Strengthening Public Health Systems:
For Human Rights and Development of Communities

Learning and experiences during the
Community Health Fellowship Programme

Of :

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CONTENT

PROLOGUE

Basic principle of science is that it evolves only against the background knowledge of previous experiences; i.e. new learning is based on previous understandings.

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I am a medical graduate, being trained as a clinician to practice medicine – study symptoms in a patient, give a diagnosis and accordingly prescribe a therapeutic regimen and advice care. Studying the biology of a human body and what causes it pain will catch fascination of any human… and that is where we are held up for 5-6 years …trying to 'study' the (biological) science of pain and discomfort… (in Humans!)

There is a huge institutional set up to teach us this scientific discipline, and similarly to deliver these services. A thought of how these huge institutions were built & functions is also alluring – but then we understand, that there are professional and organizational set-ups in place that work to serve and to co-ordinate such 'Community Life'. There are people fulfilling their individual roles for smooth running of this 'community life'.
…Ok so to identify our roles in the society we were forced (!?!) to go to schools, to learn skills for fulfilling social responsibilities we study in college - & then we'll be in a set up where we will actually fulfil these roles & functions…!!!

*Wow how calculative… How thoughtful of humans to **stay together!***

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[◊] The first key to wisdom is constant questioning. By doubting we are led to enquiry, and by enquiry we discern the truth. – Peter Aberlard

I have finished my college…

Now I'll sit in some hospital, on doctor's chair and treat patients…
Which hospital? Who are the people I will work with? What are their value systems – have they grown up the way I have? Do they see human life, human misery the way I do?

Who will see that I do justice to my profession? Who will ensure I keep up on my skills and learning – that I don't resort to cheating, neglect or unethical practices… I am a human…! Who will catch me when I make a mistake?
Who will pay me for my work? Treating people is a responsibility I have towards the society or the person who comes to me to get relief from distress?

Is there a need to think about all this when work for community is involved… everyone works in and for "their own communities"? …or people just live the life their way… and communities come and go…
Ha… why are these questions bothering me?

Why don't I simply practice medicine like other friends of mine…, within the structures that have been established for ages? Everyone says - in practice I am the best, so I should do MD medicine… simply!
Can't I be a good clinician without bothering about the larger structure of the system where I shall practice 'medicine'? Can a clinician do justice to her profession that ways?
Who are the people who built these institutional structures, have they done complete justice with their roles and responsibilities??? …O working at that level must definitely be more fascinating and fulfilling, it's a more creative… and then that is the requirement of the day!

Come on let me go ahead and learn those skills from the people who look after institutions and organizations – from people who are more ***socially conscious and community sensitive!!***

'If a man will begin with certainties, he will end in doubt, but if he will be content to begin with doubt, he shall end in certainties.' – Francis Bacon

As a clinician who wants to study Public Health, and want to learn what goes into ensuring effective functioning of institutions that give health care to the communities – who wants to know why does government spend so much on our education and lets us do private practice in isolation… with no control on our professional practice and skill development. As a clinician who has not known the world outside school and hospital… this is going to be a daunting job…

{- Am I thinking of bringing about a professional ***revolution***?!?!!}

Studying the art of social sciences, understanding communities is not an easy task…

Unlike medical sciences, which do have a theoretical base – studying society (which ever society) needs a practical base… on which you propound theories – which takes ages, or might simply never be stated as principles.

For this purpose my learning should have following components –

- what the established structures *can* teach, (formal ***education*** in practice of PH)
  [To gain the established body of knowledge]
- some personal learning (***experiential*** learning)
  [To gain practical knowledge & make it an enriching experience]
- An ongoing process of ***skills development*** to be able to creatively impact upon the improvement in the practice of ones profession (medicine and PH for me)…
  [To professionally establish myself, to be able to appropriately apply my knowledge][◊]

Formal education is available in various universities/ colleges – Generic subjects taught for the practice of PH are: Preventive and Social Medicine, and Public Health Administration or Health Management. Composite course works on Public Health tries to combine both these disciplines.

Public health administration, Social medicine and Medicine (Internal medicine & Preventive medicine) – all disciplines are concerned with the functioning and practices within the health sector; but not only practically, also academically they are they appear de-licked.
Where the links exist, if they do, and how to strengthen or establish such linkages are my major professional & intellectual quests. Medical training strategies should lie at the heart of this quest, because it is from here that these links should have best established for them to be applicable during professional role definition.

Where and how does one connect all these learnings into practice…
How will they impact on the system in such a way that doctors stay satisfied professional & give high quality to their professional practice, besides being ethical, sensitive and responsive humans…

[◊] He who never made a mistake, never made a discovery – Samuel Smiles

…study how systems are established and maintained right up to the grass-root levels – how are organizational issues dealt and planned at higher administrative levels.

Experiential learning comes through working in the field i.e. by practicing ones discipline and applying it in the work areas.
My first experiential learning in these aspects, as mentioned earlier was as a clinician, which inspired me to go a head and learn more about Public Health, social medicine & community health – that led me into a Social Science institute, the CSMCH department of JNU (Delhi), and the SOCHARA (CHC), at Bangalore.

The CH fellowship programme of CHC & SRTT offered me this unique opportunity to gather the 'ground-level field- experience'. The speciality of the programme was that it was also designed to identify the (learning) needs of people who want to establish themselves for improving the PH situation in the country, so it gave me yet more space and flexibility for reflection and exploration; and I have been stubborn enough to utilize this flexibility to its maximum! With due apologies, I express countless thanks to my mentors for their patience and gratefulness for letting me take enough time to ***explore – …to think and absorb.***

This report 'should/ might' thus reflects my attempts to put together my formal education from CSMCH with my experiential learning, as a clinician or medical intern and then as a community-health intern; and how I can relate them all with my basic education in health sciences:-

This report is not at all exhaustive of the activities and teachings that happened during the fellowship programme, which consisted of classroom teachings, group activities, discussions, presentations, seminars, role plays, field visits, visits to some organizations & guest lectures as well… I have limited the contents of this report to documentation of my personal experiences, encounters and reflections, and moreover the questions that arose during this exploration phase; than activities we fellows did for 'formal experiential learning' of the subject. Somehow, I feel that the orientation of this report is more toward personal reflections and questions, because this is what we were motivated to do more during the fellowship. This is a special skill only some people have, and I admire my mentors for this, and for taking in all the scraps that comes in our mind with so much emphasis being given to our (reflecting) hearts and (questioning) minds.

Also my field experiences, observations and learning might not be completely documented, – because experiences are better experienced & felt than expressed… at least so for me, as of now… I am just a beginner in the field of PH to be able to grasp and word all the relevant experiences in one shot…!!! Or, putting it simply – for me it is not easy to put everything decently into a comprehensible form for the reader, which should not irk the reader… (?!?) Hope with time I am gradually able to pick up on that skill too.

That is what experiential learning is all about…!!!

Men sail a boundless and bottomless sea, there is neither harbour for shelter, nor floor for anchorage, neither starting place nor destination. The enterprise is to keep afloat on an even keel; the sea is both friend and enemy; and the seamanship consists in using the resources of a traditional manner of behaviour in order to make a friend of every hostile occasion.

- Michael Oakeshett

CHAPTER I

INTRODUCTION

I had decided to make a sudden switch from clinical practice to the Public Health field, without much knowledge about its teaching or functional status in the country. I wanted to practice Public Health because in my clinical practice I realized that my training had not prepared me to work in the actual real life situation. I felt that urge to put my creative energies into bringing about this link, instead of fending for myself in improving my clinical skills in a system which was so non-conducive for a fresher. I wanted to gain qualification that would provide me with the skills and authority to work with the higher level planning structures of the health system. Little educated that I was about the subject of Public Health, I felt that having a PH degree that was recognised by govt. of India shall give me the necessary skills and position for my dream to come true…

But, mistakenly I did not realise that where medical education was a bit not in line with the system, same could be the case with the PH institutes. If there are institutes to teach PH, there is no clear cut system for them to practice and implement what they have learnt. Those who get the authority, are unable to apply the principles of PH…?? What is all this confusion? How do things work when they are not at all planned to be streamlined?

What is the work of 'Public Health' practitioners, and how do they exactly do it? I know how a physician works in a clinic; I have known how the knowledge of medical sciences gives an insight into the various aspects of disease and healthy living… but how the factors that operate outside the clinic controlled for providing and maintaining a healthy environment and healthy lifestyle…? I mean where are these links that broaden the functional areas for the operationalization of this vast knowledge of health sciences… It appears more worth while, more exciting and innovative to find out such possibilities and work in those areas to be able to create a greater impact on the health status of the people – for which our profession is meant to operate. Limiting our knowledge within the four walls of the clinic appears to be restricting; constricting when above all this there is the problem of poor systems management… right up from the level of policy formulation.

But…, all this gets too over-whelming and so broad – I should be able to go out and explore all these kinds of probabilities and develop a framework of this broad picture, for my better understanding… within which I can identify the roles functions of various professionals…, …, …etc etc. to be better informed about my position in the larger system, - when the next time I start my practice within this system.

…**T**hese were the vague; confused thoughts that brought me to CHC, where my confused state was appreciated… the more I got confused, the more I got conformed to the nature of committed community health fellows. But frankly, I don't understand what else

can confuse you more than the thought of being appreciated for staying in a confused state of mind… rather than being appreciated for asking ***the right question*** to arrive at the right answer. It is such a torture to be in a confused state …and not knowing where to look for the answers.

Anyways, something, and somebody convinced me that this fellowship could be a right beginning if I am too ignorant of the ways of the world and just want to go out and see the world… So I joined the fellowship with an open mind, keeping the faith on mentors; and my luck, wherever they lead me… ***So*** …***So shall be my learning…!***
With so much of confusion in my head, so vast was my ignorance that I wanted to know everything and so had real trouble trying to figure out what exactly should be my Learning Objectives**.** Somehow, without bothering to find a focus - I managed to decide on my field placements… Though, I am still unsure how my mentors allowed this for me (!), but it happened and I got to see a lot of …as they say… 'Both the worlds'…!!! Hopefully this has provided me with enough experience to get an idea about the practice of PH, before I actually start working in the field – a dilemma that I had faced in my clinics…

But again, the development of a framework for putting these learning together… was a difficult feat – not even complete …but somehow I was able to make some sense of things & experiences… which did take a lot of time though, and so was the time taken in completing this report. I owe my special gratitude to Thelma and Sundar, who patiently listened to me even months after my fellowship and (tried to) explain a lot of things and events to me… even my feelings… may be that is the reason I am compelled to write a long prologue – to contextualize my experiences for the readers – who even give a thought to go through the report!

Objectives for the fellowship

As my interests lay around the development of an understanding about public health systems, I decided to do my placement at SHRC, an organization that works closely with the state government as its technical advisory body. Knowing that this would give me an exposure to high profile policy level work, I also wanted to do my placement at some community based organization. For this I chose *Prayas*. I had met Dr. Narendra, the director, earlier and from what he explained about his organization I gathered that it might suit my purpose.

Thus, the broad objective for my fellowship was just to go out and see what work is going on in an organization, and get involved with their activities – I should be able to find a focus at least at the end of the fellowship about the place I would like to start working for …in the PH system.

The report thus gives a detailed narration of what I …*tried* to learn at SHRC; what I did learn and *saw* at *Prayas*; with a short chapter on work of another organization *Samavesh* that sort of made me feel a bit too emotional– about the cult of the 'non-governmental' organizations.

Other lessons:

One outstanding experience I gained during the fellowship programme was the experience, or rather an opportunity to get exposed to the "***Right*** to Health" campaign that was going

on in parallel… I call it outstanding, because where I did feel the need to improve my skills and knowledge for better health status of the people – I tried to look for answers around the development of my profession, so that the system functions properly i.e. where I was holding a narrow thinking about how 'I', as a member of this vast community can play its role in bringing about the development of this same community – '*advocacy*' was an unfamiliar tool or skill for me… I had not identified the need for such kind of strategy beforehand.

The experience was overwhelmingly enlightening and thought provoking - This was the first time I was a part of any campaign for the 'rights'…at least it was the first time that I was led into thinking seriously about the strategy and its effects.

Though witnessing the spirit of the campaign mode and the zeal and zest for human rights was very enthusing, yet I cannot avoid critically analysing and questioning the direction where these efforts and enthusiasm will lead us… Like a technical person I was more concerned with the methodology of the campaign, more than the ideology and the fervour for human rights.

…I wrote a mail full of questions, to the leaders of this campaign… and I did not get a reply.

