolving National Rural Health Mission will provide a space to begin to forge new paradigms of engagement between the various stakeholders in the field of health.

REFERENCES

1. Training Community Health Workers. Information for action issue paper. UNICEF. 1983
2. George Foster. 1982. Applied anthropology and international health: Retrospect and prospect. Human Organization. Vol. 41, 3, 189-97. As quoted in Banerji D. 1986. Social sciences and health service development in India. Lok Paksh. New Delhi.
3. Training Trainers for Development. The CEDPA Training manuals series. Volume 1. CEDPA. Washington USA.
4. Staley John 1982. People in development. A trainers manual for groups. SEARCH Bangalore.
5. Pachauri Saroj, Reaching India's Poor: Non-Governmental Approaches to Community Health, Sage Publications, 1994
6. Community Health Cell, Community Health Trainers Dialogue - Towards an Education Policy for Health Sciences, Bangalore, October 1991, mimeographed report.
7. Friere Paulo. Pedagogy of the Oppressed. Harmondsworth: Penguin, 1972

Community Health Worker Training: Linking Pedagogy and Practice[1]

Comprehensive Report on a National Workshop
10th to 12th April 2006
Tata Management Training Center, Pune

Day 1 (April 10, 2006)

Community Health Worker Training: an introduction

- **Welcome address**

Dr. Rakhal Gaitonde started the workshop by extending a warm welcome to everyone and invited Dr. Antia to deliver the welcome address.

Dr. Antia:
He began by saying that after 58 years of independence we could have achieved a lot more than we have. Health has been converted into illness or illness care. Medical profession is responsible for this to a great extent. How can health be separated from overall development? It cannot be alienated from overall development water, sanitation, nutrition, and education. We do not have to go somewhere out there to seek for exemplars. Kerala is a good example of how complete health care can be provided by spending around 50$ per capita per annum, while even some developed countries spend around 4600$ in providing health care to only 15% of its population. A close examination of the case of Kerala, which is so different from other states like Bihar, may provide answers to many questions?

Medical profession has been dictating the way health is understood. Despite 240 government medical colleges and many more in the private sector, and 14 lakh doctors, it is difficult to a get even one doctor for 30000 people. Thus, medical profession has failed to serve the people.

In the UK, after the Labor government came into power, Beveridge Report was drafted in order to guide the future of education, health and welfare was prepared. China as a developmental method started the practice of 'barefoot' doctors, and erstwhile USSR had 'Felchers' -community based health workers for their people. In India, after the independence, welfare strategy for health failed to deliver as the struggle was not just universalizing medicine but curtailing the widespread poverty. The people at grassroots need the supportive services of medical profession and health system. These supportive services are important and are not provided by the medical profession. ICSSR and ICMR reports were the blueprints, which had come out with a policy for decentralized Gandhian model for health. In 70s various experiment-based projects were started

---

[1] The following document is a comprehensive minutes of the workshop organized in order:

- To share and consolidate innovations and learnings in community health worker training across programmes over the last three decades.
- To discuss and develop initiatives for mainstreaming these innovations and learnings towards extending coverage and enhancing quality of community health worker training.
- To initiate dialogue and create networks between various health worker training programmes, and between civil society groups and the National Rural Health Mission.

namely by Arole, Miraj, Kasar, FRCH etc. They were experiments where the health was looked beyond illness and enabled people to question the system.

He stated how intelligence and knowledge are two different things. An intelligent plan may not be very knowledge intensive. Every village has its own set of knowledge base, which is different from the other. The village community sends us the message: "give us the knowledge and we will diffuse it to our situation". There is a need to learn from the women in villages. Didactic lectures, books and intellect alone will not be able to solve the problems. We need knowledge that can be diffused to all of them and that suits local situation.

FRCH passes on information and knowledge to women who percolate it down to other women in a manner that is relevant and practical. Then they get accreditation of their knowledge through NIOS (a certificate from National Institute of Open Schooling). He also stressed that *Panchayati raj* and *Right to Information (RTI)* are two tools that are very useful for people and have been incorporated in the courses (There are 110 different programmes in NIOS and one of them is on Panchayat Raj & Right to Information). RTI can be used to find out how much money comes under health to each village. Here is an extraordinary tool in the hands of people.

- **Introductory Key Note: Historical overview of CHW programmes internationally**

After a round of self-introduction, Anant introduced Prof. David Sanders who made his presentations citing the Present global context, trends in pattern and burden of diseases.

Prof. David Sanders:

Many improvements have taken place since 50s but health inequalities have increased. There are stark global inequities and within that maternal health shows worst trends. Acute respiratory tract infection, diarrhea, malaria, measles, HIV, prenatal problems are the biggest and perennial causes of child death.

Huge inequities continue to persist not only within countries but also between countries. He quoted 'would it be better to be born a Japanese cow on which 2700 $ are spent than an African citizen on whom a mere 500$ is spent'. Also most health care systems are technology based rather than need based and they are more selective than comprehensive.

He showed the ranking of causes of global burden of diseases as % DALYS. He stated that food security and nutrition is not much spoken about though micronutrients are mentioned. Non-communicable diseases are showing frightening emergence even in the poor people. For example even in the developed nation the decrease in mortality rate or TB is not due to the impact of medicines or health systems but migration of the poor to urban areas.

There is a rapid urbanization with simultaneous de-industrialization, which is reducing the employment opportunities for the slum dwellers in cities thereby causing more poverty and destitution. Current phase of globalization (Trade liberalization) starts from debt crisis. External debt has increased dramatically. Debt is a huge burden on Africa

and other developing countries. The economies end up recovering and repaying these debts, which tend to affect the amount they can spend on welfare activities. Private sector majorly affects the health sector reform. In Africa, water is privatized due to which a strong lobby is required to avail basic facilities like water etc. Water is important for food production and sanitation. Food production important for nutrition and nutrition and sanitation is important for improvement in health. Public health package does not include water and sanitation.

Community Health Worker Programmes become a way of addressing coverage and outreach; by activating a support to the people regarding health requirements; to cover up for the brain drain to urban areas. But CHW can be a success only by being a functioning part of a health care system, which can improve both her impact on people, and sustainability of the programme. Within this, the problem of compensation and conflict between CHW and Nurses is predominant in East Africa. Therefore, it is important to resolve these internal dynamics. Policy makers need to think of a mix of financial and non-financial incentives. Government must work with civil societies.

- **Introductory Key note: Historical Overview of CHW programmes in India – focus on the importance of training**

Dr. Ravi Narayan:

He recalled all the community health personnel he worked with for two and half decades. Since people are not just recipients put participants in community health work programmes, Community building becomes a priority. So the trainings taken for Community health Workers had significant components of Community building. For example, in the training camps at Jamkhed, women from various castes were made to cook together; sleep under blankets, which were stitched to each other; and view each other's blood samples under a microscope. These exercises enabled the trainees to experience a sense of solidarity, similarity and coherence as "human beings" before being members of any particular category of societal division.

Amongst the traditional midwives, there is a culture of Affective Trainings i.e., a training which perpetuated over years as a daughter learnt from her (dai) mother the practical, emotional, sentimental and skillful aspects of childbirth. Infact traditionally only a dai's daughter can become a dai as she has not only received but experienced the training[2].

He traced a genealogy of reports and experiments which have played a directional role in our health strategies but also highlighted how some efforts could have played a much more effective role in the condition of health care in India provided that their recommendations were taken more seriously. For example

1. Bhore committee talked of village health committee and voluntary health workers who need sustainable training but it was only given a lip service.

[2] We cannot overlook the fact that this practice is not void of the caste practices. It is not just owing to the fact that a Dai's daughter goes through affective training that she is an obvious choice to become a Dai. It is also because she is the daughter of a woman who plays the role of a mid-wife under the caste-based division of labor therefore becoming eligible for carrying forward the same role.

2. In 1970s and 80s, NGOs took up CHW programmes. These included some pioneering and innovative experiments namely CHWs of Jamkhed, VHWs of Indo-Dutch, Hyderabad, Lay First Aiders at Adyar, Chennai, Link workers of tea plantations in South India, Health Aides of RUHSA, MCH workers of CINI, Calcutta, Swasthya Mitras of BHU at Varanasi, Sanyojaks in Banavasi Seva Ashram at Uttar Pradesh, CHW course of St. John's Medical College at Bangalore, Rehbar-e-Sehat of Kashmir Government (Teacher-workers), CHVs of Sewa Rural at Jhagadia, Tais of Foundation for Research in Community health

- Here the CHWs were women
- They were either volunteers or receiving minimum support
- They were married
- They belonged to various caste and class representations
- Community participation was the key and support from community based groups was sought
- Innovative training methods were adopted
- Highly mobile field and supervisory staff was employed
- Women were encouraged to be part of many local activities and committees

3. On Srivastava Report recommendations many NGO trained CHWs were absorbed into government programmes as MPWs (male and female), which was further taken up in the Kartar Singh report. The Janata Experiment (1977) of introducing Community Health Guides, also known as the Rural Health Scheme was a crucial countrywide CHW campaign (which focused on CHWs selected by the community, having education up to class sixth and trained informally in the PHM for 3 months. They were paid a stipend during training and an honorarium of Rs.50/- per month when they began to work) was launched in all states except Jammu & Kashmir, Tamil Nadu, Kerala and Karnataka, but it did suffer from some inherent problems.

4. Under the Janata Experiment, the Manual for Community Health Worker was a nationally inspired demystification process. This manual could be used to teach about health to semi-literate populations. However when it was circulated, the most important section on Social and Mental health had been deleted.

5. In the National Health Policy, 1983, the CHW component was forgotten. From 1982 to mid 90s no one was talking about community health. The health budget was frozen as various pay commission s led to an increase in the salary component but the programme component kept decreasing.

6. In 1995 a new phase started i.e., the Jan Swasthya Rakshak scheme of Madhya Pradesh; followed by its evaluation and a range of recommendations which suggested a need for paradigmatic shift in the implementation of community health programmes.

7. 1990s experiments of empowerment like Arogya Iyakkam (Tamil Nadu Science Forum), Arogya Sathi (CEHAT Sathi), and CMSS (Dalli Rajhara Chhattisgarh) showed this shift ie.,

- From alternative health care providers and health extension workers to health empowerment activists
- From project management to process management
- From health activities to making people pressurize the existing health services to make it more responsive and accountable to people's needs

8. Recently, the Indian People's Health Charter of Jana Swasthya Abhiyan – December 2000, the Global People's Charter for Health of People's Health Movement – December 2000, the Mitanin Programme of Chhattisgarh – 2002, each one reflecting new ways of addressing the community health issues. And today we have the National Rural Health Mission.
ASHA's can't be alternatives or extensions; they must be a part of the system and not be preoccupied as alternative service providers. He said that after 50 years of independence, NRHM gives us opportunity for a new dialogue; he reminded the house that GOI has come to a stage were they are at the verge of a drastic change. However, we cannot romanticize that the community will take over everything. Community can take over Primary health care but not the Primary Health Care Center.

- National Rural Health Mission: An overview

Dr. D. C. Jain:

He shared the status of health as per the Government of India records and the improvements vis-à-vis some parameters like control of diseases (tuberculosis, polio, leprosy, and guinea worm) though a picture of achievements cannot overlook the overwhelming concerns and deterioration of health standards among the poor. Stark socio economic differences in IMR, NMR and MMR; critical shortage of human power (ANMs, doctors, Para medics); huge regional disparity (Kerala has 5 ANM per village and MP has 1 ANM for 5 villages); unregulated private sector; and no grievance redress mechanisms to name a few.

He shared that the lack of adequate monitoring mechanisms while formulation of schemes makes it difficult to ensure results on the ground. The time has come when the community must participate in a manner that they can confidently hold the government responsible for all the failures. Community based health workers who are accountable to the people and make the government accountable is the only way to move forward. He believed that the CHW program failed because of the word 'worker' therefore, now they are no more called workers but 'activists'.
Health certainly is a political priority, which is why the lack of (community) health personnel is being tackled. Also, it is not under-funding but under-utilization, which is the problem. He explained the major components of the NRHM and how NRHM aims to fill the gaps.

The National Rural Health Mission: an overview

The National Rural Health Mission (NRHM)[3] was announced in September 2004 as a part of the Common Minimum Programme of the Government of India with the following goal "*to promote equity, efficiency, quality and accountability of public health services through community driven approaches, decentralization and improving local governance*".[4] The duration of the Mission is seven years (2005-2012) and its focus is on 18 states[5] where the challenge of strengthening the weak public health system and improving key health indicators is the greatest. Taking an 'omnibus approach' by integrating existing vertical health programmes,[6] the NRHM seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralisation.[7]

The key components of the NRHM to achieve these objectives include the following:[8]

- Accredited Social Health Activist (ASHA) Programme: The core component of the NRHM is the Accredited Social Health Activist (ASHA) Programme, which involves placing a community based change agent at a 1000 population level, to catalyse a sustainable community-owned process for behavioural change and to facilitate access to basic health services by the poor. The primary role of the ASHA is to create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of desired health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

- Strengthening public health infrastructure: The NRHM recognises that strong public health systems are imperative for achieving improved health outcomes. The Mission has allocated additional funds for strengthening the public health service delivery infrastructure, particularly the sub centres, the PHCs and the CHCs for the provision of primary and first contact curative care. This would be accompanied by improved management capacity to organise health systems and services in public health by emphasising evidence based planning and implementation.

- Fostering public-private partnerships: The NRHM will support civil society participation to increase social participation and community empowerment, promoting healthy behaviors at the community level, and improving intersectoral convergence. This component also includes the regulation of the private sector to improve equity, transparency and accountability and reduce out-of-pocket expenses.

- Decentralisation of health planning: One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services. It envisions the setting up of the State Health Mission led by the State Departments of Health and Family Welfare, the District Health Mission led by the Zila Parishad and the Village Health Plan to be formulated by the Gram Panchayat. The NRHM has created structures at each of these levels for the planning and implementation of the initiatives to be undertaken within the Mission.

---

3 National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

4 Ibid.

5 These include: Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu & Kashmir, Assam, Arunachal Pradesh, Manipur, Nagaland, Meghalaya, Mizoram, Sikkim and Tripura.

6 The vertical health programmes converged under the NRHM include the Reproductive and Child Health II project (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP).

7 National Rural Health Mission (2005- 2012), Ministry of Health and Family Welfare, Government of India.

8 Ibid.

- **Setting the agenda of the Workshop**

The participants wanted to know what are the expectations from the workshop to which Dr. Rakhal responded with the following key points-

- It is a significant point in history when NRHM is providing with an opportunity to re-look at the last 20 to 30 years of community health workers programmes and their trainings. How can the experiences of small scale (150 villages) be applied to up scaling? What are the pros and cons of such a task like up scaling and replicating?
- Based on the learnings that various sectors like funding agencies, government and NGOs have, can a new paradigm, a new set of possible directions and probable partnerships be evolved together in order to use situations like NRHM?
- This is not the end of the process but the beginning; participants present here can act as a core group and strategies to work together can be reflected upon.

Participants enlisted the following concerns, which they suggested that this workshop should discuss:

- The divide between the state and central government, which creates a disparity at the field level
- The under utilization of funds, irresponsible spending and bureaucratic hassles.
- How does one ensure transparency and accountability downwards?
- NRHM has to achieve many goals by 2012 but does its have certain immediate achievables? There is a need to draft and share annual outputs and indicators so that regular monitoring can be made possible.
- Can issues of governance and efficiency be talked of and resolved without looking at the private sector as exemplars?
- A sense of ownership amongst people whenever we speak of community-based programmes needs to be achieved otherwise the interventions of ASHA/ANM cannot be sustained.
- When we speak of the role of ASHA, then the burden of multi-tasking, lack of support structures and inadequate compensation cannot be overlooked.
- Further, HIV-AIDS activities are not clubbed under NRHM, which defeats the purpose of converging vertical programmes. And if the parallel programmes will continue how will the impacts of each one be measured.
- There were queries as to how the political economy affects the NRHM. Is it possible to carry forward a health mission without acknowledging the various globalization forces that may be simultaneously working towards just the opposite?
- NRHM is too broad a topic and trainings are very specific. So, there were concerns whether NRHM may outshine the need to discuss and debate on pedagogies and practices of CHW trainings.

- Film on **Community Health Workers** titled Grassroots Realities[9]

Dr. Parvez Imam:

He shared that during the shooting of the film many CHW said that the availability of 'information' helped them learn about things they did not know and gave them a lot of confidence. All the health care experiments are situated in microcosm and so the conflicts / struggles are smaller / simpler in nature & hence manageable. But, what will happen when these conflicts begin to take a larger shape and come face to face with the macrosystem?

On the other hand there is another important issue of 'economic needs'. The CHWs do need economic support. But villages themselves may not be able to afford such costs. And if the government pays the CHWs then how will her accountability towards the community be ensured?

- **Experience Sharing**

2 Community Heath Workers namely **Pushpa Tai** and **Sarubai Salve** shared their experiences of how such a responsibility increases their worldview and confidence but at the same time life became tough and challenging due to multiple roles and issues of coordination with ANMs.

[9] The 23-minute film captured what health means to community health workers and where do the boundaries of health care begin or end for them. It showed how these semi-literate and ill-literate women, themselves living in extreme circumstances, are trying to use their newly found confidence to take the health of their communities back into their hands. The film was in a mix of Chhattisgarhi, Tamil and Marathi with subtitles in Hindi.

Day 2 (April 11, 2006)

Innovation in Training Content and Methodologies in Community Health Worker Programmes

- **Key Note: Adult learning Principles – How Community Health Workers learn**

Dr. Balasubramaniam:

He shared his experiences of using technology as a medium for imparting trainings in the agrarian context. When 100 million agricultural laborer families need to be covered then one has to think out of the box. However, in India training (where various innovative models of outreach can be adopted) is the weakest linkage, which is evident from the underutilization of funds for training. He emphasized on the need to strengthen only the successful conventional methods and to take alternative trainings as well as Friere's ideology more seriously. Trainings have the potential to be learner centric and induce transformation. There is a requirement to practice horizontal transfer of knowledge versus vertical transfer of knowledge. He presented how lecture and reading have much lower retention rate as compared to practical methods. Majority of the times learning takes place outside the formal set-up. Creating and structuring opportunities for people to network, communicate, mentor, and learn from each other can help capture, formalize, and diffuse tacit knowledge. Communities become a boundary-less container for knowledge and relationships that can be used to increase individual effectiveness and country's development. Based on adult learning principles, he advocated for information-communication technology involving audio-visual media to aid training Participatory content creation is possible and Participatory and interactive learning is very high. Tech mode is possible as evident from government supplying 100,000 villages with ICT connectivity, 50,000 villages by Microsoft; 20,000 by ITC and by Intel; NGOs, Banks and local companies are now provided with this technology in 7000 villages.

His presentation followed a short discussion where the usage for ICT for providing treatment with the aid of telemedicine and for dissemination of information was debated. While ICT was seen as crucial for sharing knowledge and information, at the same time, it was argued that this technology requires heavy cost investment. Secondly, ICT cannot be a substitute for face to face training and the stage at which ICT can be introduced needs to be clarified. Also, while speaking of ICT, EDUSAT being low cost cannot be overlooked as it can be used for sharing information particularly in trainings. In terms of discussing innovations, Aravind Eye Hospital was used as an example where a system of cross subsidy works. While those who can afford are charged but those who cannot afford are given free treatment. But here too the cost is not reduced; it is just the source to recover the cost that is rationalized because the poor are given adequate subsidy while the rich are expected to pay for the medical services that they may avail.

Session I: Panel Discussion

Approaches to Training: Focus on content, methodology and human resources for training chaired by Dr. Ravi Narayan

- Dr. Arole, Comprehensive Rural Health Project Jamkhed

He shared the problems faced in the areas where they started their interventions during the beginning of the 70s. These were owing to hunger and starvation, poor nutrition, low birth weight, low weight of pregnant and lactating mothers and all these continue to persist. Such problems could not and cannot be solved through medicines as the causes and roots of the problems are very different.

He spoke of the community-based approach that they adopted where the key to address problems was through prevention, integration and use of appropriate technology. For this a partnership of the health workers and the health system was sought. Learnings from the experience:

- Community Health Worker needs to act as a bridge between the community and the health system. Therefore selection of a CHW becomes very important as she must have a stand and respect in the community.
- Her responsibility is to co-ordinate the various service agencies in the community.
- Her role is to demystify health, demand accountability from the health workers, and educate the community to utilize the system.
- She cannot be a part of the system and hence the system should not be engaged in selecting or monitoring her or paying her.

For performing the above roles, she needs to have a strong sense of self-esteem, which can be derived from trainings. Trainings therefore, need to incorporate the various elements, such that it can address the psychological, social and economic issues. In trainings at Jamkhed 50% of training time focuses on the individual growth. He gave the example of Sarubai, who gained such a lot from the trainings that she has been able to make a qualitative difference to her everyday life. He emphasized on the need to incorporate sessions on income generation programmes, optimal utilization of resources, accessing different schemes of poverty alleviation etc. The rest of the 50% of the trainings should cover technical issues i.e., knowledge and skills to tackle small health problems. These trainings make them experience the fact that knowledge on health is not the monopoly of the doctors. It is people's knowledge.

He detailed out some learnings from the trainings:

- Practical means to orient the participants were useful as observed in cases where they were sent to work with the already trained health workers.
- Sessions covered in residential training became very important, as participants learnt a lot from each other especially at nights when the sessions could be a lot more informal.
- Participants enjoyed songs, dramas and other folk medium.
- "Experience plays a very crucial role in trainings" was exemplified from the fact that health workers themselves have now become trainers.
- Ongoing training is very important. The participants in the trainings often shared that they did not come to learn from the Trainer but to learn from

each other. (They equated their situation with a group of lamps that remain lit as long as they are kept together but extinguish when kept apart).

- Trainings should be used to pass on both technical know-how and inculcate a sense of social responsibility.
- Trainings can be forums to discuss the lacunae and exploitative tendencies of the health system

He also shared the pictorial materials of training content. He concluded by stating that if these health workers are effective there'll be a change in the health scenario. However, the new scenario will not be void of problems thereby requiring a new set of strategies and solutions.

- Mr.V.R.Raman, Mitanin Programme, State Health Resource Center, Chhattisgarh

His presentation was focused on the challenges of training 60000 Mitanin and how that fits into the context of ASHA under NRHM. He shared the status of health and health services in Chhattisgarh, the gaps in the supply along with the workload of existing ANMs, coverage limitations, and weaker linkages with the panchayats. Despite the given constrains there were a share of opportunities like being a new state, available space for civil society engagement and scope to experiment. The political environment called for a popular and massive programme.

Community health workers were not seen in isolation but as a part of the broader health sector reform. The support and stake of bureaucratic administration, involvement of funding from European Commission under sector investment programme was a remarkable arrangement. Further, requirement of funds for drugs was tackled by an innovative strategy of launching Mukhya Mantri Dawa Peti Yojana (under which Rupees 5 Crore were mobilized). It was and continues to be not a parallel programme, but an organic part of the health sector.

He shared the hardships and challenges faced in training the CHWs under this largest health worker programme of the country one of which were a number of political uncertainties. Traditionally, Mitanin means "friend for life". The identity of Mitanins as friends of people was established and reiterated under this programme. Mitanins had to be identified, oriented and trained in a set of challenges like unavailability of a cadre of experienced trainers, training illiterate women who come from varied terrains and dialects which are very different from one another, tedious interventions of conducting Training of Trainers as well as updating the skills of existing trainers. If ANMs were to be involved it would affect their regular function. The trainers were identified from the communities, at the village level. Also, they are not just trainers but the immediate support structure for Mitanins). Finally, the issue of monetary compensation to the Mitanins has been a matter of debate and so far no clear consensus has been sought.

- 1 Community Development Block has an average of 400 Mitanins. 1 trainer for 20 Mitanins, 3 coordinators for each block acting as district resource persons and 1 field coordinator for 5 blocks to give regular inputs, monitoring and feedback to the State Health Resource Center.
- The trainings take place in 7 rounds spread over 18 months, and each round has a set of manuals to prescribe to. This includes: determinants of health

and health services and entitlement; child health issues; Women's health; Community based malaria control; Rational and irrational practices; introduction of Tuberculosis and leprosy control, revision of dawa peti; and Panchayats interlink ages and coordination. For areas where both Hindi and Chhattisgarhi were not apt mediums to transfer information, hand made modules and posters in local dialects were used

- The 12 days camp based training and 30 days on the job training, spread over 18 months is the training strategy in the Programme that has been observed since the beginning. The first set of seven rounds of training covered 40000 Mitanin and now the programme is proceeding towards the next phase of training. All Mitanins have completed at least 5 rounds of training. The next 20000 are undergoing the first phase of training.
- The programme is now extended under the NRHM and the Mitanins have been absorbed as ASHAs.
- Broad roles and responsibilities of Mitanins include: Visiting at the outset of child birth and deliver six key messages, planning for the expected deliveries, ANC check up, planning and arranging for referral of complicated cases for institutional deliveries. There are sets of 75 health messages that the Mitanins can refer to in their attempts to educate the community. Mitanins mobilize people to identify their health needs, utilize public health services and act as interface between the community (at the level of hamlets) and the systems at the panchayat level. They will be the key animators in executing the hamlet level actions for the Panchayat plans.
- Tc ensure a better and active involvement of Panchayats, Swasthya Panchayat Pratiyogita based on 26 indicators was initiated.
- Media was used effectively through a radio programme of 16 episodes along with supplementary television accompaniments. These were backed by strategic interventions of advertising the programmes through posters. The viewership 20000 groups provided with a time-to-time feedback. This, together with very innovative folk media and theatre was used to mobilise the community to select their Mitanin, and to -sensitise them about the Programme and the roles and responsibilities that she will have.

Number of process reviews and participatory evaluation were held in which the identified gaps were worked upon for the later phases of the programme. These included: strengthening the training programmes, referral services, civil society protest mechanism and intersectoral linkages even further. Constant synergy between the priorities of the community and the administration to maintain a balance was upheld. He concluded by saying that when we work on a programme that tries to work with as well as criticize the health system, our way of protest has to be 'Silent' because the health system cannot digest open criticism.

- Dr. N. Mistry, Foundation for Research in Community Health, Pune

She stated that it was in the 19th century at the Leed's conference that Florence Nightingale mentioned about the use of community health worker for the first time (which was much before Bhore or Mudaliar Committee reports). Then the ISSSR-ICMR report stated that the community health worker is not a means or a technology to seek private health care but a reflection of a political struggle. FRCH was the secretariat for this democratically decentralized ICSSR-ICMR report. The guidelines of the report

helped the organization to envisage a structure for the community based health care services system, which had much learning. The population coverage ranged from 200 to 5000 to 30000 people.

The accountability of CHWs was always towards the neighborhood and the panchayat and not towards the government. She played the role of a neighborhood functionary who worked as the extended family member. Smaller the unit of coverage more effective could she be in terms of coverage and commitment. The CHW selected was generally a married woman who would get accepted in such a responsible position by the community. If education is identified as an important criterion, then the marginalized population is generally not represented so this criterion needs to be dealt with more sensitively and contextually. She shared the experience at Parinche from (Kaldheri) which is a mountainous terrain. Through much effort 7 to 8 illiterate women were selected by the organization and when FRCH visited the next time, a completely new set of women had come. This is because the illiterate women mobilized and brought the educated/literate women to participate. In Uttaranchal the experience showed that despite 80% literacy, it was difficult to get educated women to join as CHWs though they were offered Rs. 3000 monthly remuneration by the panchayats.

She began sharing that the trainings could range from 90 to 120 days and the spirit with which the trainers worked was derived from the one prevalent in Scandinavian countries where there is no terminology for teachers. There the teachers are believed to be learners and facilitators and referred to as "laere", as they believe in learning, facilitating and not teaching which precisely is the guiding principle in FRCH.

While practicing these principles in the Mandwa project FRCH had the following learnings:

- Education is not an absolute requirement in selection.
- Non-formal approaches to trainings are extremely effective
- A system of ongoing communication facilitates social change

Under the Malshiras project it was learnt that there is a need for symphony in training & service provision because while concentrating on the trees one cannot miss the forest. Cultural issues, societal norms, equity in distribution cannot be overlooked. But one must remember that the whole process is gradual and incremental and it cannot be done in 3 or 4 weeks.

While the earlier trainings were more focused on curative, preventive, promotive aspects of health and included national health programmes, water, sanitation, immunization, referral care, veterinary care etc. Now a holistic education is envisioned covering income generation, public issues, rights and responsibilities, ethics and equity, environment, ecology, effective communication and community mobilization (UNICEF communication skills book was used as a reference). The shift is now much broader i.e., from needs to rights. Trainings aspire to bring about a change in self-image and build a career path for the health workers. Once the awareness is aroused there is no stopping, as they want more and more. And as a Resource Center one has to provide for that. Just as skills and knowledge will build the initial base, it is the actual experience as a health worker that will add to ones development and confidence.

She also shared the stages of learning, which begins with mere exploration of ones self and surrounding environment; followed by a becoming a participator from a spectator; and then becoming a contributor. Lateral linkages among the health workers are essential for learning.

She enlisted some guidelines for module preparation learnt during the compilation of 4 modules on health and environment, basics of health, health extension activities and health education. The amygdaline approach[10] is used in the four modules. Modules must include: Positive and negative deviants, Cross cutting themes and Case stories.

Learning does not end with training or communication. It is a stepwise process: Communication, assimilation, practice, evaluation, and reflection are steps of constitute the learning cycle. The role model concept, which is relatively a new concept, can be very effective.

She shared the success of getting an accreditation from NIOS few years ago which has helped FRCH training programmes to get some recognition, standardization, professional space & scope for wider dissemination which may be of help for the NRHM.

She ended with a word of caution i.e., Sift reality from romance.

1. Health workers also have problems like every other human being.
2. If you just focus on the community health workers and not the community, you have a generation of worker isolation as Paulo Friere rightly said that you have a focal of local oppression.

- Dr. Shyam Ashtekar (discussant)

He stated that the government has resources and solutions within its system in order to meet the training requirements of a large number of community level workers based in rural areas. This according to him includes the open universities set up in 1988-89 by the government. There are self-funded universities, which are performing very well in Bihar, Bengal, Rajasthan and Andhra Pradesh. These can be used for Open and Distance Learning to train health workers/personnel. Agricultural department has done some very good work in terms of Open and Distance Learning drawing from extensive experience. These include using more than one source of instruction, developing material along with progress; using Multi-layered and Self-instructional learning material.

Edusat is a low cost dissemination programme. GOI has launched healthsat now, which many states are using. NRHM should think of using both in a big way. He believed that for CHWs Open Distance Learning is the natural choice since it is flexible, learner centric and low cost.

He advocated for getting away from planner centric models to four-perspective models, which includes the planner, the learner, the trainer/counselor, and the user community.

[10] With this approach the focus of training would be on stimulating the amygdala of the cerebral cortex. This approach is broader and deeper than a cognitive one because it signals the emotional quotient of the learner. With this orientation the training would impact the emotions, perceptions and value system of those involved.

Unless we move to this balanced perspective, programmes cannot have a contextual relevance and internal richness of quality.

On the one hand we need to use the old knowledge and incorporate it in new ways of channelization. On the other hand we need a holistic and creative manner of conducting trainings is the need of the hour because there are a variety of learner needs calling for a variety training methodologies. He spoke on the Rings Approach for large scale flexible Health Worker Programmes. This approach feeds into the need to have core perspective models so that the community accepts and adopts the new programmes. It suits heterogeneous groups, allows for multi-tasking and organic changes in the content.

The Rings model is basically a pluralistic approach by design—a post modernist view of things in community health. A matrix can be made of different themes (subjects) to be covered under the training at different levels in terms of allocation of time and resources. The gradation is termed as ring, which is expressed in terms of number of hours for each theme. This matrix can be restructured/reorganized in the form of concentric rings, with each column forming a layer of the ring and each theme forming the spoke of the ring.

In this approach one can choose either the rings or the spokes, partially or completely. It allows gradual learning by prioritizing and grading of the learning content as 'Must' learn, 'Should' learn and 'May' learn. This is also essential, as community level initiatives demand multitasking, which makes training complex. It also allows substitution & revision of the content (lessons) at different levels.

He mentioned of the various changes occurring in the national programmes. Learning material should keep pace with these changes. Generally materials are revised over 2 to 3 years, but things often change overnight. To cope up with that a multi-author project where changes can be made without hampering its pace of utility needs to be adopted. ASHAs who have studied upto the fourth standard can use this.

In case of ASHAs, 5 rings have been made for 5 episodes of training. There is a set of enlisted themes, which would feature in the rings. Each ring highlights the extent to which a topic will be covered in one series of training workshops. The topics include introduction, roles and tasks; determinants of health; water and sanitation; nutrition; human biology; pregnancy, birth and post natal care; child health; contraception; common medical problems; accident and first-aid; National Health Programmes; Community; Gender; PRI and human rights. While a theme may freeze once it is incorporated in the model, it is within the themes that topics can be altered as per the requirement.

Panel Discussion (chaired by Dr. Anant Phadke)

Dr. Anant Phadke commented that some of the presentations deviated from the crux of what they were expected to cover. However, some crucial issues to reflect upon included:

- The reality of remote areas is that no such service system exists. Then how will the ASHAs play a facilitating role in circumstances where even the bare minimum does not exist? Therefore some amount of training in curative care is essential so that ASHA can be a service provider. This aspect according to him was not clear from any of the presentations made, especially in terms of

what have been the experiences and major issues of concern when it comes to meeting the curative demands of the people. He also mentioned that from his experience, beginning health worker training with medical and technical skill training is important to acquire credibility in the community, and that in short periods of time, comprehensive, learner centric training for CHWs is not possible.

- Secondly, many theoretical claims are not supported by practical evidence like the applicable success of the Ring Approach. The proof that trainings undertaken by FRCH as well as the ones using IT and EDUSAT can be used in the context of NRHM (which has a definite time and scale requirement).
- Thirdly, all the presenters described how their programmes are being run whereas what they had to dwell upon were the learnings from these programmes to suit the upcoming endeavor of NRHM to design training content and methodology. Also, no relevant training material for the literate, semi-literate and illiterate workers was displayed or shared to exemplify all that was being said.

Later Prof Sanders also questioned the viability/ applicability of distance learning programme with respect to teaching practical skills and sustaining the theoretical up gradation. Also, ongoing supervision, mentorship and application of the learnings to practice are great challenges in distance educations programmes. Dr.Shyam Ashtekar responded that technology has to be supplemented by field-based training. Dr. Pallavi Patel argued for the importance of training of trainers and the influential role of the trainers' attitudes for CHW training to be successful. Prof. Sanders also asked why the mobilizing, advocacy and challenging roles that CHW have to play were not discussed.

Dr. D. C. Jain expressed his appreciation for all the models used in different areas by different organizations but a simultaneous concern that how the government can use the learnings from such experiments. For instance more than 4 lakhs of ASHAs need to be trained in one or two years. He urged the participants to think about the replication of the various training approaches at scale in varied contexts within the country, and asked the presenters about the timelines, costs involved, and the nature/structure of support structures and human resources required for each of the CHW training approaches. Even Dr.Pallavi Patel asked for the budgets that these trainings require. Responding to this, Dr. Arole stated that Jamkhed does not get any external funding and training the health worker never crosses Rupees 3000 to 4000. To Dr. D.C. Jain's question of timelines for training CHWs, she said that the time taken initially is quite high, but this comes down with the presence of role models/senior health workers.

Further, Dr. Jain expressed that an attitudinal change is something that is needed at the higher levels of officials. He shared his concern of how there is a need for dedicated people at all levels particularly at the district and block level for the trainings to be facilitated well. Dr. Alok Shukla responded that is no dearth of dedicated people. Instead of giving programmes and budget to the states, he suggested that the center must ask the states to come up with a viable project in order to access any funding available under such programme.

Mr.J.P Mishra highlighted some deficiencies at certain levels in the context of ASHAs.

- Firstly, the selection has been still confined to the government's discretion while in Chhattisgarh selecting Mitanins was seen as a responsibility of the community. The process in Chhattisgarh began with the involvement of 10 to

12 NGOs involvement and as the programme was scaled up, there was a competition between the Medical Officers and the NGOs in terms of outdoing each other in quality of training but as the basics were right, the results were going to be feasible irrespective of whoever takes it forward. Mitanin programme also survived the political administrative changes. Focus of initial phase of training had nothing to do with medical knowledge. One of the first outcomes of the programme had been breaking unhealthy/bad cultural practices like not giving colostrums to the newborn child, not denying water to the mother, etc.

- ASHA programme is not only centrally sponsored but also centrally designed and that is the problem, whereas the center should be challenging every state to find its own solution. In fact every state should challenge every district to find its own solution. NRHM is a very decentralized programme but it is undermined because the nut bolt of ASHA is at the center. The sooner it is decentralized to the state level it is better for sustainability.
- In certain states like Madhya Pradesh, ASHAs may be viewed with resentment with Anganwadi workers because of the compensation package.
- The most crucial difference between ASHA & Mitanins is the element of voluntarism. Voluntarism is not sustainable is the underlying assumption but Mitanin has proved it wrong.