In contrast to this - while I was in Bhopal, for the 'public hearing' event of the 'Right to Health' campaign I made a short visit to this organization '*Samavesh'*. This too was a very timely and a telling experience that sort of explained / gives answers on how one can try and overcome the limited governance capacities of the government, or provide a supporting hand to the people -not the government- for that matter – a strategy that stood in complete contrast with the 'tool' of advocacy; and more important than anything else during this visit was the fact that – The leaders could answer: why they chose to work like the way they do… they have a whole history of evolution; and the reason for this evolution was 'education' – the basis of evolution. They not only talked about their guiding principles and concepts of working with the 'communities' (which was a term not so often used, they said - *people*), but also about the working principles for their team that works for the betterment of the *people*. They felt disgusted if they were confused – they ask questions and have a clear strategy on how to proceed with answers – there is no formula to get the answer, but a formula for the methods to get to the answer… 'Ask the ***Right*** Question.'

The history of *Eklavya (ref.* chapter 5) and the evolution of Samavesh – led me to think on varied topics; as in - …Has *all this* to do something with just the ideologies and politics of the country? What about educational status? How can one ignore the importance of education – even for the role it plays in the development of ones own ideologies and understanding of politics…

Further, at SHRC, I heard something about the campaign on 'Right to Education'… and today we see the results of the campaign… and we see its memories in the eyes of the teachers at *Eklavya*. What shall be the fate of the so-called similar 'Right to health' campaign? Who will be remembering it in the same way as the teachers and students of *Eklavya* do*?*

I need not go any further on this.

…but, hey that leads me into thinking – how many politicians have actually studied political science; and how many students of political sciences are in the political and governing field… well before that – what proportion of students *want or feel the need* to study, and then practice such kinds of subjects. Why have these subjects lost their importance? Where exactly do the greater proportions of students from institute of humanities go?

> *"It is time for a major investment of effort into the development, refinement and standardization of various kinds of scales and other measures, needed to carry forward the programme of documentation and analysis of various dimensions of the human experience."*
> – Angus Campbell.

All that shines is not always gold; everyone who travels around is not always lost.

CHAPTER II

Placement at State Health Resource Center (SHRC)

I had known Dr. Sundar for quite some time now and heard about his *Mitanin Scheme* that I was told to be a government initiative. I was not sure about the type of work Dr. Sundar was doing in Chhattisgarh, apart from the *Mitanin training*, but his personality and background attracted me. I wanted to learn about public health system from him and work with him. So I suggested doing my placement there.

It was only then that I came to know that Dr. Sundar is the backbone to the Government of Chhattisgarh for their initiative of improving / strengthening their Public Health System.

…He was the Director of the State Health Resource Centre of a newly established state, Chhattisgarh! So, I need to go through the publications of SHRC before I face the Director, so that I am able to make full use of my time there with him… because he must be very busy and preoccupied with his work – in a separate cabin of his own (!).

I flicked through the report of the study done by SHRC for the purpose of strengthening of the Public Health System… wow(!) the title of that report was itself fascinating for me…

I went through the report, not interested in the exact figures and data it provided, but in the study design and various components identified as necessary determinants and indicators of Public Health System's effective structure and functioning… All these learning objectives were provided for by the report – so, mistakenly I did not discuss it in detail with Dr. Sundar. Though I was also not sure how and from where all these factors and indicators were identified.

What I did at SHRC was to just look at the various activities that took place in the office then. How things moved in an office, I was not sure of… so in trying to be a participant I remained as an observer.

The Director was not at all unapproachable, without a separate cabin for himself. I saw an excellent leader in him. He knows how to work with so many different types of people. He knows who can do what and how you can make them do that. He has built a completely non-hierarchical environment and takes care of almost all the activities of the institute… handling all the political pressure and constraints for all the health initiatives. To me he appeared to be the only brain behind all the initiatives…

*Indian **democratic politics** is too much for a technical brain to handle – but not too difficult for him to comprehend and play with!!*

After being clear with the role of SHRC in the Public Health system and after familiarizing myself (a bit) with the activities that take place at the State Health Resource Centre, I formulated a set of learning objectives for myself…

My Learning Objectives:

Keeping in mind my motivation for working in the field of PH, during the Fellowship programme I would like to get a broad understanding of**:** -

- How do we study and analyze the Health System; its structure and functioning.
- How can the final conclusions / recommendations so drawn from such a study be implemented – right from the central to state and local peripheral levels, with legislative and administrative changes visible at all levels.
- How exactly are these changes brought about – i.e. a broad understanding about law formation and politics in the system. (!?!)
- …Something about Policy Formulation and Implementation.
- Develop some of the basic skills thus required; or at least be able to recognize what skills are required and then develop on them…

Observing the functioning of SHRC and how it was established, besides knowing its visions and objectives – gave an insight into how institutions are conceptualized, established and maintained… the manpower, technology, politics, leadership and (may be sometimes) the philosophies (or ideologies) that go into it.

Taking part in some of the activities there - …was not a very fulfilling experience because as a beginner it was difficult to get fully involved in any specific activity, and complete it with quality in just 2 months time. Dr. Sundar had cautioned me on that, but said that as I was just in the exploration mood, there is no problem with just hanging around… that is what I got at the end of two months – a hang on the 'health-related' work outside the hospital set-up.

Following is my attempt to document an understanding about the strategies for Strengthening of the Public Health System, as adopted by SHRC of course, and explained by Dr. Sundar and his working philosophies and work style.

The PUBLIC HEALTH SYSTEM: Its components

Characteristics of a strengthened Public Health System and various links important to bring about this improvement in the present system –

- Infrastructure– i.e. having desirable number of Health Centres with enough staff and facilities to be able to cover whole of the population of the state. And also with a good and efficient referral system for such decentralized health services, so that people know where to go for solutions of their problems.

  New strategies making use of the private sector and civil societies will have to be examined for this.

  While planning for expansion of health services it is necessary to keep in mind the rights of the disadvantaged classes. It has been seen that the poor are unable to take advantage of the government schemes meant for them. This must be ensured during the planning process itself, so that the scheme goes to the target groups.

- Capacity building of the staff to be able to deliver *community centered health services*, accordingly provide infrastructural or functional feedbacks to higher level administrators or policy planners (this also includes capacity building of administrators and sensitivity of planners on the relevant ground level realities and issues).

  Training of voluntary workers, and people working in social sectors will have to be organized for this. This should be done on a large scale, and seen to it that effort of voluntary workers are integrated with the government efforts.

- The Panchayati Raj institutions and the Urban Local Bodies have been given the full responsibility of public health by law. For decentralization of Health Services full assistance of local government institutions should be taken.

  It is necessary to train these institutions so that they are able to carry out their public health responsibilities to its maximum capacity and make their full use in the health sector.

  Training of people working in the government system will have to be necessary so that they are able to work in partnership with local government institutions, non-governmental organizations and the private sector.

- Integration of ISM and other alternative systems with the Public Health System, with administrative unification at the district level and programmatic synergy at programme design level.

  Many people have faith in these systems of medicine and also practitioners of these systems of medicine have been able to reach the communities individually – may be more easily where the mainstream public health system has not reached. It is thus necessary to plan for their maximum development and mainstreaming them to make their maximum use in public health.

- A system to collect and maintain health statistics (MIS) that would provide a database for various purposes from monitoring the health status of the people and disease surveillance, to monitoring of the health system functioning.
- Empower the communities in Public Health – provide them with adequate health education and knowledge of the available facilities and schemes for themselves; plus empower them to be able to demand for and avail these facilities.

  For this it is important to establish an understanding of Public Health among the social workers, and communities, so that they are able to solve ordinary health problems (or those related to the determinants of health or preventive aspects of a disease) at local level.
- A good Information, Education and Communication machinery is important in the state, which would maintain a database and provide community education to ensure community participation in health.
- **Policy, politics and state level issues of administration ???**

  This is a difficult field to address, and then policy issue comes only after the entire situation has been studied and ground level needs assessed, i.e. after the policy issues have been completely identified, so that the policies don't follow a piece meal approach.

  Besides, politics and who possess the administrative powers are the critical factors in operation!

Following is what SHRC, Chhattisgarh, had to say in this context**:**

"The formation of a new state provides new opportunities. Though it inherits from it's predecessor a policy framework, it is open and willing to re-examine this inheritance and reformulate its own policy, drawing upon lessons from all the states."

"The Government of the state of Chhattisgarh is now engaged in the process of assessing the public health care system to arrive at policy options for developing and harnessing the available human resources to make greater impact on the health status of the people."

"Any attempt to explore policy options for human power development must be based on an empirical understanding of the conditions under which the present system functions and how it responds to the challenges that arise from within or outside the health care system. Our understanding of the prevailing conditions and search of policy options should also be guided by an appreciation of the capacity of the system to respond to immediate challenges as well as those that are likely to occur in future."

Work of the state planning machinery for strengthening the public health system–

- Baseline **studies** or surveys to know the health status of the people and their health care needs. Also study the present health system structure and functioning to recognize the changes necessary for strengthening the system, and the constraints…
- Making **recommendations** based on the conclusions drawn and constraints recognized – thus deciding on the Strategy and Action plan to strengthen the public health system, its structure and functioning. This includes planning and management for infrastructure and manpower development. And establishments of institutes like, the state institute of health and family welfare etc. not only for research and resource purposes but also well linked with the administrative machinery - with some powers to check the administration for rendering good, up-to-date services.
- Strategy (and action plan) for developing a **health information system, and for health education** to bring about community participation* in health care provisioning and help in community orientation of service provisions.
- Thus provide for **policy review** and policy options for developing and harnessing the available human resources to make greater impact on the health status of the people

It must be noted here that when we say Public Health Services, it should refer not only to those facilities and services that provide just preventive, curative and rehabilitative 'medical' health care from primary to tertiary level.

Primary Health Care is an integral part of communities' overall economic and social development, for which it has to coordinate on the national basis with country's total development strategy.

It thus "involves in addition to health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, and other sectors."

An ideal structure of Public Health Services at the grassroots must include a primary care team accepting a district or neighbourhood responsibility not only for local epidemiology and health education but also for environmental control – these are responsibilities usually vested in the public-health services – not just health care services.

This would require the effective linking up of the Basic Health Services with the municipality, the pollution control board, and public works department. But, in the present situation, this could only be possible if first the medical setup is completed and has been made fully and efficiently functional. Ones this has been made possible, then the goal of providing the Primary Health Care to all would be possible, with a few more inter-sectoral linkages for better nutrition, education and vocation.

To achieve this total review of the administrative system may be required, for reallocation of resources and introduction of suitable legislation to ensure that coordination takes place.

Baseline studies to know about the health care needs of the state and health system functioning.

Numbers of studies were recognized to be necessary for developing an overall understanding of situation of the public health system functioning, possibilities for the rationalization of health services, human power development and workforce management that would result in better utilization, outreach and quality of health care services.

- The studies should be able to address the following three questions –
  - How adequate are the existing human and material resources at various levels of care (sub-centre to district hospital); and how optimally have they been deployed? This is an assessment of their outreach and performance.

    It examines the availability and utilization of existing facilities. This involves mapping of facilities, personnel in place and vacancies, health care financing and cost of health care, type of services available including the extent of extension services provided, etc.

  - What factors contribute to or hinder the performance of the personnel in position at various levels of care?

    This looks into the workload of health functionaries at various levels in the state, the organizational and motivational factors that affect their performance, and the current training strategies.

  - What structural features of the health care system, as it has evolved, affects its utilization and effectiveness?

    This examines the current policies and their implementation with respect to budgetary allocation, drugs and equipment procurement; personnel recruitment and postings, transfer and career planning.

    This also requires mapping of private sector recognition of factors that would help develop a policy framework to facilitate and regulate the private sector in health.

- Apart from this situational analysis of the existing health system organization, there is also a need to examine the peoples' perception of health functionaries and facilities. Assessment of the burden of various diseases in the communities and review the specific health programmes should also be done; and a system established to be able to gather and maintain such data on a regular basis.

Together these studies will help the state planning machinery in the following ways –

- Lay down norms for various facilities and services and identify constraints on the access to the optimal utilization of basic facilities (geographic, personnel and systemic).
- Project additional requirements for health human power. As part of this component, this study will also identify competencies and social skills for various functionaries.
- Identify organizational issues and policy processes to address motivational factors that affect performance of health sector personnel.
- Suggesting organizational policies including appropriate recruitment, transfer and career planning.
- Identify potential for partnership with the private and voluntary sector and suggest ways to go about this.
- Identify components and processes to effect decentralization.

Initial activities to strengthen Public Health System's structure and functioning:

- Infrastructures development –
  - Mapping of facilities' requirements (according to the norms)
  - Action plan for funding and infrastructure building
  - Establishment of institutes like the state institute of health & family welfare
- Manpower development and capacity building
  - Recruitment of staff and development of their skills
  - Development of a cadre policy for health personnel
  - Medical education and health workers training – it's reorientation or required improvement

For community empowerment, health information and education

- Networking with various stakeholders and civil societies (or other institutions)
- A system for collection, maintenance and dissemination of relevant information on health status and health issues.
- Establishment of the state resource centre for training and health education

The idea of community empowerment, it seems has always romanticized the concept of Community Health Worker – but no one is sure which CHW programme has really been able to provide this 'empowerment'.

Chhattisgarh

Chhattisgarh is a new state formed out of Madhya Pradesh, in November 2000. It is relatively backward and a poor state with a population of little above 2 crores; with HDI of 39 (for India it is 45).

There are approximately 34% Scheduled Tribes, 12% Scheduled Caste population, with more than 50% other Backward Classes. The people here are relatively poor but state is rich in natural resources. Large reserves of coal, iron ore, limestone and bauxite are present. Almost 40% of the state is covered with forests.

Literacy levels of Chhattisgarh are relatively good (65.18% as against a national figure of 65.38%; with female literacy rates of 52.4%) but health status is relatively poor. According to SRS 2003 Crude Death Rate is 8.8 (India – 8.4) and Infant Mortality Rate is 76 (India – 66). Total Fertility Rate in 1997 was 3.6 when Indian figures were 3.3; and Crude Birth Rate in SRS 2003 was 26.3 when national figure was 25.4.

Chhattisgarh also has a relatively poor infrastructure for health services. The Health System is completely hospital based and treatment of disease has got precedence over prevention of disease. Still the state has only two Medical Colleges and even the hospitals attached with them are not fully equipped. There are 16 districts in the state, but only 9 District Hospitals. Out of 146 blocks only 114 have Community Health Centres. Many posts of health personnel lay vacant; and many remote tribal areas remain un-served. Further, to make matters complicated the uneducated quacks are taking advantage of the public in such areas.

Being a new state it also lacks laboratory facilities. There is no lab for drug quality testing, or for food adulteration. There is also no Training Institute for health workers or for collection of health statistics. A good Information, Education and Communication machinery is lacking in the state that would maintain a database and provide community education to ensure community participation in health.

Apart from this, whatever Public Health System has been established, that itself is distant from the people who are supposed to use it. Present policies have instead of empowering the people have made them more dependent on the government machinery.

Underlying this is the increasing complexity of the Health System itself. Doctors are educated in towns and in a hospital setting. They are not interested to stay and work in a rural area, where all the public facilities are very poor; if they do agree, they are not well able to relate to the rural life of their patients. On one hand the Health Department feels that people do not take advantage of the health services offered, on the other hand people feel that Government is not able to provide for even the basic health care amenities.

Thus, there is a gap both on the supply side as well as the demand side that needs to be looked into. To be able to bridge this gap the general health services need to be made more community based and the people empowered for their own health. All the policies should be made keeping communities in as the focus.

Problems identified in the Government health system functioning…

The Government sees itself as investing in this vast network of health facilities and being faced with the problem of gross under utilization of these services.

Reasons that under-lie this under utilization are identified to lie in –

- Weak systems management within the health department and poor accountability at all levels,
- And in problems of outreach and poor health education and awareness.

Government constructs a CHW programme to improve utilization by working on outreach and health education. It also stimulates pressures to improve it's own systems and accountability…

This led to the launch of a massive community health programme called *Indira Swasthya Mitanin Programme*, as one of the components of *Rajiv Jeevan Rekha Programme*. This programme was given high priority on the government agenda and showed great political commitment to people's health.

The programme was large, with the aim of training a woman in each single hamlet - 54,000 in all – and it was difficult with the limited government resources. For funds a policy decision was made to utilize the funds of Sector Investment Programme, supported by the European Commission, for this purpose. For manpower, involvement of civil societies was recognized to be important.

In a joint consultation of GoC with representatives of EC, the state officials, NGOs from across Chhattisgarh and health activists from other parts of the country as well, it was realized that Mitanin Programme was unlikely to succeed unless wide ranging structural reforms were undertaken in the Health Administration. Various areas of the health services that required such structural and practical changes in existing laws, policies, programmes and institutions of health care delivery were identified.

There was a need to make a transition from the existing state of health services to a community based health provisioning. The focus remained on strengthening community health system, primary and district level health delivery systems, health surveillance and epidemic control.

The State Health Resource Center

The State Health Resource Center was established in March 2002 under the MoU signed between the State Health Society (then the RCH Society) of the Government of Chhattisgarh and Action Aid India.

This happened in parallel with the formation of State Advisory Committee with representatives from the directorate of health services, all donor agencies and seven NGO representatives who were involved in the health sector reform process. These NGOs had played a lead role in formulating the priorities for health sector reforms in the state and helped in conceptualizing the basic tenets of the Mitanin Programme.

SHRC, though institutionally autonomous, values and utilizes SAC for social audits and rigorous interrogation. All programmes that SHRC heads, or contributes to, are implemented by the programme committees where officials of health services are present, and often play the leading role (as in EQUIP).

The SHRC started functioning with one programme coordinator and assistance of Action Aid staff, till October of the same year, when Dr. T. Sundararaman was appointed as the Director of SHRC, on deputation from the central government; and a full complement of staff was built up.

The state office has currently three programme coordinators and three support staff. There are about 27 field coordinators (assisting the 146 blocks) under the Mitanin Programme. Each field coordinator monitors 5 to 7 blocks and provides training and planning support to the district RCH society.

Action Aid functions as an internal finance section and coordinates with the State Advisory Committee for informal periodic social audits of the programme.

Goal of the Organisation

"Is to contribute and strengthen all efforts directed towards attaining health for all primarily through ensuring universal access to the basic goods and facility services and working and living conditions that are necessary for the attainment of highest level of physical, mental and social health of all."

Such a goal is interlinked with all efforts towards social development policies, which are equitable, sustainable and democratic. Such efforts shun all forms of discriminations and most necessarily reach out to the weaker and more marginalized sections of society and empower them so that they are equal participants in their own development and destiny."

The Objectives

SHRC was conceived as a functionally autonomous body fully supported by the state government, which would act as an "additional technical capacity to the State Department of Health & Family Welfare".

It was ***initiated "for the implementation of the Community Heath Worker Programme (Mitanin) and carrying forward the pro-poor reforms proposed under the Sector Investment Programme."*** SHRC would further help in designing the health sector reform agenda and in developing operational guidelines for implementation of reform programme; plus arrange for or provide on-going technical support to District Health Administration and other programme managers in implementing this reform programme.

SHRC was thus envisaged as having a core team of full time experts and support staff who would**:**

- Produce quick situational analysis on various aspects of health sector,
- Prepare policy change proposals for the consideration of GoC, based on the situational analysis and/or specific studies undertaken by it or through individual experts or institutions.
- Draw up the ToRs for any consultancy contracts and/or for engaging individuals or institutions for short term or long term assignments as may be needed from time to time
- Conduct workshop or meetings as may be necessary, on behalf of GoC, for effective operationalization of reform process.
- Undertake or facilitate operational research and epidemiological inquiry into disease prevalence and determinants
- Assist in programmes to build capabilities of various different levels of health department cadre.
- Perform such other tasks as may be assigned from time to time.

It was further stated that these tasks would be consistent with the following objectives, laid down in the MoU of partnership**:**

> *"Make structural changes in state policy, and practice, to make health services more accessible to the people who need them the most. These include the very poor and marginalized groups, tribal people inhabiting remote hamlets, women and other people at risk. This would be done mainly by strengthening community health systems, primary and district level health delivery systems, health surveillance, epidemic control and comprehensive reforms in policies, laws, programmes and institutions for realizing the vision of 'Health for All'."*

Studies undertaken

To begin with, SHRC organized a study on Workforce Management and Rationalization of services and Human Resource Management in Public Health Services. The study was organized into three overlapping but distinct sets of**:**

- Facility Survey
- Organizational Culture and Motivational Factors
- Workload Assessment

Apart from analysis of secondary data, the primary data for the study was gathered by sample survey. The components of which were**:**

- A questionnaire based survey of facilities
- A questionnaire based survey of organizational and motivational aspects of health system
- Number of field visits, focused group discussions, interviews with senior officials and self-administered questionnaire of senior officials.

The study report provides the baseline data on current situation of health services in the state and documents number of organizational practices and various lacunae in them. It thus evolved into a set of pragmatic recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capacity building aspects.

The **recommendations** were finalized only after a serious discussion with various stakeholders in a three-day workshop. The employees and their associations; the officers of national, state and district levels, the medical profession and the professional bodies, and the civil societies in health were recognized as the stakeholders for such a discussion.

The recommendations were formulated in terms of how the existing resources of manpower and materials can be optimally utilized and critical gaps identified, and addressed. It further looks into how the facilities at different levels can be structured and reorganized.

Besides these technical aspects on how the study was conducted and recommendations given, other conditions considered to be important for the same purpose was pointed out in the report, and stated there was as follows**: -**

" It was decided to not to outsource the study. This was so decided because to come up with useful and implementable outcomes a high degree of participation and even ownership of the study outcomes by the states health department is essential."

"This study approach recognizes that the leadership of the state health department is seized with the major problems and has developed an understanding of its solutions. When we propose reforms, one has to necessarily start from there and build on it, with them – rather than position oneself as an external critic and make largely gratuitous recommendations. Moreover by doing the study with the local team, assisted by national consultants with appropriate expertise, capabilities in such a vital area could be built up inside the state."

Other areas that were considered important for the follow up studies, were –

⇒ Financing of health care and the cost of health care

⇒ People's perception of health care facilities and their satisfaction with them

⇒ Assessments of burden of disease and review of specific programmes

⇒ Mapping of the private sector and development of a policy framework to facilitate regulation and growth of private sector.

Some aspects of public-private partnership, as an important component of facility survey, were however addressed.

During my stay at SHRC, some of these studies were initiated. : -

- A questionnaire for the assessment of cost of health care, at a family level was prepared and field-tested. The cost of medical care was assessed against the family's income and household expenditures. It was called as The Study of Household Expenditure in Health Care. Thus, it could also, to a certain extent indicate towards people's satisfaction and perception of health care and medical services.
- A planning was on for analysis of financing available for health care and it's allocation under the various heads, plus its utilization.
- Analysis of medical prescriptions written by various public and private doctors of allopathic medicine was also being done, to assess their skills and prescription habits.
- A study was initiated on the diet pattern and food habits of the tribal population, plus the practice of tribal medicine. This was done to prepare a database of nutritional value of their food and study the locally available medicine plus their healing practices and health culture.

Based on the results of the study, various conclusions drawn and recommendations given, following activities and major programmes that are ongoing -

- **The Mitanin Programme**
- **The Sector Investment Programme**
- **EQUIP Programme**
- **Capability Building in State Health Sector** i.e. Training of MPWs, ANMs, TBAs, Medical officers
- **Draft Training Policy for the state department of health and family welfare**
- **Draft Drug Policy for Rational use of Drugs**
- **Preparation of Standard Treatment Guidelines**

- **Malaria Control Strategy**
- **Building a strategy for Public-Private Partnership for the RCH services**

The Mitanin Programme

The Approach to Community Health Action

'***Mitanin'*** in Chhattisgarh means a friend. According to an age-old tradition in the villages of Chhattisgarh, customarily girls become Mitanin of their close girl friends. Similarly there are 'Mitans' for boys. This relationship, like marriage is also established ceremoniously and continues after marriage, establishing a bond between families.

It is this tradition which this programme seeks to revive, where Mitanin is not only a *voluntary* worker but also a friend, philosopher and guide to all the people of the *habitation*. So the community should have full faith and confidence in the 'Mitanin'. They should have friendly relationship with a sentimental element towards her, and be *rewarding* for her work.

With this position in the community, the Mitanin has to perform following work in the field of Public Health, for better Community Health**:** -

- She will give Health Education to the community
- She will take up the leader-ship role in all the Public Health activities of the village, and will encourage community work.

In this she will coordinate with the ANM or other health staff of the village and the PRI.

- She will provide first aid, and over the counter drugs for minor ailments; and refers other cases for proper treatment.

  For this she is provided with not only the required knowledge base on common health problems, their care and means of prevention, but also skilled to gradually take up responsibilities for treating these illnesses in the village.

  Further she is also given knowledge how to refer cases beyond her competence to a proper health facility. The most important thing in this is that, whether she will treat a disease or not is dependent on her the confidence she has on herself, or the sector team on her.

  For this she requires a continuos support, continued training and supervision. This is presently provided by the SHRC team and should be provided by the ANM, Panchayat and other health staff, in future.

- The Mitanins will gradually take on such other responsibilities, and perform such other functions as the Panchayat and the district administration may decide.

  She will be trained for performing these duties, and duly compensated for by the concerned department.