Dr. Sunil Kaul and Dr. Ravi Narayan suggested that the Mitanin programme too suffered from some deficiencies and before seeing it as an exemplar we must look at its evaluation report and learn from the recommendations. It is precisely from the spirit of learning from the evaluations that we can feed into all aspects of a programme.

Ms. Sarover suggested that when we have a set of NGO experiences as well as an experience like that of SHRC, then perhaps we could address the issue of human resource by analyzing the two. According to Dr. Sunil Kaul and Dr. Ravi Narayan there were some unresolved issues and debates like why are we pursuing a mission mode with specific timelines will lead states to start the process without well thought out plans. For example, CHW training started in Assam without formulation of training modules.or what has been the accepted definition of an activist etc.

Even Dr. Yogesh Jain argued that it is the role of a CHW's role that would determine the content and the methodology of the training, and therefore, the principal focus has to be on the definition of her role.

Dr. Shiv Chandra Mathur talked about the unresolved issues that have lead to a lot of disillusionment. These include

- The ongoing launching of one programme after another namely, RCH-I, RCH-II and now NRHM.
- Further the focus of NRHM is on ASHA and the success of ASHAs has been deduced trainings alone. And in trainings too, Dr Pallavi Patel argued that there are no mechanism or methodology developed to review the trainers in any of the approaches mentioned.
- While on the one hand it is a decentralized mission, on the other hand, it is taking EAG or high focus states instead of district as their focal point.
- Finally, the Central government is aiming to work with a community based health worker by involving NGOs and is also planning all sorts of inputs

under the banner of Indian Institute of Public Health Standards. This calls for a need to coordinate within such different stakeholders and we are not aware of the strategy adopted by the Central government to do the same.

Dr. Jain responded that the center has conveyed to the states that NRHM has only formulated broad guidelines as of now. But there is no willingness on the part of the state to take a proactive stand and adapt the guidelines to suit their local needs. The center has prepared the 'Core Material', which can be reviewed and changed as per requirements. Dr. Alok Shukla reacted that Mission should desist from writing training modules as they can only give proto-types. The states should formulate the actual content given their unique contexts. He gave example of literacy mission where primers were written at district levels.

Dr. S. C. Mathur asked why experiments by Dr. Antia and Dr. Arole carried out in 30-40,000 populations couldn't be replicated for the entire district/state. Dr. Antia urged that we need to have models of convergence only then resources can be used efficiently and interventions can be sustained. But Dr.Jain added that convergence is possible only at village levels but it is difficult at central and state levels.

Mr.J.P.Mishra raised the concern whether ASHAs would be the interface between the community and the system or mere health workers. Dr. Nerges Mistry responded ASHAs are link workers at the lowest level of hierarchy. Changing mindset at different levels, especially higher levels are important. Therefore, a mobilisation of the health system and not only of the community is the need of the hour.

Dr. Raj Arole highlighted that the aim of training is very important, and the fact that this aim should be to change the mindsets of people, and not to build medical skills in women. He also said that the difference in the performance of government run CHW programmes at scale versus civil society run programmes in smaller areas arises mainly due to the lack of motivation of personnel.

Mr. V.R. Raman gave relevant statistics from the Mitanin Programme to highlight the nature of human resources, timelines and costs involved in implementing CHW training at scale.

Session II: Presentation of Case Studies

A. Teaching Skills to Community Health Workers

- Dr. Shyam Ashtekar: Teaching Clinical Skills to CHWs

His presentation began with a classification of illnesses as minor, medium, acute, chronic and accidents and the relative ease or complexity of diagnosis and treatment. It contained various shared matrices that can be used to teach associated symptoms and their variables for different diseases. He mentioned about single and complex problems, which make diagnosis difficult and emphasized on the need to keep the training simple for the benefit of the ASHAs. Then he explained flow charts with interactive IT tools to make complex diagnostic problems taught simply and use of kiosks to make diagnosis available. He shared that some Community Health Workers have specific interests and increasing learning requirements therefore, they need in-depth trainings. This updated

and in-depth knowledge would give them confidence, retain their interest and build their credibility in the community. He pointed out that health specificity and clinical training of CHWs has been neglected.

- Major Shashi Menon: Behavioural Change Communication (BCC)- A Resource Approach to Training CHWs

The presentation highlighted that communication is the most important factor that can bring about change and that communication and health are inextricably linked. The presentation covered what is behavior and BCC, the steps to BCC, the forces driving the change on the basis of blocks to BCC, and the various strategies of behavior therapy that can be effectively used for BCC. Major Menon said that BCC is an interactive process and not a passive one-way dissemination of information. He pointed out that the public health system; the community and the family are resources facilitating BCC.

Discussion:

The discussion centered on the idea that the concept of health seen as simple versus it not being as simple as it is being reiterated.
This is evident from the presentation of Dr. Yogesh Jain, which raised several questions and concerns. For instance, he questioned the empirical evidence to prove that Village health workers can manage 85% of health problems. He shared that hunger and starvation could be addressed locally but there are other complications when it comes to health. The risk of trivialisation of the health of the poor by focusing only on preventive, promotive and very basic curative care, rather than secondary and tertiary curative services could lead to ignorance of another kind. 'Small places have small problems' is a myth and related to our assumption that rural life is very simple. We assume the simplicity of rural life but very often it does have complicated, diverse and heterogeneous health needs. Awareness and attitude cannot take care of everything. According to him diagnostic and curative skills are more important than mobilization and advocacy skills. Dr. Jain asked pertinent questions such as – Is the treatment by the CHW appropriate, effective, affordable? Is this CHW strategy like assigning a "second rate" doctor to the poor? Another important fact that the presentation highlighted is the complexity of primary health care, that this also needs evidence based knowledge and constant and complicated research.

Dr. Shiv Chandra Mathur had a slightly different stand. He argued that the activist role of ASHA is more important than curative role. If behavioural change is not prioritized then it is difficult to get results on the ground. He pointed out that clinical skills should be taught to CHWs only after awareness has been created about health. Skill training also has different stages ranging from acquiring skills and gaining proficiency at the skill. Therefore, more than managing medical illnesses, the NRHM expects the ASHA to change the behavior of the community.

However, within the category of behavioural change there were some concerns. Dr. Ravi Narayan pointed that behavior change cannot be limited to individuals as issues like stigma require a collective behavioral change. Dr. Narendra Gupta questioned how in a segmented scenario (as ASHAs would be a heterogeneous group of individuals and the villages where they will work would be just as fragmented) how could behavioural change be envisaged?

Dr. Abhay Shukla said that it would be impractical to expect the same CHW to do social mobilization and curative work simultaneously. Also for change and impact there is a need for large-scale mobilization. ASHA alone cannot change the system. According to Prof.Sanders, it would be difficult for any health system, scheme, programme or worker do bring about a change or impact until basic hunger and nutrition issues are addressed.

Ms. Shilpa Deshpande pointed that there is a need to overcome the dichotomy in perceiving behaviour and cognition. This dichotomy is reductionist in its approach towards human behavior. BCC should comprise of cognitive behavioural therapy techniques than only those of behaviour therapy.

Prof. David Sanders questioned the influence of globalization as an important determinant of health and that both clinical skills and BCC by CHWs should take this into account.

Ms. Anuska Kalita said that BCC is only one of the strategies for behaviour change, and that the focus has to be broadened to include the complex determinants of health behaviours and highlight the role of communities and health systems in bringing about behaviour change.

B. CHW Training in Varied Context

- Dr. Lindsay Barnes: Gender and Social Exclusion in CHW Training

Her presentation stressed on the principle that gender is not a category or an issue that can be viewed and trained upon in isolation from other issues. It is a theme that cannot be deduced to skills. It is interlinked with caste and class, attitude and behaviors and therefore needs to be intertwined with any developmental programme. If it is not viewed in integration, then Gender blindness, ignorance, discrimination may not just get perpetuated but also reinforced. Gender awareness and sensitivity is essential for all trainers to have especially in scaled programmes. Looking at the dais and doctors through a gender lens she illustrated how the former are feminized ends of health system (marginal and poorly compensated) while the doctors are the masculine ends (highly valued). She questioned why CHWs are women and what all gender stereotypes is that creating and reinforcing. Finally, she argued that Power and Empowerment extend beyond the gateways of Training. The CHWs need on site back up and despite providing that accomplishing a change is very difficult.

- Dr. Sunil Kaul: Training CHWs in the context of political strife

The presentation shared the experiences of The ANT in training CHWs in a context of cash starved economy, poor infrastructure, state bankruptcy and poor governance. In the light of no government or other funds, it was the sense of community feeling and local contribution that gave shape to their Health programme. In a context where medical expenses are the largest cause of debt, the CHWs are seen as healthcare providers and are therefore trained in clinical skills, including diagnosis of illnesses and prescription of medicines. Trainings covered medical contents and teaching the use of medicines. The learning materials are in the local language. The greatest challenge is for the CHWs to compete with quacks and for the organization is monitoring the access

of the poorest families in the village to healthcare services. He also pointed out the failures of the program and challenges ahead. Dr. Sunil Kaul was asked if the work of ANT has brought the MMR down. He replied that their work does not claim to impact such indicators so early.

- Dr. Abhay Shukla: Training CHWs with low literacy levels

His presentation focused on training illiterate health workers in the Swasthya Saathi Programme, which in 2004 got approved by Shrimati Nathibhai Damodar Thakarsi (SNDT) Women's University. The training material was largely pictorial and used standard symbols to depict concepts of illnesses and other health related constructs. Training methods involved games, discussions, body puzzles, sharing experiences, role plays, quizzes, and articulation of each health concept in participants' own words Even the Assessment of training outcomes was done with the help of pictorial multiple choice questions and programmatic monitoring through pictorial monthly recording formats. Further he shared how *Swasthya Saathi* is community run and community sustained programme. There was regular assessment, record keeping and accreditation in the process.

Discussion:

Dr. Narendra Gupta pointed that a useful addition to the training content and methods for non-literate CHWs could be anecdotal stories based on the rich oral tradition that exists in communities. The training of trainers is very important for them to be able to train CHWs in pictorial material. He also highlighted the importance of locating training in the larger context – the broader socio-cultural, political, and economic context, and the need to "make" the context enabling for the functioning of the CHW (for example, training and sensitising public health functionaries to act as support structures to the CHWs).

Ms. Arzoo Dutta pointed at the importance of gender sensitisation not just in the community but also among health systems functionaries and policy makers. The need for contextualising CHW training in the Northeastern states, without labeling the entire region as "tribal" is really essential. This will move out of the tendency of homogenising the unique cultural, political, economic and governance contexts in each of the seven states.

Dr. Nandita Kapadia questioned how pictorial learning material is very open ended. She shared her experience of how different groups of people interpret the same pictures differently.she had also said that the best form of gender training in her experience at IHMP is to give women responsibilities for action against discrimination.
Regarding Dr. Abhay Shukla's presentation on training non-literate CHWs, she asked about the process of standardising the pictures in the Swasthya Saathi Programme, as in the field areas of IHMP, different communities gave different responses even to pictures and visuals. Dr. Abhay responded that though formal pre-testing was not done but learning material was evolved in three stages by actually incorporating the responses.

Mr. J.P.Mishra argued that NRHM needs to factor the lack of uniformity in its design. Since communities are not homogeneous and diversity is inherent in a country like

India, pluralities at the level of policies to incorporate this heterogeneity is the need of the hour. Different social structures, norms, practices and differences in role allocation between men and women before we allot the CHW to women. The guidelines of NRHM are seen as diktat by the states and the central government needs to check that. In the light of this argument Dr. Ravi Narayan added that the success of NRHM depends upon how much space is available for community level prioritization of the expectations from CHW and how far the states own the mission. For instance, the ASHA needs to be given a state specific role, identity and name. He had also said that prioritisation of roles to be played by the CHW by the community rather than outsiders deciding for them. If there is will to make the NRHM a success in the northeastern states, we need to call the states by their names and not club them together.

Ms. Laboni Jana had a basic query regarding NRHM, promoting the curative role of ASHA as this could amount to creation of another new cadre of non- professionally qualified medical workers (something similar to quacks).

Dr. Lindsay Barnes responded that ASHA would not be a quack, infact she would be anti-quackery. She added that in order to play an influential role, the sex of CHW matters. In a scenario where women are undervalued in general, ASHA being from the same gender may not yield outstanding impact. The sex of the worker does matter and this has to be thought about in the conceptualization of the programme with deliberate thought and planning rather than by default and selecting whoever is available. A gender blind programme design is as dangerous as a gender discriminatory programme design.

Dr. Sunil Kaul highlighted the uniqueness of the seven northeastern states, supporting the argument that the Northeastern region should not be homogenised. He also pointed out that in the context of his region, political strife and instability is the cause and effect of all the challenges faced by the community.

C. Evaluating Training

- Ms. Seema Deodhar: Evaluation and monitoring of the training process

Her presentation highlighted the various aspects of evaluating the training process and its outcomes in CHW programmes. Monitoring objectives and indicators of training that were determined in the pre programmatic planning phase need to use both qualitative and quantitative methodologies. The documentation of evaluation and monitoring should feed into the training programme continuously for corrections, contextualisation and improvement. In evaluating training, feedback from the learner should be an integral part. The feed back however, is a general response or reaction, but does not give you what learners have learnt or accomplished. Feedback and response need to be separated. Response is followed by evaluation followed by assessment. Assessment of learning should include skills, knowledge and attitudes, as all these three aspects are equally important to determine the outcome of training. The performance of the learner depends on various micro and macro factors, and this is an indicator of the larger programme and the presence of an enabling environment than just training.

Panel Discussion (Chairperson- Dr. Nandita Kapadia):

Evaluation of training is a grey area and there are no fixed methodologies for it. Evaluation needs to incorporate, not just of knowledge but also of field-based skills. However, before embarking on evaluation, there needs to be clarity on the skills that is expected from the worker, which are related to her roles and responsibilities. We have to design tools and see what has worked and what has not. The forces of rusting and unlearning need to be checked. Therefore, mechanisms for retention and sustainability of skills and knowledge are required. She also highlighted the importance of separating programme indicators from training indicators as the former enables to measure impact on the community while the latter reveals the impact on the CHW/Trainee. Knowledge about learning principles and theoretical aspects of learning helps to determine the learning goals, the outcome and process indicators, the methodologies and duration/content/spacing of training sessions.

Dr. Narendra Gupta suggested that the focus has to be on monitoring and evaluation of the training rather than the CHW's performance as this process of training, which will determine her performance. Dr.N.H.Antia argued that eventually the CHW is accountable to the community and therefore, they are the ones who should evaluate her performance.

Dr. Abhay Shukla added that the community must get a structured opportunity to evaluate the organization, as the organization is also accountable to the people.

But Dr. Nerges Mistry argued that the community evaluation cannot be held as the final word because within them there are groups with vested interests, many groups within the community would want to maintain status quo in power relationships which if the CHW is trying to contest would work against her in the community's evaluation of her performance.

C. Partnerships for innovations in training CHWs in state programmes

- Dr. Alok Shukla:

His presentation highlighted that the partnerships sought under the Mitanin Programme at all levels. For this there were consultations with government, professional bodies, NGOs, Panchayats and village level groups. Mobilization formed an essential part of the entire programme. Changes at all the levels were envisaged and achieved like policy level reforms at the top. Secondly, changes in the position and legitimacy of health workers evident from the fact that 20000 Mitanins contested village panchayat elections and 7000 won. These are evidences of systemic change that the Mitanin Programme brought about. Whatever might be the success or failure he congratulated the SHRC team for taking a risk, having spent time and effort for this size of programme. Supply side will remain important & therefore the issue of governance, infrastructure, cannot be side stepped.
The Mitanin programme was different from either an NGO or a charismatic leader led movement. It was conceptualized and operationalise as a movement led by the system. This meant that it would be based within the procedures and processes of the system. He explained that Dr. Sundararaman had taken the risk of his reputation to undertake

the initiative of the Mitanin programme. He also focused that the Mitanin programme or any CHW programme should lie at the heart of a larger Health Sector reform Agenda. He also pointed out the criticality of ' real hard data' and how the state government cannot choose to ignore it and its implications.
He highlighted the concept that the 'ASHA' should not be viewed as an employee of the state, and the state cannot provide her a duty chart.

- Mr. Biraj Patnaik:

He shared some of the challenges of a large-scale partnership based programme. Firstly, engaging with a heterogeneous civil society with different social perspectives. Here it was better to focus on processes than individuals. Poor governance and lack of willingness at various levels of bureaucracy were other issues to constantly tackle.Biraj pointed to the difficulties of working together with state and civil society groups. He also stated that as civil society groups represent heterogeneous interests and hence can be difficult to engage in a large-scale state programme. He defined policy change as a 'virus', which permeates the whole system and needs to be addressed and understood quickly.
He also felt that the strategy followed by some governments of ' contracting out' to NGOs could lead to difficult situations.

Panel Discussion (Chairperson-Ms. Shilpa Deshpande):

Dr. Peter Berman commented that the models and examples are there but how can the urgency of a national mission and the compulsions of a programme be dealt with. In a large-scale programme like the NRHM how can mistakes from the previous programmes be avoided? One of the suggestions was to make systematic and systemic changes, evolving strategically viable structures of efficiency to ensure better results. Secondly, ensure greater flexibility but that is difficult especially when guidelines are often viewed like directions.
He also explained that the NRHM needs to be looked at from 2 aspects, i.e. organisational / institutional and technical aspects or 'organisational technology'. He explained that both of these require evidence and hence can take time to be operationalised.

Mr. D.K. Saxena added that the state of Jharkhand has created the set guidelines as per their local needs. For better decentralization and community ownership, they are facilitating the village health committee, which will further select the Sahiyyas. This will help them to provide the services to the last house of every village. Jharkhand, the youngest state has lots of hope from ASHAs/equivalent. They are developing mechanisms such that both the system and the community respond to her efforts. Also, partnerships are essential in the success of the programme.

Mr. J.P. Mishra agreed that if the demands were not matched with the supply side, the programme would not achieve its objectives. Any community health worker programme is not a mere health initiative but a community empowerment initiative. Since ASHA is envisaged along the same line of thought, it comes with a lot of hope and expectations. He shared the learnings and dynamics of the Mitanin programme, especially in scaling up. He gave the example of the processes of the creation of Mitanin unit costs, which

was undertaken through a participatory method and also the Nagaland Communitization act. He spoke about the multi-sectorality of the scaling initiative. Community based initiatives might start in one sector but grow into another sector as argued by the Planning Commission document (9th plan Mid-term evaluation document). Finally, he shared that charismatic leaders started Mitanin Programme but while scaling it up there was a transition from individual led movement to system backed support. And then the struggle got encapsulated in larger structures. He also felt that demand side mobilization needs to be matched with health sector reforms agenda on the supply, and they need to keep pace with each other, else it can become problematic.

In the light of charismatic leadership, Dr. Sunil Kaul asked whether we would find "workaholics" like Dr. Sundararaman. The dedication and uniqueness of such people is difficult to replicate. But, Dr. Alok Shukla argued that if the willingness and space is there, then there are enough charismatic and vibrant people to take the task forward.

Questioning the effectiveness of the Mitanin Programme, Dr. Abhay Shukla said that there is a strange dichotomy between the birds eye-view and worms eye-view and they do not match. It has a committed team who has managed to achieve certain things which have not been achieved by many previous programmes. However at the grassroots there are large gaps. While NGOs have a different set of output expectations and receive different kind of support from bureaucracy, a Mitanin Programme has a unique character. It had a conducive environment to operate in. He also was unclear as to the kind of partnerships that SHRC had with NGOs and to what extent the commitments made by each side were met.

Mr. Biraj Patnaik responded as to how different people see the Mitanin differently and from both the internal and external evaluations done lessons could be learnt. To clarify further on partnerships, he shared that the government funded the NGOs involved, and the funds were routed through the district RCH society. Then the State Advisory Committee was formed to engage in policy making and with other NGOs on designing modules. Sometimes the commitments were not met due to constrains like pressure groups operating outside the system.

Dr Alok Shukla added that the need for social processes to be facilitated and consequent outcomes to be realized is a very long process and the state cannot keep waiting. It has to make an attempt and try to deliver health care to all. Mr. D.K. Saxena also endorsed the fact that the unavailability of some structures or the lack of social processes does not mean that the work should not begin.

Dr. Nandita Kapadia questioned whether it was possible to go to a village and ask ASHA to empower the community. It seems too abstract. She needs to be given specific roles along with flexibility and space for any other issue that may come up in her village.
Dr. Abhay Shukla said that because ASHA is not an employee, it is difficult to give her a structured duty chart.

Dr Antia urged to use the word "confidence" instead of the word 'empowerment'. He mentioned that health is just one of the ways to approach people, as it is the most mystified and when you demystify it people gain confidence.

Ms. Shilpa Deshpande (chairperson): There have been civil society & state partnerships, which have a range of experiences. In some cases partnerships have been contractual and in some cases they have been on mutual understanding of how do the NGOs present in the workshop see and perceive their role in the light of such options and accordingly go forward.

Mr. J.P. Mishra had some concerns with respect to ASHA's link with incentives, which works out nearly equal to ANMs salary. If that is the implicit orientation the selection process may get vitiated.

Ms.Mekhala Krishnamurthy raised the point that just as the government needs to create a larger sectoral dialogue and involvement in such initiatives, NGOs also need to self assess, where they are positioned to play a role in such work. They also need to have clarity on the scope of such work and the role they might be able to play in it.

Dr. Pervez Imam questioned the use of terms like systems and structures, which according to him were rigid. Secondly he even raised a concern of involving MBAs and CAs in Community health projects. While Mr. J.P.Mishra clarified that systems and structures have a crucial role to play in either large-scale or even small-scale projects. Dr. Sundararaman shared that we need to understand the skills that an MBA or a CA brings to the table before we dismiss them. Their expertise in Management Information System, Monitoring and Auditing skills cannot be undermined and need to be utilized.

Dr. Ravi Narayan concluded the day by saying that this workshop is the end of the beginning and must take on certain issues. Firstly, seriously study all the partnership and how systems were developed why they failed or how we can protect them? The issue of partnership, taking place since mid 1990s has shown positive outcomes. In Karnataka in late 90s, the Civil Society Organizations (CSOs) were invited to chair and be the secretariat of the task force of Karnataka followed by writing the state health policy & the Integrated Health Management Programme. The supports by many CSO to the Rajiv Gandhi Mission in Madhya Pradesh lead to the evolution of schemes like Swasthya Jeevan Gurantee Yojana & Jan Swashthya Rakshak. Today, there are examples of the Mitanin programme and the upcoming Sahiyya working group partnering with NRHM. He also added a few words of caution like not to reduce NRHM to ASHA & deduce the work of State Health Resource Center to Mitanin Programme. Learn from Karnataka and Orissa where government and civil societies are partnering to try & improve the government's institutional mandate in reaching people. He suggested not reducing the importance of interventions to individuals. Despite charismatic individuals, bureaucrats, and technocrats being responsible for initiating many innovative ventures, it is the systems that enable any venture to get executed. Finally there is a need to strike some sort of synergy between the broader scenario of larger movements of the civil society and larger forces of globalization. There are various examples of innovations. Large number of materials is available. One should build a set of accessory resource inventory of grassroots level learning material as a reference package.

Day 3 (April 12, 2006)

Training Content & Methodologies for Community Health Workers at Scale

- **Key Note: Approaches to achieving scale: Missions and Movements**

Dr. T. Sundararaman:

He began by saying that neither all the big programmes are a failure nor all small-scale programmes are successful.
Dr. Sundararaman's key point was that one needs to acknowledge the difference between scaled CHW programmes and small scale programmes. These have implications on all aspects of running these programmes and hence these should be viewed as two distinct entities and not clubbed generically as CHW initiatives. He went on to highlight the differentiating factors between small scale and large scale programmes. He explained that small scale programmes tend to be very focused, with high quality inputs and have tended to focus on curative care also. They also have a very strong and dynamic leadership factor, which is very critical to their functioning and eventual success. On the other hand they do tend to underestimate costs, and can get unsustainable in the long run.

His presentation highlighted the critical factors for the success of small scale programmes and the cautions, enabling and disenabling factors in running large scale programmes. He also detailed out aspects for operationalising large scale training and a need to understand that the quality of training (which includes ongoing support, monitoring, referral support, evaluation) is defiantly impacted at such scale. He explained that the idiom of opportunity needs to be explored in such large scale programmes. He also explained that a certain pace within the programme needs to be maintained, and is critical to political commitment. He also felt that by reaching full coverage, the programme creates for itself a critical space within a state.
He also explained that though state run programmes have more structured processes, a certain amount of flexibility needs to be allowed for corrective processes. This also relates to phasing in a CHW programme in a state and learning from the first phase for the future.

He explained that motivation follows a 'Gaussian curve' , and this can be applied to the public health system, or any system involved in a scale up process. 5% of all the individuals involved in this would have the sensibility, motivation and potential to work seifless ness, and impact the overall programme.

It is not NGO versus government but designing and implementing a successful programme, ensuring a good quality of referral support and monitoring large scale interventions. As Foucault argued that Power is privileging and disprivileging under the same scenario. Therefore, "how can power be subverted from within" was a key question the answer to which could have yielded a successful model of intervention. A model that could bring about change. He said that there are predictable consequences of actions and inactions but it is alternative actions that have unpredictable results. If we go on building exceptions and alternatives then we might get change. In negotiation, partnership, and persistence one needs a place to stand and then leverage change. He concluded with an appeal to persist in working with large-scale state programmes.

Dr. Abhay Shukla:

He shared the experience of Swasthya Saathi Initiative based on partnership with Peoples movement. Training inputs were standardized especially the ones for the semi-literate. Village health activities were sustained locally thus a decentralized and cost-effective model was developed. Linkages with the public health system especially in terms of inviting government officials as trainers on topics like how to keep water sources pollution free. In May 2004 the functionally literate CHWs have been accredited through a course designed by Saathi-Cehat approved by the SNDT University.
He also explained their work in Madhya Pradesh, which involves working in 40 villages of Barwani district. Here selection process has been initiated through gram sabhas and as there is a majority of non-literate health workers, special training curriculum has been prepared.

Discussion:

Dr. Nerges: She argued that goals of all these rights based approaches shared in the presentation are largely similar i.e., to build a critical mass, reduce exploitation and both focus on activating and creating linkages with the public health system. To some extent both seem to want to integrate with larger socio-economic issues. Sundararaman suggested this through an enlightened systematization with the focus on human dynamics. The second approach could be piggy banking on movements, as well as for integration of the voluntary sector with government led & owned programmes. He finally showed the role that these learnings would play a crucial role in taking forward the in ASHA programme in Madhya Pradesh.

Ms. Shalini questioned Dr. Abhay Shukla on his presentation which did not share the constrains that Saathi-Cehat experienced while working with peoples movements as Peoples Organizations (PO) have their own flow and way of functioning. While up-scaling we need to partner with other organizations and for that the NGO has to put in a lot of efforts in pushing their agenda which may become problematic while working with a PO which has a different perspective all together. Dr. Abhay Shukla said that there could be long discussion on the problems of coordinating. Basically, the agenda was to bring health on to the agenda of people's organization. This is a complicated process especially when health is dealt as a service issue. Funded NGOs dealing with PO, which does not receive any fund, is a complicated. Level of interest of PO in health is fluctuating. Main initiative was taken by NGOs and when larger issues crop up the PO also gets involved in mass action and that compensates for the other routine problems faced.

Prof. David Sanders: said that the success of community workers programme depends on the political activeness of the people and availability of technical tools for community mobilization, without any of which, it is very difficult to sustain itself.
Mr. Raman agreed that sustaining political will is difficult and challenging. Prof Sanders raised the question of 'how to sustain the political will within which community health programmes and health initiatives in general could survive? Can participatory approaches in training start engendering political movements, which then coalesces with similar activities in other sectors?' He said that the challenge is to convert political will into a political wish, which again can be problematic.

Dr. Sundararaman responded that it would be difficult to replicate processes as they are unique and context specific. Regarding the political will, which tend to fluctuate, cannot be seen as constraining and discouraging. If the facilitation is intense enough then even if the political will reduces some core messages will always have a space in peoples mind like a woman living in rural house hold can take care of the health of a child and need not depend on the doctor for everything. Political approaches to training means a very different style of training and that kind of training may not be replicable or up scalable as there it involves a special relationship between the trainer and the trainees, involves context, confidence of the trainee that the trainer has some commitment and is not merely a technical person.

While Dr.Sundararaman said that health policies and decisions at the level of the government have been made and it is difficult to ignore them but Dr. Anant Bhan pointed at the fact that till date India has a hypocritical health policy; determinants of health based on the pathology; constant undermining of development in real sense of the term; pharmaceutical corporates patenting policies; a reduction in public health spending etc. Responding to Dr. Sunderaraman, Dr. Anant Phadke added that in a retrogressive scenario, how can there be a recommendation to work with the state. But the way you embrace it or get engaged in it is deeply politically problematic. To engage is one thing but to embrace it is another stand. And this is also threatening for the activist/movement perspective. Gain for SHRC is loss for PHM! Finally, he argued that this workshop has tried to make some contribution in the history of the people's health movement in India and this kind of contribution is bound to have its historical (time & area specific) limitations. By the word movement itself it is clear that it is episodic. Even if we failed we have made some contribution.

- **Group Discussions on aspects of CHW training at scale**

The participants were divided in three groups and each group was asked to discuss, document and present their reflections in front of the entire house. This intense and vibrant session had the following learnings:

Group 1: Content, Methodology and Human Resources (Facilitators: Dr. Sunil Kaul and Mr. Raman)

- What are the essential principles for determining curriculum and pedagogy for CHW programmes?

The group discussed that the kind of training will depend upon the kind of role expectations from ASHA. The group enlisted some non-negotiable like the modules should be generic and flexible for contextualisation; the content should contain topics on Equity, Gender, Entitlements, Rights and Responsibilities; the categories of 'must know' and 'good to know', the information on basic medication and home based medicines; trainings must be in regional languages and use audio-visual tools.

- What are the methods, structures and institutions for contextual and effective implementation at scale and how can monitoring and evaluation be integrated?

The group suggested that the trainings should have an empowerment and confidence building approach; the nature should be interactive and participatory with use of infield training and working on-job with existing CHWs. A Cadre of Trainers by conducting TOTs should be developed. After the initial phase of trainings, preferably the CHWs

with field experience should move on to become trainers thus following a Cascade approach. As far as an exemplar model is concerned they recommended an SHRC like structure which supports health sector along with CHWs; autonomous with mandate & recognition by the government; partnership at all levels; led by a dynamic person from outside the government. Regarding Monitoring and Evaluation, it needs to be inbuilt, use techniques like peer reviewing.

- How can a cadre of trainers/facilitators/ supervisors be developed and supported?

Basically the group discussed that a decentralized model of trainings with downward accountability would inculcate a greater sense of ownership and responsibility amongst the trainers at each level. The experienced CHWs can be oriented (TOTs) into becoming trainers for the new health workers. Trainings should also be conducted in different phases, focus on inculcating confidence as well as decision making abilities and finally, manage to incorporate and reiterate progressive traditional practices.

Group 2: Partnerships (Facilitators: Mr. Mishra, Dr. Mistry and Dr. Mathur)

- What are the critical learnings from civil society and government engagement historically?

The group discussed that a very varied and contested history of state-civil society partnerships in the health sector are available including a Rich evidence and experience from the past as illustrated in this workshop itself.

- What are the emerging trends and experiences (SHRC-like institutions)?

There is an emerging consensus that political spaces for productive engagement exist in some places and can be opened up and negotiated in others. It is in this context and in the spirit of critical reflection, that the group approached the question of partnerships.

- The group enlisted various types of Partnerships: Government with Government; Central and State Government; State and District; Inter-departmental partnerships; NGO with NGO; Government-NGO Partnerships etc.

- These partnerships can be initiated at various levels:

1. Government of India creating enabling frameworks (prototypes of partnership);
2. Mentoring Group by Expanding their network or Evolve and operationalise shared principles of collaboration and state-level facilitation;
3. State Governments develop state-specific frameworks for engagement

- The Scope of Partnerships depends upon the nature of engagement; the processes of facilitation are dependent on state-specific histories, current contexts and opportunities. But, there are broad principles based on strengths and experience, shared ownership and level of engagement.

- Framework for Partnership

1. Vision/ advisory level
2. Policy detailing, the development of tools and instruments for implementation
3. Implementation: network of implementing partners and formation of resource support agencies
4. Design a criteria for partnerships at various levels
5. Follow a transparent selection process and procedure

Group 3: Support Structures for CHW Programmes (Facilitators: Dr. Sundararaman and Prof. David Sanders)

- What are the ideal contexts and support structures required for effective CHW programmes?

The state is aware of its inability to provide and now it is opening up for innovative interventions where NGOs can play a crucial role. If community mobilization and advocacy are important aspects of the NRHM then here is a context where the civil society organizations can step in. Though ASHA is viewed as a support worker she too needs supports like Trainers (who could be from NGOs), Medical practitioners (who could be upgraded ANMs), ANM, AWW, Panchayat members etc. but until the PHCs do not work ASHA may not be able to do much. The other support structures for ASHA include Technical Assistance Agency/Resource Center at the district level; statutory bodies like Panchayat Health Committee, which ASHA can energize; local institutions like Village Health Committee, which ASHA can mobilize and organize.
Basically a training and technical structure is what is required at the district and state level which will provide for facilitation of advocacy and mobilization role.

- What are the prevailing opportunities and constraints within which the NRHM is operating?

The opportunities include a vast range of technical skills that various experiences in public health have generated. People can be mobilized for demanding accountability in a manner that they do not alienate the system but get the most out of it.

- How can these be effectively influenced and informed?

The attempts for setting up District Programme Management, Public Health Foundation and Public Health Resource Network can enable an effective use of the current opportunities.

Concluding Remarks

Dr.Shiv Chandra Mathur pointed towards the concern of ownership and leadership of the NRHM.

1. The organizational culture of the government needs to be understood. Some kind of exchange of information between enthusiastic bureaucrats and field level workers is needed.
2. Need for an ASHA programme needs has to be examined and determined at the district level.
3. There is no linkage between ANM and ASHA and we need to lean from the Dai Training Programme, which failed because of no liaising between the dais and public health workers that was sought.
4. There should not be isolated structures for ASHA training, as she needs to be linked with other public systems and structures.
5. Mission cannot work in a government department. It needs to be an autonomous unit with linkage with the government.
6. If the center plans, funds and directs all the missions and programmes then why are the states asked to own them or take them forward. Why can't the center make 'health' a state subject?

Mr.J.P.Mishra said that health is a state subject and the more focus and ownership taken at the state level, the wider and deeper would be the impact. The quacks in villages are not mere representations of the private sector but an exhibition of the Private Practice of Public scenario.

Dr. Sundararaman shared that costing of the CHW programme is a necessity. A community health worker programme can address issues of social inclusion, nutritional security and emergency thereby changing the nature of community health work.

If we train people on effort intensive areas with low volume of expenditure then a low cost high impact activity based programme can be very well developed.

Prof. David Sanders: Success of ASHA (and NRHM) depends on the socio-political context, technical factors and financial input. While technical factors can be planned, socio-political factors are less amenable to manipulation. Key socio-political factors include community mobilization and political will, which are synergistic. Participatory planning and implementation can facilitate community mobilization. Community-based workers can catalyze and sustain community mobilization. But Community mobilization and political will often dissipate as political context changes

Key technical factors include Capacity development for training and ongoing support and supervision from levels above; participatory approaches to assessment and analysis, using appropriate technologies and methods; planning with Intersectoral action and sustainability in mind. Capacity development in two aspects is very essential technical health and advocacy/mobilization.

He was impressed with the enthusiasm and energy prevalent within the various groups to aspire for a hopeful and successful future. The opportunities afforded by current political conjuncture e.g. NRHM was, according to him, one of the reasons for that.

National Workshop on
Community Health Worker Training : Linking Pedagogy and Practice

Reflections and Recommendations

The Workshop

The Foundation for Research in Community Health (FRCH) and the Social Initiatives Group (SIG) at ICICI Bank had organised a National Workshop on Community Health Worker Training: Linking Pedagogy and Practice during April 10 - 12, 2006 in Pune.

The workshop represented an effort after almost a decade to bring together a diverse group of individuals with an aim to initiate sectoral dialogue and action on community health worker (CHW) training, and sustain it through a network of resource and research organisations. Located within the current context of the National Rural Health Mission (NRHM) and its core strategy of introducing a trained community health worker – the Accredited Social Health Activist (ASHA) – the workshop aimed to share and consolidate innovations and learnings in community health worker training across programmes over the last three decades; discuss and develop initiatives to mainstream these innovations and learnings to extend coverage and enhance quality of community health worker training; and to initiate a dialogue and create networks between various health worker training programmes, and between civil society groups and the NRHM.

The current context within which the workshop was organised presents a substantial body of past experience and evidence, gathered over 30 years of innovations in community health worker programmes, and the current opportunities presented by the NRHM and its core strategy of the ASHA – a trained community based change agent at a 1000 population level, to catalyse a sustainable community-owned process for behavioural change and to facilitate access to basic health services by the poor. In this context, the workshop was organised to address the issue of training in CHW programmes – learning from innovations in CHW training in various contexts and operationalising these at scale in the context of the NRHM.