  The Mitanin thus becomes the main link between government and the people in the habitation. For this it must be stated here, that to derive full benefits of the scheme the

actual functions of the Mitanin, which she does for the health department, must be planned and coordinated at the village level only. Thus, powers must be delegated to the PRI for this, and capacity building of the PRI becomes more important.

The programme design thus, also has an in-built withdrawal strategy for SHRC.

Objectives of the Mitanin Programme

Main objectives of the programme are to –

1. Improve health awareness and health education of the communities.
2. Promote community initiatives for communicable disease control
3. Improve utilization of existing public health care services.
4. Provision of first contact curative care at the hamlet level. This not only provides immediate relief from the common health problems but also avoids needless, often hazardous care.
5. Organize community, especially women and weaker sections on health care issues.
6. Sensitize Panchayats and build up its capabilities.

Four critical components for achieving these objectives –

1. Mitanin selection
2. Mitanin training
3. Support to the Mitanins in her tasks
4. Making health system improvements that enable the system to respond to the demand for services that her work brings about.

Operational objectives set for the programme –

- Select, train and deploy a Mitanin in every habitation of the state.
- Ensure effectiveness of the Mitanin by supporting her internally in the habitation by women's health committee, village health committee and the elected Panchayat; and externally by a cadre of trainers and the local government employees.
- Ensure skills and effectiveness of the Mitanin by providing her with at least 20 days of camp-based and 30 days of on-the-job village level training.

The Mitanin

Mitanin is a hamlet based unpaid community health worker or health activist. She is drawn from among the women of the hamlets who volunteers herself and is also agreed on by the villagers. She is recognized to possess leadership potential and is provided adequate and regular training and supervision in her work.

She is preferably a married woman supported by her family in her Community Work. Her educational level is not important but good level of literacy is highly desirable.

She is not paid for her work, so the most important principle is that her livelihood should not be compromised. This is like a part time job she is doing voluntarily. Three hours daily for 4 days a week would be sufficient for her hamlet based activities. Once in two weeks she is required to go out of the village for training or meetings with other Mitanins and their trainers. In between she has to go for residential training, at a training centre for 3-4 days at a time. She is provided with compensation on these days for loss of livelihood.

Mitanin also helps create and sustain a local village health committee that provides her a continuos support. Besides, the village Panchayat, the ANM, local PHC and the

AWW are also expected to work and liaison with her for effective support and coordination.

Programme Structure and Operational Guidelines

MITANIN TRAINING

For any programme to be a success, the leader should meet the workers regularly, troubleshoot their problems, constantly update their knowledge and keep their motivation high – providing timely retraining and replacements, wherever gaps occur.

Training **-** Training builds up specific competencies by imparting knowledge and developing various skills to use this knowledge, and bring about attitude change within them, where required, and in the communities.

Mitanin training strategy envisages 20 days of camp based training and 30 days of on-the-job training. There are seven manuals provided to them, which she can always refer back to for guidance and are to be used regularly in meetings for revision. These manuals or training modules are written in their local village language, in the style of a conversation. Titles of these can be listed as follows –

1. Introductory book on health and Mitanin Programme.
2. Introduction to public health services and facilities.
3. Basics of child health action.
4. Basics of women health action.
5. (A) Local planning for malaria and gastero-enteritis control.
   (B) Manual on Tuberculosis and Leprosy.
6. An introduction to first contact curative care.
7. *'Kahat hai Mitanin*' – a pictorial book with key messages for Mitanin that she can use for local communication.

- Training camps are staggered over a year, with training sessions extending at stretch to a maximum of 4 or 5 days, usually 2 to 3 days. The training contents for these camps are –
  - *First Round of Training* – three day residential training with the first three training manuals. This training ends after a field trip.
  - *Second Round of Training* – two day training, preferably residential. This training reinforces child health training and all the issues of first round.
  - *Third Round of Training* – with training manual No. 4.
  - *Fourth Round of Training* – may be a two or three day non-residential training using training manuals 5A and 5B. This round may be repeated to cover more communicable diseases if they are a local priority.
  - *Fifth Round of Training* – should be at least of four days and residential. This training introduces the Mitanins to the village medical kit and first contact curative care.

- *Sixth Round of Training* – three day training with training manual 6, that reinforces the curative care aspects.
- *Seventh and the final Round* – at least four days residential. In this training, they would be taught how to assess the local health status and draw up a local health plan. Further means of continuing the Mitanin work and for sustaining the programme would be discussed.

➢ The in-service training would constitute one or two days in a month. In this the trainer makes a visit to the village and works with the Mitanins. Occasionally, the trainer can gather all the Mitanins of the village in one place to provide training and discuss issues in a group, rather than individually. This provides quality peer learning and helps boost up their morale.

This in-service training is most essential part of Mitanins training, her work, her motivation and her support system.

Knowledge is imparted gradually as per the schedule and the training modules, and simultaneously, skills are developed; as in –

- skills for establishing rapport with the family
- Learning Dos and don'ts of how to approach and address family on various topics at the doorstep.
- How to counsel family on different themes, like newborn care, child nutrition, malnutrition, women's health, etc. In this they are taught to avoid victim blaming for the sufferings, and she also has to promote the use of Public Health system, through this counseling.
- Identifying anaemia, jaundice, dehydration, case of high-risk pregnancy, grades of malnutrition, signs of pneumonia, estimating fever, respiratory rate, spleen size, and so on…
- And accordingly what action to take and what advice to be given in such situations.
- How to construct local inquires on availability of health services and how to increase public awareness and utilization of these services.
- Conducting a village level meeting of women and children, and of all maintaining a basic health and health services register.
- How to make a blood smear for malaria, how to do tepid sponging for fever, how to make mosquito repellant oil, how to map places of mosquito breeding and draw up a local plan for its control.
- How to identify lesions of leprosy and to test for sensation loss.
- How to disinfect water in pots, wells or other water storage devices.
- How to identify medicines in her kit and use them appropriately.

Given the low literacy level and lack of experience for such work it is unrealistic to expect most Mitanins to grasp adequately from camp based teaching. Unless the trainer goes to her village and makes house-to-house visits with her, and helps her

with meetings etc. once or twice a month – they would find it very difficult to pick up the knowledge and skills.

Working with them on-the-job would really make them capable, the camp having provided them with the motivation and introduction. Learning is better in concrete situation.

Also, Mitanin needs continuos support and that she is regular visited; and needs to collect feedback from her about service delivery.

For these types of activities and relationships, it is preferable to have women trainers. The trainers are motivated and educated women suitable for such work, facilitators often identify these trainers. They are also identified according to proper geographical distribution – one per cluster of gram-Panchayats. Often, a trainer has about 20-25 Mitanins under her to train in-service.

TRAINING STRATEGY

Mitanin Selection -

The health department or the local administration could have been given this responsibility of CHW selection. But here, the health department employee would go in for a person who can be persuaded to take up the tasks and in case of PRI, where there is no tradition of consultation but rather of patronage – Sarpanch's family member or someone he is obliged to would be selected.

Or a local NGO can take up the responsibility of identifying a CHW in their area. Their prolonged contact and familiarity with the local people may help they identify easily the person who is sensitive to the local issues and have empathy for the poor and marginalized. But such NGOs can cover a very small area of the state. These were the areas chosen for the pilot phase of the programme.

Also, Mitanin is seen as a part of a social process for empowerment – for social and economic justice. She is thus a person owned by the community, acting on its behalf – not at the behest of the government, and much less as a philanthropist or a funding agency. (Health is seen as a right, attained for justice – not as charity.)

So, the critical factor in Mitanin selection is that the village should make the choice.

To combat the problems of wrong selection and for providing ownership of selection to village people, three major innovations were made –

- A team of facilitator for Mitanin selection is trained and is chosen after one or two months process by a small district group constituted for the purpose. They are given the task of informing all the villagers about the programme and role of Mitanin. He also meets all the sections of the village separately so that needs and views of the weaker sections are also articulated adequately and different point of views are adequately negotiated for healthy partnership.
  The selection is done in a general village meeting with good attendance, and special emphasis is on involving the Panchayat and its health committee in this process.

- Selection of Mitanin is done at hamlet level, which ensures greater penetration of health messages and participation of almost all the people in the village, as a hamlet tends to inhabit people of similar groups. This also ensures lesser number of families for Mitanin to cover – usually around 50 which makes the work feasible on voluntary basis.
- The selection process involves a number of women and tries to build in enthusiasm for a collective will to action, and to instill a feeling of ownership among people. These women who participate, though not selected in as Mitanin get involved in women's committee that provide continuos support to the Mitanin and discusses various issues of health in the village.
  This is Social Mobilization. This campaign is centered on *kalajathas* (troupe of artists), built in the selection phase.

Training of trainers -

The trainers are trained by the State training team and the District resource team (three persons per block). District resource team consists of government as well as non-governmental people, three in each block, making a total of about 210 district trainers are trained for this purpose.

Thereafter the state level training the district resource team would train 25 trainers per block. These block level trainers receive initial training of four days and then on monthly intervals as per schedule.

These 25 trainers would then split into groups of 5 each and each team trains two groups of about 40 Mitanins, as per their schedule. Thus, in a block, there have been almost 10 training camps for 400 Mitanins, held in 5 parallel camps in the first round followed by another five camps the next week. This was to be repeated for all the consecutive training rounds.

Mitanin trainers work in a group, so that if there is some redundancy, still there will be 2-3 good trainers in a camp, and working together they can manage better.

After the first training camp each pair of trainers commit for the next month to visit eight villages twice, so as to help the Mitanin get started and provide some in-service training. This makes 27 days for trainer's work in the first month – 4 days in getting trained, 6 days in training, one day in post training review, and 16 days in village visits. That is what the minimum quality training would take.

In the next month the trainers are retrained over three days and they give two days of training in two batches, and another 16 days for village visits. This makes 23 days in a month, and most likely it would remain the same for the next 18 months, for a really good Mitanin Programme.

After about eight months of training and activities at village levels, then the curative aspects of heath care are introduced, and given a drug kit for this.

Before introducing Mitanins to medicines and cure of disease, an understanding of health and disease has been made. This is to fight the prevailing culture of seeing health as analogous to taking tablets and medicines. Also, this would prevent the public from demanding medicines before listening to all the health advice and education.

She is also involved with numerous preventive and promotive activities in the village, which are much more important, so for that to not to get overshadowed by the curative aspect of her work, this strategy is important – first things first. Her work also involves explaining to the people that use of injections is a waste and how much of their expenditure in drugs is a waste. And this must be done before starting to give medicines herself.

Three strategies are identified to prevent "transmission loss" in this training pyramid.

a) Good quality training at the top most level where maximum transmission loss occurs. It is seen that very little is lost between the trainer and the Mitanin.

b) Better to go for an approach where training material can be read out and then discussed and explained by the trainer. Apart from these presentations of the readings must be made, with group activities, role-play etc. The training material is made keeping these training needs in mind.

c) *Training Evaluation* - at the end of training, a set of questions is circulated separately that help in revision and also evaluation. The consciousness that their work is going to be evaluated also gives some seriousness to the training process and prevents its degeneration into strings of speeches.

   The evaluation is done according to a base-line set for the necessary knowledge level.

In the training strategy it has been made sure that there is much space to redo everything and allow one round of turn over at every level before the final team settles. There is further space to provide training to the Mitanins selected late in the programme and for those who missed their training rounds.

Support to Mitanin in all her tasks

The nature of support envisaged comes from two levels –

A) *Support within the village comes from –*

- The Women's Health Committee providing support of local people for whom Mitanin works at the hamlet level. After each training that Mitanin attends she shares her learning in the committee and the committee members' share all the tasks designated to the Mitanin.
  This is in the sense that Mitanin is seen more as a convenor here, rather than a solitary worker.
- Panchayat: this is the most critical part for the sustenance and maintenance of the programme at the local level. To involve them and maintain their interest, block level meetings of Panchayat leaders, attended by the collector, with specific requests should be periodically organized.
  These requests could be like – for ensuring coordination between AWW, ANM and Mitanin, planning for malaria control, or for TB and leprosy etc.
  But this can only be done after some effects of the outcome are visible at around 18 months of the programme.

- Other Mitanins: the Mitanin trainer also helps in this, and to make them realize the organized strength they have - as people are moved for the change.

B) *Support from outside the village –*

- Trainers, who regularly visit them, at least twice every month.
- ANM/ AWW/ MPW/ LHV: as they make their regular field visit to the area. But here it is important to maintain a democratic and not a top-down relationship. They need to be explained they have to work in cooperation and not by delegation of responsibilities.
- Medical Officers: provide referral services, making occasional visit to the village on Mitanins request and so providing them with encouragement.
- District Administration: they provide encouragement and support for what the village and the Mitanin demands, and also by consulting them whenever a village level programme occurs.

Improvements in the health system…

…To make it responsive to people's needs and demands.

The State Advisory Committee (the state-civil society partnership that has set down the parameters for the Mitanin Programme) has identified a set of systemic changes for reform that would go along with the Mitanin Programme. They are as below: -

1. Community basing of health services
2. Delegation and Decentralization
3. Strengthening health intelligence, surveillance, epidemiology and planning machinery
4. Control of Epidemics
5. Dealing with Health problems of the poor
6. Capacity Building
7. Policy for Rational use of Drugs
8. Improving internal systems of the Department of Public Health
9. Workforce Management and Transfer Policy
10. Drug Distribution and Logistics
11. Clinical protocols for Uniform Treatment across the state
12. Management Information System
13. Decentralized Laboratory Service
14. Mainstreaming the Local Indian System of Medicine
15. Dealing with the problem of Drug Resistance in Malaria.

Work on many of the above areas is proceeding in parallel to the Mitanin Programme. Some work that brings systemic improvement in complete synergy with the programme are –

- TBA training programme
- Coordination with ANMs, through village and block level meetings organized, during the training sessions and during their regular village visits.
- Improved designs with village level programmes
- Strengthening referral services up to CHC, with feedback mechanisms to Mitanins for identified categories of health problems.
- Linking data inputs from the community through Mitanin Register with the MIS and Disease Surveillance system.
- Streamlining drug procurement and distribution mechanism
- Eventually formation of a village health plan with the district health system, with in-built feedback from disease surveillance and MIS to enable decentralized planning of health services.

SOME MORE READINGS-

Access to health services, in the country has been 'a part of wider struggle for access to fruits of the overall socio-economic development of the country. The roles of specific health interventions to raise the health status of the masses have been limited as compared to the socio-economic improvements.'

Since independence, India has planned and created number new categories of health personnel like malaria workers, FP workers & MPWs. But many manpower schemes have turned counter productive and wasteful. CHW schemes were started, based on the success of bare-foot doctors of China; but it did not succeed as expected. Though CHWs are considered as agents of social change and meant to bring about community participation, but 'their functioning is hampered by the political and economic context within which they work.' These also result in problems with election of CHWs. This is mostly seen to happen due to lack of understanding on the part of planners about the context and setting within which they have planned the CHW scheme, leading to wastage of precious health care resources.
Anyhow, it is the lack of community participation and centralized, arm-chair planning, without needs assessment are the major problems for an effective formulation and implementation of health policies in the country.

Broad guidelines for establishing a primary health care programme:

- it should start with an overall understanding of the life styles and cultures of the community
- there is need to understand other basic services rendered in the community, so that health care delivery can be better coordinated with other services in agriculture, clean water supply and sanitation services, school health programmes etc which have close links with the health of the communities.
- PHC should be viewed as a process where people participate actively, not only to solve their health problems but also strive to promote their health continuously.
- This calls for keen sensitivity to people's needs and the development of managerial and social skills.

Some Reflections

Mitanins – Their potential and …their future.

Potential for the Health department –

In the present organization of the health system following is the stated functional structure of health services at the grass root level --

The *local health unit* closest to the people serves the first line of responsibility for **community health**. The health officer serves as the administrative head of this unit, who besides providing for the medical care facilities at the PHC or CHC, also collaborates with the local self-government, and may perform any or all of the following functions:

- coordinate health planning
- investigate communicable diseases
- maintain free clinics for early diagnosis and treatment of communicable disease
- provide laboratory services
- conduct immunization clinics
- maintain public health nursing services
- collect vital statistics
- supervise water supply and sewage disposal
- supervise for the quality of food, milk and meat available in the markets
- investigate and supervise general sanitary conditions in public places
- conduct health education programmes
- provide preventive and rehabilitative services in chronic disease control
- promulgate rules and regulations
- provide mental health services
- provide medical care to the indigent
- provide maternal and child health care
- provide for Family Planning Services

Under the 'Rural Health Scheme', which started in 1977, a three tier system of health care delivery was established, based on the principle of "placing people's health in people's hands", as recommended by the Shrivastava Committee.

Under this scheme there are two functionaries at the ***village level*** – The Village Health Guide and a Trained Birth Attendant. They are selected from the local population itself and provided training with a manual and a kit to carry out their functions. They receive technical support and continuing education from multi-purpose workers posted at the sub-centre. The village health committee or the Panchayat should ideally provide other administrative support and supervision.

The VHG besides providing for the first contact primary health care, MCH and FP services and health education is also supposed to look after sanitation of the village. He is supposed to help bridge the cultural and communication gap between rural people and the organized health sector.

There are '*Anganwadi' Workers* also at the village level, provided for under the ICDS Programme. She undergoes a 4 months training on health, especially on nutrition and child development. Her services include health check-ups, immunization, health education and supplementary nutrition to children less than six years of age and to pregnant and lactating women.

Sub-centres are the most peripheral outposts of the existing health care delivery system, supposed to be manned by one male and one female health worker. Both are responsible for the work assigned to them by the medical officer of the PHC for implementation of various national health programmes, and cater to the health needs of the community and refer patients to the health clinics.

The female health worker's (ANM or LHV) duties mostly emphasize on MCH, FP and immunization, whereas male health workers (MPW) are mainly utilized for maintaining sanitation and control of communicable diseases.

This is the formally proposed organization of the health system, but due to number of reasons it has failed to function at the grass roots the way it was supposed to.

Training of health workers came as government projects or scheme, which had no long-term strategy. It came in the form of *Jan Swasthya Rakshak* in Madhya Pradesh (and old Chhattisgarh) and as *Jan Mangal Joda* in Rajasthan.

These Training programmes also never came at regular intervals and have never been monitored or evaluated. There has never been any consistency in their training schedule nor has there been any regular support to the scheme or to these CHWs. So the reasons of their failure have rarely been documented, and whenever the scheme has been evaluated and feedback provided, no proper strategy for corrective measures have been possible.

Against this backdrop now if we see the Mitanin Programme, we will see that they are given all the tasks visualized for the CHW proposed under the Shrivastava Committee, and most of their functions complement the community activities for the peripheral outposts of the public health system. The Mitanin Programme is also conceptualizes and operationalized on the theme of – 'placing people's health in people's hands.

The experiences of other failing government CHW programmes, against the success stories of the Mitanin Programme, provide an excellent learning to the health department.

The training structure of the Mitanin Programme can now be considered as a model for training other CHWs. The structure provides enough flexibility and space for local adaptation, in fact that is how it was meant to be. Here it must also be noted that functioning abilities and operational capacities cannot be seen as components different from the structural components of the programme.

Potential for the Public Administration, or the Government –

CHW should be seen as a major carrier of health education – and only till the time general education has been universalized and has attained a quality. This is when the health education will be completed during their 10-12 years of schooling and people would

become literate enough to acquire further knowledge according to needs, and would know where and how to access this knowledge.

There are so many activities listed for the ANM and other health workers that it would be inappropriate to expect them to carry out all these *activities with minimal assistance and limited skills and knowledge background*. Natural and social *geography of the state, with poor transportation and problems of lack of security* services pose a further constraint to the problem of outreach for these workers.

So, *Mitanins* cannot be seen as another partially skilled health worker assistant, but as an empowered citizen of the community… with adequate knowledge base on health and health care, plus a unique link between community and service providers. Here a thought needs to be given to the fact that till when one Mitanin in a hamlet will need to be replaced with another when the government is unable to replace and develop the more qualified and more needed staff faculties… But, definitely, it needs to go on till the community has not been able to understand the concepts of health education and is not using the pubic-health services provided through the government… And till the community has not acquired other means of continued quality health education for its people and children, or does not have health services close to their houses or at an easily approachable distance from there. That is to say - till the time government's negligence done till now, has not been fully compensated.

If *simultaneously, intensive* efforts to improve the basic health-care services are not made to improve the outreach of the existing the public health system, all the efforts going on in the Mitanin Programme will become a waste… rather it may ruin the whole system to an irretrievable state. It would become too difficult to get this opportunity again, and then to be able to utilize it.

(The need for better infrastructure, training, management and organizational development for efficient functioning and community orientation of the health department can no longer be neglected, or postponed. That is to say, all the funds that were for the SIP, should now be permitted to go in for the actual SIP activities… as it was visualized then by the EC.)

Mitanins can be seen as community's social health activists, who support and take care of the health of the local people and represent them or lead them in the quest for better health and development. They are now the enlightened and most sensitive people of the communities who have a high degree of acceptance in the community, and (to an extent) in the political front also. They represent the great human power of democracy, only it needs to be ensured that they don't become the tools of politics in the hands of those who have acquired more prestige in this democracy.

Non-payment of Mitanins for their work has proved to be one of the **major strength** in this aspect; which has always been critiqued by everyone, everywhere – except of course the *enthused* Mitanins themselves. Another important link is that the Panchayat has always been involved in their selection or in the endorsement of their functioning.

And then, the money for village development, which often goes unutilized at village levels, can now be utilized where the Mitanins can provide local leadership. In these development programmes, where community participation is non-negotiable element of

the planning process, the cadre of Mitanins thus formed cannot be neglected – for the time being till whole of the hamlet's families are empowered through this process of development.

And then**,** in the long run the communities can become self-reliant and intelligent enough to realize their needs, their rights and their leaders. They can demand for, and can act in order to fulfill their social and democratic needs - their rights and duties.

The Mitanin Programme, when it started was the major agenda on government's list – the question of "why?" provides a doubtful answer. It might have been considered important for people's development, or may be for the political party's development – who knows…!?

But**,** SHRC really made a great stride and snatched the Mitanins from the political game. It tried to educate them on matters of health and governance, without letting education and status become a barrier for them. It equipped them with leadership for their own hamlet, without them being a representative for any political party.

Congress**,** who came with the idea of Mitanin, also must not have realized that it would work that ways. Now Congress is no more in power, despite having given such a wonderful scheme for rural health, and BJP can't withdraw the support to this programme. It has gained a lot of momentum, which is now spilling over to force the government to invest in 'health sector!' and frame their policies accordingly… and this is creating real upheaval in the government, with so much funds being asked for in the welfare sector.

With my personal interactions with the Mitanins, I can say that Politics is now almost sidelined at the grass roots, and Mitanins are "in" that may help link the government health centres with the people.

For them, governance is more important…

Governance has now become more important, though the Mitanins have yet many political and socio-economic challenges to face, to be able to reach to its full potential. This may be one of the factors (besides having gained recognition and good-will among the villagers) for them wanting to contest the Panchayat elections.

A mid-term process evaluation of the Mitanin programme has been done. This evaluation was based upon various indicators to assess their skills and programme implementation process…

The knowledge level of Mitanins remained around 50-60%, those who made adequate house visits and regularly filled their registers were never more than 30% and hardly 10% could effectively coordinate with the Panchayats, government officials or health personnel.

The knowledge levels are by no means poor for those women who have never before studied so seriously! – In the training programmes there is a lot of stress on reading of training modules, and there are lot of these modules to be studied, still the Mitanins

'though complained of inadequate training modules, no one complained of too much.' It shows that the programme is giving them, what they want and need.

So what, if almost 50% of the Mitanins were not able to work as efficiently as the rest of them… they at least aspire for it and definetly bear the potential for lot more if adequate support is provided by the…'superiors' (!)

Their function to be able to effectively relate and coordinate with the Panchayats and health personnel **is their true potential** and most important aspect of their functioning. But it can only be achieved after much of confidence has been instilled into them and these officials also respond adequately to their demands, which is anyway most important aspect of good governance. So, again the programme cannot be a success in itself until the government system is also not built up strong enough from within to respond to people's demands and deliver what they truly need. And, Mitanins cannot be considered as an extension to the government health staff…

Mitanin is the voice of those women who would never have been heard in such a backward state as Chhattisgarh even in the next 10 years from now. They have created a wave in the health department, and have a potential for lot more, which no one can avoid or deny.

It is strange that though I was never involved with programme implementation, still now, as I write the pages of this report I can feel that force that has been created in Chhattisgarh by this programme, and can feel the energy that has made it a possibility. Though still - there is still lot to accomplish and lot of challenges to face …if it has to continue in the same direction.

There is thus a major need to search ways for building capabilities and systems that would help in exercising these roles of community representatives and local leaders; as a major component in bringing about overall development of village societies and Government systems. Be it CHW scheme or Panchayati Raj or any other Public Service Department.

…So that a democratic system does not just work for preventing concentration of power in a few hands, but also that it gives adequate powers to each and every individual …and the freedom to be able to use them adequately.

!!!!!!!!!!!!!!

Here there is an important issue of recognizing and accepting women as the best person for local leadership in health initiatives and so… overall development**!**

Need of CHW in the PH system

– Is it the best or a cheaper or quicker alternative to a strengthened PH system?