The workshop brought together representatives from the central government and from the states of Jharkhand, Chhattisgarh, Rajasthan and Nagaland; civil society representatives and practitioners from more than fifteen different groups and programmes in various parts of the country; academics from international and national universities; and media persons to share experiences of and perspectives on content and methodology of training community health workers.

The Focus Areas

The workshop focused on training content and methodology innovated in both government and civil society groups in CHW programmes over the last three decades and systems to implement these innovations at scale by integrating with the NRHM. The presentations, discussions and debates focused on important aspects of CHW training – methodology and human resources; training in varied contexts within the country; partnerships for conceptualising and operationalising community health worker programmes; and support structures required for the successful implementation of such programmes. The focus areas of discussion in the workshop were the following:

- Locating CHW programmes within the larger context: One of the issues that was highlighted foremost in the workshop was to locate CHW programmes, and the aspect of training within them, in the larger context of globalisation and the macrosystemic environment of debt and structural adjustment policies that exacerbate inequities both within and between countries in all dimensions of development, including health. Professor David Sanders, in his introductory key note address, traced the international history of CHWs and the emphasis on people's participation in ensuring basic health of communities. It positioned CHW programmes within global economic, social and political processes, which in turn determine the characteristics and efficiency of these programmes. The discussions indicated the global debt crisis and the medicalisation of health as significant social, economic and political determinants of negative health outcomes, especially for the poor and vulnerable. In this larger context, CHWs have internationally been perceived as agents for realising

the right to health for the poor.

- Past experiences of CHW programmes: The workshop traced the long history of innovation in the area of CHW programmes in the country, with civil society organisations having pioneered the development of successful community health worker models in different geographies. For instance, as was presented in Dr. Ravi Narayan's address, the health workers of the Comprehensive Rural Health Care Project in Jamkhed, the *Sahyoginis* of the Foundation for Research in Community Health (FRCH) in rural Maharashtra and the health workers of Aarogya Iyakkam in Tamil Nadu, have achieved some success in emphasising an empowerment approach to health and in achieving desired impact on health outcomes, albeit with limited population and geographical reach. While civil society groups have shown consistent success of community health worker programmes in achieving better maternal and child health outcomes, those undertaken by the state at scale have shown mixed results. Noteworthy among these are the Community Health Volunteer Scheme initiated in 1978 by the Janata Dal Government, and the Jan Swasthya Rakshak programme launched by the Government of Madhya Pradesh in 1995. These programmes, however, did not have the desired impact on health outcomes due to structural gaps in the system, issues in training and lack of supportive human resource. The disparity in experiences of community health worker programmes initiated by civil society groups in intensive field areas and by states at scale were traced to three main factors namely, *programme design* that involves the conceptualisation of the role and profile of the community health worker, support structures at the level of the community and linkages with the health system; *lack of state capacity* in terms of technical resources to conceptualise and implement the programme at scale; and *lack of civil society participation* in designing and implementing these programmes in order to draw on the experience and technical knowledge of such groups to formulate informed state policies.

- The NRHM and future opportunities: The most recent conceptualisation of CHWs at scale has been the Accredited Social Health Activist (ASHA) Programme, which is a core strategy of the National Rural Health Mission (NRHM). The NRHM was perceived as a renewed political commitment of the present government, presenting an opportunity for mainstreaming the experiences and learnings from civil society innovations. However, the impediments of the past scaled CHW programmes were identified and the need for change recognised. The workshop highlighted the issues, debates and queries relating to the perceived lack of autonomy for states in decision making and fund utilisation vis-a-vis the central government, the gap that arises due to this between the conceptualisation and implementation, and the lack of state capacity to independently undertake these functions. Moreover, the ambiguity in the implementation plan regarding selection, training, support structures, linkages with the public health system, monitoring and evaluation, and fund allocation for the ASHA programme was also raised.

- Innovations in training content and methodology in CHW programmes: The workshop highlighted innovations in training community health workers in various programmes from different parts of the country. The discussions on the training models and systems in the Comprehensive Rural Health Care Project of Jamkhed; the training methodology and content developed by FRCH; the innovations in using information-communication technology in CHW training presented by Dr. Shyam Ashtekar; and the training structures and support systems in the Mitanin Programme of Chhattisgarh contributed to ideas about planning and implementation of CHW programmes at scale. The process of "training for transformation", emphasising self discovery and awareness about social realities, learning from peers and a phased training plan with continuous support, and a flexible learner-centric approach were the core principles of training in these CHW programmes. Keeping these non-negotiables in focus, the experiences from the Mitanin Programme highlighted the realities and challenges of training CHWs at scale.

- CHW training in varied contexts: The workshop discussed issues related to the need for contextualisation of CHW training to respond to the heterogeneous realities like the relative strength and ubiquity of public health facilities, the prevalence of non-literacy among CHWs and situations of political strife and conflict. Experiences of the Action Northeast Trust in implementing CHW programmes in eco-politically unstable areas of Assam, with a complete absence of health facilities added to these discussions. The need for contextualised training material and media for non-literate

workers (for example, the material innovated by Sathi-Cehat in tribal Maharashtra), adapting material to local practices and beliefs and the use of local dialects were highlighted by experiences from different programmes in the country. Besides, the roles of the CHW and therefore, the skills that the training programme builds require to be defined contextually, depending on the health needs of the community and the available health services. This was exemplified by experiences of different programmes in training CHWs on preventive promotive skills with the primary role as a behaviour change communication agent, versus training in clinical skills for providing basic diagnostic and curative care. Another major highlight in the workshop was the issue of integrating gender in CHW programmes. Experiences of Jan Chetna Manch from rural Jharkhand emphasised the need to focus on gender as an underlying factor in health, and therefore, the necessity to build perspectives on gender into training programmes for CHWs.

- CHW training at scale: The workshop discussed approaches to achieving scale for development programmes through state systems and people's movements. Experiences of the state level Mitanin Programme in Chhattisgarh and the people's organisation based Aarogya Sathi programme facilitated by Sathi-Cehat, in their attempt to sculpt out their own approach by integrating fundamental innovations in design and implementation, have the potential to provide learnings for such programmes at scale. The workshop facilitated focused discussions on various aspects of CHW training at the scale – content, methodology and human resources; monitoring and evaluation of training processes; support structures and partnerships. Also emphasised was the need for partnership building, capacity building and sharing of resources between the state and civil society in conceptualising, operationalising and implementing CHW programmes at scale. In this context, the workshop discussed issues related to ambiguous boundaries between state-civil society engagement, and co-option of civil society by the state. However, drawing from the evidence and experience of the varied and contested history of such engagements and partnerships in the health sector, there was an emerging consensus that political spaces for productive engagement exist in certain situations and can be opened up and negotiated in others. The issue of partnerships was approached in this context and spirit of critical reflection on the scope, framework, types and the processes involved in building these relationships. Innovative ways of integrating civil society efforts and experiences in the field of CHW training with the vision and space provided by the state as articulated in the NRHM were discussed and hoped to be achieved.

Future Directions

The workshop is the beginning of a sectoral dialogue and indicates various initiatives that can be undertaken in the future to sustain and forward this effort. Some of the main learnings and recommendations are the following:

- Government and civil society partnerships at each level of the decentralised structure of the NRHM – at the state, district, block and village levels – to facilitate training of the ASHAs, their trainers and the other personnel involved in this process.

- Capacity building and training of government personnel, especially at the district and block levels, on developing and implementing training for the ASHAs. At the state level, this can involve efforts such as workshops to orient the State Mission Directors / State Facilitators about the various innovations and best practices in CHW training in the sector.

- Integrating learnings from civil society innovations about community mobilisation and CHW training into the conceptualisation and implementation of, and support to the ASHA programme at the level of scale.

- Undertaking review and development of state training modules in a participatory manner by involving personnel from different levels, as well as seeking feedback from local and sectoral experts. Related efforts have been initiated in Jharkhand for the development of the Sahiyya training modules. The training content which was initially defined by personnel from the state, district and block levels, in collaboration with local civil society groups, is now being reviewed and finalised in a state level workshop by sectoral experts from across the country.

- Developing contextualised training content and methodologies, that can sensitively respond to the unique contextual realities in different geographies across the country. Contextualisation can involve development of training modules in local languages/dialects; designing content to address local problems, beliefs and practices; defining the roles and scope of the ASHA to best suit local needs; and adapting training to suit the profiles of the human resources available in different regions.

- Building gender sensitivity into training content for the ASHAs, as well as for personnel at all levels associated with the training system.

- Developing specific training content for non-literate ASHAs, keeping in mind the high prevalence of illiteracy in the country, especially among rural women.

- Consolidating sectoral experiences in CHW training into easily accessible resource material and undertake its active dissemination to facilitate the ASHA programme.

- Undertaking research on training content, methodology and systems in different contexts to build the body of sectoral knowledge.

Community Health Worker: the scope of and hopes from ASHA[1]

Swati Dogra

The Foundation for Research in Community Health along with the Early Child Health Team of Social Initiatives Group of ICICI Bank arranged a workshop titled, "Community Health Worker Training: Linking Pedagogy and Practice" during 10th to 12th April 2006. This exercise was especially crucial in the light of the National Rural Health Mission[2] that focuses on ASHA and aspires to undertake the herculean task to train four lac community health workers across 18 states in India.

Three sectors including the government, who has launched this mission as well as the non-government sector along with the funders, were represented in the workshop. Consequently, there were numerous and often differing perspectives, that reflected the varying contexts and experiences that each one present in the workshop represented. This diversity is especially significant in a country as complex as India where there is simply no ONE way of getting things right. The need is for sharing, consolidating and learning as a way to effectively move forward.

While the focus was on sharing experiences, the workshop strongly surfaced the tentativeness with which NGOs and government can work together. The thin line between partnering with each other versus embracing the others' modus operandi; the fear of collaboration taking shape of cooption; the apprehension of converging ideas and experiments at the cost of losing originality of each, were some underlying hiccups that the workshop raised. But a clear message to build exceptions and find alternatives by embracing bold and innovative partnerships was seen as a way of looking ahead. These new sets of relationships need to value the strengths of each partner along with understanding their inherent weaknesses.

The following article examines this National workshop, which gathered various camps of practitioners of public health to reflect on each other's experiences and evolving directions for the future. While the event may not have encapsulated the diversity completely, it certainly is a 'beginning' of inter-sectoral dialogues.

In a nation, where the political environment is going ahead and allowing economic categories of wealth, accumulation, consumerism and fetishism to become the basis of development. In a scenario where hunger, malnutrition and abject poverty are barely getting marginal attention against the food courts, medical tourism and so called economic boom, the **National Rural Health Mission** (2005-2012), is seen by many as an opportune moment.

---

[1] Accredited Social Health Activist (ASHA), is a strategic position created under the NRHM for promoting access to improved healthcare at household level through a female health worker.

[2] National Rural Health Mission (NRHM) is launched in 18 states namely Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghaya, Madhaya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. Through this mission, the Ministry of Health and Family Welfare, Government of India aspires to make architectural correction in the basic health care delivery system by improving the physical and qualitative access to public health by the marginalized section of our country.

NRHM indicates a political will to synergize health with nutrition, hygiene, sanitation and safe drinking water; sees health as a part and parcel of a larger system as well as focuses on the Public Health Center; it attempts to increase public expenditure on health; envisions decentralizing management of health programmes, assets and personnel; aspires to mainstream Indian systems of medicine and make comprehensive primary health care universally available.

Regarding the NRHM itself, the participants raised various questions and concerns especially because improving health cannot merely involve bio-medical interventions, but requires an addressal towards social, economic, political and cultural dimension. These could be summarized as the following:

- Who owns the NRHM?
- Why has a mission mode been chosen?
- How can a mission based on the principle of decentralization be centrally envisaged?
- How can decentralization of the mission be ensured?
- Why are the State Governments viewing the guidelines given by the Central Government as a final diktat?
- How real and achievable are the goals of this mission?
- Does the mission have yearly objectives, outputs and indicators?
- Why the HIV-AIDS activities are are not clubbed under NRHM?
- How does NRHM intend to converge vertical programmes?
- How can the impact of NRHM be measured in the light of other existing health programmes?
- How important are the non-government initiatives to the government?
- Who will synthesize learnings from small non-government experiments and utilize them for NRHM?
- How will the aspiration of involving a range of stakeholders and players be coordinated?

Along with these questions that the workshop brought to the table, there were discussions on how basics of community health have been understood both by the conventional and alternate thinking. But it was interesting to note that within the alternate camp, multiple experiments have given rise to varied perspectives of looking at health. These models were developed in different states to address needs of precisely those areas where they were based. The experience and learnings of each programmatic intervention is crucial because they have provided impetus for policy level changes and continue to point at the lacunae in the public health systems.

What has been the approach to community health?

Demystification model: It is believed that health is not equal to treating illness. Illness dramatizes health and medicine mystifies it. This drama and mystification alienates people from understanding their own mind and body. The medical system has failed to reach out to the people and therefore, a need to develop systems of localized,

decentralized and integrated models of health care need to be re-established. Rather than making patients out of people and then looking for medical solutions to cure them, the focus on community health needs to be on promotive and preventive systems that our country has a rich heritage of.

However, there were arguments against this simplification model, which is believed to necessarily homogenize problems of the poor. The risk of trivialising health of the poor by focusing only on preventive, promotive and very basic curative care, rather than secondary and tertiary curative services could lead to ignorance of another kind. The assumption that rural life and people living in villages have simple problems tends to overlook complicated, diverse and heterogeneous health needs. Science and medicine have influenced our categories of understanding to such a great extent that complete dismissal of it is something that seems difficult to achieve.
While both the approaches are interested to reach out to the people's health in an integrated manner, one sees health as a category within the broader category of health. The other does not limit health to a functional part of the wider structure but looks at specialized categories within health itself.

How health programmes view Community Health Workers?

With evolving and changing perspectives in the development sector, community health worker programmes have taken on the shape of a community empowerment initiative. Here the activist role of a CHW has gained priority. However there continue to be constant dialectics between the roles of a CHW. Is he or she going to be a service provider or a demand generator i.e., Instead of being a supplying agent, the CHW, will be an animator who mobilizes people to avail health facilities as their right. Under this dichotomy some argued that Clinical skills should be taught to CHWs only after their mobilization and facilitation skills are developed. Therefore, more than managing medical illnesses, the NRHM should be working towards training the ASHA (Accredited Social Health Activist) to work on the existing health practices and behavior of the community.

Within the category of behavioral change, which the CHW is supposed to influence, it is not individuals but groups, especially the hegemonic ones whose mindset needs to be changed. Here too there were a series of questions that were raised:

- If the ASHA does not already have an influential position then how would the dominating practices get shaken?
- How will a ASHA belonging to the non-dominant group influence the dominant mindset?
- If she is from the dominant group then how will she get acceptance in her own community if she becomes a representative of the oppressed side?
- If the ASHA is well received then will that indicate that she has succeeded as a change agent or succeeded as a conformist?

These questions become crucial if the NRHM aims to regularly monitor and evaluate the impact of ASHA.

But coming back to the role of ASHA as a supply agent versus a demand generator, the reality of remote areas with minimal service system becomes the point of attention.

- Without enough hospitals and doctors, even if the CHW mobilizes the people, who will the people go and demand health facilities from?
- What facilitating role can be played under circumstances where the bare minimum does not exist?
- Then don't diagnostic and curative skills become as important as the mobilization and advocacy skills?

Therefore, some amount of capacities in curative care does become essential.

But the new roles entrusted to the same CHWs have not over ridden the older roles thereby creating work load and multiple role expectations which gives rise to another set of pragmatic issues:

- Is it practical to expect the same CHW to do social mobilization and curative work simultaneously?
- Is it possible to view social commitment and responsibility in isolation from economic needs and monetary value?
- If a woman is utilizing her home-based labor time to carry on activities for the community then for how long will her spirits of voluntarism be the only source to bank upon?
- How will the compensation to a CHW be calculated? What relation will the amount have with the amount of compensation paid to the Auxiliary Nurse Midwife and Anganwadi Worker?

How a Community Health Worker has been trained and oriented?

The various experiences shared by the organizations present in the workshop, enlisted that trainings that are most conducive to adult learning are the ones using non-didactic and non-conventional participatory methodologies. Trainers need to be facilitators and address the multiple learning requirements of participants need to be addressed. There was a concern that ASHAs will have new and varied requirements to learn and grow. The career path of ASHAs needs to be looked at from a long-term point of view. On-site and In-situation back up along with regular lateral sharing is the key to polish and improvise on the knowledge and skills. Use of pictorial and non-classroom modes of trainings have been improvised and must be incorporated in any adult learning endeavor.

On the one hand it was agreed that, experiential and affective learning enables long term and deeper impact. On the other hand, it was felt that the use of technology and distance learning should also be explored. Evaluation of the trainings and trainers was suggested to be inbuilt in the programme.

Interms of content, trainings conducted in programmes of CHWs have covered a range of issues and themes. They have been forums to pass on technical know-how and generate a sense of social responsibility. While innovative, interactive methodology along with holistic and integrated approach was commonly accepted as the most effective, there were some debates on the extent to which integration of issues and topics would be possible. This was an offshoot of the existing dilemmas with respect to the role of CHWs.

- From curative, preventive and promotive of health to even broader and more sensitive themes of Community building need to be incorporated in the content of CHW trainings.
- Income generation, public issues, rights and responsibilities, ethics and equity, environment, ecology, effective communication and community mobilization are some of the significant topics that CHW trainings should cover.
- Through trainings, a set of holistic and integrated approach to development needs to be instilled.
- Even information on national health programmes, water, sanitation, immunization, referral care, veterinary care as well as discussing lacunae in the available systems should be added to the content of trainings.

However, many models of focused, on-going and contextual capacity building interventions have succeeded in programmes of limited outreach. There were concerns as to how they could be up scaled. It is a fact that the structure for implementation and availability of physical and economic support is crucial for performance even more than the training component. But success of NRHM cannot be reduced to a community health worker strategy alone.

How can the challenges for ASHA be understood from the above?

The multiple expectations owing to the multiple lacunae in the health delivery system are envisioned to be addressed through an Accredited Social Health Activist (ASHA) provided she gets proper orientation and training and has a back up of support available to her. Without adequate structural strength, it is highly unlikely that the hopes from an activist model of a Community Health Worker be turned into a reality.

Both her position and role become strategic because she is viewed as a part of the system as well as an independent entity at the same time. This perception comes from the fact that if you institutionalize and standardize a role and position then it takes an objective and mechanical shape, which the NRHM hopes to avoid. So, there is a need of a person who stems from the system but yet does not suffer from the bureaucratic hassles of it. Secondly, to ensure an effective performance, she needs to convince and reach out to the community whom she should be accountable to. ASHA has been envisaged as a **position** designed from the top, which needs to be accountable to the bottom and as a **role** that facilitating demands and mobilizes supply. The legitimacy of ASHA in the existing system that is already in place like both the local governance institutions as well as public health systems will influence her ability to bring about any change.

ASHA has been carved out to be a position and role that can work at the root of the problem tree and actually influence the shoot. It is also a model that has been allotted space to maneuver as per the local requirement. It is a part of the mission that acknowledges and aims to utilize the concepts of decentralization, people's participation and partnership, in practice. But the success of ASHA depends upon availability of:

- A set of motivated trainers,
- An investment in physical infrastructure (availability of efficient PHCs)

- Cooperation of Medical practitioners, Auxiliary Nurse Midwives and Anganwadi Worker
- Support and acceptance from Panchayat members

The other support structures for ASHA include Technical Assistance Agency/Resource Center at the district level; statutory bodies like Panchayat Health Committee, which ASHA can energize and; local institutions like Village Health Committee, which ASHA can mobilize and organize.

But the difficulties that ASHA will face due to lack of doctors, the role clash that she would have with the ANMs, the lack of mechanisms to coordinate with AWW, the marginalization of the existing mid-wives and their enriched experience are some key issues that the mission leaves out. Secondly, the declaration of ASHA being a woman comes from and feeds into a whole range of gender stereotypes. It was pointed out during the workshop that if we look at the dais and doctors through a gender lens then the former are feminized ends of health system (marginal and poorly compensated) while the doctors are the masculine ends (highly valued). The nature of work that community health workers have been doing despite being very valuable is not recognized as an established profession. Selecting women to play roles of such amorphous nature can therefore be questioned. If women have a marginal say in terms of control over decisions, how will be able to single handedly bring about a completely opposite outlook. Perhaps it is essential to look at different social structures, norms, practices and differences in role allocation between men and women before we allot the CHW position to women.

NRHM has a formidable task of factoring in some space for diversity as well as evolving strategically viable structures of efficiency to ensure better results. The workshop provided a forum to view NRHM as an opportunity to re-look at the last 20 to 30 years of community health worker programmes (and their trainings) for the purpose of up scaling and replicating. To learn from them, the government needs a set of central accessory **resource inventory** of grassroots level experiences and learning material as a reference archive for NRHM.

Since community mobilization is seen, as a major component of the mission, partnerships with civil society organizations who have expertise in facilitating processes of change, is the need of the hour. A **training and technical structure** is what is required at the district and state level which will provide for facilitation of advocacy and mobilization role. So the Ministry of Health and Family Welfare needs to create space for meaningful utilization of the various small NGO experiences in NRHM. Simultaneously, the NGOs should be willing to work in an all-together new mode of partnership with the government.

Today, many of the stakeholders can become a part of the success and failure of the NRHM. The question whether we are ready or not. Is it time for government to make way for NGOs and for NGOs to step into bigger and wider roles? Can the government and NGOs jointly take up the responsibility of critiquing the health system from within? Is it possible for the non-government structures to become such a part of the system that it would neither ignore nor acquire power but subvert it from within?

To conclude, the NRHM can play a major role in influencing the health status of our country provided there is an independent lobby within the NRHM that can constantly network with practitioners, trainers and researchers towards Resource Pooling. And it is precisely for this reason that practioners from various stands find it a topic to congregate for. Within NRHM, the role of a community health worker requires clarity so that it can actually show the kind of results it is expected to deliver. For the success of ASHA, both trainings and larger structural back up are extremely crucial. The component of training can be best taken forward if the existing expertise from the non-conventional experiences is utilized. Themes of gender, justice and equity cannot be reduced to modules but crosscut in the overall orientation of the Trainers. While the government needs to innovate models of participation and partnership, the civil society organizations must respond to the pressures of up scaling.

Community Health Workers in India:
Dr. Ravi Narayan
CHC-PHM

- FRCH and ICICI SIG WORKSHOP
- 10-12 April 2006
- TMTC, PUNE

CHW'S IN INDIA - AN OVERVIEW

Bhore Committee (1946)

"Formation of village health committees and voluntary health workers who need suitable training.."

CHW'S IN INDIA - AN OVERVIEW

CHW's of the NGO Sector - I (1970s & 1980s) Experiments

- CHWs Jamkhed
- VHWs - Indo-Dutch, Hyderabad
- Lay First Aiders - VHS-Adyar, Chennai
- Link workers - CLWS of tea plantations in South India
- Health Aides - RUHSA
- MCH workers - CINI, Calcutta
- Swasthya Mitras - BHU, Varanasi
- Sanyojaks - Banavasi Seva Ashram, Uttar Pradesh
- CHW course of St. John's Medical College, bangalore
- Rehbar-e-Sehat of Kashmir Government (Teacher-workers)
- CHVs - Sewa Rural, Jhagadia
- Community Health Guides - other projects

CHW'S IN INDIA - AN OVERVIEW

The CHW's of the NGO Sector - II (1970s & 1980s) Overview

- Predominantly women
- Mostly voluntary or link workers with minimum support
- Mostly mature, married volunteers
- Care to prevent the cooption by village leaders and representation of all segments
- The participation of the community in identifying CHWs and their supervision
- The training programme - innovative components and methods
- Well trained and highly mobile, field and supervisory staff
- Many projects had women on local action / advisory committees
- Many had local women groups supportive of the process.

CHW'S IN INDIA - AN OVERVIEW

The CHW's of the NGO Sector - III

"This is a beautiful hall and the shining chandeliers, are a treat to watch. One has to travel thousands of miles to come to see their beauty. The doctors are like these chandeliers, beautiful and exquisite, but expensive and inaccessible..."

"This lamp is inexpensive and simple but unlike the chandeliers it can transfer its light to another lamp. I am like this lamp lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole earth. This is Health for All."

Muktabai Pol, a Village Health Worker From JAMKHED India, in Washington, DC, May 1988

CHW'S IN INDIA - AN OVERVIEW

Medical Education and Support Manpower Shrivastava Report (1974)

"What we need therefore, is the creation of large bands of part-time, semi-professional workers from the community itself who would be close to the people, live with them and in addition to promotive and preventive services (including those related to family planning) will also provide basic medical services needed in day to day common illnesses (which account for about eighty percent of all illnesses)".

These are essentially self employed people and therefore do not form part of the Government bureaucracy. They could be primary school teachers, housewives, practitioners of different systems of medicine and dais..."

CHW'S IN INDIA - AN OVERVIEW

The Janata Experiment (1977)

"The Janata Government launched the CHW Scheme, which focussed on CHWs selected by the community, having 6th standard education and trained informally in the PHM for 3 months. They were paid a stipend during training and an honoraria of Rs.50/- per month after the training, when they began to work. This scheme was also called the Rural Health Scheme."

CHW'S IN INDIA - AN OVERVIEW

Rural Health Scheme (GOI) 1977 - 1 Aims & Tasks

"The aim is to provide simple medical aid within the reach of every citizen by organising a cadre of medical and paramedical community health workers, of whom the trained practitioners of the indigenous systems of medicine will be a part"

"The tasks expected of the CHW is, immunisation of the newborn and young children, distribution of nutrition supplements, treatment of malaria and collection of blood samples and looking after elementary curative needs of the community"

CHW'S IN INDIA - AN OVERVIEW

Rural Health Scheme (1977) - 2
Philosophy

- Health work looked after largely by government will now also rest in the hands of the people
- The CHW will be 'of the community', 'accountable to the community' and the community in turn will supervise his work
- As expression of community involvement and participation, the community should supplement the resources required for the continuation of this work
- Community to completely takeover the programme at a subsequent time".

CHW'S IN INDIA - AN OVERVIEW

The Rural Health Scheme (1977) - 3
Coverage

- "The Scheme was launched on October 2nd, 1977 in all PHCs of 28 districts of the country where unipurpose workers had been reoriented as multipurpose workers and one PHC in each of the remaining districts of the country ".

- "The scheme was accepted by all the states and union territories except Jammu & Kashmir, Karnataka, Tamil Nadu and Kerala".

CHW'S IN INDIA - AN OVERVIEW

The Rural Health Scheme 1977 - 4
Issues of public debate

- Government sincerity in providing health care to the rural masses welcomed
- Inadequate preparation criticised
- Medical profession charged scheme with promoting quackery.
- Lack of pilot studies done on feasibility was a weakness especially because heavy investment of public finds required for implementation
- Is it possible to use non health workers picked from the community in a sustainable manner?
- Do such initiatives make any meaningful alteration in the state of health of the people?
- Is the approach practical? Feasible? Acceptable?

CHW'S IN INDIA - AN OVERVIEW

The Rural Health Scheme, CHW (1977)
Learning from the Evaluation - I

SOURCE

The evaluation of CHW Scheme - a collaborative study by NIHFW, New Delhi,

INSTITUTIONS

NIHFW-New Delhi, AIIH & PH-Kolkata, IIM-Ahmedabad, IIPS - Mumbai, ICMR-New Delhi, Gandhigram Institute for Rural Health and Family Planning, Madurai

SAMPLE

76 PHCs, 60 state level officers, 142 district level officers, 142 medical officers, 227 supervisors, 225 MPWs, 203 village level workers, 299 CHWs, 6013 community members, 604 community leaders, 73 BDOs, 42 Zilla Parishad members

CHW'S IN INDIA - AN OVERVIEW

The Rural Health Scheme, CHW (1977) Learning from the Evaluation - II

- Acceptability - Massive support
- Community enthusiasm for long term financial responsibilities low.
- Objectives, roles and responsibilities of personnel differently understood by officials at different levels.
- Selection process - Need to involve community proactively
- Selection criteria suggested include age 30+; females preferably; local residents if possible; Ex-servicemen and dais priority"
- Allopathic dominance to be balanced by involvement of other systems.
- Trainers training, reading materials for PHCs, supervised field training with emphasise on prevention and promotion to be strengthened.
- Periodic refresher courses and regular monthly meetings.

CHW'S IN INDIA - AN OVERVIEW

The Rural Health Scheme, CHW (1977) Learning from the Evaluation - III

- System of procurement and supply of medicines and drugs should be designed based on methodologies of material management
- Honoraria - panchayats to be entrusted responsibility
- Recruitment of III Medical Officer in PHC to support training
- Good supervision, periodical orientation and refresher courses be provided
- Simple monitoring scheme to be developed for concurrent evaluation
- Training of multi-purpose workers to be linked with CHW training - because the multipurpose workers would be source of technical guidance and supervision to the CHWs

CHW'S IN INDIA - AN OVERVIEW

ICMR / ICSSR Health for All Report (1981)

Community Health volunteers with special skills,

readily available,

who see health as work and not as a 'job'

view it as a social function

CHW'S IN INDIA - AN OVERVIEW

National Health Policy (1982)

"Health volunteers selected by communities and enjoying their confidence and to whom certain skills, knowledge and use of technology could be transferred"

CHW'S IN INDIA - AN OVERVIEW

The Jan Swasthya Rakshak Scheme of Madhya Pradesh (1995)

Criteria	JSR Scheme	CHW Scheme
Year	1995	1977
Training duration	6 months	3 months
Goal	One JSR / village	One CHW / 1000 population
Eligibility	Upto 10th std	Upto 6th std
Training stipend during training	Rs. 500 p/m	Rs 200 p/m
Honoraria	Loan - subsidy from Jawahar Rozgar Yojana	Rs. 50 per month
Certification	Para-medical certificate	Informal certificate
Content of manual (special)	• Working with community • Anatomy / Physiology •Dengue / Tuberculosis / STD / Blindness •Patient examination	• Mental Health • Minor ailment in Ayurveda/ Yoga/ Unani/ Siddha/ Homeopathy/ Naturopathy • Medicinal plants

CHC, 2006

Source: CHC, 1997 17

CHW'S IN INDIA - AN OVERVIEW

The First JSR Evaluation, CHC, 1997

Recommendations

- JSR functions and responsibilities - further clarity
- JSR under panchayat supervision
- Health project committee in health department
- More female candidates
- Reduce education limit for women and adivasi candidates
- Develop linkages with other sectors
- Use appropriate effective local media
- Training to be strengthened in problem identification, community experience and problem solving
- Supportive facilities like hostel to be provided
- Distance learning module and regular refresher courses
- Re-certification on periodic basis.
- Supportive supervision to be built up
- Independent examination assessing practical skills and knowledge
- Core project team with support of peer group of trainers

CHC, 2006

Source: CHC, 1997 18

CHW'S IN INDIA - AN OVERVIEW

The Second JSR Evaluation, CHC, 2001

Recommendations

- Pause - consult and redesign
- Ground work before launching scheme to include training of master trainer and state level information on scheme
- Training of JSR trainers at district and block level.
- Orientation of village health committees and gram sabhas to JSR scheme
- SC/ST - OBCs should be encouraged and AWWs of ICDS scheme
- Less didactic and more problem solving approach and participatory training
- Strengthen medical supply and practices
- The need for wide spread public information
- Systemasise linkages with government staff
- Develop simple reporting systems
- Technical monitoring of public health systems by gram sabha and village health committees
- Involve NGOs in experiments - training, management and action involvement

Source: CHC, 2001

CHC, 2006 19

CHW'S IN INDIA - AN OVERVIEW

The CHW's of the NGO Sector (Beyond 1990s) Experiments for empowerment

•Arogya Iyakkam (Tamil Nadu Science Forum)
•Arogya Sathi (CEHAT Sathi)
•CMSS Dalli Rajhara Chhattisgarh

Features:

•From alternative health care providers and health extension workers to health empowerment activists'

•From project management to process management'

•From Health Action to putting people's pressure to make existing health services more responsive and accountable to people's needs

CHC, 2006 20

CHW'S IN INDIA - AN OVERVIEW

The Indian People's Health Charter of Jana Swasthya Abhiyan - December 2000

- "... A Health Care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concepts of health care ..."
- "... Village level health care based on village health care workers selected by the community and supported by the gram sabha / panchayat and the government health services which are given regulatory powers and adequate resource support ..."

Source: CHC 2000

CHW'S IN INDIA - AN OVERVIEW

The Global People's Charter for Health of People's Health Movement - December 2000

- "... Promote, support and engage in actions that encourage people's power and control in decision making in health at all levels including patients and consumer rights ..."
- "... Build and strengthen people's organisations to create a basis for analysis and action ..."

Source: CHC PHM 2000

CHW'S IN INDIA - AN OVERVIEW

The Mitanin Programme of Chhattisgarh, 2002 Programme Overview

- Concept based on local cultural roots of Mitanin
- Role of Mitanins to include health education, leadership of public health activities and care of common illnesses
- Mitanin to work in close association with: ANMs, AWWs and PRIs
- Block Medical Officer to train Mitanins
- The first training of six rounds would include building of certain attitudes, knowledge and skills
- Selection of women as health workers
- No regular honorarium but voluntarism
- Linking CHW initiative with health sector reform
- Building state and civil society partnerships

Source: CHC 2006

CHW'S IN INDIA - AN OVERVIEW

The Mitanin Evaluation by CHC - December 2005 Areas of Recommendation

- Objectives
- Strategy
- Community Involvement
- Linkages
- Number of Mitatins
- Misuse of Mitanins
- Education Level
- Community Mobilization
- Health Education
- Medical Care
- Budget
- Morale
- Training
- Monitoring
- Remuneration
- Support
- Sustainability
- Vision

CHW'S IN INDIA - AN OVERVIEW

The ASHA Training Programme of the National Rural Health Mission - 2004

"A new band of community based functionaries named as Accredited Social Health Activists (ASHA) who would be a health activist and mobilize the community towards local health planning and increase utilization and accountability of existing health services".

CHW'S IN INDIA - AN OVERVIEW

The ASHA Training Programme of the National Rural Health Mission - 2004

Some Concerns of People's Rural Health Watch of JSA

- Activists or appendage
- Lack of adequate regular compensation
- Limited provisions for first contact care
- RCH focus overshadowing comprehensive primary health care
- Training to be substantial and adequate
- ASHA not to substitute or replace existing workers including ANM and AWW
- Need for specially developed cadre of local trainers and facilitators
- Adequate budgetary provisions to support all ASHA components
- Mission not to be accompanied by privatization initiatives
- Applying Indian public health standards
- Involving Ayush doctors and providing support.
- Need for community monitoring of ASHA.

COMMUNITY HEALTH WORKERS IN CONTEXT: GLOBALISATION, HEALTH SYSTEMS AND PRIMARY HEALTH CARE

David Sanders
School of Public Health
University of the Western Cape
Member of the Global Steering Group of the Peoples Health Movement

WHO Collaborating Centre for Research and Training in Human Resources for Health

Outline of Presentation

- Global trends in **burden and pattern of ill-health** in the era of Primary Health Care - 1980 to 2004
- Historical **evidence for key factors promoting health**
- Impact of **globalisation** on poverty and health determinants
- The development and evolution of **health systems** and policies, including **health sector 'reform'**

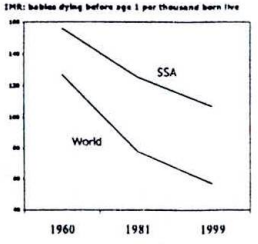
Progress in Global Health

- Life expectancy – increases from 46 years in 1950s to 65 years in 1995
- Child deaths – reduced from projected 17.5 to 10.5m per year
- Substantial control of poliomyelitis, diphtheria, measles, onchocerciasis, dracunculiasis through immunisation and disease control programmes

Growing inequalities in global health

widening gap in infant mortality experience

IMR decline (Percent)	1960-1981	1981-1999
World	38.5	26.9
SSA	19.2	14.1

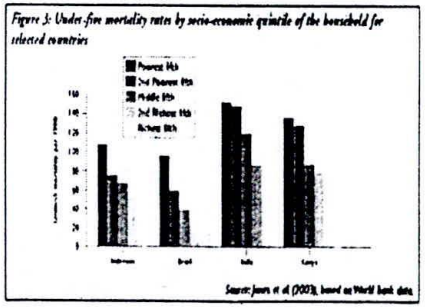


UNICEF: State of the World's Children

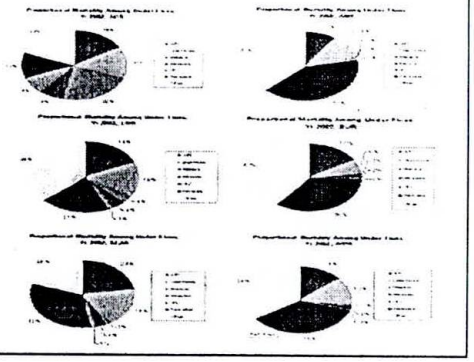
Global health inequities

- A woman has a nine in ten chance of reaching the age of 65 years in a high-income OECD country,
- **but a four in ten chance in Malawi.**
- In Tanzania, every sixth child born alive will die before the age of five years,
- **while in high income OECD countries, every 167th child dies before the age of five.**

Growing inequalities in child health – within countries



regions (WHO 2002)



Leading global risk factors and contributions to global burden of disease : % DALYs, World

Ezzati et al 2002

Classification of most diseases of the poor in underdeveloped countries

Nutritional	Communicable			
	Airborne:		Water-related and faecally transmitted:	
	Viral	Influenza, Pneumonia, Measles, Chickenpox	Water-borne/ Water-washed:	Cholera, Typhoid, Dysentery, Amoebiasis, Hepatitis A, Poliomyelitis, Helminths
	Bacterial	Whooping cough, Diphtheria, Meningitis, TB	Water-washed:	
			Skin and eye infection	Trachoma, Skin infection, Leprosy
			Skin infestation	Scabies, Typhus
			Water-based:	
			Penetrating skin	Schistosomiasis
			Ingested	Guinea worm
			Water-related vectors:	
			Biting	Sleeping sickness
			Breeding	Malaria, Yellow fever, Onchocerciasis

A Historical Perspective

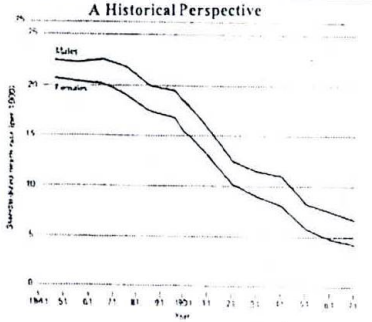


Figure 2.12 Death rates (standardized to 1901 population) in England and Wales (From reference 17, courtesy Sheffield Provincial Hospitals Trust.)