Community Health Programmes became well known in the seventies. Many organizations carried out different forms of community health work across the globe, and India too has a rich experience of such programmes.

The central motive for these organizations to start a Community Health Worker programme has mostly been one of the following-

1. Some doctors, often doctor couple wants to put their skills to the service of poor.
2. Institutions trying to make a scientific demonstration of the validity of the approach and development of tools or models to replicate this approach.
3. Organizations whose prime motive was to give cost-effective quality care.

When these programmes have run as small projects under voluntary leadership, they have shown to do well. But, when they are large programmes integrated with the main system, as those run by the government, they tend to perform poorly.

One aspect that has been established, by the pioneers of community health action was that improvements in health status could be brought about by a team of well-trained and guided community health workers despite their low literacy skills and educational levels.

Further, there seems to be residua of absolute non-negotiables involved in the success of these programmes –

1. Referral linkages for higher level of illnesses that can't be handled at village level. Usually, at least in the form of a 10-30 bedded rural hospital.
2. High quality leadership providing active support and training throughout the programme.
3. Programme duration of atleast 5-10 years for substantial effect on the health status to be visible.
4. Usually women as health care providers at the community level.

When the government tries to replicate the programme on a gigantic scale, as in the Mitanin Programme, at least these four lessons provided by the CHW programmes that run for a miniscule part of a population can not be compromised with.

Government constructs a CHW programme to improve utilization of health services, by working on outreach and health education. It also stimulates pressures to improve it's own systems and accountability… CHW of a government scheme cannot be an extension of semiskilled professional in an inefficiently functioning health care system… but as an strength to provide for the elimination of some the flaws in the system.

These CHW, apart from improving outreach and health education, generates pressure to increase accountability. This pressure is perceived within the government as being desirable and related to the larger issues of health sector reforms. *But of course these 'pressures' and 'reforms' need to be properly coordinated and timely reciprocated, for maximum benefits and right direction.*

NGOs look at the need of CHW as an alternative against the failing public health system.

With this perspective, if we try to answer the question as to why often the NGO's CHW schemes succeed and government schemes fail. – To this we can add the question as to why these schemes keep coming back in the government policies… and have not yet been realized as very important factor – We Can Add the following points to the discussion.

- **NGOs look at** the need of CHW as an alternative to provide for 'easy' health care against the failing public health system. They provide 'easy' medical care with little assistance from a private doctor and are usually accompanied by other developmental activities done in the same area earlier, by the same NGO.
- NGOs have their own laws and principles different from a government set up. With this it is possible for them to provide those services, and to an extent which the public sector *has not been able to* provide.
- The area covered by the NGO is quite small and their organization itself is not very vast. …The staffing pattern and organizational structure of an NGO is very different and *not feasible in a government sector*.
- **Government** schemes till date have also given the role of extended health professional to the CHW, and have not recognized their role as <u>community representatives</u>. This could have been due to the general politics that prevails and more so, due to the pressure for more health care services.

(And now since when Mitanins have been given the role of drug depot holders, they also appear to be facing a similar sort of a problem in their functioning. Drug delivery becomes the 'visible' service delivery of the Mitanin and it overshadows their role of sensitive community representatives. The development of the Mitanins role has been in a phased manner, and so has been able to provide the general impression about their capabilities and 'various' social roles.)

- The Government cannot look upon CHW schemes as a developmental alternative in rural areas. It can also not be seen as an alternative for the absence of doctors and effective public health care services– which means that lesser skilled professional and cheaper facilities for the villagers when more skilled professional and better facilities are available in urban areas with better accountability and accessibility.
- Having not been able to realize their local leadership potential they have not been able to build up adequate pressure and if whenever it was able to, the government could not provide an adequate and timely response to it.
- There has been limited success in efforts of the government to be able to link these CHWs with the Panchayats (local elected representatives) as an effector mechanism for Panchayats in the area of health. This is in addition to the problem of inefficiency of the Panchayats in health related activities – d/t various problems of the system itself… a separate issue in itself.
- The government has not yet mastered the skill of <u>decentralization</u>, which is most important for CHW schemes, and for Panchayati Raj also. This just

cannot be neglected and is necessary, right up to the village and at least the district level.

And to achieve this, civil societies must be seen as an institution besides the government set up not as an answer to or as an alternative to government structure at the grass root peripheries.

(*Size* is the uniqueness of the Mitanin programme, as that for Godzilla, "size does matter", *for good governance*. To make this size manageable, its local adaptation was important, and that was the compulsion for the Mitanin Programme to collaborate with the civil societies.)

There is thus a major need to search ways for building capabilities and systems that would help in exercising these roles of community representatives and local leaders; as a major component in bringing about overall development of village societies and Government systems. Be it CHW scheme or Panchayati Raj or any other Public Service Department.

It can thus be said: that the CHW programme can (If it has not)
bring about '*Empowerment*'
of the weakest section of the society - to bring about
health awareness and community development.
As a government initiative, it can be an excellent tool or strategy for
'*Community Participation'*.

…The only challenge is that it be properly utilized to its full potential and protected from the prevalent style of government system's functioning, that is- passive-functioning and corruption.

One important issue to be considered here is that such programmes should not be confused as an alternative health care system for the remote rural areas.
But, it must be considered only and only as a supplement of the system to increase its outreach and to ensure proper utilization, as and when required by the communities, through their full participation.

Thus, a strong and a well functioning Public Health System with highly skilled efficient staff is the most important component.
CHW programme is just a beginning - in starting to build an effective system;

- In a way that the communities be involved from the very beginning, in its planning and formation process.

CHAPTER III

Placement at *Prayas*

The organization *Prayas,* as I had known from my prior meetings with Dr.Narendra Gupta; seemed to focus on all the various parameters of Human Rights and socio-economic development of the communities. They had also worked with government health officials and village communities for better health status of people and better health care system.

Seeing the wide variety of work they are involved with, and also knowing that they are working to improve (or find out ways to improve) the public health system and its access to the communities, I had got interested to do my placement there.

I thought that not only I will get a chance to learn about the health system and how we can work to bring about a change in its present state of functioning, I will also see 'communities' closely and learn how to work with them or study them. This will enable me to understand the functioning of the health system and its workers in relation to the local environment and needs of the people and also how they can be more responsive to the communities' perspectives and attitudes.

And then, having had no previous exposure to community-based organization or civil societies I also saw it as a great opportunity to know about them – as a part of the larger system. *Prayas*, being a very powerful and a renowned NGO of Rajasthan, proved to be a great experience in these lines.

Accordingly, I formulated my learning objectives for this 2½ months of placement, or rather prepared a framework to put my observations into a learning process…

Learning Objectives

Having done my first placement with the resource center at state level, where the kind of work done was of coordinating and instructing the district level institutions or voluntary bodies and supplying resource materials and guidence to them; now the next step in my socialization process is to see how actually are these works done by local or district level bodies.

My learning here would include the following-

- How district level bodies involve the communities in planning and implementation of their programme and to what extent they are able to do it
- How they support and coordinate with other neighbouring organizations; and, inversely what is provided to them by these or state level organizations / institutions – how much of it is relevant in the local context and how and when can they manipulate or bargain to suit their local needs
- The relevance of projects, and their approaches at the field or grass-root level
- How do the communities look up to these activities and how they respond to these initiatives
- A little more exposure to experience with the "communities"

- See the interface /intervening structures between the government services and the communities…

Also, taking up some work responsibility would be a skill developing exercise for me. Then of coarse further learning and liking depends on the specific work environment I get here.

Learning from the roles Prayas play as a civil society, besides as a community-based non-government institution that helps government implement some community based programmes- is more or less subtle but I am sure it shall be an important part of my socialization and search process.

Working with Prayas happened after seeing the work of *Samavesh* and a few other service providing NGOs in Karnataka - these gave me a broad understanding about the roles, 'functions' and 'functioning' of civil societies, NGOs and their interactions with the local governing bodies; and the communities – all this is most important to know the ground level situation of the country! …more so for me, as I mentioned – I have never had such exposure previously.

And at SHRC I got an insight - to an extent, about the politics of governance… or wait a minute – may be that was the process of governance I tried to learn there and here at Chittorgarh I learned about the politics!!? I am sorry, had I been an arts student, I might have been able to explain it and taken a stand… but, as of now – it's just an experience for me! And definitely, its got to be a mix of both, it is difficult to draw a line between the processes (technical aspects) of gover*nance* and politics of gover*nment*.

***Prayas* – a profile**

Prayas (Endeavour) is a voluntary organization working for social, political and economic development.

The organization has a **vision** to build a society free from social, cultural, economic, religious, geographical and gender-based discrimination.

Its **mission objective** is that only revitalization of the self-esteem of poor can bring about improvement in the quality of life.

Primary objectives of Prayas are:

- To enable poor to have opportunities for their social, economic, physical and cultural growth.
- To create alternative knowledge and mechanisms for community development.

- To lobby to secure social, economic, political and cultural rights of all
- To respond to contemporary poverty related community needs
- To campaign for gender sensitive conduct and equity.

Substantive Area of Work Focus:

Prayas focuses its work on *aidivasis* (tribal community) *dalits* and gender issues.

Main activities include:

- Universalization of quality education
- Women's social and economic empowerment
- Community based protection and promotion of natural resources
- Advocacy for plugging the process of land alienation through invoking of protective legislation.
- Development of off-farm income opportunities
- Campaign for the marginalized, the *dalits* and for women's rights.

Geographical area of Operation: Chittorgarh Dt. of Southern Rajasthan and some parts of Udaipur and Madhya Pradesh.

Source of Funds:

Foreign Funding Agencies:	Indian Funding Agencies:
a) n(O)vib, Oxfam, the Netherlands. b) Action Aid India, Bangalore c) SDC (Swiss Agency for Development Corporation) New Delhi d) SPWD (Society for Promotion of Wasteland Development) New Delhi e) Plan India **f)** Winrock International Institute for Agricultural Development, Arkansas, Morrilton.	a) Sir Ratan Tata Trust, Mumbai. b) Integrated Population Development, Govt. of India. c) Population Foundation of India, New Delhi. d) CRY (Child Relief and You) New Delhi. e) Aravali, Jaipur

Prayas has been a registered NGO since 1979, I visited it in its Silver Jubilee year. It has had its long and prosperous history, which is very inspiring, but I think I should restrict myself to its present functioning. What all activities I got to see and know about, and got the chance to be a part of…

In short, Dr. Narendra Gupta, founder member of this NGO had started with his clinical practice in the village area of Devgarh, but he gradually realised that only medical care is not what the people seek for their better health. He got involved with other important and more compelling matters of people's health… and working on them, he finally started this organization called *"Prayas"* (Endeavour); and got it registered in 1979.

Fighting for people's rights with the government and creating awareness for health among the people, made the government to ask him / or invite him to run a local PHC

because none of the medical staff stayed there for long. He worked there for quite some time, but many government doctors did not like this idea and some conflicts arose due to which charge of that PHC was taken from him. Since then the organization did not work directly on matters of health; apart from taking up some projects of Government of India, or some other organizations like WHO, CRY, Action Aid etc.

Recently, that is, just one year back they started their own programme on empowerment of rural poor for better health; which they called as the *"Jan Swasthya Sashaktikaran Abhyan"* The project is funded by n(O)vib (Netherlands)and runs in two blocks of Chittorgarh District, Choti Sadari and Badi Sadari that are old field areas of *Prayas.*

During my stay of 2 ½ months there, two more projects on health were finalized. One project was from OXFAM on HIV/AIDS in Chittorgarh itself. Another one was with UNICEF on similar but more detailed lines, as the n(O)vib project. This project was not for Chittorgarh but Dhoulpur, a seperate district in Rajasthan. I got a chance to visit this place also.

Despite these projects on Health and Health systems, most of the time I was not working with these projects, as it was not feasible to get totally involved with their activities during this short period I was to spend in the organization; and also may be, because I wanted to study the over all functioning of civil society. Such activities may not be directly related with health services or health sector but had some relations with them, as they do impact on ones health status. So also because I might not get this chance later!!

Also, apart from their projects on health, for selected districts of Rajasthan, *Prayas* was one of the key NGO involved with the implementation of the IPD project of Government of India.

List of some of the ongoing Projects

- *"Jan Swasthya Sashaktikaran Abhyan"* (People's Initiative for Health Security Project)
- *"Swasthya Suraksha hetu Jan Pahal"* (People's initiative for Health promotion).
- Primary schools of alternative education
- A project of CRY
- Protests and campaigning on the issue of Land alienation*
- Campaigning for social and human rights of *Kanjar* community
- A project on electricity connections, to reduce transmission loss
- Formulation of a Rural housing scheme
- A project on Joint forest management
- Usual routine functioning of SHGs and *Kala Jathas*
- IPD project – planning for Gender Sensitisation training for health personnel, setting up of FCC and selection of Counsellors for the same.
- Finalising of a project proposal for HIV/AIDS and planning meetings for its implementation
- Various *'Melas'* (camps) for children, women health, and for the disabled and handicapped
- Various workshops, conferences and campaigns, with other networking NGOs**

The list above is not exhaustive for all the activities that happened as a part of organizational functions. There were other ongoing activities taken up, from time to time, that were not a part of any project work. These were like - a visit to Baran, for investigation of Hunger Deaths that happened in a specific tribal community of that area. It was investigated as a case for deprivation of Human Rights, followed by a dialogue with the commissioner for corrective strategies, with a newspaper release about the activity.

Land rights of the tribal – Issue of land alienation

According to law, the Government of India allots each tribal family a land for their social and economic development; and they are not supposed to sell off this land to anyone nor is anyone supposed buy this land. If such a transaction does takes place then a criminal case is filed against the one who buys this land from a tribal, and the person who sells off this land *may* not get back his land because then they are considered as 'unworthy' for the land. In such a situation, the land might just stay with the person who bought it…

Often due to economic constraints tribals have sold off their lands at very cheap prices, because they were unable to cultivate the land due to lack of resources… this often makes them homeless. And, if and when caught for selling off their land against the law – they don't get the land back. Thus, the purpose of the law itself is defied.

Prayas identified many such cases and tried to get such people together to claim their land back and to advocate for a change in law so that the tribals don't loose upon the benefits given to them by this law.

They organized a workshop for tribal farmers where they told them about their legislative rights and how according to rules they can get their land back. The attendance in the meeting was not very good, may be because of the distance and work. It was decided to have a village level meeting for those who had lost their lands. They were asked to come with all the relevant documents of their land etc. and together they will try to negotiate with the person who has bought off that land… or file their cases in the court with a plea to change the law.

At a later date I got to hear from the *Prayas* staff, and also read in the newspapers that where people refused to give back the land, the villagers and *Prayas* activists together forcibly took over the land. The police also could not interfere!

The above issue very well showed the role of civil societies can play in influencing the implementation and formulation (mostly amendments) of government policies and in ensuring that such public services are known to the marginalized people, and they adequately avail these services. Civil societies can similarly try to address other serious problems with ***determinants of health*** - the socio-economic

underdevelopment, ineffective agricultural development, inequities, migration of populations, poverty and landlessness… …weaknesses of health systems and poor environmental health issues.

But…

…***'health-care'*** policies don't seem to so straight forward nor so well understood by all, nor peoples attitudes toward it are studied or analysed so that any civil society would actually know how to influence the government or the people for its adequate utilization… this sounds a bit difficult feat to me – I would know only the technical and professional ("bio-medical"-??) functions of the policy aspects. …Lets see how *Prayas* does it… it is renowned to have done so in the past.

Health Committee

Prayas recently got the government orders to formulate a 'Health Committee' at Pratapgarh CHC to ensure its effective functioning; to help monitor and co-ordinate its services to be more community oriented i.e. *Prayas* shall voice the concerns of the community to the health officials, and where need be take the dialogue forward to the government authorities for the necessary policy modifications. I attended the first meeting of this committee, which was chaired by the chief medical officer of the CHC, attended by the medical officers, some nurses and health workers under his jurisdiction, and a few village women; besides the members of *Prayas*.

Health Committees are seen in principle as an important feature for community participation in primary health care provisioning. They are supposed to oversee and promote health activities, are brokers between the communities and the health authorities; they are elected by the communities, but where available, the local resident physician or nurse, are the ex-officio members. The by-laws are supposed to be drawn by the ministry of health; but here as committees are not a regular feature, may be on an experimental basis, *Prayas* seems to have been given quite an authority to direct the functioning of the committee.

Before the outcomes of such committees become visible, which is definitely going to take some time; one needs to see its functioning quite closely to know its impact on hospital's functioning through such 'de-professionalized' monitoring structure, which is supposed to have community representation, and thus an '*explicit'* (?) community participation. It thus becomes important to understand the new dynamics created within the decision making and functional authorities of the hospital.

Integrated Population & Development Programme

The Reproductive and Child Health Programme (RCH), the way it had started, lacked community orientation, which was tried out in RCH II.

The UNFPA funds the IPD project to strengthen this community orientation of RCH programme; with stress on women empowerment and on reducing gender discrimination. The evaluation of this project is done by result based 'monitoring'; unlike earlier when it was done on the basis of inputs made in the programme.

Objectives of the RCH Programme

1) to add quality to Health Care provisioning
2) infrastructure development for better health care services
3) bring in a rights based approach in Reproductive Health Care services and Family Planning Programme

Activities for community orientation of the RCH Programme

- Population development – policies for the same and social sensitization of the policy implementers; also for decreasing gender discrimination, gender based violence and declining child sex ratio.
- Advocacy work
- Reproductive Health Care and health education.

Country programme 5 of programme 6 in its Phase II

This is the formal name of the **IPD** project that started in 1996 - as the programme administrators refer (!)

The areas of work under it are –

I) Reproductive Health Care services and their Management
II) Women empowerment and community initiatives
III) Adolescent Reproductive and Sexual Health (ARSH)

These are the 'Hard' core activities, for accomplishment of which many soft activities are planned. These soft activities are like organising workshops and training sessions for the government officials and the participating civil societies; infrastructure development for facility up-gradation and service provisioning.

For the monitoring and evaluation of activities performed under this programme, seven indicators have been formulated. Various activities to be performed, as a part of this project, are referred to by their output indicators for which they are being performed… {This denotes the importance attached to the indicator for assessment of outcomes of the programme. The programme appears to be indicator driven – making it look mechanical and overshadowing the need for assessment of other unprecedented effects or overall impact.}

Output indicators under Activity (I) of IPD Programme

- Output 1 – decrease unmet needs of couples for contraception to 70%
- Output 2 – provide facilities for Emergency Obstetric Care
- Output 3 – decrease the incidence of high-risk sex behaviour in reproductive age group i.e. 15-49 yrs.
- Output 4 – is related to management of quality assurance in health system

Output indicators under Activity (II) of the IPD Programme

- Output 5 – people (both males and females) are enabled to demand for quality reproductive health services within a rights framework, through supportive environment in the community and health system
- Output 6 – institutional and community mechanism enabled to address Gender Based Violence.

Output indicators under Activity (III) of the IPD Programme

- Output 7 – improvement in the knowledge about adolescent reproductive and sexual health and life skills of adolescents, in-school and out-of-school.

Prayas is one of the key NGOs that are implementing this programme with the UNFPA and Govt. of Rajasthan. This information about the IPD Programme was given during various meetings and workshops I attended as a representative of *Prayas*, or on its behalf.

One was the review meeting at the DM's office, for the activities that were done under the IPD project in the district of Chittorgarh. UNFPA's District Programme Management Unit (DPMU) organised it and was attended by the DM and CM&HO of Chittorgarh, DPMU staff and representatives of the local NGOs and civil societies and key institutions concerned with this project.

Another was an orientation workshop at State Resource Centre, Jaipur with the government officials, civil society representatives and DPMUs of the IPD Project on the issue of Gender Based Violence and for the establishment of Family Counselling Centre in their area. I represented *Prayas*, who not only had the responsibility of setting up a Family Counselling Centre at Pratapgarh CHC, but also works as a civil society monitoring body for this hospital. I also attended a monthly meeting organised at the FCC established in the main police station of Chittorgarh, which is run by another local NGO working on women's rights.

I also got a chance to attend a life-skills training workshop for the village animators. The workshop, was meant for 'output 7' of the IPD programme, and was organized by another NGO working in Chittorgarh. The participants showed great zeal and involvement, performing skilfully in all group activities and role plays. It was a real pleasure to see their enthusiastic tutors - how they instilled spirits in them to keep up the motivations and remove inhibitions from the village women who had always stayed behind their veils. But

the tutor confessed – "I am not sure if what we are doing is really worth it. We, ourselves had real problems understanding this life-skill education and had a tough time practicing for these classes. Don't know how much these women will grasp - to replicate it in front of the other village women. Even if they do – what about its application… …!? …"

…There are no means of assessment, to provide a feedback about the direct community level impact of these activities.

Where no one can deny the importance of having a life-skills education, at the same time it becomes difficult to comprehend its operational-ability, in such disjointed ways through a national programme, which works through a targeted approach. Can't the Education Department be reinvigorated and be involved in a big way for such activities… …?

Being a witness to this district level implementation machinery of the RCH programme, some questions come to my mind regarding the RCH and family planning programmes – after population control policies took the shape of family welfare how did the health department and the administrative machinery got together on these maternal and child care initiatives; and how is the health department playing its role in the process of population development.

The history of evolution of family planning programmes will reveal this process of integration of services for development and health - but it just gets overwhelming to think about the dynamics that must be operating between these two public systems – the public administration and the health administration. I wonder how much the 'health administrators' are aware of the operative principles of public administration and ditto for the public administrators about the (unseen) realities of health care system and its management. I feel that this must be an important determinant in the type of dialogue that takes place between these two departments – *who* gives suggestions, *who* takes the decision, *who* evaluates and assesses the operation of the programme and its overall impact vis-à-vis the relevance of the operational plan and problems faced in its implementation. And then, besides these two departments, there are the special-interest groups, the NGOs and the civil societies; *who* have their powers, positions and ideologies impacting on the decision making and implementation process… does enough harmony; and understanding of the subject exist among all these stakeholders to make the ultimate decision for the ultimate wager – the communities.

…*am I being too idealistic?* – but I feel, I am trying to look for loopholes that might lead to wrong planning or policy implementation… this doesn't give a vision of what a perfect system requires, or how it should be like, or what 'sins' (?) people commit to make the system as bad as it is, but it seems to be leading me to an understanding of how a vicious cycle is created that destroys good intentions and so, a good system.

…*am I sounding lost?* I hope this exercise provides some clarity… … at least show the right approach for breaking such cycles. Such an understanding might just help in reducing the risk of making mistakes - …something which is very evident as we trace the history of Indian Public Health System, its structure and function; vis-à-vis the health status versus the economic growth of the country.

If you are not a part of the solution, you are a part of the problem.

Declining child sex ratio

Disturbed child sex-ratio is a glaring problem in most part of the country and more so in Rajasthan and Punjab, that are relatively more developed among the states in the north.

National figures are – 927 for the year 2001; which was 953 in 1991, 962 in 1981; and 972 in 1961. These figures indicate sex selective abortion with increasing discrimination against girl child; which would lead to numerous negative social consequences.

UNFPA also funds a project for controlling the declining child sex ratio in 5 districts of Rajasthan. They are Jhunjhunu, Rajsamund, Dhoulpur, Chittorgarh. *Prayas* here plays the role of a resource NGO and assists other local NGOs in organization of workshops for this project. I got to participate in four such workshops: one at Rajsamund, which was organized for the local NGOs; two workshops at Dhoulpur for local NGOs and for health personnel; one at Chittorgarh for the media.

Of all these the workshop organized at Rajsamund, was my favourite as it was most informative and enlightening, besides it had the best follow-up with substantial results. Detailed minutes of the workshop are given below, and explain well the importance of sex-ratio, cause, significance and implications of declining child-sex ration.

Workshop on declining child sex ratio

At Rajsamund with local NGOs

17th September'04

Introduction

The partner organizations of *Prayas* in Rajsamand district are *Jatan Sansthan* and *Mahila Manch* in whose collaboration district level activities are carried out.

The workshop with the representatives of the NGOs was organized by *Jatan Sansthan*; and was attended by representatives of various NGOs from across the district.

The workshop began with a round of introduction of all those present. Representatives from various NGOs gave a brief introduction of themselves and their organization. They also stated their expectations from the workshop and how they can contribute in this programme

Sh.Mukesh from *Jatan Sansthan* welcomed all the participants and briefed them about the project and the objectives of the workshop.

Objectives of the workshop –

- To discuss the issue of declining child sex ratio with the local NGOs with it's causes and consequences.
- Thus, work out a strategy of activities to be carried out for stopping this trend and making the PCPNDT Act rigorously implemented.

Briefing on the issue –

Pallavi, as a resource person from *Prayas* briefed the delegates with the census data on sex ratio at national, state, district and block levels…

She said that if we look back in history and demography of developing countries, we see that females live longer and have always out numbered men. Also according to science female fetuses are inherently stronger and so have better chances of survival, still we see that about 100 females are missing in the district for 1000 male children?

She also informed the participants about the PCPNDT Act and its provisions.

Possible reasons of the missing girls and it's consequences –

The group discussed the issue, sharing their own experiences and social learnings.