Death rates (per million) in 1848/54 and 1971 in England and Wales

	1848/54	1971	% reduction attribut. to each category
Communicable			
Air-borne	7259	619	40
Water/food-borne	3562	35	21
Other	2144	60	13
Total	12965	714	74
Non Communicable	8891	4070	26
All diseases	21856	5384	100

A Historical Perspective

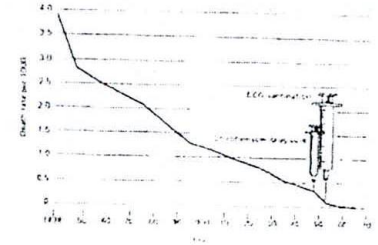
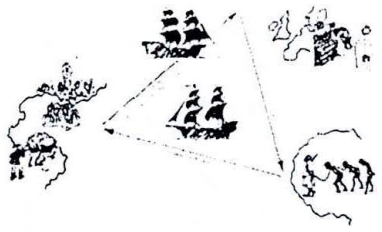
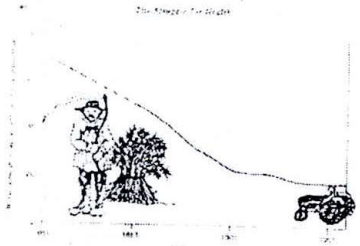


Figure 2.13 [illegible] (From reference 17, courtesy Sheffield Provincial Hospitals Trust.)



13



14

Effects of agricultural and industrial revolution

- Rapid urbanisation
- Overcrowding, squalor in towns as infrastructure cannot cope with influx
- High unemployment, child labour
- Disease, crime and violence is rife (read Charles Dickens)

15

HAS

DEATH

(IN A BASK)

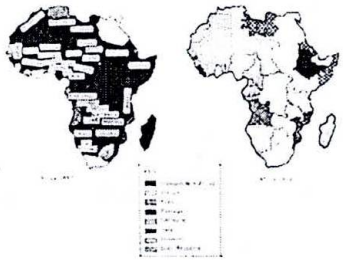
Been invited by the Commissioners of Common Sewers to take up his abode in Lambeth? or, from what other villainous cause proceeds the frightful Mortality by which we are surrounded?

In this Pest-House of the Metropolis, and disgrace to the Nation, the main thoroughfares are still without Common Sewers, although the Inhabitants have paid exorbitant Rates from time immemorial!!!

Unless something be speedily done to allay the growing discontent of the people, retributive Justice in her salutary vengeance will commence her operations with the *Lamp-Iron* and the *Hatter*.

SALUS POPULI.

Lambeth, August, 1832.



17

Main reasons for Africa's (and Asia's) Health Crisis

Increasing poverty and inequality worsened by inequitable globalisation,

Selective PHC and Health sector "reform", and

HIV/AIDS

The institutions promoting economic globalisation

- World Bank
- International Monetary Fund (IMF)
- World Trade Organisation (WTO)

The debt crisis, structural adjustment and globalisation:

- A crucial development in the current phase of globalisation…

External debt

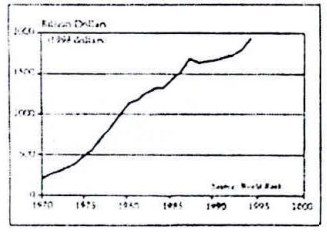
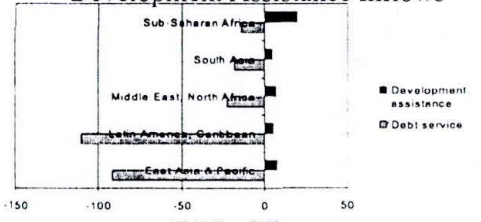


Fig. 3-6 External debt of developing countries, 1970–94 [illegible]

Debt Service Payments Dwarf Development Assistance Inflows



(*Source: Calculated from World Bank World Development Indicators database*)

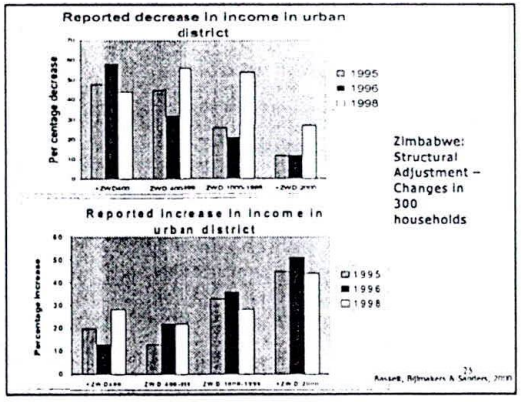
Structural Adjustment Programmes: the main components

- Cuts in public enterprise deficits
- Reduction in public sector spending & employment
- Introduction of cost recovery in health and education sectors
- Phased removal of subsidies
- Devaluation of local currency
- Trade and financial market liberalisation

Impact of SAPs on health

"The majority of studies in Africa, whether theoretical or empirical, are negative towards structural adjustment and its effects on health outcomes".

Breman and Shelton, WHO CMH WG6, 2001



Globalisation is primarily about trade…

- Globalization, defined as the process of increasing economic, political, and social interdependence and global integration which takes place as capital, traded goods, persons, concepts, images, ideas, and values diffuse across state boundaries, is occurring at ever increasing rates

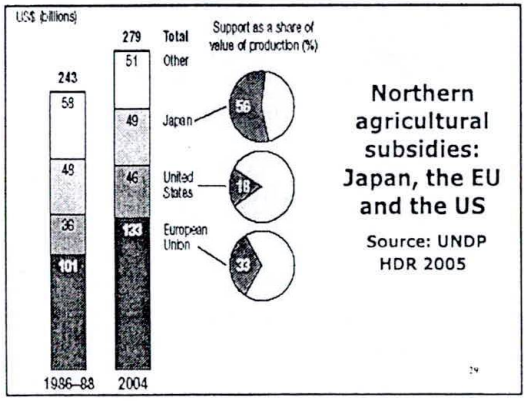
(Hurrell, 1995, p.447)

Unfair Trade (1)

- "..drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations"
  (G8 Communiqué, Genoa, July 22, 2001)
- BUT… many developing countries have destroyed domestic economic sectors, such as textiles and clothing in Zambia (Jeter 2002) and poultry in Ghana (Atarah 2005), by lowering trade barriers and accepting the resulting social dislocations as the price of global integration
- Import liberalization was a key element of structural adjustment programs; a recent study found that PRSPs may include "trade-related conditions that are more stringent, in terms of requiring more, or faster, or deeper liberalization, than WTO provisions to which the respective country has agreed"(Brock and McGee 2004)

Unfair Trade (2)

- In addition industrialized countries apply much higher tariffs (tariff peaks), sometimes amounting to more than 100 percent, to the labour-intensive exports that are of special importance to developing countries. For example, the EU tariff on raw cocoa exported from Ghana is just 0.5 percent, but the tariff rises to 30.6 percent on chocolate imported from the same country (Elliott 2004b). Thus, although 90 percent of cocoa beans are grown in developing countries, they account for just four percent of the value of global chocolate production (IMF, 2002).
- Privatization of water and sanitation in many countries over the past decade has often spawned intense political resistance because of their predictably negative effects on the poor and economically insecure (Loftus and McDonald, 2001; McDonald, 2002; Shaffer, Brenner and Yamin, 2002, Budds and McGranahan, 2003; Center for Public Integrity, 2003).

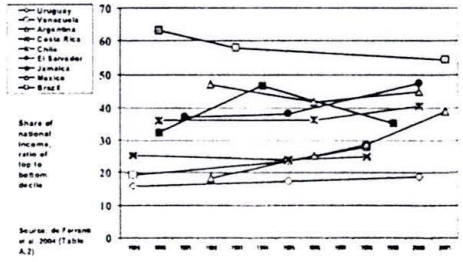


Northern agricultural subsidies: Japan, the EU and the US

Source: UNDP HDR 2005

The result... unequal growth of wealth within countries

Trends in income inequality, selected Latin American & Caribbean countries



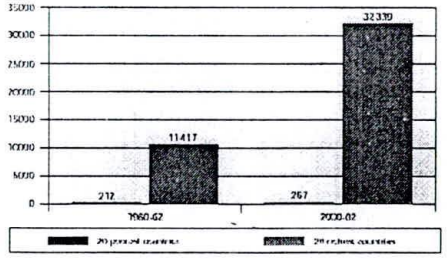
Henry Kissinger:

- "Thus the process of development begins by widening the gap between rich and poor in each country … What are developing countries to make of the rhetoric in favour of rapid liberalisation when rich countries with full employment and strong safety nets argue that they need to impose protection measures to help those of their own citizens adversely affected by globalisation?
- **The basic challenge is that what is called globalisation is really another name for the dominant role of the United States ….**"

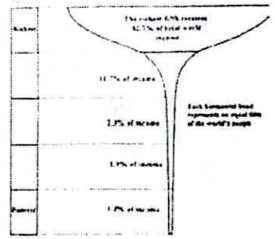
'Globalisation and World Order'
Lecture at Trinity College, Dublin, October 12, 1999

The result... unequal growth of wealth between countries

GDP per capita in the poorest and the richest countries, 1960-62 and 2000-02 (in constant 1995 US$, simple averages)



..and unequal distribution of global income



UNDP 1997

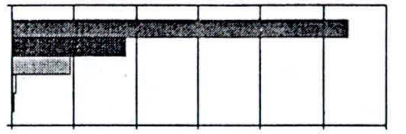
..and growth of poverty

Poverty in Southern Africa

	Population living below poverty line 1996	Population living below poverty line 2001
Lesotho	49%	49%
Malawi	60%	65%
Mozambique	69%	69%
Swaziland	48%	66%
Zambia	69%	86%
Zimbabwe	61%	75%

(Source: Cited in UNOCHA, July 2002)

Would it be better to born a Japanese cow than an African citizen?



- Japan annual dairy subsidy, per cow
- EU annual dairy subsidy, per cow
- Per capita annual income, sub-Saharan Africa
- Per capita cost of package of essential health interventions
- Per capita annual health expenditure, 63 low income countries

Joseph Stiglitz

Chief Economist World Bank, Nobel Prize for Economics 2001

" **… while I was at the World Bank I saw first hand the devastating effect that globalisation can have on developing countries, and especially the poor within those countries …**

… international trade agreements … and the policies that have been imposed on developing countries in the process need to be radically rethought …

… many wrong-headed actions were taken, ones that did not solve the problem, but that fit with the interests of the people in power"

Stiglitz J. *Globalisation and its discontents.* Penguin Books 2002

The Health System, its financing and Health Sector 'Reform'

37

Sub-Saharan African Country *per capita* expenditures on health (1997-2000)

Recommended expenditure: >$60/capita (Brundtland); >$34/capita (CMH)

Number of countries	Amount of spending
4	> $60
2	$34 - $60
11	$12 - $34
18	< $12
13	Data not available or population <1.5 million

World Bank, *World Development Report* 2004

38

Historical overview of international health policies

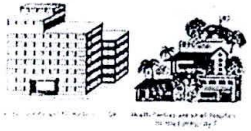
- What preceded PHC?
- Why PHC?
- What is PHC?
- What is Comprehensive Care?

39

What preceded PHC?

- Maurice King – Medical Care in Developing Countries
- Djukanovic & Mach – basic health system with focus on health centres

40



Categories of auxiliary

Categories	Levels
Curative medicine and paediatrics	Medical assistant
Nursing	Enrolled nurse, graded dresser
Midwifery	Auxiliary nurse midwife
Health visiting	Assistant health visitor
Environmental health	Assistant health inspector and assistant

42

Evidence base for PHC

Pre Alma Ata:

- Work of McKeown and McKinley demonstrated importance of socioeconomic and environmental factors
- China achievements
- CBH projects in several other countries demonstrated the impact of comprehensive approach and community level workers
- Newell – "Health by People"

43

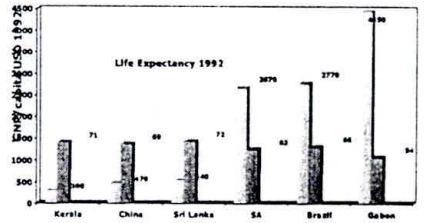
•Principles of the Primary Health Care Approach

- Universal **accessibility** and coverage on the basis of need (equity)
- **Comprehensive care** with emphasis on disease prevention and health promotion
- **Community and individual involvement** and self-reliance
- **Intersectoral action** for health
- **Appropriate technology** and cost-effectiveness in relation to available resources

- Elements / Programmes of PHC

44

Inequality is unhealthy:
GNP & life expectancy in selected countries



Source: Amartya Sen 1995

Common Features of GHALC Countries

- Political and social commitment to equity
- Education for all with emphasis on primary level
- Equitable distribution of public health measures and PHC and increased community level coverage

Mosley, 'Good Health at Low Cost' 1985

In order **to make P.H.C. universally accessible** to the community as quickly as possible, maximum community and individual self-reliance for health development are essential. To attain such self reliance requires full **community participation** in the planning, organisation and management of P.H.C. .....

(p.34, WHO/UNICEF)

47

Comment

The concept of PHC had **strong sociopolitical implications.** It explicitly outlined a strategy which would respond more equitably, appropriately and effectively to basic health care needs **and** address the underlying social, economic and political causes of poor health.

49

'It can be seen that **the proper application of primary health care with have far-reaching consequences**, not only throughout the health sector but also for other social and economic sectors at community level. Moreover, it will greatly influence community organisation in general. **Resistance to such change is only to be expected'**

Alma Ata Declaration, 1978

49

A Split in the PHC Movement

In 1980s, a focus on cost-effective technologies and a neglect of social and environmental determinants and processes led to substitution of "selective" for "comprehensive" primary health care (PHC) – e.g. UNICEF "Child Survival and Development Revolution"

Selective Primary Health Care "Child Survival and Development Revolution"

Growth Monitoring
Oral Rehydration Therapy
Breast Feeding
Immunisation

Family Planning
Food Supplements
Female Education

REHABILITATIVE	CURATIVE	PREVENTIVE	PROMOTIVE
NUTRITION REHABILITATION	O.R.T. NUTRITION SUPPORT	EDUCATION FOR PERSONAL & FOOD HYGIENE MEASLES VACCINATION BREAST FEEDING	WATER SANITATION HOUSEHOLD FOOD SECURITY

Primarily Individually Focussed	Primarily Population Focussed
Rehabilitative approach	Preventive approach
Curative approach	Promotive approach

53

The Health System and its Human Resources

- **The WHO definition of health systems includes "all the activities whose primary purpose is to promote, restore, or maintain health:**
- Interventions in the **household and community** and the outreach (health information and education, etc.) that supports them;
- Facility-based system and **broader public health interventions**, such as food fortification or anti-smoking campaigns.
- All categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic and indigenous

Health sector 'reform'

Includes the following components:

- decentralisation;
- actions to improve the efficiency of national ministries of health;
- universal delivery of a core set of essential services;
- broadening health financing options;
- working with the private sector, including GPPIs and
- adopting sector wide approaches to aid rational planning.

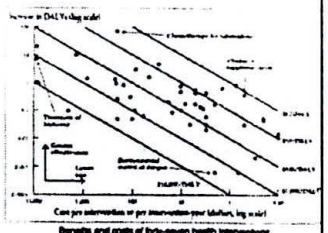
Cassels 1995

Impact of Health Sector Reform on Health Systems

- H.S.R. impacts on public sector health systems through at least three of its key strategies:
  - **the quest for efficiency through 'rationalisation' of staff and delivery of a core set of essential services;**
  - **greater involvement of the private-for-profit sector; and**
  - **decentralisation.**

Health sector 'reform'
Quest for efficiency

- **Health policy is increasingly influenced by cost-effectiveness approach**
- 1993: World Bank *Investing in Health* Report argued for wider application of cost-effectiveness analysis (CEA) to ensure value for money in public health systems.



Source: World Bank, 1993 World Development Report

Health sector 'reform'
Quest for efficiency

Inappropriate Use of Cost-Effectiveness Analysis

"[C]ost-effectiveness analyses have shown **improved water supply and sanitation** to be costly ways of improving people's health. **Case management of diarrhoeal disease is considerably more cost effective** than improvements in sanitation, and .... encouraging people **to wash their hands and making soap available** have reduced the incidence of diarrhoeal disease by 32% to 43% in different settings....

Commission on Macroeconomics and Health, 2001/02

CEA cannot evaluate the effectiveness of 'broader' interventions that may result in health improvement through numerous direct and indirect mechanisms

For example, water provision can:

Improve hygiene practice and thus reduce incidence of diarrhoeal disease

Save women's time for caring and economic activity, thus improving household income and food security

Contribute to increased agricultural production, thus improving household income and food security

Health sector 'reform'
Quest for efficiency

Result was to de-emphasize determinants of health, focus on essential "packages" of interventions – reminiscent of selective PHC

Public Health package:

- Immunizations
- School-based health services
- Family planning and nutrition education
- Programs to reduce tobacco and alcohol consumption

Clinical package:

- Pregnancy-related services
- Family planning and STD services
- Tuberculosis control, mainly through drug therapy
- Care for the common serious illnesses of

Does WHO's enthusiasm for CEA together with a focus on social determinants represent 'policy incoherence'?

Quest for efficiency cont.-

The move from equity and comprehensiveness to efficiency and selectiveness leads to:

- A return to vertical programmes;
- Erosion of intersectoral work and community health infrastructures
- Fragmentation of health services and reversal of health gains

..subverting the Mission of Public Health

- "Ensuring the conditions in which people can be healthy"

(Institute of Medicine)

Health Care Packages

The merit of the package approach is that the process of priority-setting is explicit. Thus, the approach encourages public debate about prioritization and the rationing of health care...

Tarimo: Essential Health Service Packages, WHO/ARA/CC/97.7

Health Care Packages

While.. essential packages can aid decision-making...confusion has arisen through their presentation as "products", ready for testing and implementation.... this "quick fix" claim is presumptuous and wrong....Although the package description gives a clear outline of the tasks to be performed by health workers at each level, there is no elaboration of how this is to be organized.

Tarimo: Essential Health Service Packages, WHO/ARA/CC/97.7

Health Care Packages

Cross-sectoral collaboration and ways of ensuring a consumer voice in the process of decision-making and implementation have not received serious attention ....

Tarimo: Essential Health Service Packages, WHO/ARA/CC/97.7

Health Care Packages

Finally, what happened to community empowerment and participation? In one country example, community participation is presented as one of the twelve interventions, rather than an integrated coherent part of the whole. There does not appear to have been any community participation or public involvement in the determination of package contents, nor any attempt to assess what people on low-incomes themselves see as priority concerns.

Tarimo: Essential Health Service Packages, WHO/ARA/CC/97.7

Health Care Packages

The PHC approach is about advocating and supporting communities to assess their needs, decide on priorities, implement activities, and monitor progress. The relative neglect of the need for community participation and intersectoral action in the construction of packages poses an obstacle to the implementation of primary health care along the lines envisaged by the Alma-Ata Conference.

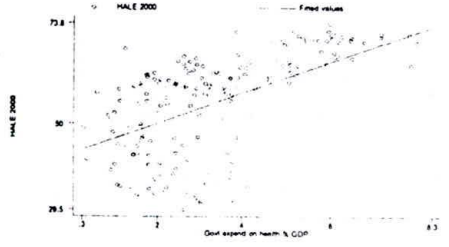
Tarimo: Essential Health Service Packages, WHO/ARA/CC/97.7

Health sector 'reform'

Increasing Private Sector involvement

- HSR usually increases private sector involvement in health care.
- Private health care as a parallel system draws on resources of the public health sector.
- Increased private sector work opportunities lead to "dual practice" of public sector HR, resulting in eg. "moonlighting", competition for clients and time, internal migration, pilfering, etc.

Healthy life expectancy (HALE) and government expenditure on health as per cent of GDP 2000

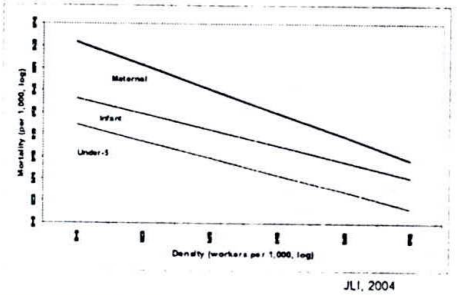


Mackintosh and Koivusalo 2005

Health systems & personnel

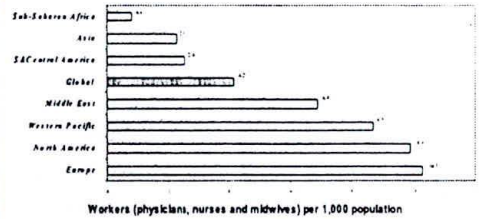
- Health personnel vital, consume between 60 – 80% of recurrent public health expenditure (WB, 1994).
- Current health workforce data are aggregates that mask unequal distribution between rich and poor African countries and between rural and urban areas

Health Worker and Mortality



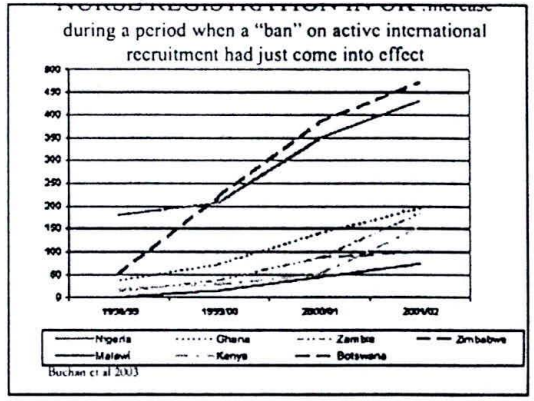
JLI, 2004

HRH DENSITY BY REGIONS



Health professional migration from Africa

- Between 1985 and 1995, 60% of Ghana's medical graduates left
- During the 1990s Zimbabwe lost 840 of 1,200 medical graduates
- **In 1999, 78% of doctors in South Africa's rural areas were non-South Africans**
- 2,114 South African nurses left for the UK



Buchan et al 2003

Context of current migration trends: "Pull" : Needs in recipient countries.

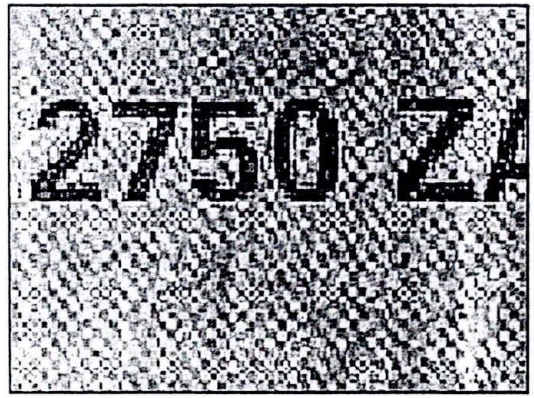
- The 27 OECD countries have a workforce of approx. 3 million professionals educated in poor countries.
- Buchan estimated that the US alone will need 1 mill. Nurses over the next ten years.
- The UK currently needs 10k more doctors and 20k more nurses to meet needs of new health plan.
- The GATS (General Agreement on Trade in Services) is likely to aggravate "trade" in health professionals by increasing the size of the private sector North and South (GATS Mode3) and easing cross-border movement (GATS Mode 4).

Context of current migration trends: "Push" : HIV/AIDS

- A dramatically increasing disease burden due to HIV/AIDS (1 in 8 South Africans HIV positive; highest infection rate among young women; 1 in 5 South African nurses are HIV positive).
- Upcoming roll-out of ARV treatment, which will put a massive additional workload on health service staff.

- *"You feel hopeless that you cannot do anything for them, you are fighting a losing battle".*
- *"When thinking about the situation we are facing at work we just feel hopeless and helpless because we think that at the end of the day it may be you in that*

Lehmann and Zuku, 2004



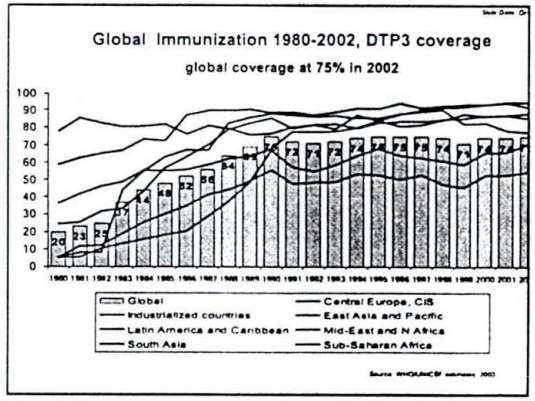
International migration—winners & losers

How much do importing countries gain from international migration?

- In 1970s, the US government calculated that it gained US $20,000 for every skilled worker from a poor country.
- UN Conference on Trade and Development (UNCTAD): for each professional aged between 25 and 35 years, US$ $184,000 is saved in training costs by rich countries
- The loss of approximately 20,000 skilled

In summary: health status is declining and public health systems in Africa and many Southern countries are collapsing as a result

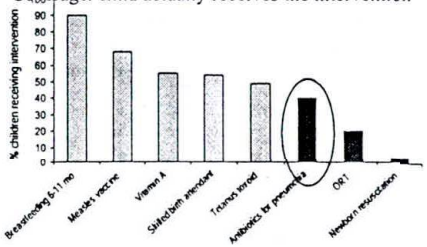
- Increasing poverty and failure to address health "determinants" resulting in poorer health status
- Declining per capita health spending reducing
  - Health personnel numbers and morale
  - Drugs availability
  - Transport for outreach & supervision
- Promotion of the private sector through "health sector reform" and new trade agreements
- HIV/AIDS affecting and infecting health personnel
- **... reversing previous gains in PHC implementation**



A Case Study of IMCI

IMCI pneumonia case management (Tanzania)

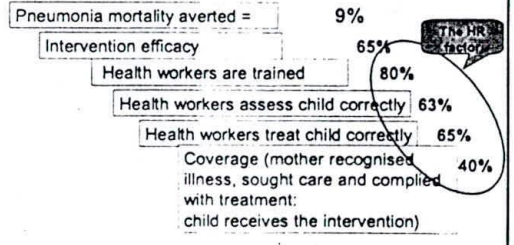
Coverage: child actually receives the intervention



Source: Jones et al, *Lancet* 2003, 362: 65-71

IMCI pneumonia case management (Tanzania)

Coverage under actual programme conditions

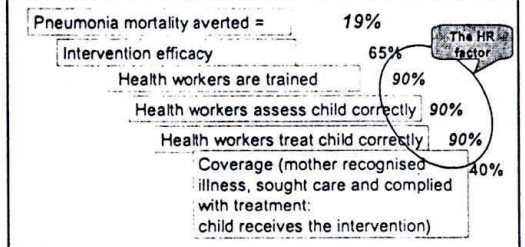


Tugwell framework applied to multi-country evaluation data

Source: Tugwell, *J Chron Dis*, 1985; 38(4):339-51

IMCI pneumonia case management (Tanzania)

Coverage under improved programme conditions



Source: Tugwell, *J Chron Dis*, 1985; 38(4):339-51

Why should interventions be delivered in community settings?

- Many child deaths occur outside health facilities
- Currently the coverage of many effective interventions is low — well under 50% in many cases — and the quality of care is deficient in many communities.
- Care for neonatal conditions has received little emphasis in public health programmes, and only 3-12% of children born at home in 5 South Asian and Sub-Saharan African

Why should interventions be delivered in community settings?

- children from poor families are less likely to access government health facilities than those from wealthier families
  - -poorer families tend to live further from such facilities
  - -even with improved quality of care, utilisation of such facilities may remain low for many reasons — lack of

Why should interventions be delivered in community settings?

- An analysis of cost effective interventions for saving newborn lives examined three different delivery approaches — outreach, family-community and facility-based clinical care.
- Outreach and family-community care in combination at 90% coverage could result in an 18-37% reduction in mortality even before facility-based care is strengthened.

Definition of Community Health Workers

'Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers'

WHO 1989

Who are Community Health Workers?

- **generic type eg** village health workers, community resource persons, or workers known by local names.
- **more specialised cadres eg** community rehabilitation facilitators, community-based directly observed therapy short-course supporters, traditional birth attendants (TBAs), HIV/AIDS communicators, etc.
- All CHWs perform one or more functions related to health care delivery, are trained in

Which interventions can be delivered in community settings?

- interventions to **promote healthy behaviours** eg hand washing and breast feeding
- **preventive interventions** eg insecticide-treated nets for malaria and micronutrients
- **more complex tasks eg** case management of childhood illnesses such as malaria, pneumonia and neonatal sepsis
- **active involvement and empowerment of communities** through activities of CHWs

Evidence for impact and cost-effectiveness of community health workers

- .A meta-analysis of community-based trials of pneumonia case management on mortality suggested an overall reduction of 24% in neonates, infants, and preschool children 26.
- A trial in Tigray, Ethiopia, of training local coordinators to teach mothers to give prompt home antimalarials showed a 40%

Evidence for impact and cost-effectiveness of community health workers

- A systematic review of pneumonia and malaria management by CHWs identified seven intervention models i.t.o assessment of children, system of referral to health facility (verbal or written) and location of drug stock.28
- Strongest evidence for mortality reduction was for community-based pneumonia case management and active detection. Malaria-only programmes ignore the clinical similarities between pneumonia and malaria

Evidence for impact and cost-effectiveness of community health workers

- A controlled trial in rural India showed home-based neonatal care and management of sepsis can more than halve neonatal mortality where high 29
- Simultaneous presence of two of seven clinical signs was 100% sensitive and 92% specific. Health workers could use these signs to identify neonates for referral or

Evidence for impact and cost-effectiveness of community health workers

- In Pakistan Lady Health Worker (LHW) programme performance in recognizing and treating ARI was weaker than for diarrhoea management and vaccination counselling, underscoring need to improve performance in disease recognition. 31
- Evaluation of a primary care programme in the Gambia showed greater child morbidity

Evidence for impact and cost-effectiveness of community health workers

- A recent systematic review of 'lay health workers' delivery of simple interventions33 was conducted mainly in high-income countries (35 of 43), but nearly half of them (15 of 35) in low-income and minority populations.
- Benefits over usual care were shown for lay interventions to promote immunisation uptake in children and adults, and to improve outcomes for malaria and acute

Evidence for impact and cost-effectiveness of community health workers

- In a recent review of the effects and costs of expanding immunisation in developing countries, one of the interventions with the highest impact on coverage was the use of CHWs36.
- Use of CHWs in periodic outreach programmes in urban Mexico37, and in the Amazon, Ecuador38 led to community involvement and improved services by ensuring that houses were located precisely, potential recipients were registered and vaccination days chosen with parents.

Evidence for impact and cost-effectiveness of community health workers

- CHW-led women's groups in Nepal provided education to reduce neonatal and maternal mortality. The programme achieved substantial reduction in both neonatal and maternal mortality rate39 and was very cost-effective. 40.

health professionals (doctors and nurses) and other health workers in child care

- In Bangladesh, children attending first-level government health facilities were fully assessed, correctly treated or advised re continued care at home41.
- Lower level workers (family welfare visitors and nursing aides) performed much better than higher level workers (paramedics, physicians, and nurses) in rational prescription of antibiotics and provision of appropriate advice to caregivers.

Factors influencing success of CHW programmes

Health system factors

- CHWs function best in a well-functioning health system with appropriate management capacity, functioning referral channels, good hospital care and reliable supply chains 5. But they may also be key in poor health systems.
- Interactions between CHW programmes and formal health services are affected by degree of involvement of local communities and health personnel.

Factors influencing success of CHW programmes

Health system factors

- Health professionals often perceive CHWs as lowly aides15,50,51 or assistants within health facilities, overlooking their community health promoting role. This may be partly addressed in professional training. Rivalry may develop between nurses and CHWs53. Harassment and other constraints may prevent female health worker

Factors influencing success of CHW programmes

Community factors

- Many CHW programmes have emerged and been sustained in situations of political transition and popular mobilisation47.
- Mobilised and well-informed communities, community-based workers and formal health services have rapidly disseminated child survival interventions and reduced mortality eg Nicaragua, Zimbabwe 48.

Factors influencing success of CHW programmes

Community factors

- Mobilisation of specific communities even without general popular mobilisation can improve maternal and newborn health. Eg Nepal community-based participatory intervention involving local women improved hygiene behaviours, increased access to safe delivery through enhanced care-seeking and improved local transport,

Factors influencing success of CHW programmes

Political, macroeconomic and international factors

- Poor accountability of local governments and politicians. can lead to "reward" appointments eg LHW programme in Hala, Pakistan 20% were from different locations than their place of work31
- Stronger community participation in selection and monitoring of CHWs could reduce abuse of appointment systems, although attaining this depends on general political context45

Factors influencing success of CHW programmes

Political, macroeconomic and international factors

- Expenditure ceilings and macroeconomic policies - sufficient 'fiscal space' is necessary to enable governments to finance health systems.
- Conversely in China in 60s and 70s surplus from collective production funded 'barefoot

Improving performance of community health workers

Effective strategies to improve performance

- An earlier review concluded that CHWs did not consistently provide services likely to have substantial impacts on health and that quality was often poor58.
- a recent review concluded that supportive supervision leads to benefits and that well-organised supervisory systems have the potential to improve motivation and provide

Improving performance of community health workers

Strengthening the management capacity of district health teams

- Focussing limited resources on priority problems can be done effectively in low-income settings, eg Tanzania programme equips local decision makers with decision-making tools64.
- Improved priority setting by local management at district level could reduce under-5 mortality substantially

Improving performance of community health workers

Financial and non-financial incentives

- Most CHW schemes aspire to volunteerism 65.However, most programmes pay their CHWs a salary or an honorarium.
- Sustained community financing is rare, apart from China's "barefoot doctors".
- Even on a part-time basis, the costs entailed by lost economic opportunities may be higher than small honorarium. Other financial incentives include: small state salary, payments for attending training sessions68.

Improving performance of community health workers

Financial and non-financial incentives

- Fee-for-service payments or payments linked to drug sales may encourage inappropriate treatment and overuse of medications. Non-financial approaches eg further training, flexible hours, may distort care less.
- Policymakers should consider a mix of financial and non-financial incentives,

Factors influencing success of CHW programmes

- Socio-political context and technical factors influence success of community-based programmes and activities
- While technical factors can be planned, socio-political factors are less amenable to initiation/manipulation
- Key socio-political factors include community mobilisation and political will – which are synergistic
- Community mobilisation and political will often dissipate as political context changes
- Community mobilisation can be facilitated by participatory planning and implementation
- Community-based workers can catalyse and sustain community mobilisation

Key technical factors include:

- participatory approaches to assessment and analysis, using appropriate technologies and methods
- planning with intersectoral action and sustainability in mind
- implementation using community-based workers to achieve high coverage
- training and ongoing support and supervision

110

CHWs: service providers or change agents?

- Accumulating and more rigorous evidence of effectiveness of CHWs in service provision
- Much anecdotal and some case study evidence of CHWs and Promotores de Salud facilitating access to/organising around basic needs, although often in a favourable political context
- Importance of documenting and evaluating factors- both socio-political and technical -

Conclusions

- **Progress in health undermined by globalisation and neoliberal economic policies, health sector "reform", the HRH crisis and (especially in Africa) HIV/AIDS**
- **Efficacious health interventions exist but have poor coverage**
- **PHC successful in certain health care programmes but social mobilising role and intersectoral focus (determinants) neglected**
- **PHC must be revitalised and in particular community-based actions and CHWs**
- **Government health departments** must work with other

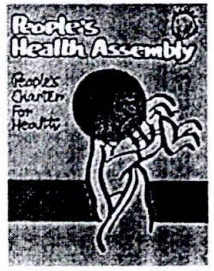
PEOPLE'S HEALTH MOVEMENT

The Peoples Health Movement (PHM) is a large global civil society network of health activists supportive of the WHO policy of Health for All and organised to combat the economic and political causes of deepening inequalities in health worldwide and revitalise the implementation of WHO's strategy of Primary Health Care.

www.phmovement.org

113

PEOPLE'S CHARTER FOR HEALTH



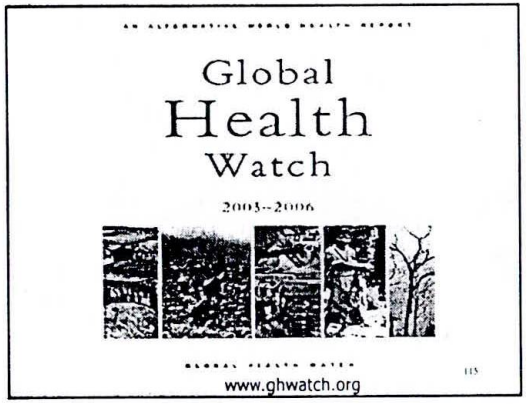
A tool for advocacy:

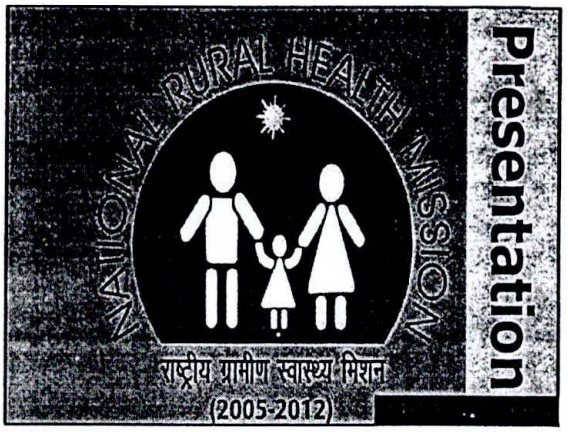
Health as a Human Right

Tackling the broader determinants of health

- Economic Challenges
- Social and political challenges
- Environmental challenges
- War, violence, conflict and natural disasters

A people-centred health sector


Global
Health
Watch
2003--2006
www.ghwatch.org



OVERVIEW OF THE HEALTH SECTOR

ACHIEVEMENTS

- Remarkable improvement in select health parameters
- Control of diseases
  - Eradication of Smallpox in 1977
  - Eradication of Guinea worm disease in 2000
  - Interruption of polio transmission anticipated by end 2005
  - Leprosy elimination expected by end 2005
  - TB cure rate more than global target of 85%
- Improved disaster management and public health response to outbreaks
- Medical Tourism

SELECTED HEALTH PARAMETERS

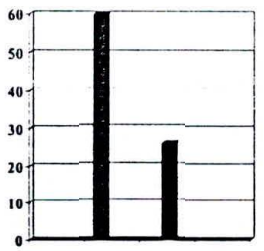
	1981	1991	2002
Life Expectancy (in years)	55.5	60.3	63.2
Infant Mortality Rate	110	80	60*
Under 5 Mortality Rate	152	94	73
Neonatal Mortality Rate	70	51.1	40
Maternal Mortality Rate	NA	NA	407
Crude Birth Rate	33.9	29.5	24.8*
Crude Death Rate	12.5	9.8	8.0
Total Fertility Rate	4.5	3.6	3.0
Decadal Population Growth (%)	24.66	23.85	21.34

Source: Sample Registration Survey, 2003; Census of India, 2001 & Compendium of India Fertility and Mortality Indicators, 1971-97 by Registrar General of India, 1999(* 2003 data)

NATIONAL GOALS & MDG

	Current	X FY Plan 2007	NPP 2010	MDG 2015
IMR	63	45	<30	27*
NMR	44	26	<20*	<20*
MMR	407	200	<100	100
Institutional deliveries	47%	80%	80%	

Socio economic differences



Poorest 20% of population

(60/1000 live births)

have more than double the NMR as compared to the richest 20%

(26/1000 live births)

Status

CRITICAL SHORTAGES IN INFRASTRUCTURE

Required	Available	Required	Available	Required	Available
158792	142655	26022	23109	6491	3222

CRITICAL SHORTAGES IN MANPOWER

Doctors at PHC	880	Multipurpose Worker (Female)/ ANM	11191
Surgeons	1121	Health Worker (Male)	67261
Obstetricians and Gynecs	1074	Health Assistant (Female) / LHV	3198
Physicians	1457	Health Assistant (Male)	5137
Pediatricians	1607	Pharmacists	1869
Total specialists	5335	Lab Technicians	6344
Radiographers	1017	Nurses / Midwives	12722

Regional Disparity

State	Villages per ANM	Population per ANM	Births per ANM
Tamil Nadu	1.62	3463	66.13
Kerala	0.22	3723	63.29
UP	5.2	6371	207.7
MP	5.79	4632	149.6
Chhatisgarh	5.53	4532	120.1
Maharashtra	4.09	5209	107.3
Assam	4.6	4065	111.79
Jharkhand*(Prov.)	6.49	4165	118.7
Bihar*(Prov.)	3.76	6191	111.79
Rajasthan	3.44	3602	114.9
INDIA	4.5	5339	106.72

STATUS

Citizens' perception

Limited access to Public Health set up.

Doctors & Paramedics **not available** when required.

Private sector **unregulated** & charging too much

Weak grievance **redressal mechanism**

Unmet demands

No community **participation**

SYSTEMIC DEFICIENCIES

Lack of **Holistic Approach**

Health **not a priority.**

Under funded, yet not utilised.

Shortage of **infrastructure & human resources**

Lacks **community ownership** and accountability

Non integration of **Vertical Disease Control** programmes

Non responsiveness to Citizens' grievances.

NATIONAL RURAL HEALTH MISSION

NRHM - THE VISION

- Architectural correction in health care delivery
- Special focus on 18 states with weak indicators.
- Improve availability of quality health care in rural areas
- Synergy between health and determinants of good health
- Mainstream the Indian Systems of Medicine.
- Capacity Building.
- Involve the community in the planning process.

WHAT IS NEW IN NRHM

Envisages significant step up in expenditure to 2 – 3 % of GDP

Intersectoral convergence with other Health determinants.

Integration of existing schemes.

Merger of societies at State & District level

Decentralised planning at Village and District level.

Community ownership of Health facilities.

Fully trained ASHA in each village.

Under IPHS, upgradation of CHCs into 24x7 FRUs.

Mainstreaming of AYUSH

Public Private Partnership.

Risk Pooling

13

Improving Health Care Delivery System

Reducing Maternal & Child Mortality

Population Stabilisation

Intersectoral Convergence

Reducing the Disease Burden

IEC

Financing the Mission

Issues & Challenges

Progress & Expected Deliverables

14

IMPROVING THE HEALTH CARE DELIVERY SYSTEM

a) Institutional Framework of NRHM

b) ASHA

c) Strengthning Infrastructure

d) Human Resource development

e) Procurement of Drugs & equipments.

f) Partnership with Non Government Providers

g) Innovations

15

OUTCOMES

2005 - 2012

•IMR reduced to 30/1000 live births by 2012

•MMR reduced to 100/100,000 live births by 2012

•TFR reduced to 2.1 by 2012

•Malaria Mortality Reduction Rate – 60% upto 2012

•Kala Azar eliminated by 2010

•Filaria reduced by 80 % by 2010

•Dengue Mortality reduced by 50% by 2012

•Leprosy eliminated by December 2005

•TB DOTS series – maintain 85% cure rate

16

CORE STRATEGIES

17

DECENTRALISED PLANNING

•Financial Envelope to be allotted to the districts on normative basis.

•Perspective planning as well as annual plan.

•A small component to be set apart for state and District level innovations.

•Involvement of the community and PRIs in developing the Village and District Health Plan

•District Plans to converge into State Plan.

•Capacity of States & Districts to be built for planning and appraisal

INFRASTRUCTURE

- Additional Subcentres required. Population norm to be revisited.
- Only 65,000 have their own buildings. Norms for construction of new buildings and annual maintenance grant to the existing buildings.
- All CHCs are to be made operational as First Referral Units (FRUs) providing emergency obstetric and new born care.
- 50 % of PHCs to be operationalised on 24x7 basis.
- 1 MMU per District @ average cost of Rs.30-40 lakh.
- Mainstreaming AYUSH in 10% private health facilities.

HUMAN RESOURCES

- ASHA
  - Link between community and health delivery system
  - Chosen by the Panchayat and be accountable to them.
  - Performance linked incentives
  - Anchored in the Anganwadi system
  - Provided with a basic drug kit
  - Depot holder for contraceptives and IEC materials
- States to be encouraged to fill up vacant posts of ANMs / MPW
- One AYUSH doctor being positioned within the PHC.
- Two additional specialists in every CHC.
- Block level pooling of doctors to ensure that there is at least one functioning hospital for 100,000 population.

CAPACITY BUILDING

- Financial Services of professional including MBAs, CAs at District and state
- Skilled Mission teams at each level.
- Comprehensive training for all categories
- Training of the PRIs
- Training of ASHA, Mentoring group for ASHA.

PUBLIC PRIVATE PARTNERSHIP

- Guidelines for accreditation of private health providers.
- Pilots on social franchising, contracting, OBAs in selected districts

RISK POOLING

- A Task Group is currently working on these aspects.
- Pilots in different parts of the country.

Likely capacity needs Developing & Supporting

- More than 7 lakh Village Health and Sanitation Committees
- More than 1.75 lakh Sub Centre level Panchayat Committees
- More than 25000 PHC level PRI/HDC/RKS Committees
- More than 6500 CHC level PRI/ HDC/RKS Committees
- More than 1200 Taluka/ Sub Divisional level Hospital Committees.
- 6000 Block level Mission Team and Block Resource Groups
- 600 District level Mission Teams and Resource Groups
- Developing 1.75 lakh ANMs, 26000 LHVs, 26000 Staff Nurses, 26000 Medical Officers into Skilled Birth Attendants.

KEY ACTIVITIES ACCOMPLISHED

KEY ACTIVITIES ACCOMPLISHED

Institutional frame work Established	• Mission Steering Group • Empowered Programme Committee • Mission Directorate • State/District Health Mission • Advisory Group on Community Action • Committee on Intersectoral Convergence • National Programme Coordination Committee • North East Advisory Committee • Mentoring group on ASHA set up
Guidelines Disseminated	• Mission Document • IPHS • ASHA • Training module for ASHA • State Health Mission / District Health Mission • Merger of Societies • Draft MoU • Skilled Birth Attendants

KEY ACTIVITIES ACCOMPLISHED

Training schedule for ASHAs	•Guidelines regarding selection disseminated •First Training manual disseminated •Second module ready •Training of state trainers completed
Untied funds to Sub Centers	•Untied grant of Rs. 10,000 per Sub Centre released to all states to be spent in supervision of the Panchayats.
Up gradation / strengthening of CHCs / PHCs	•States asked to identify two CHCs per district for up gradation. •Rs. 20 lakh fon each CHC as first installment released. •Second installment to be released on Facility Survey. •IPHS Guidelines for PHCs/Sub Centers being drafted

KEY ACTIVITIES ACCOMPLISHED

Capacity Building	•Induction of 700 professionals including MBAs, Charted Accountants etc. at state & District level in PMU in the EAG states. •Rs. 10 lakh per district released to 50 % of the EAG states for district planning.
Stepping up of Immunisation	•AD Syringes introduced. •Alternate vaccine delivery •Mobility support to Districts/ States for supervision. •Cold chain.
Increased focus on financial management	•Pending UCs reduced from Rs. 6135 crore in March 2004 to Rs. 3634 crore in July 2005 •The unspent balance reduced by Rs. 900 crore in the last 6 months.

STATUS OF TASK GROUPS

	TASK GROUP REPORTS FINALISED
1	Goals of the Mission and its key components/ strategies
2	Strengthening Community Health Care through Community Activities
3	Strengthening Public Health Institutions for Health Delivery
4	Role of PRIs & Community Action
5	Technical Support for the Mission
6	Exploring New Health Financing Mechanism
7	District Planning/Decentralised Planning
	TASK GROUPS DELIBERATIONS COMPLETED
1	Promotion of PPP (including NGOs) for Public Goals & Regulation of Private Sector
2	Strategies for Urban Health Care
3	Financial Norms for NRHM
4	Medical Education

New Programs

- RCH-II launched and under implementation
- Janani Suraksha Yojna launched in all States.
- Sterilization compensation scheme launched by GOI
- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started in 9 States and being rolled out in all states under RCH II. Work shops on IMNCI held in 4 States.
- With the help of Neonatology Forum completed training on Newborn Care in 140 districts in the country.
- Integrated Disease Surveillance Project operationalised.

MONITORING

TOOLS

NFHS-II, RHS 2002 to provide Baseline data for district level.

Facility Survey of Public/Private health infrastructure

Triangulated monitoring system under RCH
external evaluation, social audit, government reporting.

E-moding.

MONITORING

LOCUS

Mission Control Room,

Helpline, web site

MSG members and Jt. Secys in the MOHFW,

State Nodal officers

Gram Panchayats/Block level/District Health Mission.

MONITORING

MONITORS

- Panchayat,
- Rogi Kalyan Samiti, External evaluators,
- Finance Management Group
- Quality Assurance Committees at State/District level
- Citizens' Charter at Facility level
- Hospital Management Society.
- ASHA Mentoring Group.
- Integrated Disease Surveillance system
- Fund release linked to performance indicators in MoU.

JANANI SURAKSHA YOJANA

- JSY launched all over the country to promote safe delivery.
- Incentive for BPL families of Rs. 1300 for safe delivery in EAG states, Assam and J & K and Rs. 1000 in all other states .
- Two private facilities per block being accredited under the Scheme.
- Assistance also being given for Caesarian section.

MILESTONES & ACTION PLAN

EXPECTED DELIVERABLES DURING 2006—07

Deliverable during 06- 07	Remarks
Selection of 1.5 lakh ASHA and training of all the ASHAs selected during 2005-06	• Mission envisages a trained ASHA for every 1000 population or less in 18 Special Focus States.
Mobile Medical Units (MMU) to be provided to 200 districts	• Mobility support to all districts
At least 25,000 Sub-centres to be strengthened.	• Over 75,000 subcentres made functional duriung 2005-06. All to be made fully functional Mission period.
At least 700 CHCs to be upgraded to FRUs.	• All 3222 CHCs to be upgraded to FRUs over Mission period.

Expected Deliverables 2006-07

Deliverable during 06- 07	Remarks
At least 700 CHCs to be upgraded to FRUs.	• All 3222 CHCs to be upgraded to FRUs over Mission period.
At least 500 PHCs to be operationalised on 24x7 basis.	• 50% of all PHCs are to be made 24x7 by 2010 and balance over the rest of the Mission period.
Rogi Kalyan Samitis (RKS) to be set up in District Hospitals	• All 550 District Hospitals to have RKS. During 2005-06, 238 District Hospitals have set up RKS. Balance shall set up over the next two years.
Preparation of District Health Action Plan in 300 districts	• District Health Plans to be made in all Districts by 2008
No. of Institutional Deliveries	11.7 million
No of Safe Deliveries	15.6 million

CHALLENGES

CHALLENGES & ISSUES

- Complexity of the sector
(Cross linkages with poverty, illiteracy, social customs)
- Governance issues
- Involvement of states
- Assured availability of incremental Outlays for Mission period.
- Shortage of manpower / lack of capacity
- Empowerment of PRIs & community
- Impediments in release of funds

THANK YOU

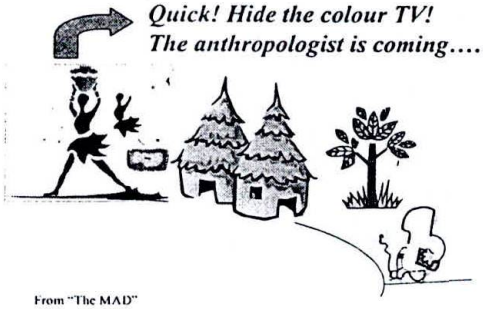
Community Health Worker Training:
Linking Pedagogy and Practice
New Avenues

K.Balasubramanian

Foundation for Research in Community Health
&
SIG
11th April 2006
Pune

Murphy's Law on becoming a discoverer

Christopher Columbus was the best deal maker in history.
He left not knowing where he was going, and upon arriving, not knowing where he was.
He returned not knowing where he had been, and did it all on borrowed money and became a famous discoverer



INDIA's RANKING
1st IN WORLD

IRRIGATED AREA
CATTLE POPULATION
BUFFALO POPULATION
MILK PRODUCTION
PULSES PRODUCTION
TEA PRODUCTION
JUTE PRODUCTION

INDIA's RANKING
2nd IN WORLD

PADDY PRODUCTION	(CHINA)
WHEAT PRODUCTION	(CHINA)
GROUNDNUT PRODUCTION	(CHINA)
SUGARCANE PRODUCTION	(BRAZIL)
ONION PRODUCTION	(CHINA)
FRUITS PRODUCTION	(CHINA)
VEGETABLE PRODUCTION	(CHINA)
TOBACCO PRODUCTION	(CHINA)

Poorest

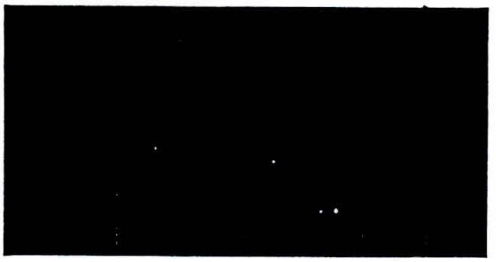
- Major portion of poor people in primary sector
- 60% of the workforce contributes around 20% of GDP
- Low Productivity, highest cost of prodution
- Globalization and market liberalization moved in without preparing this sector
- Government extension is supposed to prepare 127 million farm families (100 million agricultural labourers particularly women are generally forgotten)

Returns to Rural Investment in India
1970 - 1993

	Returns in Rupee Per Rupee Spending	No. of poor reduced Per Million Rupee Spending
Agriculture R&D	13.45	84.50
Irrigation	1.36	9.7
Roads	5.31	123.8
Education	1.39	41
Power	0.26	3.8
Soil and Water Conservation	0.96	22.6
Health	0.84	25.5
Anti-poverty Programmes	1.09	17.8

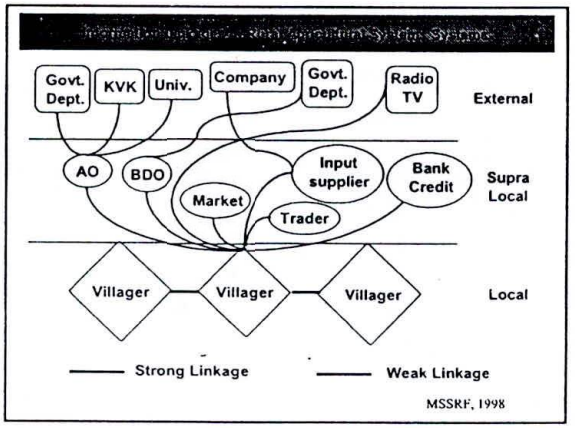
Source: IFPRI-World Bank

How will you reach them in agricultural sector...



Training...

- Weakest linkage in India
- To reach 127 million farm families and 100 million agricultural labourers families
- We have to think out of box



Development

- When you extend the canvass of the community for horizontal transfer of knowledge and help to develop a community based knowledge management
- Conventional Training programme for Vertical Transfer of Knowledge

Impediments in Horizontal Transfer of Knowledge

- Gender
- Caste
- Class
- Religion
- Age
- Regional

But can be overcome with appropriate mobilization process

Freire criticism still valid

- Conventional education and training: a banking concept in which the students are depositories and teachers are depositors- negating education and knowledge as a process of inquiry
- Learner-centric, self-determined transformative learning – Andragogy

Average Information Retention Rate

Self-Directed, Personal Strategic Learning

- **70 percent of learning in various sectors taking place outside formal training**

(Peter Henschel)

- Tacit knowledge, which is informal knowledge about how things really get done, is extremely difficult to capture, codify, and deliver through discrete learning objects and traditional training programs. Communities are a way to elicit and share practical know-how that would otherwise remain untapped.
- Creating and structuring opportunities for people to network, communicate, mentor, and learn from each other can help capture, formalize, and diffuse tacit knowledge. Communities become a boundaryless container for knowledge and relationships that can be used to increase individual effectiveness and country's development.

Roadmap for Capacity Building

Through formal learning- strengthen natural learning and facilitate a self- directed personal-strategic learning

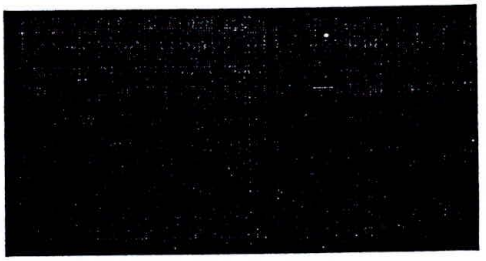
Generic information

(Value Addition)

Locale - specific knowledge

Capacity building –making every extension official Facilitator in the local community for adding value to the information and converting into locale specific knowledge

Self- Directed Learning promoting knowledge management at individual and community level



Vertical and Horizontal Transfer of Knowledge

	I Know	I don't Know
They Know	*Development*	*I learn*
They don't Know	*Extension & They learn*	*Participatory Innovation & We learn*

Adult Learning…

- Is community learning;
- Lots of self-directed learning with some formal learning
- Learning by doing
- Mostly based on horizontal transfer of knowledge and with some vertical transfer of knowledge
- Extension consists of "facilitation" as much if not more than "technology transfer".
- farmers are clients, sponsors and stakeholders, rather than beneficiaries of agricultural extension.
- Farmers are not men- but also women- more gender sensitivity

Building a Learning Community

No	PHASE	ACTIVITIES
1	Mobilization	Socio cultural activation, Conscientization, understanding among the stakeholders, identifying the needs for capacity building from various stakeholders view points
2	Organization	Identifying the organization types, helping the communities to build organizations Planning the programme by the community through their organizations
3	Capacity Building	Interactive learning, Learning by doing, Blending of frontier knowledge with traditional wisdom
4	Technical Support	Support in trouble shooting linking the community with experts and other programmes, facilitation and supporting conflict resolution mechanisms
5	System Management	Enabling the community to manage its own knowledge management system on the basis of which development programmes are initiated.

Roling

No	Forms of Participation
I	Passive Participation
II	Participation in information giving
III	Participation by consultation
IV	Participation for material incentives
V	Functional participation
VI	Interactive participation
VII	Self-mobilization/ active participation

Source: Pimbert, M.P. and J.N. Pretty (1994).

Interactive Learning is crucial

Technology Mediated Open and Distance Learning (Tech MODE) can play a major role in reaching large number of people in less cost.

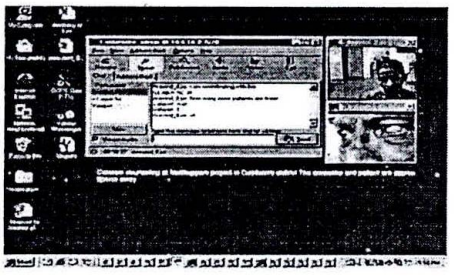
British Open University (started in 60s) ranked 5th- above Oxford University

Tech MODE Type	Description	Characteristics
Synchronous Formal	Group based-classroom type- virtual teaching with instructors and students meeting at a fixed time and interacting	Has the advantage of real-time and interactivity, but low flexibility and reach is limited.
Asynchronous Formal	No classroom type of learning though instructor teaches the students through software support- No interactions in real time and feedback through post, email and discussion boards	More flexibility, no advantage of real time, and reach is limited.
Formal Self-Study	Similar to asynchronous system but without the support of instructors. Structured and designed courses.	Offers high flexibility and larger reach. No real time interactivity and learners may not get adequate support.
Informal Self-Study	Self-learning without an instruction base-mostly through browsing the print materials interacts using search engines- learning using webs and portals	Very high flexibility- No real time interactivity and no systematic learning-Larger reach
Community Based	in which group of people coming together and learning through web-based discussions in which experiences are shared	Very high flexibility with possibilities of real time interactivity-larger reach
Blended Learning	Blending of all types of e-learning and including the conventional face-to-face classroom interaction	Potential varies based on the mix

Why Tech MODE

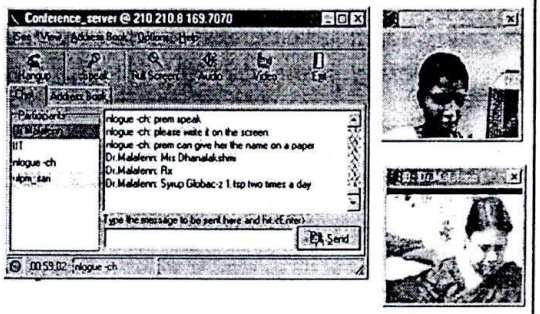
- Communities respond to audiovisuals
- Contents can be created, used, destroyed and recreated
- Participatory content creation possible
- Participatory and interactive learning: high.

Health Services - Remote Eye Care

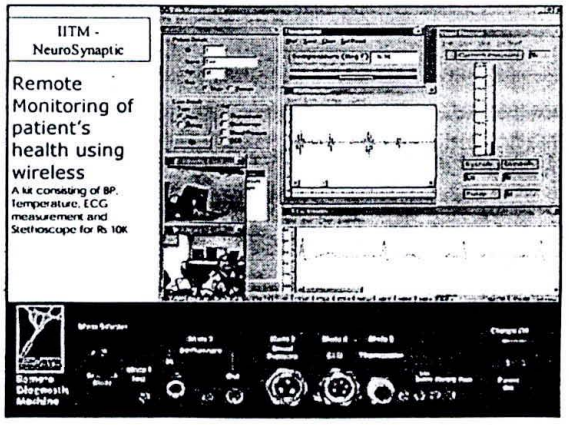


Aravind Eye Hospital with n-Logue

Health Services – n-Logue's Online Clinic



*Dr Mala Fenn is a leading Gynecologist in Madurai



Tech MODE Possible

- 100,000 villages with ICT connectivity by government
- 50,000 villages by Microsoft, 20,000 by ITC and by Intel
- NGOs, Banks and local companies now in 7000 villages.
- Edusat and other opprotunities.

Community Health

- Underrepresented in Mission 2007
- Potential for blended learning
- Content in local languages possible but at present abysmally low
- Standards for sharability and search on health in Indian languages (agrovoc in agriculture)

Training of 60000 Mitanins in Chhattisgarh: Content, Methodology and Human Resource Issues

A Critical Overview

V R Raman & Dr Kamlesh Jain,
SHRC, Chhattisgarh

A Brief Introduction

- Chhattisgarh, a new state born on 1st November, 2000, has launched many initiatives to reform the Health Sector. A 14 point agenda for reforms was agreed upon by the government with the civil society groups as a result of regular debates and discourses.
- Mitanin Programme is the key among these Health Sector Reforms as well as its community interface.
- 'Mitanin'/Mitan is a local tribal tradition of bonded friendship for a life between two. By naming the CHW 'Mitanin', the effort was to reinvent the same spirit for Health.
- Meant to reach out to the community through about 60000 Hamlet level Mitanins, it is probably the largest ongoing community health activist programme of the country now.

Current Status of the Programme

Total No. of Selected Mitanins So Far: 60092 in all 146 blocks of the state

- Almost 40000 Completed 7 rounds of training and proceeding towards continuation phase of the programme.
- Rest about 20000 selected in 65 second phase blocks have more or less completed 5 rounds of training and moving towards next levels.
- The Remaining training tasks for current programme under 1st Phase are to completed by the end of May 2006.
- The Programme has been extended by the state under ASHA scheme for further 5 years and continuation trainings are planned.

Part 2: Why Such a Programme?

Compulsions behind Mitanin Programme

Chhattisgarh: A Brief Profile

Area:	146361 Sq. Km. (6 times of Kerala State-Ninth largest State of the Country)
Population:	20795956 (Census 2001) Rural-80%; Urban-20%.
Population Density:	154 /sq.K. (National-324)
Tribal Population:	34% (Has 7 of nations primitive tribal groups)
Sex ratio:	990
Literacy Rate:	65% (Female Literacy - 52.4%)
Forest Cover:	40%
Other unique features:	Rice bowl of India, Museum of Mines, Forest based economy

Health Status & Services Situation

Health Status:		
Indicator	India	CG
IDI	45	89
Birth Rate (2003)	25	26
Death Rate (2003)	8.4	8.8
Infant Mortality Rate (2003)	64	76
Maternal Mortality Rate	400	498
Total Fertility Rate	2.85	2.79

Health Services Situation (NFHS-2):

- Full ANC Coverage for pregnant women: 12.89%
- Institutional Delivery: 21.05%
- Safe delivery: 42.13 %
- Children fully vaccinated by 12 months of age: 57.58%
- Couple Protection rate: 38.4%
- Proportion of the eligible couples (currently married women NFHS) protected with sterilization: 35.4%
- Proportion of eligible couples (currently married-NFHS) protected with spacing method: 15%

Geographic Divisions and Health Facilities gaps

- Total Districts: 16 (16 DHs- 9 functional)
- Total Blocks: 146 (116 CHCs- 34 functional & 512 PHCs- 327 functional)
- Total Gram Panchayats: 9986 (4692 Subcentres- 1458 functional)
- Total Villages: about 19000 (about 17000 AWCs)
- Total Hamlets/habitations: more than 70000
- Very low population density and huge areas to cover for health functionaries, hence many areas remain uncovered or underserved

Gaps in Health Services Provision

Supply Side Gaps:	Community Level Gaps:	Other Critical Issues:
✖ Infrastructure ✖ Human Resource/ Manpower ✖ Skills, capacities and Motivation ✖ Drugs, Supplies and Equipments ✖ Programme Design ✖ Referral arrangements	✖ Inadequate awareness ✖ Poor utilisation of services ✖ Need for behavior changes ✖ Minimal community participation	✖ Staff vacancies ✖ Specialist vacancies ✖ Gaps in skills/ training for programme/ non training infrastructure ✖ Gaps in Programme Management ✖ Inadequacy of drugs and supplies to meet increased needs ✖ Governance Issues ✖ Cadre Issues

Other Issues

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

And the Oppertunities...

- Scopes of a new state
- The political priorities were in need of a popular and massive programme in health. A possibility of translating it into a strong community network was evident.
- The state-civil society engagements were open and a hope was emerged of setting up and imparting a pro-poor health reforms agenda
- Community Health worker Programme was not seen in isolation, it was part and parcel of a broader health sector reform.
- Over and above these, a determinant administrator was there among the key visionaries whose direct support could last for about 3 years...

What is New as We Seek to

The Approach to Community Health Workers as it is attempted in the Mitanin Programme

Compared to earlier efforts

Earlier Key Programmes

- Community Health Worker- Jamkhed, SEWA Rural, Mandwa/Parinchay(FRCH), RUHSA,(Vellore), SEARCH(Ghadchiroli), VGSS; etc.
- Community Health Worker – 1977
- Village Health Guide- 1984
- Link Workers & Depot holders
- JanSwasthya Rakshak- MP-1997

Earlier State run Programmes and Mitanin Programme- Comparisons

✖ **Largely Male** especially in JSRs and CHWs	✖ **Only Female** ▪ More concern on health – in family and in society ▪ More focus on health education ▪ Less interest in becoming a quack

The Selection Process

Earlier Programmes:	Mitanin Programme:
✖ Usually by health staff ✖ Or by Panchayats- as representing the community-but panchayats often represent vested interests & health staff seek docile help not partnership-	✖ By the village general meeting; ✖ Subject to approval of the village community & Panchayat: ✖ both of the above processes have been sensitized by meetings conducted by trained facilitator and mobilized and motivated through specific processes like kalajatha.

The level of operation/coverage

✖ Usually one for village	✖ One for each hamlet ✖ Better coverage ✖ Effectively handles issues of marginalisation of some communities

Curative centeredness

Earlier Programmes	Mitanin Programme
" because without catering to felt need one cannot mobilize for prevention" ✖ In NGO CHW programmes effective curative care demonstrated but little preventive or promotive indicators studied ✖ In government programmes like JSR curative care remained was poor quality; ✖ No specific plans for preventive /promotive work	" curative care supplementary- not central" ✖ Introduced in training only after all other preventive and promotive aspects of the programme are trained and deployed and assessed: ✖ Effective plans for preventive and promotive care ✖ Indicators chosen and used (IMCI, health entitlements and issues education, local planning etc)

Tendency to quackery

Earlier govt. programmes	Mitanin Programme
✖ Drugs had to be prescribed ✖ No referral systems ✖ Paved way to irrational treatment (JSR and similar programmes.)	✖ Drugs provided by the government ✖ Active referral system ✖ Resisting harmful curative care and promoting rational practices has been made part of the programme

The Honoraria Issue

Earlier programmes	Mitanin Programme:
✖ Honoraria drives and ensures participation- in training (for JSR) and in work (for CHW). ✖ Were free to collect user fees from beneficiaries	✖ No honorariums: ✖ Livelihood compensation at Rs 75/ training day started after completion of initial training and deployment phase ✖ Motivation and regular/quality supportive supervision has to sustain the participation ✖ Social and Economic empowerment through various measures envisaged.

The arguments for and against honoraria

The Debates came up for Remuneration:	Mitanin approach eveolved was based on:
✖ needs compensation for loss of livelihood. ✖ When everyone else is paid – why not this volunteer- it is discriminatory and unfair. ✖ We cannot secure participation without it ✖ We cannot sustain participation without it and it is difficult to retrain every time there is a drop out.	✖ Only that much work given as can be done without loss of livelihood ✖ Should be seen as representative of community, -paying her is inadequate for livelihood but makes her lowest paid employee of department ✖ Safeguards selection process from pressures ✖ Loss of livelihood and actual costs needs to be compensated

Training strategy

Earlier State run Programmes:	Mitanin Programme:
✖ Training a one time activity- with or without compensation – period varies from few days to few months ✖ Left for work at the society just after training, no follow ups.	✖ 12 days of camp based training and 30 days of on the job training and support per year. ✖ Camp Training spread over the year – usually two or three days at a time ✖ Training support a continuous process- the initial 18 month period now extended to further 5 years under ASHA ✖ A team of fulltime volunteer trainers (20+2 per block) to provide support

Monitoring and Support

Earlier Programmes:	Mitanin Programme:
✖ No specific plans ✖ After training, they are on their own with many (not always) ethical informal arrangements	✖ Detailed budgeted plan of support and deployment ✖ a specific area of work is introduced at the village level and supported till outcomes begin to be seen After each training- on the jobs training strategy. ✖ A Monitoring strategy is in place and regular troubleshooting is on

Run By NGO or by Government – Earlier Programmes:

	Problems:
✖ NGO programmes are/were run parallel to the state. ✖ Currently NGO programmes are promoted by Govt and projected by NGOs as substitute to state action In many places ✖ Government programmes are run without any role for civil society	✖ State retreat from commitments ✖ NGOs cannot provide widespread coverage and systemic solutions ✖ NGOs in the small scale provide motivated personalized leadership – but in large scale they too get bureaucratized ✖ Government programmes failed to generate and sustain motivation; ✖ seek advantages as patronage

Part 4: The Framework

Conceptual & Operational Details

Mitanin Programme– the basic approach

- ✖ It was not parallel or a substitute to the public health systems, but a form of strengthening the public health systems, by:
  - Creating a public consciousness of health services as one fundamental right
  - Creating public accountability
  - Creating a better understanding of what health and health care is.
  - Basing of all health programmes at community.
  - Linking Mitanin programme organically with health sector reform programmes – MPW training, referral systems, disease surveillance, HMIS, standard treatment protocols; operations research etc.
- ✖ The Programme is basically training, training and more training followed by field level support so as to sustain the community initiatives

Key Objectives of the Programme

- Improve awareness of health and health education-
- Improve utilisation of existing public health care services and advocacy for equitable access and its effectiveness
- Provide a measure of immediate relief to health problems of weaker sections of society- curative and preventive
- Organise community ,especially women and weaker sections on health care issues
- Sensitize panchayats and build up its capabilities in planning and imparting health

The Selection and Training

- Chosen by the village/hamlet
- Facilitated by a trained facilitator's interaction with village and the formation of village committees and women's committees
- The facilitator's training gives them the social and political insights needed for such a process.
- Supported by a strong component of rigorous cultural and social mobilisation: Focused around the kalajathas
- After Selection, Mitanins are trained in various health & health related issues in 7 rounds: 20 days camp training spread across 18 months period: Each camp followed by further field support & functional training of 30 days.
- A continuation Phase of 12 day training per annum has been approved for those blocks completed 1st set of 7 trainings.

Training Contents

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

Training Contents contd....

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

Expected Active Role of Mitanin as result of these training

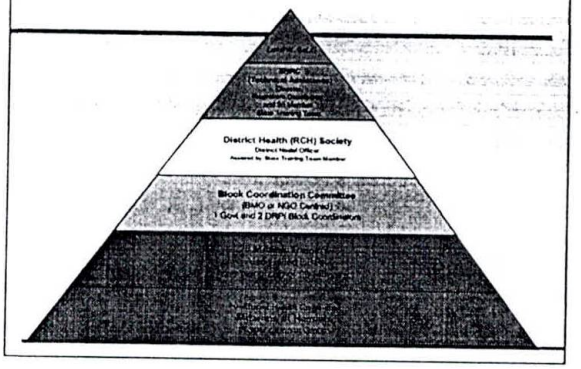
- Visit on Child birth and delivering essential neonatal care messages:
- Planning for the expected deliveries and facilitate for proper ANCs; Prompt referral for complications and inst. delivery
- Regular Health Education, awareness and initiatives for health entitlements through women's groups: 75 messages
- Identification of malnourished children- refer the severe cases and counseling for common cases
- Mobilize community for public health services- find out gaps and help the health worker to fill them
- First level curative care using drug kit-early detection, first contact care and prompt referral- focus common but killing diseases on Fever, Coughs & Colds and Diarrhea
- To act as community interfaces for health programmes
- To lead the hamlet level initiatives under Panchayat Health Planning
- A Monitoring strategy is in place so as to capture this in various levels right from hamlet, trainer, Block, District & State.

Current Organisational Structure

- About 60000 Mitanins
- 2920 full time trainers @ 20 per block
- 438 District Resource persons @ 3 per block
- Key functionaries of the partner NGOs
- The Govt functionaries: the health dept field staff in block with BMO as the head
- District Health Department & administration, Nodal officer and State Level Department Functionaries
- SHRC core team for the programme

(25 Field Coordinators, Publication Unit, Programme Coordinators, State Programme Coordinator & Director)

Management Organogram



Challenges faced and redressal approaches initiated

Training Challenges and Strategies that Addressed them–1

- There was serious Lack of experienced community health persons to impart actual training of Mitanins. Earlier concept was to use ANMs as trainers but looking at the actual training load and its reflection to their routine function, their role was limited to one fifth of the training team.A training team of volunteer trainers (1 per 20 Mitanins) and District Level Resource Persons formed to address this. They were pooled out of NGOs or active social workers through a process.
- Where the trainers weak was the actual technical understanding and health experience so as to train Mitanins in various issues. Hence was adopted the manual based camp training and regular on the job training simultaneously.
- The trainers are regularly supported through DRPs so as to enhance their capacities and the DRPs by Field coordinators of SHRC and the FCS by the state technical team available at SHRC so as to enhance their capacities.

Training Challenges and Strategies that Addressed them–2

- Process reviews and participatory assessments among Mitanins revealed a number of gaps in the training strategies and processes, which were addressed through a number of course correction measures. Also initiated course corrections as per evaluation findings.
- A large number of Mitanins are illiterates or semi-literates. The text based modules were found of little use for them hence the fashion of modules were changed with less text and more pictures, adopting from CEHAT etc.
- There was an issue of varying local vernaculars and the Hindi modules were not fitting in- this was addressed by forming hand made training module versions in local vernaculars like Halbi, Gondi, Chhattisgarhi, Sadri etc.
- Cluster/Panchayat level sittings of Mitanins initiated so as to motivate them and to enhance their knowledge and skills.

Training Challenges and Strategies that Addressed them–3

- A 16 episode radio programme and some TV inputs was aired to supplement the training on various issues. A planned listening of these was organized ensuring feedbacks from the womens groups.
- Tools to facilitate health education/action were circulated widely- both inhouse preparations and those material prepared by forerunners.
- Measures for enhancing coordination with ANM and AWWs initiated through ANM/AWW trainings and AWC level events.
- Technical training and up gradation of trainer skills at all levels are initiated on a pilot basis.
- Lack of Participation addressed through setting up a unique competition among Panchayats based on best performance on 26 Mitanin, health services, health outcomes and determinants related indicators.

Training Challenges and Strategies that Addressed them–4

- Continuing Mobilization initiatives imparted to enhance Mitanins acceptability at the community level-through Panchayat meetings, wall writing, I Card/other measures. Some areas on this are still weak too.
- Health Service Provision Gaps were identified and these were tried to address through negotiations at various levels.
- Lack of resources for proper drug kit provision and refills for Mitanins addressed *(further burning issues are still there)* through negotiation of a unique "Mukhyamantri Dawapeti Yojna" worth Rs 5 cr state budget per annum. The Programme got a state budget too.
- Systemic issues like inbuilt corruption also affects training camps in many areas as the health department is directly conducting training camps in many places- a number of transparency measures are adopted to 'reduce' this.

Persisting Challenges, though partially addressed...

- Training Inputs are still weak in some areas, new options needs to be invented
- Weak Referral and service linkages, partly because poor/negative supply side responses; rest because of systemic weaknesses and lacunae.
- Loose of focus on core/priority issues by department structures needs to be redressed.
- Intersectoral issues are still to be addressed
- Various issues like right to food, right to health are built up to an extent at the community level, but the community linkages and responses varies from locality to locality
- Issues related to widespread corruption
- The civil society protest and resistance on many issues remain weak- community action needs to be strengthened.
- A similar to civil war condition in some parts of the state
- A number of political uncertainities

The Critical, but Additional/Parrellel Inputs

- Silent support to interlinkages with ongoing social initiatives
- Organisational Processes
- Regular Troubleshooting on various field level and systemic issues
- Convincing the system on right-based approaches
- Media Interventions
- Creative and contributive inputs towards the administrative priorities of the health department so as to maintain the department attention to CHW (this gives you space to propose positive strategies as well)

Further Training Envisaged....

- Panchayat level Health Planning and Swasth Panchayat Contests.
- Strengthening the training already imparted through newer methodologies like audio visuals etc.
- Working with/for vulnerable social groups- the disabled, old aged, single women headed families and other special families..
- The right to food & food security issues
- Household/Home based remedies- The Herbal systems (AYUSH) Interface
- Imparting various information related to overall community development

Thank You all for being with us...

Approaches to learning – Thoughts from FRCH

Nergas Mistry
FRCH, Mumbai / Pune
11th April 2006

EVOLUTION OF HEALTH POLICY IN INDIA

- Bhore Committee (1946) – Social Physician Concept. Local effort and spirit of self-help
- Mudliar Committee (1961) – Building foundation of preventive health work associated with medical relief. MCH to be at fore front
- Srivastava Report (1974) – Create bands of para-professionals from community itself
- ICSSR-ICMR HFA (1981) – Democratic, decentralized and participatory people owned health model

CHW

- NOT a technology for primary healthcare
- REFLECTION of a political struggle

Berman

COMMUNITY HEALTHCARE SYSTEM (CHCS)

POPULATION	FUNCTIONARY	RESPONSIBILITY TO
200 – 250	CHF (70%)	Neighbourhood Gram Panchayat
5,000	Sahyogini (80 – 85%)	Group Gram Panchayats
30,000	People's Health Complex * (90 – 95%)	Panchayat Samiti

( ) Approx. Proportion of Total Services Covered

* Hospital-Cum-Training Centre
Extension Functions
Reverse Referral Services

IMPLICATION OF A NEIGHBOURHOOD FUNCTIONARY (1:250)

- Functions as an Extended Family Member
- Very high accessibility / Accountability
- Can undertake domestic and professional functions

Why Not 1:1000 Worker – Population Ratio

- Village Not Homogenous Entity
- (Cast – Creed – Socio-economic Units)
- Requires Full-time Functionary
- (Implications in her payment and time commitments)

LAERE vs TEACHER

Communication with....	Communicating to .....
ONCIOUSNESS AISING	TARGET GROUPS/INTERVENTIONS

Lessons from the old .... Mandwa (70s) Malsheras (80s)

- Experienced potential
- Education not absolute requirement
- Value of non-formal approaches & PDC promoting social change
- Synchrony in communication & service delivery
- Don't miss the forest
  - Address harmful cultural values, societal norms, structural inequities

INTEGRATED MULTIPLE FUNCTIONS OF COMMUNITY WORKER

Human Health: Preventive/Promotive and Curative
- All National Health Programmes including FP, RCH
- Water – Sanitation – Nutrition – Immunization
- Referrals to Existing Public / Private Services

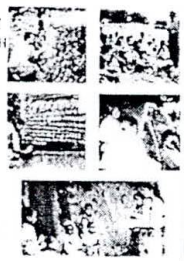
Veterinary Care

Public Information
- Participation in Panchayati Raj
- Right to Information

Income Generation

Environmental / Ecology Education

Community Mobilization
- Accountable to her community as should be the ANM & AWW
- Support not appropriation of functions that are best undertaken by the Community



Approach to Learning

- Problem-based learning
- Need-based learning
- Integrated learning
- Competency-based learning
- Ethics as an integral part of learning incorporate:
  - Equity
  - Effectiveness
  - Environmental protection
  - Responsibility

Training geared to :

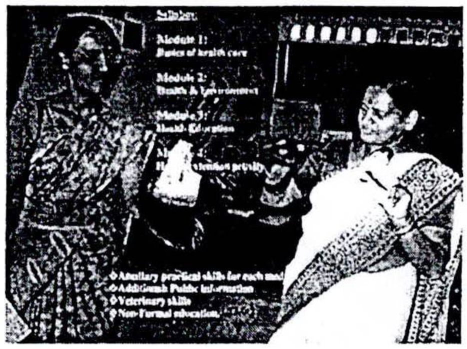
- Change in self image
- Provision of skills, knowledge and information
- Sharing and networking
- Organizational skills
- Access to economic empowerment
- Advancement with retention of traditional roots

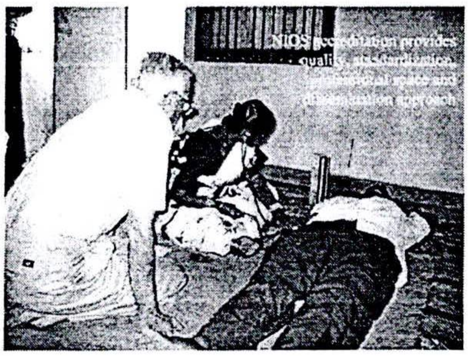
learning
- Exploration, Self + Surroundings
- Spectator - Participator - Contributor
- natural linkages
- 33% field work - Problem solving

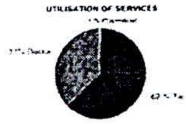
Water

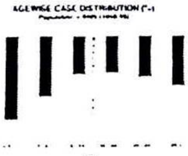
1. Water Cycle
2. Water Sources
3. Water Distribution
4. Watershed Management
5. Cropping Pattern and Water Utilization
6. Water Pollution
7. Water-borne diseases
8. Water Purification
9. Water Management

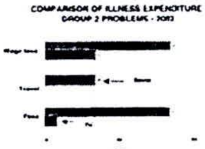
Techniques in modules
• [illegible] • [illegible]
• [illegible] • [illegible] • [illegible] for self-learning











LESSONS LEARNT

- Careful Selection Criteria Applied Through A Community Based Process
- Choosing Right Worker-Population Ratios
- Well-designed Training and Retraining (Reverse Referral) (Developing of Skilled Master Trainers)
- Frequent and Skilled Supervision
- Logistical and Motivational Support (Responsive Health System)
- Cash / Kind Returns – Traditional Remuneration Patterns of Communities
- Integrated form of Functioning
- Gradual and Incremental Restructuring
- Lateral Linkages : Meetings and Newsletter
- Community Ownership : Initiate while Training
- Sustainability Factors to be Established Early in Process

Lessons from the new (Parinche, Ralegan etc)

- Sift REALITY from ROMANCE
- Integrate EXPERIENTIAL with SKILL/KNOWLEDGE
- The "amygdyhan" approach BEFORE modules
- LEARNING = Communication → Assimilation → Practice/ Evaluation → Reflection → Internalization
- Unbalanced individual focus = Generation of worker isolation + new circle of local oppression
- Driving process forward THROUGH THE LEARNERS (ROLE MODELS)
  - practice and experience of science and art
  - leadership qualities
  - integrity and responsible approach

"Why Homo sapiens carry a spark of rationality is a deep enigma. We who are animated stardust can nevertheless reflect on the nature of our universe even to the extent of glimpsing its rules on which it runs. What does it mean ?

The physical Homo may count for nothing but the existence of MIND in some organism on some planet in the universe is surely a fact of fundamental significance. Through conscious beings the universe has generated self-awareness."

Paul Davies
Cosmologist

The Rings model for Health worker learning programmes

A 'new' model for large scale health worker programmes for flexi-learning

1

What we did before we were in YCMOU

- We wrote books with many chapters, with subheads—long narratives, full themes, 'complete' or 'full' (hold-all) versions
- Printed books and edited them thru years
- Single/twin author projects –years of dedicated work, and projects.
- We waited till print edition was available.

2

Reshuffling was painful, and caused rifts and divides

- We had a PHC group in Maharashtra—9 members—with different orientations.
- Books were the battleground. Discarding old work and accepting new ones was a problem.
- Need to have a way of using new and old work/ideas in a productive and creative manner.

3

What we did not think

- Variety of learner needs/
- Various learning abilities between/within groups
- Variety of ways of doing things in programmes-multiple authors
- Frequent changes/updates may be necessary
- Sequencing and grouping of lessons should be flexible

4

Lessons from large scale CHW programmes

- We must get away from planner centric models to four-perspective models
- The 4 perspective model includes the planner, the learner, the trainer/counselor, and the user community.
- Unless we move to this balanced perspective, programmes can not have a context relevance and internal richness of quality.

5

After we joined the Open University

6

At YCMOU we realized

- The need to be flexi by principle and by design, not as a convenience.
- Use more than one SIM sources/options, on a common framework.
- Develop material as we progress, with part of material in hands, and that too a limited edition.
- We decided to make multi-layered learning material

7

The ODL model

- The original *correspondence course model* has now evolved into Open & Distance Learning (ODL) model which mixes contact sessions with assignment/ work center experience.
- Self Instruction Material, workbook and Couenslor Guide are the basic components.
- We now call it a flexi-learning model.
- With IT use, we can also harness the Virtual classroom EDUSAT model. We can do with fewer trainers.

8

The SIM, WB & CG

- Self learning material (SIM), Workbook (WB) with counselor guidebook (CG) is the minimum strategy.
- The SIM+WB+CG was mainly in book format. Now it is being reinforced with IT aids.
- For CHWs, the ODL model is the natural choice since it is flexi, learner centric, and low cost.
- Virtual classroom/IT ad-on tools can enhance the programme in many ways.

9

The student evaluation needs of ODL

- The academic programme does need student evaluation—individual or group.
- It adds quality, simply by announcement of evaluation before the programme.
- Evaluation helps us to improve the programme
- Programmes without academic evaluation can degenerate sooner or later.

10

The learner versus trainer approach

- Learners need a say in programmes-if they are really need-based, problem-based. This is the main plank of adult learning.
- Most of even enlightened and 'good' programmes are planner-trainer dominated--the topics, sequence, language, messages, artwork, are all pre-decided.
- W need a shift, esp. in large scale programmes.
- It has to be a network based approach, even making learners contribute and

11

The varying needs of health workers

- Different, diverse and even opposing priorities of learner groups. *(for instance the Kolam tribe needs to have more children to even survive)*
- Need assessment necessary *before offering* a programme. At least keep space for local needs.

12

Different learning levels

- Different ages (25-50) have differing learning levels. Generally, the older students are less eager for learning or unlearning.
- varying schooling levels (even non-literate) even in the same district or blocks.
- Development level in each block may be different, with varying exposure to ideas/messages/services/goods etc. For instance Navapur block is developed as compared to Dhadgaon.

13

The various situations of health training teams

- Teams may perceive needs and priorities differently.
- The resources may also be different-for example home birthing may be necessary in some blocks while completely redundant in others.
- NGOs may be additional factor in some blocks.
- The time available from doctors/nurses may be vastly different. Special teams may not be available.

14

The needs for updates

- Topics need updates-every 2-3 years. Health approaches/programmes change, so do technology and solutions. RCH programme has undergone several changes in content and context. NLEP, NTCP, NACP, IMNCI, ICDS are all changing. The learning material should keep pace with changes.

15

The multi-author project approach

- There cant be a single author for the entire set of Learning material-it takes time, is of less quality, and ignores a richer possibilities.
- That saves time, enhances quality, brings richness.
- But a multi-author project is possible only on a decided scaffold/framework. It is easy if we have a plan—goes haywire if we have none.

16

The must learn-should learn-may learn- rings

- We realized in our dai (TBA) programme, that 3 books-ANC-NC-PNC are better replaced by must-should-may learn books. It makes life simple for all the trainers and learners well.
- The rings approach easily can do that rather than the thematic approach.

17

The scale is important decider

- A small scale NGO programme (20+) village can be an intense programme, customized to local situation and programme goals. Here we are at the *'best' end or right side* of the range of variables.
- A large scale/generic programme requires broader approach.
- In large scale programmes the 'trainers' and learning environments are not at the best end, but *west-end/left side*.

18

Lesson replacement needs

- With time and location, some lessons need to be replaced. (eg: small family is good in most places, but in *Kolam* tribe big is necessary. Heat stroke may be replaced with cold injury in different places).
- There may be less drastic replacements.
- The design must provide for this flexibility, and not as an

19

The assignment needs

- Health workers hear/see in the classroom or PHC but 'learn' more in assignments, after the contact sessions.
- Hence assignments must be neatly planned. A workbook makes it possible to record the work.
- CHW programmes must alternate *contact phases* and *assignment phases* for good quality programmes.

20

The matrix vs the narrative approach

- Need to move from long narrative lessons- to small units laid into a matrix.
- This makes flexibility possible-like it is easy to replace bricks
- It makes learning and training easier.

21

The Rings model

22

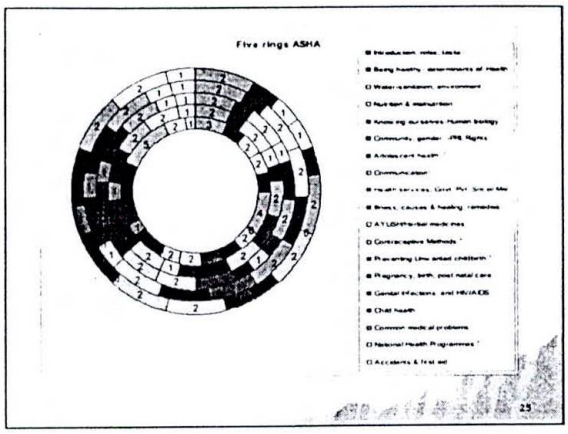
The matrix to Rings n spokes

- Once we make a matrix (see next slide), we can arrange the sequence either by columns or rows.
- The matrix renders itself for arrangement in rings
- In the ASHA case, we had made five rings for five episodes. (see slide)
- The 'spokes'/sectors are single themes

23

	THEMES	Ring1	Ring2	Ring3	Ring4	Ring5	Tot hrs	% share
1	Introduction, roles, tasks	3	2	2	2	2	11	7.1
2	Being healthy- determinants of Health	2	1	1	1	1	6	3.8
3	Water-sanitation, environment	2	2	2	2	1	9	5.8
4	Nutrition & malnutrition	2	1	1	2	1	7	4.5
5	Knowing ourselves-Human biology	2	1	2	2	1	8	5.1
6	Community, gender, -PRI, Rights,	4	2	2	2	2	12	7.7
7	Adolescent health *	0	2	1	2	0	5	3.2
8	Communication	2	2	1	0	2	7	4.5
9	Health services, Govt, Pvt, Social Mar	2	2	1	1	1	7	4.5
10	Illness, causes & healing, remedies	2	1	2	1	1	7	4.5
11	AYUSH/Herbal medicines	2	1	2	2	2	9	5.8
12	Contraceptive Methods *	2	2	2	1	2	9	5.8
13	Preventing Unwanted childbirth *	0	1	2	0	0	3	1.9
14	Pregnancy, birth, post natal care	3	2	2	2	2	11	7.1
15	Genital Infections and HIV/AIDS	1	1	1	1	1	5	3.2
16	Child health	6	2	2	2	2	14	9.0
17	Common medical problems	5	2	2	2	2	13	8.3
18	National Health Programmes *	2	2	1	1	2	8	5.1
19	Accidents & first aid	1	1	1	1	1	5	3.2
20	Local needs							
	hrs	43	30	30	27	26	156	100.0
	days (7.5 hrs per day)	5.73	4	4	3.6	3.47	20.8	

24



The advantages of Rings-approach

- Renders gradual learning arrangement possible- Must /Should /May learn
- Offers multitasking, which is what community respects
- Complexity can be graded ring by ring-suits heterogeneous target groups.
- Lessons can be redone/replaced/ substituted at several level

The spokes or sectors (themes) conversion

- It is easy to choose either rings or spokes, partially or fully. In ASHA case the first book was Ring1 and next book is 2-3 themes together (MCH, medical care)
- Theme offers some advantage-like topics are together
- But flexibility may be compromised-- the theme nearly 'freezes' once it is made.

The lesson framework-size and style uniformity

- The lessons must be of a uniform size.
- Like the leaves of a banyan tree-sapling or a huge tree—have the same size and plan.
- Uniform lesson size and style allows organic growth and management of a broad & multi-thematic learning programme.

Small is beautiful!

- A plan there must be-to offer small lessons that can finish in 30 minutes and give a break. The *Learning Objectives-content-KAP, recap, exercises*-- all must be there.
- Small lesson size makes focused learning possible. Avoid multiple LO/message crowding in the same lesson.

Independent lessons-links yes but repetition needless.

- To reap the advantages of Rings model, we must take care to make the lessons as independent as possible. Avoid repetition of messages, esp differing/divergent messages
- What we need is links to pre and post topics.

Bound book vs spiral model

- The flexi approach should be embodied in a spiral book, rather than a bound book—at least at the central-state level. The districts can make their own bound books.
- Spiral book offers flexibility for corrections /replacement (bound book is a fait accompli)
- The spiral approach makes shift to either Rings/themes possible.

31

The ASHA context

- We used this approach for ASHA.
- The Rings model proved robust enough to withstand drastic change to thematic from book 2.
- Ring 1 can also be replaced by a book for non-literate ASHAs.
- The need for upgrading/add rings or themes can be met with the matrix approach quite easiely.

32

Fundamentally pluralistic

- The Rings model is basically a pluralistic approach by design—a post modernist view of things in community health
- Several possibilities around several foci (rings need not be concentric), multiple makers and users, flexible with locality and time needs. Deconstruct is the word.
- Steers away from *whole truths* and *grand narratives* and *diktats*. It provides for *participatory* approach.

33

IT use in CHW programmes

34

IT solutions to syllabus and learning material,

- In addition to print material, we now have IT solutions. CD based lesson bank can be used directly or in print format as need be.
- This gets rid of centralized printing and renders distribution economical.
- IT offers flexibility and control by local training teams.
- Adds a rich AV component.

35

The use of IT

- **IT will make it much more effective, and easy for trainers, provided computers are available.**
- **PowerPoint shows with clips are the best and cheapest forms of IT use in CHW programmes.**
- **Interactive programmes need much more preparatory work.**
- **Books for take-home can be modeled as ppts.**
- **IT minimizes 'transmission loss'.**

36

What is YCMOU doing now?

37

What YCMOU is doing

- In the primary care programmes--for dais, health workers, Anganwadi workers—we are now following the rings model.
- All the five ASHA rings with pictures
- Power-pts with vi-clips are the basic stuff and print material is a take home aid.
- Development of a resource-bank of freely downloadable lessons,

38

Using rings and IT in several programmes

- The YCMOU school is now using Rings model in many programmes-Dai, CHW, Hospital assistant, and later for Anganwadi sevikas.
- Uniform lesson size and plan makes it possible to share common lessons in other programmes.
- The rings approach makes it possible to launch programmes as soon as R1 & 2 are available, and use feedback.
- We are even thinking of replacing centralized printing/storing/distribution and ask study centers to download and photocopy as they need.

39

Appeal for network and resource banks

- Contribute
- We will suitably edit and acknowledge the source
- We will put it on ycmou-website
- Free access

40

Thanks

School of Health Sciences
YC Maharashtra Open University
Gangapur, Nashik 422222
Ycmouhealth_nsk@sancharnet.in
Ph 253-2230718, 2231714(ext 3020)
Website: Ycmou-hs
Dr Shyam ashtekar (Director)
Dr Dhruv Mankad (Sr consultant)

41

Proposed Training Strategy for Accredited Social Health Activist (ASHA)

(Training Division)
Department of Health & Family Welfare
Ministry of Health & FW

Roles & Responsibilities of ASHA

- To create awareness and provide information to the community on determinants on health
- To counsel families on maternal and child health components
- To mobilize the community and facilitate them in accessing health and health related services
- To assist in development of village health plan

Roles & Responsibilities of ASHA (cont.)

- To escort/accompany pregnant women & children for treatment/admission to nearest health facilities
- To provide medical care for minor ailments
- To act as Depot Holder for essential provisions
- To inform about the births, deaths and outbreaks in the community
- To promote construction of household toilets under Total Water & Sanitation Campaign

Criteria for Selection of ASHA

- One ASHA per 1000 population
  (Areas in tribal,hilly,desert the norms could be relaxed to one ASHA per habitation, depending on workload)
- Primarily a woman resident of the village-married/widow/divorced
- Preferably in the age group of 25 to 45 years with formal education up to 8th class
- Should have effective communication skills, leadership qualities and be able to reach out to the community
- Preference to disadvantaged population group

Selection Process of ASHA

District Health Society (DHS)
↓
District Nodal Officer (DNO) / Block Nodal Officer (BNO)
↓
≥ 10 Facilitators per block
↓
Community (a short list of 3 names from each village)
↓
Gramsabha (To select one of the three names)
↓
ASHA

Training Strategy for ASHA

- ☐ Induction Training – 23 days spread over 12 months
  - ❖ 7 days pre-deployment
  - ❖ 4 episodes of 4 days each
- ☐ Periodic Training
  - ❖ 2 days training every alternate month
- ☐ Constitution of level specific Training Team
  (STT, DTT and BTT), should include the members from Department OF Health, PRI,WCD, Rural Development, NGOs, etc.
- ☐ Identification of Training Venue
- ☐ Development of training plan for each level

Training strategy for ASHA (cont.)

- Cascade model of Training
  - TOT for STT at NIHFW
  - Training for DTT at SIH&FW
  - Training for BTT at DTC
  - Training for ASHA at PHC/ AWTCs /Panchayat, etc..
- Continuing education. & Skill Up gradation
  - Resource Agency/ NGO
- Convergence- Joint of ASHA/ AWW/ ANM

Adaptation of Training Material for ASHA

- Draft training material to be made available by GOI
  - Training modules (books) based on thematic approach
  - Facilitator's guide for each book
- To be reviewed by states locally and adopt as per their needs within the context of ASHA guidelines
- Translation in local language
- Printing
- Responsibility: State Nodal Officer

ASHA: Issues for discussion

- Identification of nodal officer at State / District / Block for ASHA training.
- ASHA - proposed / selected – district-wise
- Selection process
- Constitution of Training Team (STT/DTT/BTT)
- Training material
- Training plan for each level
- Release for funds for training

THANK YOU

Clinical training of CHWs

Dr Shyam Ashtekar

The Basic Plan

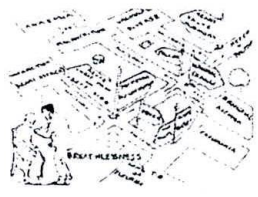
Categorizing illnesses & health problems

GROUPING ILLNESS FOR A DECISION AT THE VILLAGE LEVEL

GROUP OF ILLNESSES	DIAGNOSIS	TREATMENT	RISK	EXAMPLES	HOW COMMON IN A VILLAGE	WHAT TO DO IN THE VILLAGE
1. Minor illness	Very easy	Very easy	Very safe	Colds, cuts, ordinary headache.	Very common	Treat the illness. Educate people
2. Medium illness	Easy	Easy and [illegible]	Moderate	Dysentery, diarrhoea, sore throat, child pneumonia	Common	Treat, but caution is essential. Follow up after treatment
3. Acute serious illness	Complex	Often / may need doctor's help	Risk of morbidity and mortality	Meningitis, cholera, peritonitis, appendicitis, renal stones	Few episodes	Detect early, start treatment if possible and send to a hospital
4. Chronic serious illness	Complex	Usually need doctor's help	Long term risk to healthy life	Cancer, TB, filariasis,	Few episodes	Detect early, start treatment if possible and send to a hospital. Give home care after return.
5. Accidents	Complex	Difficult	Great risk	Snake bite, burns, fracture, internal bleeds, poisoning	Rare in most villages	Give the right first aid, send to a hospital

The general symptoms

Some symptoms are 'complexes' (fever, weakness etc) while others are for 'spot diagnosis' or single conditions.



The single conditions

Problems like sore eyes, pus in ear, etc are easily recognized.

Problems like sore eyes, pus in ear, etc are easily recognized.

Some CHWs need it simple!

Many CHWs cant take complex and abstract thinking for clinical decisions. We have avoided all complexity in ASHA phase1

.

Others may desire more clinical training.

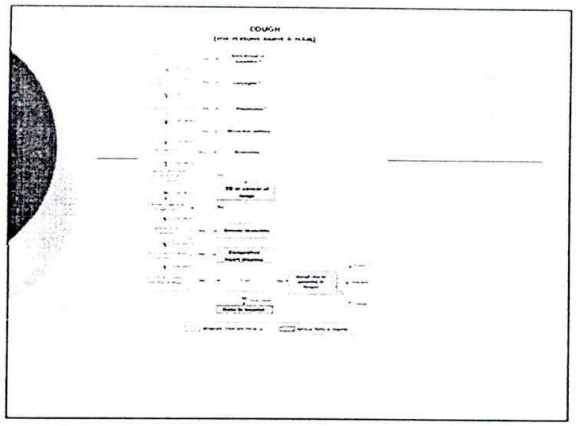
- Some CHWs may want to learn more—about fever, cough, loose motions, weakness, or abdominal pain.
- This opens up more variables and learning complexity.

The Diagnostic table

The matrix has several uses, but takes time for learning. It is mainly a thing to fall-back upon.

The Diagnostic guide (flow chart)

The flow chart remains an easy decision tool, but the CHWs must be supported to follow the technique



The IT flow charts

With IT programmes, diagnosis can be available even in kiosks.

The IT flow charts

- With IT programmes, diagnosis can be available even in kiosks.
- Illustrated flow-charts need to be developed.
- With interactive tools, the complex diagnostic problems become simple.
- Evan 'quacks' would benefit and help their clientele with these tools.
- Good help for consumers.

Immense potential

- Clinical training of CHWs is a neglected area (we are still in the denial mode)
- But we are also doing willy nilly it in IMNCI
- Flow charts can change and simplify the IMNCI substantially.

And about healing

- Healing, an essential function of any health worker is also being denied—to the detriment of the programme itself.
- It is possible train CHWs in 6m-1y for managing basic health problems.
- A graded portion of primary care EDL, AYUSH, non-drug remedies will be vital to CHW programmes.

Thanks

School of Health Sciences
YC Maharashtra Open University
Gangapur, Nashik 422222
Ycmouhealth_nsk@sancharnet.in
Ph 253-2230718, 2231714(ext 3020)
Website: Ycmou-hs
Dr Shyam ashtekar (Director)

Behaviour Change Communication: A Resource Approach to training Community Health Workers

Dr M. S. Menon, MD. Major (Retd)AMC.
Director, Kripa Foundation
Cardiologist, S L Raheja Hospital
Prof & HOD (Med), CMPH Med College.

KRIPA FOUNDATION

Battling Substance Abuse and HIV/AIDS

Largest NGO under Ministry of Social Justice and Empowerment
Impact: Through 40 facilities in 11 Indian states
Activities: Addiction Awareness, Counselling & Rehabilitation, Employee Assistance
Help lines, HIV-AIDS Care and Street Children Program

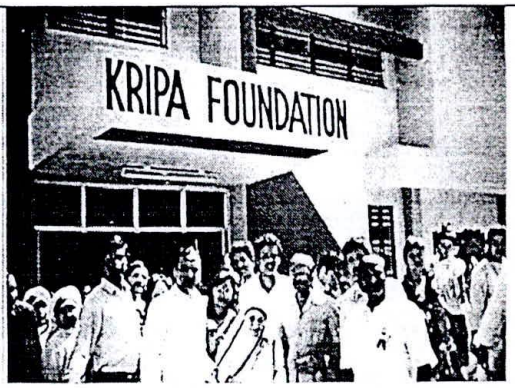
Kripa Projects
Kripa Institute of Training, Kripa Institute of Research, Kripa-AIDS
Regd. off: Kripa Foundation 81/A, Mt. Carmel church, Chapel road (W) Mumbai 400050
website: www.kripafoundation.org Email: kripadarc@mtnl.net.in
Helplines: HIV/AIDS: 022-26429158, Substance Abuse: 022-26405411

2

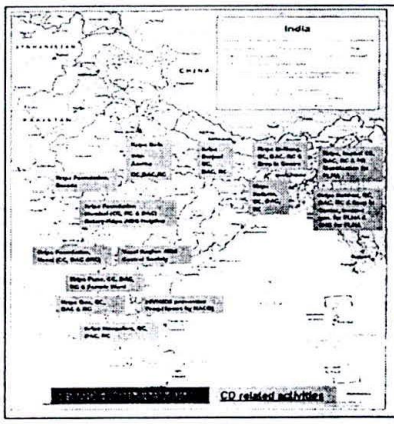
VISION

A GLOBAL HEALING PRESENCE

GOAL
Empowering those affected by Chemical Dependency and HIV/AIDS



Mother Teresa at the inauguration of the Vasai Centre: 15 May 1994



KRIPA FOUNDATION (since 1981)
40 facilities.
14 locations.
11 Indian States.
Substance Abuse and HIV/AIDS related activities across India

Behaviour

....the aggregate of the responses or reactions or movements made by an individual in any situation.

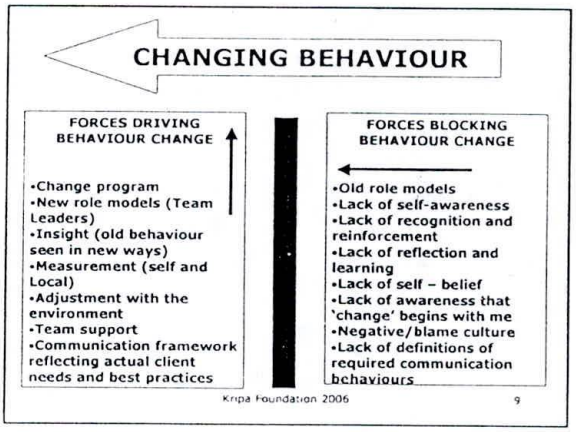
Behaviour Change

Behaviour change would refer to extinguishing maladaptive behaviour patterns and help people learn new adaptive ones.

Helping people make behaviour change involves a series of relatively structured and predictable steps that can be adapted to meet the needs of a person or a problem.

Steps to Behaviour Change

- Describing the behaviour: specific and measurability
- Establishing a baseline: frequency and severity
- Establishing goals
- Developing strategies: behavioural therapy
- Implementation
- Assessment
- Reinforcement



Communication...1

....is the process of exchanging information and ideas.

An active process, it involves encoding, transmitting, and decoding intended messages.

There are many means of communicating and many different language systems.

Communication...2

- Speech and language are only a portion of communication.
- Other aspects of communication may enhance or even eclipse the linguistic code.
- These aspects are paralinguistic (text), nonlinguistic (body language, gesture), and meta linguistic (slides, sign language).

Importance of Communication skills for Community Health Workers (CHWs)

- Communication and health are inextricably linked
- Poor communication and impoverished relational contact can predispose to bad health
- Effective communication is invariably the conduit by which health needs are identified and successful interventions planned and implemented

Need for Understanding Holistic Health in different Communities (Urban, Rural)

Health Goals:

Physical, Mental & Social.

Spiritual.

Available Resources:

Public Health Systems.

Social & Spiritual Systems.

Modalities in BCC

- Knowledge transfer (Inputs)
- Therapies
- Non-verbal (e.g IEC material)
- Therapeutic Duty Assignment
- Individual and Group

Behaviour Therapy: Definition

Behaviour therapy is a form of psychotherapy which seeks to improve the way a person feels by changing what they do.

It is commonly used to overcome phobias.

Can be useful in generating "**help & health**" seeking behaviour.

Behaviour Therapy: Use

- **Behaviour therapy** helps you weaken the ***connections*** between troublesome situations and your habitual reactions to them. Reactions such as fear, depression or rage, and self-defeating or self-damaging behavior.
- It also teaches you how to calm your mind and body, so you can feel better, think more clearly, and make better decisions.

Areas of CHW Interventions

- Community issues and traditions (stake holder supported)
  - nutritional, environmental
- Family / Social issues (faith / spiritual leader supported)
  - Early marriages, relationships, codependency
- Individual issues (peer supported)
  - personality and psychological (anxiety, depression, phobia), hygiene practices, interpersonal stressors, addictions, PTSD, communication

Integration of Behaviour and Cognitive Therapy(CBT)

Cognitive therapy teaches how certain thinking patterns are causing symptoms — by giving a distorted picture of what's going on in life, and making one feel anxious, depressed or angry for no good reason, or provoking one into ill-chosen actions.

When combined into **CBT**, behavior therapy and cognitive therapy provide you with very powerful tools for stopping your symptoms and getting your life on a more satisfying track.

Therapies for Behaviour Change

- Desensitization:
  Gradual exposures, reducing fears, phobias, obsessions, compulsions and anxieties
- Shaping:
  Gradual change,Successive approximations of desired behaviours, develop new patterns of behaviour
- Reinforcements:
  To enhance learning and solidify gains.E.g.. If you eat your medicines then you will be allowed extra time to watch TV.
- Skill training:
  Assertiveness training, decision making, problem solving, communication skills
- Token Economics:
  Reward system e.g, School children, Day Treatment Programs, Hospitals, Prisons etc.

Generating Competencies

Training Programmes

(new skill, upgrading, professional level)

Training Methodology

(didactic, field work, own time work, role plays, games & street theatre)

Accreditation

(university, state, national)

Stake holder participation

Peer group training

Group activity

Role play and games

IEC based training

CHW Cohort Development

- Community needs assessment
- Stake holders/Key informant identification followed by interactions
- Structured and unstructured observations
- Peer group (potential CHWs identification)
  - Rapport building
  - Recruitment
  - Training
  - Testing
- Community rapprochement of external CHWs

Monitoring, Evaluation and Growth

- Block, local and institutional levels
- Supervision schedules
- Leadership training
- Skill updating

Discuss this scenario for approaches by a CHW

An anemic rural lady of marriageable age from a conservative community, attends the PHC and gives a history of prior sexual exposures.

Discuss a CHWs approach to interacting with this lady.

Dr Yogesh Jain

Thoughts

85% of the health problems in a village can be managed by at the village level

By the village health worker

People in small places have small problems

And thus require lesser quantity, quality or level of care

The four fold path for judging the effectiveness of the health worker based model:

Does the presence of the health worker improve **the access of people to health care?**

Does it reduce inequity?

Is the treatment effective ?

Is the treatment appropriate?

- Choice of drugs
- Can she look after vomiting?

Is the treatment affordable?

- Shorn of all components of primary health care, it is a second rate doctor that you offer to the "others".

You take cotrimoxazole or furazolidone for your child's gastroenteritis and I give Ciproflox
You use cotrimox for your child's pneumonia and I use amoxicillin
You use MDT or MDT plus for your leprosy and I use daily rifampicin
You get treated with DOTS and I take a daily regime
You get 4 tabs of Chloroquine for your fever and I get my blood checked and get treated accordingly- take SP or mefloquine
You get GV for your pyoderma and I will use oral antibiotic

Clinical skills

fever
cough cold
malaria
Pneumonia
watery diarrhea
dysentery
scabies
pyoderma
fungal infections
red eye
ear pain
gingivitis
bodyaches

clinical skills

vomiting
white discharge
anemia
intestinal helminthiaisis
small wounds
diagnosis of pregnancy
examination of pregnant woman
colicky pain abdomen
dyspepsia
dysmenorrhea

Clinical skills not known
Asthma
tuberculosis treatment initiation

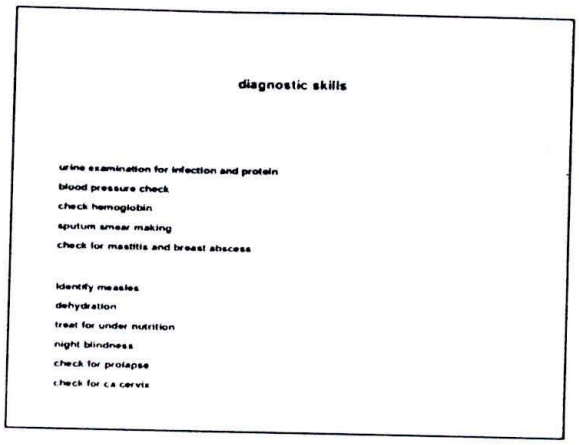
diabetes
hypertension

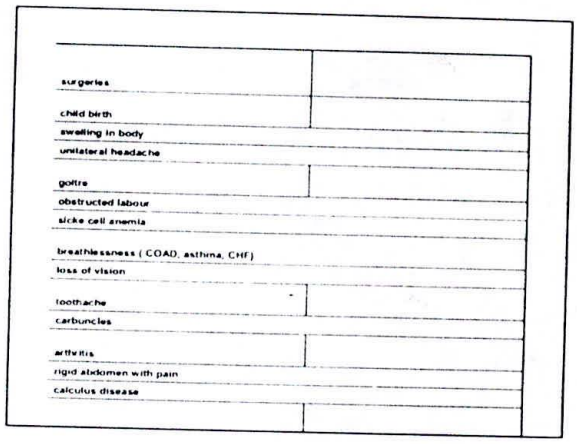
dog bite
snake bite

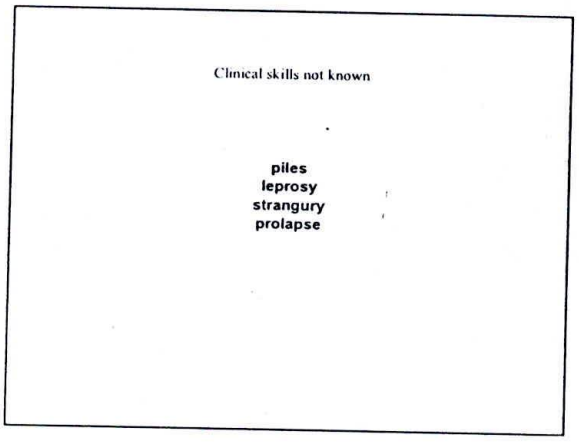
jaundice
aphthous ulcers/ glossitis

fractures
continuing menstrual bleeding

seizures
appendicitis


diagnostic skills
urine examination for infection and protein
blood pressure check
check hemoglobin
sputum smear making
check for mastitis and breast abscess
identify measles
dehydration
treat for under nutrition
night blindness
check for prolapse
check for ca cervix


surgeries
child birth
swelling in body
unilateral headache
goitre
obstructed labour
sicke cell anemia
breathlessness (COAD, asthma, CHF)
loss of vision
toothache
carbuncles
arthritis
rigid abdomen with pain
calculus disease


Clinical skills not known
piles
leprosy
strangury
prolapse

Gender and Social Exclusion in Community Health Worker Training

Lindsay Barnes
Jan Chetna Manch, Bokaro
April 11th, TMTC, Pune

What is social exclusion?

- Discrimination of opportunity and access on basis of identity
- 'Gender' hierarchy cannot be seen in isolation from other forms of discrimination: e.g.. caste/community/class

How to work for social inclusion

- Implies an acceptance of equality for all
- Need to address all forms of discrimination
- Hierarchies of gender / caste/ community/ class are interwoven
- Cannot tackle only one form of exclusion in isolation

So, why to focus on 'gender' in CHW training?

- Within poor communities gender is a cross-cutting division
- Women have specific problems of health
- Women have less access to health care
- Gender discrimination impacts health and needs to be addressed in the training
- 'Gender' blind training perpetuates / reinforces discrimination

Steps in addressing 'gender' in CHW training

- Selection of the right people as trainees
- Getting the content of the training right (add on / weave in?)
- Ensuring the trainers are aware (the most difficult bit)
- Empowering women CHWs to provide services (after the 'training' is over)

Things to consider when selecting a CHW

- Sex of the CHW (Should we only select women?)
- Attitudes of the trainee (Commitment to social justice, equality etc)
- Power linkages (Who do they 'represent'?)
- Aptitude / previous experience
- Education / literacy skills

'Doctors' & 'Dais'

• Village rich	• Village poor
• Higher caste	• Lowest caste
• Educated	• Not literate
• Mobile	• Limited mobility
• High value work	• Low value work
• Brash confidence	• 'Quiet' confidence
• Less experience	• Vast experience
• Less 'knowledge'	• Years of experience
• Allopathydrugs	• Herbal/massage
• Well connected	• Outside 'system'
• MALE	• FEMALE

Approach & content of training

- Positive discrimination in training to ensure inclusion (men/women; high/low caste; tribal/non-tribal)
- No 'recipe book' for 'gender'
- Need for behavior change (gets personal)
- Skill building to go hand-in-hand with awareness

Looking at ill health

- A middle-aged village woman has acidity ..... need to go beyond antacid.....
- Diet & hunger, fasting
- Low self esteem
- Stress (& violence?)
- Anaemia
- Access to health care.....

Women CHWs and empowerment

- Awareness, skills & experience not enough
- Issues of 'power' go beyond 'training'
- A non-empowered CHW will not be effective
- Empowerment cannot be 'trained'

Training of Less Educated / Non-literate CHWs

Some lessons from the Swasthya Sathi programme

Anant Phadke, Abhay Shukla
SATHI-CEHAT
Flat No. 3 & 4 Aman-E Terrace, Plot No. 140,
Dahanukar Colony, Kothrud, Pune 411 029
Tel: 020 25452325/25451413
Email: cehatpun@vsnl.com

Swasthya Sathi programmes in collaboration with People's organisations

THE GROUND REALITY IS

- 91% of women in rural areas of EAG states do not have middle level education
- Non-literate / functionally literate CHWs would form a significant proportion of CHWs
- This is especially true if
  - CHWs are to be women from disadvantaged communities (adivasi, dalit)
  - If remote, backward areas too are to be fully covered in any CHW programme including the ASHA programme

YET

- Barring exceptions, very little effort to prepare, standardize training methodology, training material for the non-literate CHWs

Specificities of Non-literate / Functionally Literate CHWs

- Knowledge and maturity through life experience and capacity for abstract thinking

But

- Problems with reading, writing text
- Less attention span with textual material even if functionally literate
- Being adults, firm socio-cultural beliefs

Special measures needed in training of non-literate CHWs - I

A) User friendly approach and setting

- All the training geared around clearly formulated 'learning objectives'
- Eliminating all unnecessary information load; each bit of new information to be organically linked to the 'learning objectives'
- Shorter training camps of three to four days' duration each to suit the convenience of trainees, especially the women-trainees

Special measures needed in training of non-literate CHWs - II

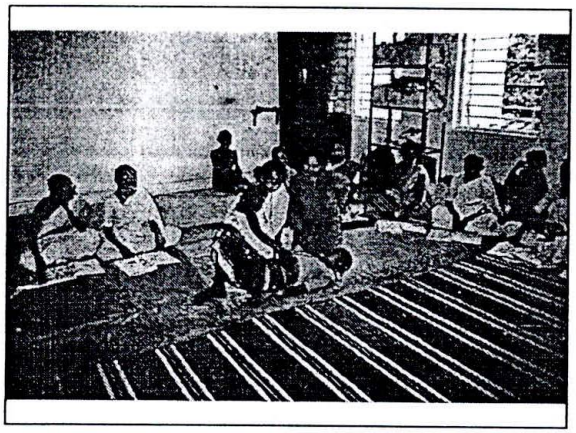
B) Special Training material : pictorial literacy

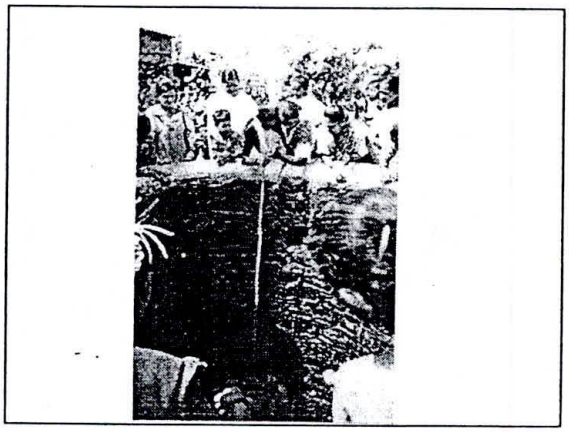
- Use of specially prepared multicoloured pictorial manual – each page one main concept
- Use of standard symbols leading to *'pictorial literacy'*
- *Key questions approach* – set of easily memorisable questions for diagnosis
- Physical, three dimensional training aids (e.g.rubber model of uterus, human torso)
- Innovative diagnostic flow charts

Special measures needed in training of non-literate CHWs - III

C) Special Training methods

- Minimise didactic presentation
- Due importance to practicals (e.g. body mapping, use of paper 'body puzzle'), role plays, games (diagnostic card games, quiz competition)
- Importance of small group discussions and of each trainee articulating key points in her own words
- Importance of reiteration, regular revision
- Each key concept to be linked with life experience

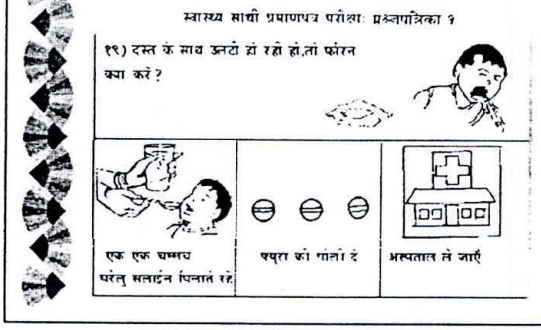




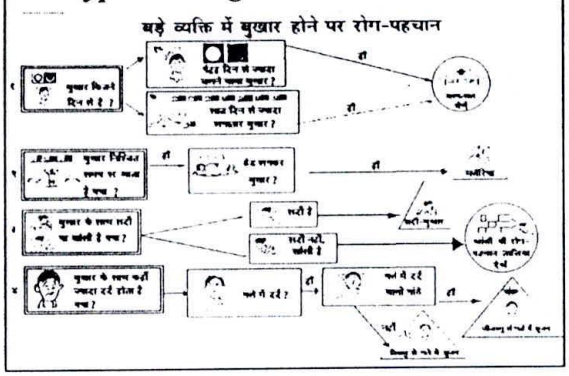
Assessment, Record Keeping

- Pictorial Multiple Choice Questions (MCQs) to assess the grasping by the trainee of the knowledge component of the training (assessment of skills, attitudes needs a different process)
- Use of specially prepared pictorial monthly record format

Typical Pictorial Multiple Choice Question

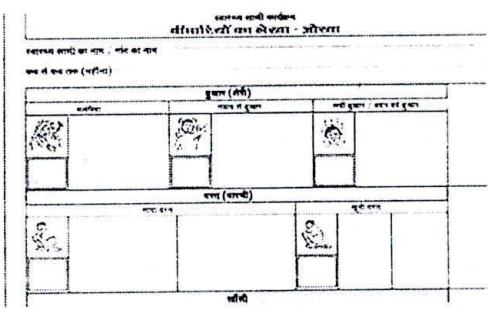


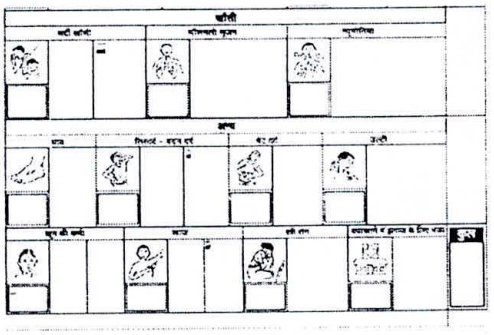
Typical Diagnostic Flow Chart



आज की स्वास्थ्य सेवा कैसी है?

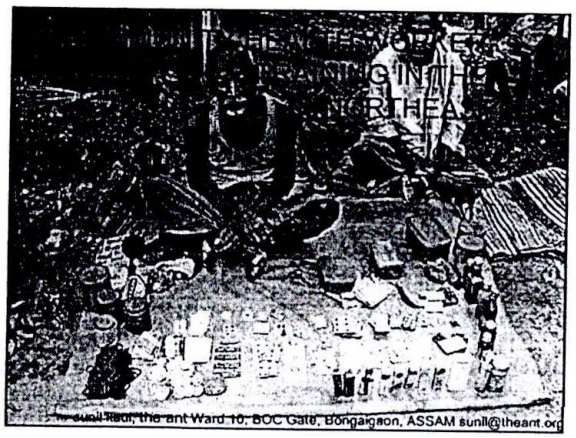
Monthly Pictorial Record Format

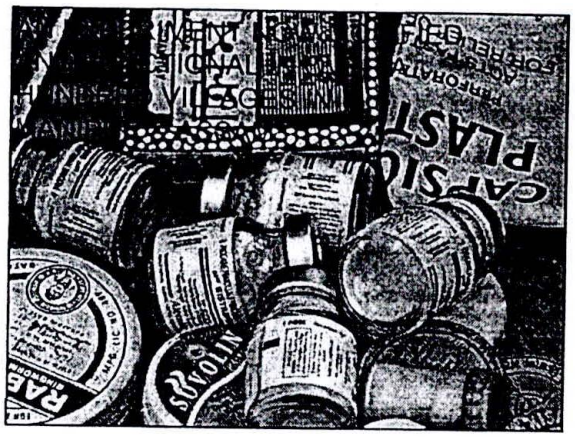


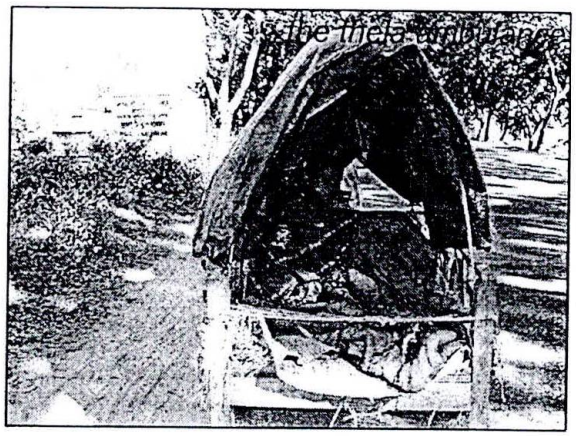


Approval by SNDT Womens' University

- SATHI training course approved by SNDT Women's University since 2004
- Over 100 women CHWs in Maharashtra and M.P. have appeared and passed the SNDT approved pictorial MCQ examination and received certificates







COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

CONTEXT

Poor infrastructure
- 87% villages unelectrified in Assam
- 90% of villages do not have all-weather road

State bankruptcy affecting salaries for long periods
Poor governance – apathetic response, no action
Militancy, Bandhs, corruption, etc.
Good literacy; acculturation to listen to lectures
Community feeling good in tribals
Low starvation; cash-starved economy
Medical expenses largest cause of debts/landlessnes

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- *Health context in area of work*:

About 1 lakh population with 3 ANMs

Direct work in health 28 villages; other 25 villages 1 CHC – 1-2 MOs; 1 PHC – MO 3 times a week since 2 months

Any immunisation apart from Polio <5%. Some areas of more than 10000 have NEVER seen Pulse Polio also

1 insurgent group in work area; now ceasefire since 6 months

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- Selection Of Villages

need based according to opinion of local advisors, existing health workers, NGOs etc.

Criterion: distance from health centres, visits of health workers and distance from Bongaigaon

Even if choice of CHW is per 1000 or so, always grounded in one village hamlet of whatever size to ensure accountability to own village.

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- CLEAR LETTER TO VILLAGE ELDER **Jm{_`mar Xohm \$mhm_{J[a\$moalm¡ \$moam|Zm`**
- **(TRAINING VILLAGE HEALTH WORKERS)**
- **{g{~Zm§ amBOmo\$moa,**
- bmo_OmZm`-gmOmZm`m Om|{Z Jm{_{Z gw~w§\«$m am`Omo OmZm`md Jmo~m§ O|Zm Om§{gOm| gm¡{gZmo JmoZm§ Om`mo & ZmWm` gaH$ma{Z {_am¡-{Oam¡ Wm§Zm-WmZm` Xohm-\$mhm_gm{b\«$m Om|Zmo _m hmoZmo hmXm| ? Om|{Z gm~¡go _mZ{g`m gaH$ma{Z ANM (Auxiliary Nurse and Midwife) Amamo hoëW

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- CLEAR EXPECTATIONS FROM BOTH SIDES –
- **Zm|WmL>m Om|{Z\«$m` _m _moZJmoZ?**
- **Om| Zm|Wm§{Z\«$m` _m bwJ¡`mo?**
- gmgo {g{Z`a S>m$Q>ma Amamo am|J{W JmoZm§ _m|mgo _mZ{g\$moaOm| Q`>oqZY&Zm|Wm§{Z Jm{_`md Jodbm§ _ob qbZmZ¡ gmgo \«$mQ> -{\«$V Amamo Jmogmo JwXw§ {hYOmd gm`I'Zm haY&Jmg¡ 1000/ (go amoOm) am§{Z _w{b Om`Im¡ {~Wm§L>m No loss, No profit {hgm~¡ \$mZZmo hmJmoZY&{~Wm§Im¡ ho\$mOm~ hmoZmo Amamo {~Wm§{Z Im_m{Z _mdZm`{Z gmo_moYX¡ XmZ\«$mo_~mo Om|{Z{g_Y \$moa_mBhaZmo Wmlm` _moZgo Health Committee XmZm§Jm¡Y&hmXmoVZm§ (National) Amamo WHO (World Health Organisation) {Z JmoZm§Wma _w{b\$moa(Essential Drugs) {Z List Amd WmZm` JwZ JmoZm§ _w{b\$moaY&Jm{_{Z\«$m` 100/ ( goOm¡ ) am§ Im§Zm haZm`Y&XmZ\«$mo_~mo Q`>oqZ {~mogmoago{Z

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

PROCESS of LETTER TO VILLAGE

- Letter addressed to headman but handed to ordinary person with explanation of 'scheme" for handing over letter to headman – *avoids cornering of seat.*
- Letter gives last date for contacting us – *ensures village takes one step too!*
- Letter outlines need for meeting in our presence

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- Letter to headman asks for collecting some training /equipment fee per household to make CHW accountable to village and remind her that she is a trustee of the medicines and other items given for the village
- Letter seeks "SMART and trustworthy women from village; daughters-in law preferred

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- ***Open village meeting***
- ✓ to prevent nepotism
- ✓ to build pride of CHW that village 'selected' her
- ✓ to clarify expectations
- ✓ to explain in details
- ✓ to build acountability
- ✓ to talk of health and politics of drug costs, of hospitalisation
- ✓ to explain that medicines are not free but shall be paid for
- ✓ Conditions of hosting update meetings with women staying in individual houses
- Negotiations – as a partnership – duties of self and expectations from them outlined

40% HOUSEHOLD ATTENDANCE A MUST – AT LEAST

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- PREPARATION OF TRAINING

Containers, Box, all medicines packed and ready

Guideline in vernacular – Axomiya /Bodo

Body models

Hall etc on hire

One more visit desirable to CHW house to build relationship with family

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- TRAINING

Children allowed to come with father/ nanny

First day light work to allow late comers to join in

2 types:

- 3 day basic training (village pharmacist)

  7 days training X 3 months (barefoot doctors); occasional 7-10 day modified module

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- VILLAGE PHARMACIST MODEL
- ❑ Names of medicines pronounced
- ❑ Handbook of medicines read out and usage explained and practised – has 20 odd drugs in vernacular simple language explaining usage, doses, S/E and precautions
- ❑ ***Symptom diagnostic chart*** with 1st 2nd and 3rd choice medicine – Rider: Refer patient if not improving or worsening in 2 days since treatment

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

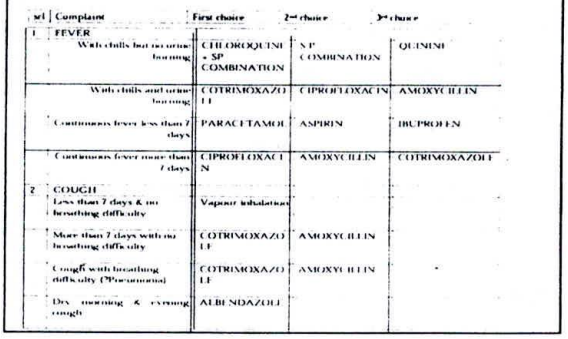
- Common Symptoms based charts on

- Fever +
- Pain +
- Loose motions+
- Pain Abdomen+
- Cough+
- Skin rash+

Leucorrhoea+
Irregular menses+
Eye /ear discharge+
First Aid

Medicines book use

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST



sl	Complaint	First choice	2nd choice	3rd choice
1	FEVER			
	With chills but no urine burning	CHLOROQUINE + SP COMBINATION	S P COMBINATION	QUININE
	With chills and urine burning	COTRIMOXAZOLE	CIPROFLOXACIN	AMOXYCILLIN
	Continuous fever less than 7 days	PARACETAMOL	ASPIRIN	IBUPROFEN
	Continuous fever more than 7 days	CIPROFLOXACIN	AMOXYCILLIN	COTRIMOXAZOLE
2	COUGH			
	Less than 7 days & no breathing difficulty	Vapour inhalation		
	More than 7 days with no breathing difficulty	COTRIMOXAZOLE	AMOXYCILLIN	
	Cough with breathing difficulty (Pneumonia)	COTRIMOXAZOLE	AMOXYCILLIN	
	Dry morning & evening cough	ALBENDAZOLE		

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

1	TAB ALBENDAZOLE	16.TAB FLUCONAZOLE
2	CAP/SYP AMOXYCILLIN	17.TAB FURAZOLIDONE
3	TAB ANTACID	18.DROPS EYE/EAR GENTAMICIN
4	TAB ASPIRIN	19.TAB IBUPROFEN
5	LOTION BHC	20.TAB IRON & FA
6	TAB/SYP CHLOROQUINE	21.POWDER ISABGUL
7	TAB CHLOROQUINE	22.TAB METOCLOPRAMIDE
8	TAB CHLORPHENIRAMINE	23.TAB/ SYP METRONIDAZOLE 200/400
9	TAB CIPROFLOXACIN	24.CREAM MICONAZOLE
10	TAB CODEINE	25.CREAM NITROFURAZONE
11	CONDOM (ZAROOR)	26.TAB OCP (MALA-D)
12	SYP/TAB COTRIMOXAZOLE	27.POWDER ORS
13	SYP COUGH EXP.	28.TAB/SYP PARACETAMOL
14	CAP DOXYCYCLINE	29.TAB RANITIDINE
15	TAB DICYCLOMINE	30.TAB SALBUTAMOL
		31.TAB S-P COMBINATION

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- BAREFOOT DOCTOR TRAINING
- ❑ 400 PAGE manual in Bodo /Axomiya
- ❑ System consolidation of anatomy, physiology and illness treatment
- ❑ Start with system whose illnesses likely in the training season
- ❑ Training between April and June - maximum need and chance to practise knowledge

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- BAREFOOT TRAINING
- ❑ Each morning topic to build sensitivity to poor, equity issues and politics of health
- ❑ Manual referred and followed for sequence for easy recall later
- ❑ Models, computer, AV equipment used
- ❑ Training venue – away from village to build credibility of training and bring concentration

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- BAREFOOT TRAINING
- ❑ Village encouraged to substitute as labour lost by health worker while on training
- ❑ Between one phase of training and other, "home work" that takes the CHW to go house to house so that it builds up expectations
- ❑ Meeting by staff in village with manual and photographs of training to build credibility

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- BAREFOOT TRAINING
- ❑ Thermometer and BP instrument provided and training given to match injection giving capability and hence status and credibility of existing 'quack.'
- ❑ Concept of ' wrap medicine in a health message'
- ❑ Although no injections taught, empirical identification of 7 day old fever as Typhoid and allowing Ciprofloxacin for 14 days, etc. of Fever plus shivering minus urinary burning as Malaria and to be treated as such unless proved otherwise
- ❑ Physiology can cure pathology concept – fever/cough/pain are friends; look for causes and treat!

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

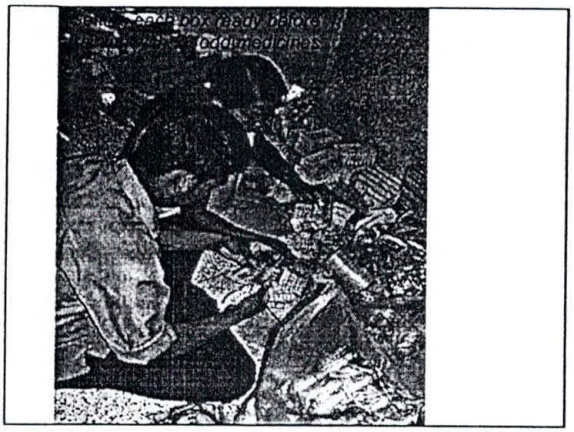
- Box with Rs 1500 worth generic medicines given per CHW – price list for CHW and for patients provided (10-20% margin for CHW as handling charges to prevent losses of wrong counting, spillage, expiry etc
- Model of CHW as volunteer to build sustainability; home visits not expected
- Total Rs 2250 per Basic training of CHV plus monthly meetings for ever

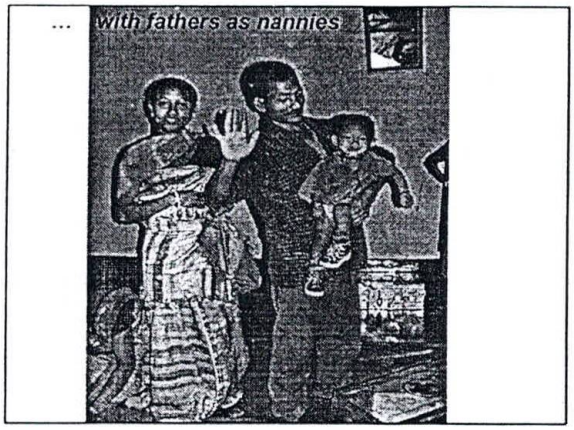
COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- Update training every month or 2 months
- Simple Records of treatment - name age gender symptoms, medicines with dose and money collected
- Monitoring of how many medicines per prescription, dosages,
- How dirty is the booklet/ manual?
- Records collected every month by field visit of staff / president of CHW association
- Revision tests, iterative training periodical

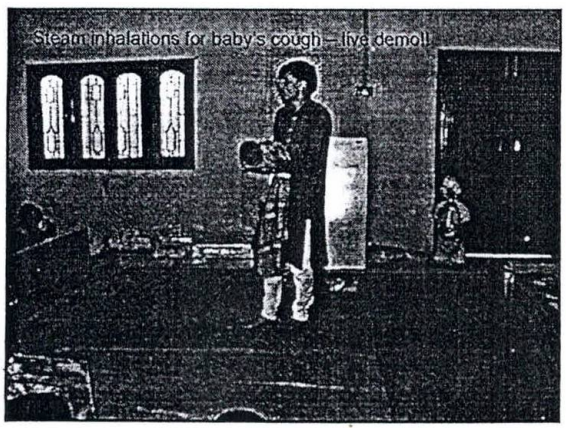
COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

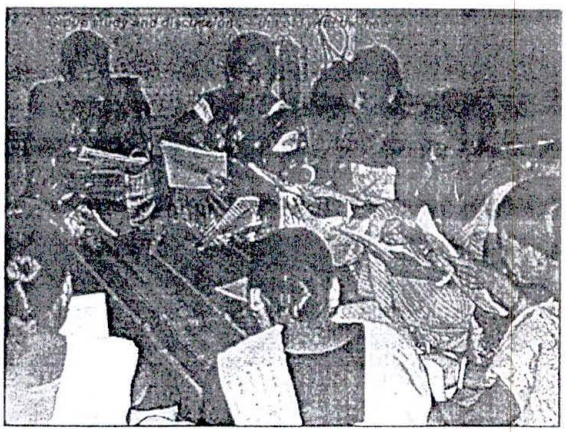
- Periodical Rapid Rural Appraisals through CHWs
- Leadership trainings of CHWs
- Linking CHW to street theatre campaigns on health, entitlements etc
- Support like pamphlets for better adherence to treatment
- Malaria, others street theatre
- Entitlement advocacy

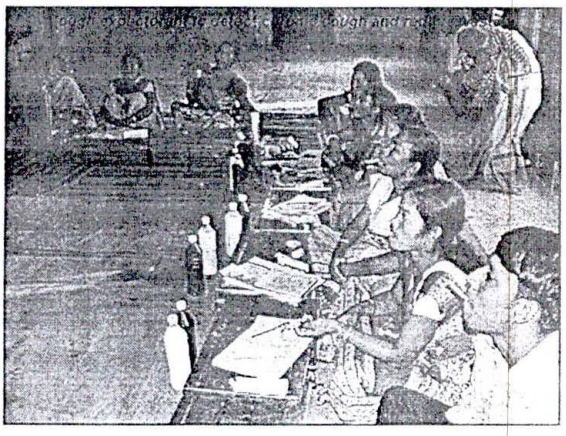

Children are welcome


... with fathers as nannies

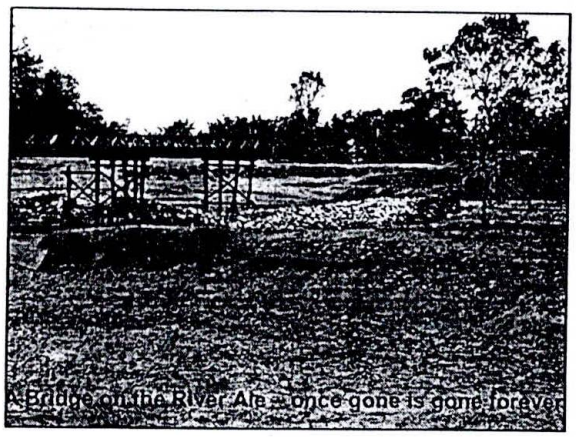

Training with body models


Steam inhalations for baby's cough – live demo!!



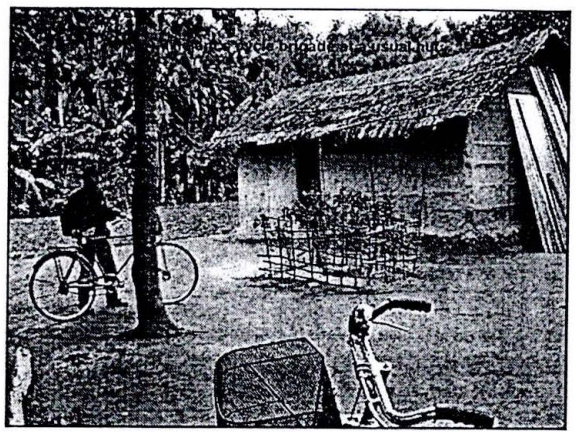



Update and sharing meeting



Bridge on the River Ale – once gone is gone forever

President of CHW association on monthly support visit with other team members



COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- ***??Achievements***

Over 80% continue to take medicines and prescribe

28 (of 33 trained) see 8 to 10000 patients a year – continued average of 5 rupees pp

70% satisfaction rate amongst treated patients (informal surveys by TISS/ IRMA students)

Good response in mono-community villages or those with shared ancestry

Within 6 months, procurement and disbursement of medicines by President (Depot) and 2 others (sub-depot);

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- *Clear failures*

- ❑ Health committees
- ❑ Leadership conversion in non-tribal villages
- ❑ Asking people to pay some fee for services – ready to pay more for medicines though
- ❑ Drug revolving fund in village box has dropped;

COMMUNITY HEALTH WORKER TRAINING IN THE NORTHEAST

- *Challenges*

- ❑ Sustaining interest of CHVs and village – asking for injections; new medicines; more illnesses
- ❑ Loss of credibility in emergencies as CHV has to rush to 'quack'
- ❑ If sustainable, how to show health programme to others?? What is the need for maintaining data?
- ❑ Should we use CHVs for 'health duties"on regular pay? For how long? What then? Who pays?

CHW Programme
Through Government Efforts

Chhattisgarh Experience

Dr Alok Shukla
Biraj Patnaik

Highlights of the Mitanin Programme

- **Chhattisgarh formed in November 2000**
- **Programme Started in January 2002 with the Help of Action Aid India and other Civil Society Organizations**
- **Now the programme is in 16 Districts, 146 Blocks, 20,000 villages, and more than 60,000 habitations**
- **More than 60,000 Mitanins, trained and in position**
- **Partnership with all stakeholders**
- **State Health Resource Center is the main facilitator**

Highlights of the Mitanin Programme

- A very Intensive process of community mobilization
- Facilitation both by Government Employees and NGOs
- Only Female CHWs
- One CHW per Habitation
- No Honorarium to be paid to CHW
- Separate Consultation with Women/SC/ST
- Ratification by Panchayats

Highlights of the Mitanin Programme

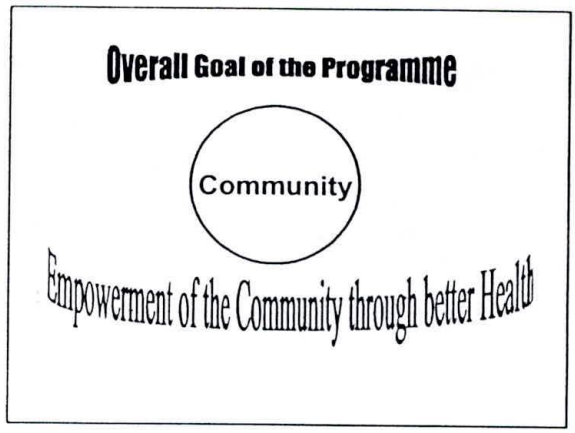
- 6 Rounds of Training Completed
- Mitanin Medicine Kit Distributed
- Policy Reforms successfully completed –
  - Essential Drugs List
  - Manpower Policy
  - Training Policy
  - Integration with Indian Systems
  - Public Private Partnerships
- Many Mitanins elected in Panchayat Elections
- Effect of the Programme is already evident in morbidity statistics

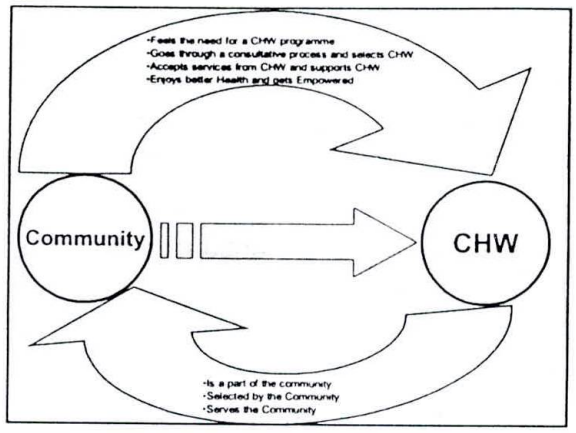
What is needed for a successful Community Health Worker Programme?

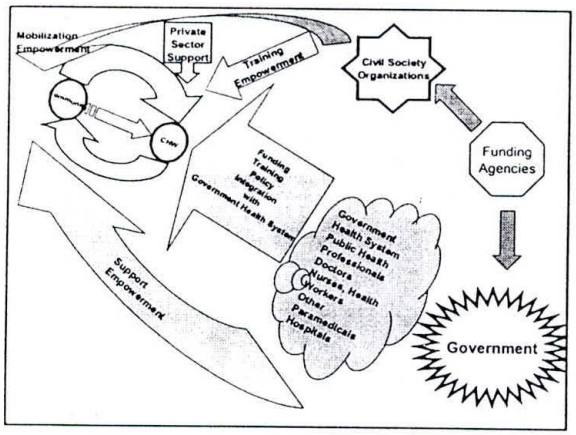
- Commitment of the CHW
- Acceptance and active participation of the community
- Good quality and effective training
- A functioning and effective Public Health System
- A functioning and effective referral system
- Government support

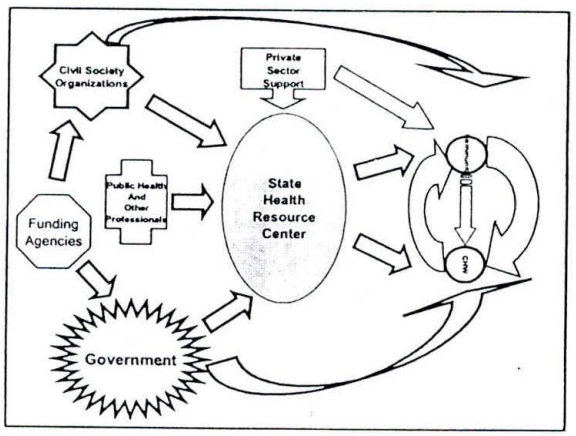
Who are the Stakeholders How to Bring them together

- Community
- CHW
- Government – Central State and Local (PRIs)
- Funding Organizations – both Indian and foreign
- Public Health Professionals
- NGOs- Civil Society Organizations
- Hospitals – both Government and Private
- Doctors, Nurses, Health Workers and other Paramedical workers









Lessons Learnt – 1

It can not be an unstructured movement

- There are many technical issues involved in health
- Good health care requires multiple tiers of increasingly complex health services
- Constant hand holding and support is needed for the CHW
- Improvement of health can not happen by a one time campaign – It is a systems issue

Lessons Learnt – 2

A Central Organization is Needed

- To Negotiate with different Stakeholders
- To Organize Logistics
- To Conduct Operational Research, and Provide Data to the Government for Policy Reforms
- To conduct the massive training exercise
- To coordinate between various providers of basic health and referral services

Lessons Learnt – 3

Involvement of Government is Essential in a Large Scale Programme

- Policy reforms are required for systemic changes
- Large Scale investment in social sector infrastructure is needed e.g. hospital infrastructure, safe drinking water, sanitation etc.
- Government Health system must be integrated with the CHW programme for meaningful results
- Health of People is anyway the responsibility of the State

Lessons Learnt - 4

State-Civil Society Partnership is necessary for success

- While State can invest money and bring about policy changes, civil society can mobilize the community, and motivate CHWs
- Civil Society Organizations can bring about greater objectivity and accountability in the programme
- State can learn from experiences of civil society organizations
- It is equally Important to involve professional bodies of doctors and paramedicals

And Finally – Don't Forget

A CHW Programme is a learning Experience

It Evolves as you Implement it

Thank You

Evaluation and Monitoring of Training Process

FRCH

Monitoring of Training Process

To collect and analyze set of core training indicators for

- Improvising training
- Assessment of learners and trainers
- Learning directed to Organizational goals.

Monitoring Indicators

- Attendance
- Dropout
- Learning Assessment
- Learning Objectives and Outcome
- Gaps in Training
- List of New Topics suggested by Learner

Continue...

- Treatment Record
- No of Student attending Non Formal Education
- Information provided
- Different kinds of Group formed and activities
  - Self help Group
  - Youth Group
  - Bhajan group
  - Adolescent group etc

Continue...

The Quantitative Information was supplemented with Qualitative Information...

- Types of patient seeking Treatment
- Type of Information Disseminated
- Proceedings and activities undertaken in various Groups.

Continue...

Strength:

Information was collected by Documenters regularly.

Limitation:

Information Overload.

Evaluation

- Collect Learners performance in training and at Community level.
- Determining the relationship between training and learning and transfer of learning at Community level
- Further Intervention

Levels of Evaluation

- Level I: Feedback

Learner's response to Training Process
Community's response to new functionary
Method: Focus Group Discussion
Individual Interviews
Questionnaire
Frequency: Six monthly
Target: Learner and Community
Evaluator: Internal and External

Feedback

Strength:

- Training relevant to needs.
- Assess motivation, interest and participation of learner.

Limitation:

- Does not tell what learner has accomplished.

Level II- Learning Assessment

Assessment:

- Learner's change in attitude
- Knowledge gained
- New Skills accomplished

Three components were given equal weight(33% each)

Learning Assessment

Methods Used

- Attitudinal Change : Case studies
  Role Play
  Observation
- Knowledge: Written and Oral exam
- Skills: Observation ,Role Play

Learning Assessment

Frequency: Every Year
Evaluator: Internal and External
Strength: Judgment could be made about learner's capability for performance.
Limitation: To what degree learning can be applied in real life situation.

Level III Performance

To assess to what extent student can apply learning in community or real life situation.

Method: Observing Informally
Testing in Community

Evaluator: Supervisor who works closely with student

Performance

Performance depends on many factors:

- Family support
- Back up services
- Size of village
- History of Village
- Economic status of village
- Organizational policies
- Party Politics

Level IV - Impact

What Impact has training is achieved

Organizational level:

Human Resource- Approximately 200 trained women
NIOS Accredit ion

Financial resource: New Project Resource Center

Impact

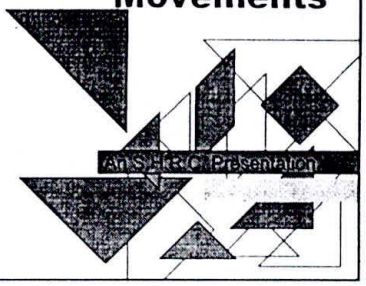
- Community Level
  Service.
  Information center.

Evaluator: FRCH, HIVOS, Village Level Committees

Learning

- Increase Participatory Approach in Evaluation needed.
- Documentation of changes in organizational, National, International policies is required.
- Learning can also occur when teaching gap.
- Regular preparation of monitoring report and its dissemination.

Approaches to achieving scale: Missions and Movements



The Godzilla Postulate

SIZE DOES MATTER

- Small Scale Programmes with NGO leadership – Flourish.
- Large Scale Programmes – Government organised - Flounder

Is it Size or is it Sector?

The Godzilla Corollary..

- The Godzilla Postulate applies to all programmes requiring community participation: Literacy; Non formal education, Quality Improvement of School Education, Watershed Programmes, Agriculture innovations .....
- Well – perhaps not the self help groups....

Is it Size or is it the NGO character?

The PSM(?!) postulate:

When Scaling up 'Government –Led' Programmes will always do better than 'NGO- alone' programmes.

- More bureaucratized. Poorer Systems and Processes..
- Besides...An NGO programme scaled up becomes politically incorrect.. Retreat of the state!!!!

(note PSMs are NGOs that disown being NGOs and aspire to be called peoples movements....)

How small is small?

- Usual sizes of small NGO programmes:
  - 30 or 60 villages
  - 50 or 100 villages
  - Seldom below 20....

Programmes have minimum critical size also.. For the group to become established for visibility. Single village programmes tend to do poorly.. Like each one teach one also does not work...

So what is lost with scale..

1 Motivated Leadership: The Antia Factor..

"Its alright one can do it in Jamkhed or in Mandwa- but how can one get an Arole or an Antia in every place...."

- Requirement ... one Antia per every 30 villages or at least every 150 villages Chhattisgarh would require approximately 2000 Antias
- The commitment and the costs...

And what else goes

2. Quality of Training: the problem of transmission loss in the training cascade..
3. Quality of Trouble-shooting– On the Job Support…
4. Quality of Monitoring…Identifying the weak areas and responding to them.

And further lost with scales are...

5. Quality of Referral Support in the CHW programme: (reform in institutional structures that play higher order roles needed to complement and later sustain the programme).
6. A tradition of working with local community that provides links.
7. An ability to persist, learn and correct..
8. Evaluation: manage able Sample Size and representative qualitative inputs.

Need to recognize that in all above dimensions- even in evaluation – it is not just multiplying the small to get the big…(design and approach also needs change…

Evaluation of the literacy campaign experience.. Michel Tharakkan, Ramakrishnan, Poromesh Acharya, Denzil Saldhana and ……finally RH Dave!..

But before we go on...

The small too is not without its problems..

- Tends to be focused on single items and less diverse- like curative care centered ness.
- Tend to be evaluated with little relationship to costs- especially the overheads..
- Tend to be unsustainable without considerable foreign funding agency support..
- Tend to duplicate/parallel government programmes and therefore, in current context,… a recipe for privatization…(of course without realizing the dynamics of scales..)

Referral Support

- All small NGO programmes had a very good base hospital with a medical team.
- But when we scale up the PHC and CHC have to play this role.
- Not a problem, not just an opportunity but part of the purpose itself.
- Mitanin Programme becomes an idiom of health sector reform and some of this may outlast the Mitanin itself!!!!

Mitanin as Health Sector Reform..

- The creation of the SHRC.
- The linkage of funds flow of Mitanin programme to developments in all parallel areas of public health system strengthening.(over 14 specific dimensions)
- The 39% increase in state budget- the over 50% increase in total public health expenditure.(but now reached 4% of outlay)
- The creation of 874 HSCs, 200 PHCs and 16 CHCs to close all institutional gaps, the move to 2 doctor PHCs, the 4 specialist , 7 doctor CHC, the pressure to make FRUs functional, the opening up of ICDS centers..

Long way to go.. But the Mitanin is the flagship.. Bringing health one step further on the political agenda. In myriad number of ways.. Eg increasing immunisation on hearing the announcement / effect on the visiting CMs and VIPs….the flow of aid…. etc.

Securing the community level processes

- In absence of long involvement with local community(and even if..) who speaks for the community?? In NGO programmes we have a discerning listener… Whose gaze defines what is spoken…
- But when the dt adminstration gives the appeal.. Either the panchayat elite appropriate the voice, or the department functionary does. Who informs the community, who enthuses the individuals? Who amplifies the voice of the weak?
- Hence the need for the trained facilitator- the prerak- and or a defined process of social mobilisation- songs and plays taking through the spirit of the programme.
- But who selects the prerak?

Principle: An intermediary force is a must but such a force brings with it a new set of problems …

Moral Dilemnas..

- We are accountable for the predicatable consequences of our actions.. The consequences of lack of defined process of facilitation are 100% predictable – given the relations of power embedded in existing hierarchies.
- But even when we define the nine –step selection process and train the prerak – the outcomes are not predictable – given that we have not changed relationships.
- And what about the predictable consequences of our non action– in the unfolding ASHA programme..

Programme duration as a variable

- Need to allow for programme structures and personnel to evolve.
- Need to allow for people to come in and leave and others to come in
- And after a structure stabilises one needs to do and redo many parts of the programme..

And all this needs time and persistence with the programme and learning curves…..

- This happens in small programmes too – but external documentation often misses it as compared to first person accounts.. But it needs to be built in!

Pace of the Programme as a variable..

- Need to sustain pace of the programme for both the effect of social mobilisation and to keep it on the political agenda.
- Enough time to allow for a minimum set of well defined processes and enough to allow for evolution of structures.. And constant corrections..

But longer duration by itself is not a virtue…
And one needs constant innovation

Staggering the Programmes

- Pilot phase – builds the tools-builds the state leadership- tends to do poorly.
- First phase- builds the district teams, gets the systems in place.
- Second phase-- reaches out to full coverage..
- Subsequent phases- re-do various aspects, bring in corrections , innovations etc.

Addressing Transmission losses in training cascades..

Three Key Steps :

- High voltage: Capable full time top of the pyramid: key resource persons
- Good conductors: Insistence on systematic use of training material.
- Step up transformers: Use of training evaluation (and on the job back up).

Emergence of a training cadre..

- Whether and how --Related to existing human resource availability.
  - **Do we have surplus ANMs…even outside the government employment(like in andhra pradesh)**
  - **Can the existing ANM play this role?**
  - **Do NGOs have the required persons or expertise?**
- This cadre needed in monitoring and provision of on the job training.
- But would have low/zero clinical skills.
- All experience would eventually be learnt from the field and limited by the quality of supervision possible.
- Needs strategy of trainer recruitment and replacement and evolution of this workforce.

Strategy of Monitoring

The small NGO programme relies on the review meeting.

But in the large programme ....

- Need to put in place a set of defined processes- the cluster meeting, the block trainers review, the district coordination meeting, the state nodal officers review, the state field coordinators review.
- Need to put in place a large workforce to do this- the trainers cadre.. The nodal officer heirarchy.. The field coordinator.
- Need to carefully make a choice of Monitoring Indicators

Monthly Monitoring Indicators

- New born visit and six messages
- Over 10 to 20 'first day' requests for curative care
- Visit in last trimester of pregnancy and the plan for child-birth.
- Attendance at the immunisation day.(convergence and service facilitation)
- Knowing the children at risk and counselling
- DOTS provider role
- The hamlet level meeting.

Observable, Measurable, verifiable from parallel sources, aggregatable....

Evaluation

- Getting sample sizes involves costs and research teams.
- Needs clear definition of outcomes and its measurability.
- Need care in relating processes to outcomes.
- Qualitative studies needed to catch enormous diversity.
- Qualitative studies needs training in qualitative methodology, the anthropologists or sociologists skills.. and this is difficult to obtain and even more difficult to standardize.
- Internal evaluation with in built externality with key processes under qualitative study offers a way forward.
- To be wary of experience- need to have grounding in methodology.

How to get an Antia everywhere...

The Gaussian curve:

- All biological and most social systems display a bell shaped ' normal' distribution. So too should motivation..5 to 25 % in any group of a reasonable size- will potentially have a sense of motivation- to work with self lessness. Whether it be NGOs or government officers or BEEs
- And one needs to have a way of searching for and finding this 5%. How to sift through – and how to adsorb onto the system..

The Power Principle

- Needs to define the determinants of the x – axis location of the system- where motivation is on the y- axis..
- There are relationships of power embedded in
  - Knowledge...
  - Institutional structures
  - Mind-sets/attitudes...
  - Programme designs-
- Not just the key decision – but every single detail is power-laden!!
- Relationship to these define the x- axis of motivation
- And the leadership needs to be able to question existing relationships in all of these domains. And that indeed defines leadership
- Need to have the catalyst in place who can constantly work on redefining these determinants...at every level.

The recipe....

- Get a mix of state and civil society at every level. – never one or the other alone.. Carefully define the institutional mechanisms for this
- Let structures/ key persons evolve with considerable flexibility and innovation..
- Put in a strong dose of social mobilisation- questioning existing values –eg patriarchy, caste symbols,
- Have a catalyst in place to absorb the right persons and highlight , support and build capabilities in- to mentor.
- Negotiate, negotiate, negotiate-

In conclusion...

- The conditions of success are stringent.
- Given the relationships – failure would be the norm.
- But given an understanding of the processes enough exceptions can be made to define a new rule.
- And Persist. Often you do not win over the opposition– you just outlast it.
- But one needs to construct a place to stand and a way of leverage

Thank you

Swasthya Sathi initiative

CHW programmes in collaboration with People's movements

Abhay Shukla, SATHI -CEHAT

Background to collaboration between health activists and people's movements

- Recognition by us as health activists that to expect long term sustained collective initiative around health related activities *alone* is usually difficult
- Growing realisation among social movements for a need to combine resisting systemic injustice with *developing people-based alternatives in various spheres of life*

Hence the decision by certain Health activists and People's movements to *systematically collaborate to develop health initiatives*, esp. CHW programmes and health rights initiatives

Specific features of the SS initiative

- Embedded in existing people's organisations involved in mobilising toiling people around basic socio-economic issues
- From the outset, a system of financial sustenance by communities, enabling continuation of the programme; objective of moving towards Public health system support
- Health workers with a range of healthcare skills to meet basic requirements of First Contact Care and to replace local quacks
- Standardised training inputs for these programmes (esepcially for less educated / non-literate health workers)

Swasthya Sathi programmes - I

- Programmes in collaboration with community organisations since 1996 in four areas of Maharashtra and MP; over 100 Swasthya Sathis working
- Exclusively women, range from non-literate to high school, both adivasi and non-adivasi rural areas
- Village health activities sustained by local resources
- Locally provide care for minor illnesses, reduce medical deprivation and exploitation
- Building hamlet health committees for community health awareness and activities

Swasthya Sathi programmes - II

- Innovative forms of training with pictorial manuals and games, focus on functional knowledge and social attitudes
- Certification of SATHI-CEHAT's health worker course by SNDT University
- Move for public system support for health worker programmes in form of 'Pada Arogya Sathi' scheme

Effort to develop decentralised, community reliant and more cost-effective model of health care

Why the need for linkage with the Public health system?

- In principle, public health is a state responsibility and PHS should give regular resources for community health activities
- Voluntary or semi-voluntary efforts by CHWs cannot proceed indefinitely without support
- Organised, regular financial support from communities is difficult to sustain
- Referral and public health activity linkages essential

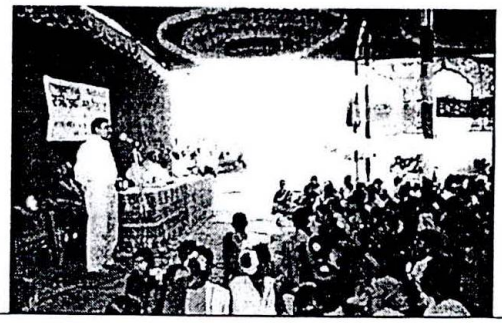
Pada Swayamsevak programme under Nav Sanjeevani Yojana

- Mostly males officially selected as health workers
- Appointment only for monsoon season
- One-day training, no training material, no medicines provided formally
- Tasks limited to chlorination of water, informing the PHC about disease outbreaks
- Very limited role as a health worker, low community involvement

Members of SATHI team interacting with PSS scheme from 2000 onwards

Stree Arogya Melava

2nd February, 2003 at PHC Saiwan



Response from Health department

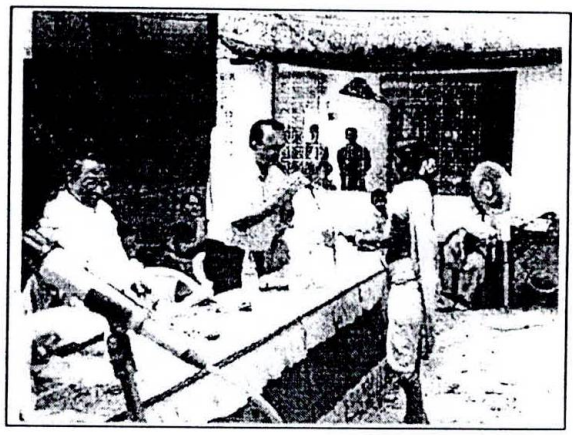
- Meeting with Additional Director of Health Services and District Health Officer, Thane to concretise the project and to ensure regular supply of medicines; dialogue with PHC Staff
- Based on suggestion from SATHI team, a special budget of Rs. 50,000 was allocated by the Health Dept. to ensure basic drug supply to trained health workers
- Assurance of cooperation in training, involvement of District training team

Training Process

- Total 50 women PSS trained in two separate batches (PHC Saiwan and Kasa)
- 12 days of contact training spread over three training sessions
- **Topics covered in the training** - role of health worker, causes of illnesses, types of organisms, basics of human anatomy, about medicines, nutrition / malnutrition and common illnesses like diarrhoea, fever, cough, anaemia, pain in abdomen, women's health etc.
- **Involvement of Government officials** in some components of the training like chlorination of wells

Distribution of SNDT University Certificates by Secretary, Health Govt. of Maharashtra

- Curriculum prepared by SATHI-CEHAT for the training of functionally literate CHWs has been approved by the SNDT University
- The University conducted examination of the CHWs with pictorial multiple choice questions
- All CHWs cleared the exam, most with score over 70%
- In May 04, certificate distribution at the hands of Health Secretary, Maharashtra



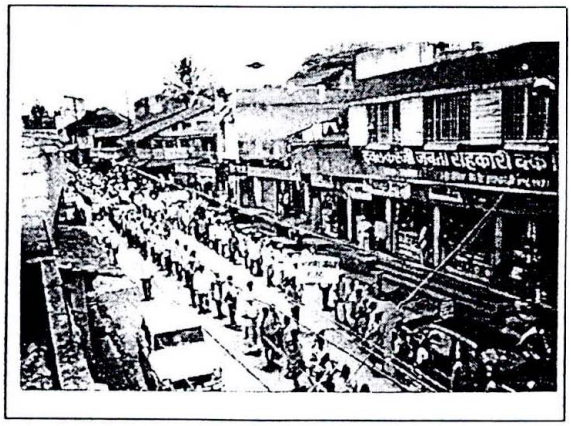
Efforts to ensure upgraded training to Pada Swayamsevaks

- Intervention in case in Mumbai High court on child deaths in tribal areas; court orders selection of women as PSS, upgraded training with help of NGOs
- Health dept. has initial dialogue with SATHI and YCMOU representatives on upgraded training
- A dozen Health NGOs and Community organisations working in tribal areas of Maharashtra come together in Feb. 05, to coordinate efforts for upgraded training to Pada Swayamsevaks
- Women selected as PSS in nearly 10,000 hamlets in the state in June 2005
- However, upgraded training yet to take place despite proposals and dialogue

Intervention in ASHA programme in Pati, M.P.

- Govt. of M.P. gives SATHI team responsibility for monitoring selection of ASHAs in 40 villages of Pati block of Barwani district
- Selection process through women's group meetings, hamlet meetings and proposal and approval of names in Gram Sabhas in Jan. 06
- In 27 out of 40 villages, *no literate women available despite efforts to locate such persons*
- Need for development of special training curriculum and materials for non-literate ASHAs essential for the process to proceed further

Role of PO in confronting health system contradicts the collaborative role required for PHS support: hence two-pronged approach by PO and NGO



Issues of sustainability and replication of CHW programmes based in POs

- Local collective resource generation important as initial boost to programme, but not possible on sustained, regular basis
- Some form of Public system subsidisation held as a principle – however practical problems in eliciting such support
- Political will from below and above should reach minimum level of correspondence

Need for initiative and ownership by community + Public resources and support

- Neither purely community dependent, nor NGO dependent, nor Public system dependent model is satisfactory
- Need for
  - initiation, ownership, active involvement of community
  - resources, referral and technical support from PHS
- Requires Community organisation + minimum political will from the state; shared change agenda for such partnership to be forged

Group Discussions "Innovation-at-scale"

Groups: 11:15 – 12:45

Presentations: 12:45 – 1:30

I. Content, Methodology and Human Resources

- What are the essential principles for determining curriculum and pedagogy for CHW programmes?
- What are the methods, structures and institutions for contextual and effective implementation at scale?
  - How can monitoring and evaluation be integrated?
- How can a cadre of trainers/facilitators/ supervisors be developed and supported?

II. Partnerships

- What are the critical learnings from civil society and government engagement historically?
- What are the emerging trends and experiences (SHRC-like institutions)?
- What are the potential roles that civil society can play in the NRHM
- What would be the minimum requirements/commitments from each side?

III. Support Structures for CHW Programmes

- What are the ideal contexts and support structures required for effective CHW programmes?
- What are the prevailing opportunities and constraints within which the NRHM is operating?
- How can these be effectively influenced and informed?

Facilitators

- Group 1: Content, Methodology & Human Resources
  - Raman, Abhay Shukla, Sunil Kaul
- Group 2: Partnerships
  - JP Mishra, Nerges Mistry, S C Mathur
- Group 3: Support Structures for CHW Programmes
  - T Sundaraman, David Sanders

Content, Methodology & Human resources

group members

A basic question:
What is the health worker supposed to do?

shd content go beyond the govt. defn of the chw - YES
CHW SHOULD have a curative role beside the preventive & promotive one
Shd have a med box to prescribe from.

1. How to determine the curriculum? & pedagogy

Non negotiables:
- Generic models of modules
(flexibility for contextualization to community needs practices.)

Content:
- Equity, gender issues, awareness on entitlements & rights.
- regional languages
- must know, good to know, wht u want to know
- basic medicines e..g deworming, malaria, home based meds

Methodology:
- A confidence building approach
thru facilitating learning & constructing knowledge'
- more participatory than didactic
- infield training to be a major component
Supplementing training with
pictorial methods
folk media
role plays + other interactive methods
audio visual media
-apprenticeship : before training they shd work with experienced chws

Human Resource's
- Training of the trainers is crucial
(motivated, local dialect, culturally from the same milieu)
- After the initial phase of trainings, preferably the chws's with field experience should move on to become trainers
- Communication skills critical

structures & institutions:

- Cascade approach
moving up , chw, facilitator , trainer
hamlet -village- block- district- state

- shrc type structure
supporting health sector as well along with chws
- should be autonomous with mandate & recognition by the govt.
- a contd. process of discussion bet ngo / public & govt. before even the inst & its structure is decided upon.
[this may give each state a locally sensitive (hopefully) the structure ahs to be autonomous]
- led by a dynamic person from outside the govt.
- PArticipation & partnership bet state & civil society at every level

- quality control by having persons in each team.. inbuilt monitoring from within. the implementor shd not be the monitor

Monitoring & evaluation

- chws monitoring each other / peer review
- inbuilt training

3. How to develop & support a cadre of trainers / facilitators /supervisors?
(The last stage trainer didnt get paid for months b/c phc was empowered to pay them.)

assess outcome of training
gender & equity training at all level

- phased training
    - objective of training - for each module
+ overall CONFIDENCE & ability to take decisions
- experienced chw can train the newer ones
- disc. with a regional person on traditional practices

focus: innovations at scale

gp 1- content methodology & human resources

gp 2- partnerships

gp 3 support structure for chw progs

II. Partnerships

Past Forward

- We have a very varied and contested history of state-civil society partnerships in the health sector
  - Rich evidence and experience from the past as illustrated in this workshop
- However, there is an emerging consensus that political spaces for productive engagement exist in some places and can be opened up and negotiated in others
- It is in this context and in the spirit of critical reflection, that we have approached the question of partnerships

The Scope of Partnerships

- The nature of partnerships and the processes of facilitation are dependent on state-specific histories, current contexts and opportunities
- But, there are broad principles
  - based on strengths and experience
  - shared ownership
  - participation

Framework for Partnership

- Vision/ advisory level
- Policy detailing and the development of tools and instruments for implementation
- Implementation
  - network of implementing partners
  - resource support agencies
- Require a criteria for partnerships at various levels
- Require a transparent *selection* process and procedure

Types of Partnerships

- Government-Government Partnerships
  - GoI-State Government
  - State-District
  - Inter-department
    - Case Study from Rajasthan
- NGO-NGO Networking and Co-ordination
  - Chhattisgarh SAC
- Government-NGO Partnerships

Where do we begin the partnership building process

- GoI
  - Create enabling frameworks (prototypes of partnership)
- Mentoring Group
  - Expand the network
  - Evolve and operationalise shared principles of collaboration and state-level facilitation
- State Governments
  - Develop state-specific frameworks for engagement

Supporting structure for CHW programmes

Contexts and support structures

- NRHM is not cast in stone : scope for flexibility and modification
- ASHA roles: promotive, preventive, curative, need to balance (community mobilization, advocacy roles)
  - The central government had provided scope for it in the guidelines
- Draw from state level experiences
- Enabling environment and structures is very important

- Supportive structures and enabling polity is required at all levels
- Village, block, district, state
- We need a contextual order of public health expertise at all levels

- **Village Level**

-PRIs: functional Panchayats, health committees,
-Local committees- statutory, not statutory

- Convergence of energy at the village level, no one structure may have been able to do all its tasks

Block Level

- support teams: which include -Trainers/facilitators/supervisors cadre and LHVs, ANMs, etc

District level

-Technical Assistance Agency: training, technical inputs, advocacy, also focus on community mobilisation issues
-District level planning – needs a capacity building initiative (i.e.Public Health Resource Network etc , also look at South Africa's experience on the same)

- **State level**

-Context: health reforms, enabling environment
-Experiences: SHRC, SWG

- **State level Body is needed** – technical support, advocacy at all levels

Other Key Issues

- Accountability : nature?
  - joint review
  - Watch committee
- Involvement of people's organizations
  - How does one build in space for collective action for health issues in large scale govt. run programmes
    - Jharkhand VHCS need to be seen as a form of this

Some impressions of CHW workshop.

1. Impressive degree of energy and experience
2. Opportunities afforded by current political conjuncture eg NRHM
3. Opportunities being exploited in new states where 'space' exists for policy implementation
4. ASHA to be introduced in several ?18 states
    - **Success of ASHA (and NRHM) dependent on socio-political context and technical factors and financing**
    - While technical factors can be planned, socio-political factors are less amenable to initiation/manipulation
    - Key socio-political factors include community mobilisation and political will – which are synergistic
    - Community mobilisation and political will often dissipate as political context changes
    - Community mobilisation can be facilitated by participatory planning and implementation
    - Community-based workers can catalyse and sustain community mobilisation
    - Key technical factors include:

    Capacity development for:
    - training and ongoing support and supervision – from levels above
    - participatory approaches to assessment and analysis, using appropriate technologies and methods
    - planning with intersectoral action and sustainability in mind

5. Capacity development
    - 2 areas at least – technical health and advocacy/mobilization

    Technical
        - Training methods and materials for ASHA as well as for levels above esp in Public Health (see UWC SOPH slides)

    Advocacy
        -

Community Health Worker Training: Linking Pedagogy and Practice
A National Workshop
April 10 – 12, 2006, Tata Management Training Centre, Pune

Participants

Dr. Abhay Shukla
SATHI -CEHAT, Pune
cehatpun@vsnl.com
020-25451413/ 5438513

Dr. Alok Shukla
Secy., Dept. of School Education, Govt. of Chhattisgarh
dr.alokshukla@gmail.com
0942502196

Dr. Anant Bhan
anantbhan@gmail.com
09371066840

Dr. Anant Phadke
SATHI – CEHAT, Pune
cehatpun@vsnl.com
020-25451413/ 5438513

Ms. Arzoo Dutta
State Facilitator, National Rural Health Mission
Nagaland
arzoodutta@yahoo.com
9435019521

Mr. Biraj Patnaik
Principal Advisor
Office of the Commissioners of the Supreme Court,
New Delhi
biraj.patnaik@gmail.com
011-41642147, 09826418554

Prof. David Sanders
University of Western Cape, Cape Town
sandersdav@uwc.ac.za
0044 -2083485797

Ms. Deepanwita Chattopadhyay
ICICI Knowledge Park
deepanwita.chattopadhyay@icicibank.com
040-23480022/03

Dr. Dhananjay
Sathi Cell
cehatpun@vsnl.com

Dr. Diane Lynn Spatz
School of Nursing
University of Pennsylvania
spatz@nursing.upenn.edu

Mr. Suryavanshi
Institute of Health Management, Pune

Dr. Dinesh C. Jain
Deputy Commissioner
Child Welfare and Training,
MoHFW Government of India
dcjainfw@yahoo.co.in
011-23062791

Dr. D.K. Saxena
Joint Secretary, Department of Health and Family Welfare,
Jharkhand

Mr. J.P. Mishra
Health & Family Welfare Sector Programme in India
European Commission Technical Assistance, New Delhi
mishra@echfwp.com
011-26490204

Dr. Balasubramaniam
Commonwealth of Learning, Chennai
kobala2004@yahoo.co.uk
09444376280

Ms. Kaveri Nambissan
wallden@sancharnet.in
02114-280130

Dr. Lindsay Barnes
Jan Chetna Manch, Bokaro
lindsay_india@yahoo.co.in
09431128882

Ms. Laboni Jana
Child In Need Institute, Kolkatta
laboni@cinindia.org
033-24978206/8192/8641

Ms. Mira Sadgopal
Tathapi Trust
tathapi@vsnl.com
020-2411037/24270659

Dr. Narendra Gupta
Prayas, Chittorgarh
narendra531@rediffmail.com
0164-2215400/2253903,
09414110328

Ms. Niloufer Randeria
Sir Dorabji Tata Trust, Mumbai
sdtt@tata.com
022-56657176

Dr. Nandita Kapadia
Institute of Health Management, Pune
ihmp@vsnl.com
02431-221382,221419

Ms. Pallavi Patel
Chetna, Ahmedabad
chetna@icenet.net
079-22868856/22866695

Dr. Parvez Imam
f20 Communications, New Delhi
f20com@yahoo.com
011-26430493

Dr. Peter Berman
The World Bank, Delhi
pberman@worldbank.org
011-24619491, 09871387191

Dr. Raj Arole
Comprehensive Rural Health Project, Jamkhed
crhp@jamkhed.org
02421-221322, 09423162534

Ms. Sarubai Salve
Jamkhed

Dr. Ravi Narayan
Community Health Cell, Bangalore
ravi@phmovement.org
080-51280009

Ms. Ronita Chattopadhyay
Child in Need Institute, Kolkata
lca@cinindia.org
033-24978206/8192/8641

Maj. Sashi Menon
Kripa Foundation, Mumbai
mamenon@vsnl.com
022-26778806, 09820068332

Mr. Shiv Chandra Mathur
State Institute of Health &
Family Welfare, Rajasthan
shiv_mathur@hotmail.com
0141-2706534

Dr. Shyam Ashtekar
Yashwantrao Chavan
Maharashtra Open
University, Nasik
ycmouhealth_nsk@sancharnet.
in
0253-2230718, 09422271544

Dr. Sunil Kaul
The Action Northeast Trust,
Assam
scowl@sify.com
03664-225506, 09435122042

Dr. T. Sundararaman
State Health Resource Center,
Raipur, Chattisgarh
sundararaman.t@gmail.com
0771-2236175, 09827137201

Mr. Vijay Nambissam
wallden@sancharnet.in
02114-280130

Dr. Vikram Rajan
The World Bank, Delhi
vrajan@worldbank.org
011-24619491

Dr. V.P. Pandey
Sahiyya Working Group,
Jharkhand
panipandey@yahoo.com
0651-2550730, 09431588909,
09835121833

Dr. Yogesh Jain
Jan Swasthya Sahyog, Bilaspur
janswasthys@gmail.com
07752-270966, 09425530357

Dr. Willam McCool
School of Nursing
University of Pennsylvania
mccoolwf@nursing.upenn.edu

Mr. V.R. Raman
State Health Resource Centre,
Raipur
weareraman@gmail.com
0771-2236175, 09425207375

The Foundation for Research in
Community Health
3-4 Trimiti Apartments - B
85, Anand Park
Aundh
Pune – 411 007

Dr. N.H. Antia
Dr. Nergis Mistry
Mr. Appasaheb Ghadge
Dr. Bharat
Dr. Devraj Chauhan
Ms. Gauri Gokhale
Ms. Neeta Rao
Ms. Pushpa Tai
Dr. Rakhal Gaitonde
(subharakhal@gmail.com)
Dr. Sarika
Dr. Subhashree
Ms. Seema Deodhar
Ms. Shalini
Ms. Vaishali Gaikwad
Ms. Vaishali Sonawane

Phone:
020-25887020
020-25881308
Email: frchpune@giaspn01.vsnl.net.in

Ms. Swati Dogra
(swati_dogra@rediffmail.com)

Ms. Sathyasree
(sathyasree1974@yahoo.com)

Social Initiatives Group
ICICI Bank Limited
ICICI Bank Towers
Bandra-Kurla Complex
Mumbai – 400 051

Abhijit Visaria
Tel: 022 2653 8084
abhijit.visaria@icicibank.com

Anuska Kalita
Tel: 022 2653 8031
anuska.kalita@icicibank.com

Devanshi Chanchani
Tel: 022 2653 7065
devanshi.chanchani@ext.icicibank.com

Mekhala Krishnamurthy
Tel: 022 2653 7077
mekhala.krishnamurthy@icicibank.co
m

Sarover Zaidi
Tel: 022 2653 8038
sarover.zaidi@ext.icicibank.com

Shilpa Deshpande
Tel: 022 2653 7093
shilpa.deshpande@icicibank.com

Organizing team

The Foundation for Research in Community Health (FRCH)

Dr. N. H. Antia
Dr. Nerges Mistry
Dr. Rakhal Gaitonde
Dr. Neeta Rao
Ms. Shalini

Ms. Swati Dogra
Dr. Anant Bhan

The Early Child Health Team of the Social Initiatives Group (SIG), ICICI Bank

Ms. Mekhala Krishnamurthy
Ms. Sarover Zaidi
Ms. Anuska Kalita
Mr. Abhijit Visaria