They said that the basic reason for less girls being born is that they are killed before they are born as they are considered the weaker sex that is a burden and great responsibility on the family. Instead males are preferred because they stay with their parents and carry their lineage forward. Preference for a male child has been a part of our patriarchal society since time immemorial… you can be a proud father of a son but never of a girl.

Earlier the girl child was killed as soon as they were born, but now due to availability of diagnostic USG they are able to know the sex before the child is born so they get the abortion done. Still killing of girl child was not so common as feticide today; so the decline in sex ratio is the problem of technology and development.

In today's world it is not fair to think this way as women have now proved that they are in no way less than men, and are also more concerned and caring for their old parents. There are families who do not consider girls as a problem, but now they want a small family so they go for sex detection in early pregnancy so as to ensure that they have at least one son. They would abort their second girl child for a boy but would never abort a second male fetus.

The baffling question was that *why do women themselves let this happen to their girl child and to their own body…* the reason for this is definitely the age old patriarchy which even women have accepted. Knowingly or unknowingly they support it and are unable to fight themselves out of it for the sake of their husband/ son/ brother/ or farther.

And for the same reason they become enemies of their own sex…

So there is need of empowering women with enough freedom and economic security so that they are able to decide for themselves what they want and not become suppressed by this patriarchy at least if they don't want a matriarchal society!

Despite so much of women's liberation, and now when many don't believe that girl's are a burden, still the sex ratio is not in favour of girls. This is due to many old illiterate and un-liberated women who are aware of this technology… many women agreed that it would continue until the older generation of women die off.

BUT by then it would be too late. By that time girls will become a precious commodity and will need to be kept in parda or prevented from going to college and married off early… some even jokingly said it may also bring back the custom of swayamwar. While other's pointed out that it's a serious matter and may be Dropadi pratha will also start. …which is seen in some communities where bride price is also paid.

The problem of female feticide is so well evident that there are villages known where a *baraat* had come after 150-200 years. There are instances of bride price being paid instead of dowry and inter-caste marriages in families where it was strictly prohibited, due to lack of girls in the same caste.

Issues of concern in deciding for the strategy

Where population and population growth rate is the major problem, couples are expected to plan for their family size and increase the use of contraceptive methods. In doing so, *where pregnancies have to be planned, how do we ensure a sex balance?*

Where population control is the major focus, another more serious issue is the type of care provided for family planning, e.g. the quality of services for MTP, for sterilization operations, the advice given to the eligible couples on family planning and their freedom to choose between options…

Thus, there are further deep issues to women's health, pregnancy risk, and risks due to abortions; and their rights which are linked with the issue of declining sex ratio, which are of a much greater concern and needs to be handled for a just society.

So where everyone was convinced that control in family size is important, they were not sure whether population control will lead to the country's development. They thought that due to large population there is scarcity of resources to bring about development.

But since independence where population has grown twice it's size, economic resources have grown five times.

So, though not at the national level, yet at the family level people need to realize the benefits of small families, in terms of available resources.

People do not consider children as liabilities but as an asset, which do not ask for investment but are earning hands for the family. These people need to realize their responsibility towards their children and get familiar with alternative healthy life style possible with small family size.

One of the delegates pointed out that where family planning is very important, population growth is studied 'and popularised' region and religion wise, neglecting the more serious issues of increasing feticide and declining female population. *This gives us a very sad picture of our social structure and mind construct of our people.*

The group thus concluded that decreasing sex ratio is a problem of advancing technology and development; and increasing population was considered a problem of low education and poverty, rather than ignorance or religion and caste!!

Strategy and Action Plan!!

After such a deep discussion on these issues, with much active participation and enriching inputs from the group members; they finally had to decide on a *workable* strategy within the given conditions. And keeping the discussion in mind, need to implement the plan and materialize our vision/efforts.

A work plan was discussed and responsibilities divided amongst the various local groups. While Jatan Sansthan had tried to get the information regarding the committees to be formed as per the PNDT Act but they could not get the complete information. So it was decided that a group of people would collectively ask for the information. The participants said that most of the people from the district go to Gujarat for medical services as they do not have confidence in the services within the district. Thus sex determination and abortions are also done largely in Gujarat, which is not our work area (?!?). Yet some members wanted to go to the clinics as dummy clients and ask for sex determination to find out whether such tests are being conducted.

Next meeting of the group was planned after a fortnight to share the information collected till then.

"Jan Swasthya Sashaktikaran Abhiyan".

(People's Initiative for Health Security Project)

This health project planned and proposed by *Prayas* is funded by a funding agency from Netherlands called n(O)vib. A project of Government of India and WHO (1999), which *Prayas* had implemented in its area, inspired this project proposal.

To begin with, the project was started in two blocks of Chittorgarh district – Choti Sadri and Bari Sadri, and has been running for quite some time now. It seems to have sort of got stabilised as one of the routine activities of the organization, and its field staff.

The work I was asked to do for this project was to prepare a questionnaire for investigation (verbal autopsy) of maternal and infant deaths; and to prepare a proposal of the health insurance scheme for the beneficiaries of the project, in consultation with them.

Verbal autopsy has lately been considered as an important tool for ascertaining the causes of deaths in developing countries, where most of them go unreported and uncared for due to lack of proper health care services.

Such an exercise helps gather data for insight into the problem - its frequency and its cause – which is otherwise unavailable for analysis and health-care planning. Hopefully, it was a part of this project for similar reasons, but here it is likely to be used for advocacy purposes. By the time filled in forms come in, I won't be here for analysis or its utilization… so I tried to leave a number of foot notes for future users of the form, and tried to explained things to the permanent staff.

It was necessary to field test the form in front of the field workers; and then ask them to fill the forms in front of me. In accordance to how much they were able to understand about the utility and interpretations of the questions and the responses, for their convenience I made the necessary modifications in the form; also to identify or remove the observer's bias and minimize the wrong interpretation in analyzing the forms - as the forms were supposed to be filled in by the field workers who are the local villagers and would be interpreted by a more qualified, technical staff of *Prayas.*

As an important component of health care security, Health Insurance had to be an important part of this n(O)vib project …a buzz word in health sector!

So, a health insurance scheme had to be formulated 'to meet the local needs'… (!?!)

…for the area where the legitimate health facilities available were the (poor) government health care center and 4 private registered medical practitioners, who have clinics in the village but not their residences. [This means that emergency care and care of the critically ill was a major problem, in terms of health care provisioning.]

We had a meeting with the Health Team of *Prayas* at the Choti-sadri office, to discuss on the issues around the various components of an insurance policy.

The focus of discussion remained around the… recognizing and listing of the common disease conditions seen locally where health insurance or financial coverage was required the most – on the basis of recognized need of the people and expenses incurred on such illnesses, people's paying capacity and their willingness to pay for such an Insurance Policy. And also to recognized groups for whom this policy would (or could) be made; and who could be targeted or convinced (!) to accept this policy.

Major points that came up in discussion with the village people were –

- Major chunk of expenditure in seeking health care goes to 'OPD-type' of illnesses. For which people neglect treatment most of the times, either due to money constraints or they don't give it much importance and don't recognize its seriousness. But, the basic reason was that they mostly went to the non-registered doctors *nearby* or *faith healers.* It was said that they avoided government facility in the initial stages of their illness due to the uncertainty of finding a doctor or medicines… and may be because they will anyways have to spend the same amount of money in commuting, and buying medicines etc. besides the time spent.
- Once these common or early stages of illnesses are neglected, they get complicated leading to very heavy expenses at a later date… So, the major expenses come in treatment of complications of an illnesses arising due to neglect, or unavailability of treatment or due to wrong therapy.

Thus, OPD coverage was recognized as the major link in Insurance policy, or a necessity in health *assurance.*

- For the people the problem was not only the lack of money for health care facilities, but the unavailability or inaccessibility of the health services itself.
- Then there were issues as to which health facility to be recognized as one providing legitimate treatment to the policy holders… in this the health seeking behavior and the type of health facility available were the constrains.
- Because government facility was anyways the only reliable service available, so people can be explained and motivated to not to go to the untrained doctors. Also then, there was no need to provide coverage for diseases covered under the national programmes.

  This would also build pressure on the government officials to provide the facilities available, as now the people would know what is provided in a government facility and demand for the same. The other problem that now arose was… that those who were not insured may then be devoid of these medicines.

  Anyhow, Insurance policy was still identified as a strength and necessity in such a situation, as the policy can be used as a means to be able to mould the health seeking behavior of the people, and may be able to force the health facilities to be more responsive and quality conscious.

Government facility was thus '*accredited*' for the insurance policy. In case of distance from the house of the policy holder, nearby registered private hospitals or clinics will have to be identified by the insurance agency, which were anyways not many in the area.

- And then we had to identify important inclusions and exclusions for the policy.
- Conditions that were considered important for **Inclusions** in the insurance coverage were - snake bites, cases of RTI / STDs, obstetrics care and skin diseases. It is important to note here, that these conditions are hardly covered in health insurance policy. Maternity benefits, also unlike other policies, should not be limited to first two deliveries.
- For **exclusions** everyone wanted to keep the list to the minimum, so according to what the company already excludes in their policy, we decided on –

  -- Common cold, jaundice, acidity, nutritional deficiencies, services covered by the national health programmes; Neurotic illnesses, *psychosis* (?), asthma, chronic illnesses like COPD, *hypertension, coronary heart disease, diabetes*

But, if any of these illnesses gets severe and presents as an emergency requiring surgery or necessary hospitalization, then the financial risks should be covered.

- Some minor and common ailments which may at times get severe or require expensive treatment, the minimum cost of illness to be reimbursed could be limited. The health team suggested that if any illness costs more than Rs.100/- then it should be covered. But, that would come out to be very difficult, so arbitrarily, and as a guesstimate everyone preferred to having something like –

  -- Reimbursement is made when the total expenditure exceeds Rs.75 per day, and / or a treatment is required for more than 10 days.

- Then, what do we define as a family. Usually in a family insurance plan, it is defined as 2+2, but this sounded highly inappropriate. The policy should cover all the children at no extra premium. It can limit the number of episodes of illness or the maximum sum insured for the children, instead of specifying children or their number. Or, can have two cut offs – for a family of 5 and a family of 6-8.
- An extra premium can be taken in case the policy holder or her spouse requires coverage for their parents. This extra premium on which people would agree upon could be Rs.75/- per annum per parent, when the premium for the family is Rs.250/- per year.

Thus, we see that though there was a well recognized need for health insurance, i.e. financial assistance for health care services, the terms and conditions of the policy did not at all suit the people.

Despite having all these points on board – 'without adding any confusion' to the smooth running of the project, I was asked to draft Insurance policy, which would suit our needs and also be easy for us to negotiate with the HDFC. '*Parivar Suraksha Bima'* is the Health Insurance Policy which HDFC already has. We made arbitrary changes within the policy, without doing any calculations on the basis of overall impression of the paying capacity of the people, their health needs and services available in the area.

In this draft we also tried to explain to the HDFC people why we want these changes… they can get their calculations done by their underwriter! The company ignored all our concerns – which is anyhow very much understandable. The health workers were able to convince considerable number of villagers for the utility of the insurance policy and HDFC insurance was given to them…

Here, anyone would ask that:

Leaving aside the local context for the utility of health insurance policies that are available - as we see in this case, it is a well known 'Law of Medical Money' that medical costs rise to equal the sum of all private insurance and government subsidy – and this is being done in a village which is already poor and has no access to 'decent' level of health care – not even a proper health education. Where is all the cost i.e. the premium going? What is the need for people who can't control the hygiene of their immediate environment – for them to put aside money for 'unexpected' kind of health risk?

Even leaving aside a simplistic question for complicated technicalities -

We can still say:

It was so strange - if no policy actually was able to meet the needs of the people, why the idea of having an insurance coverage for the villagers couldn't be dumped…? Are the donors so strict about the protocols mentioned in the project proposal…? But before that, I couldn't even understand the need of introducing such a thing in such a project that is titled as 'People's Initiative for Health Security Project' – who are the people who have has taken the initiative of health security, and above all what kind of this security is provided… there have been numerous examples of 'initiatives' at village levels but getting a private business firm to get involved with this – that too not as a part of their social responsibility – is a feat beyond my comprehension.

It is a well known fact that health insurance is a tool for risk-sharing, in case of an 'unexpected' health event – paying a premium for it is more like a luxury for the one who has extra bucks in his pocket; and is also at quite an experimental stage to state its utility with much authenticity. It is well known, that by an informed choice - it is only the middle and the upper class who takes up any health policy, if they want to – and here the poor villagers were 'educated' or may be, 'informed' (if that is the term to be used) for it to be one of the better option to 'ensure good health'. Aren't there ethical issues involved

in introducing such a policy by an NGO without research attached with this approach, without having used or tested other tools or even before assuring better preventive, promotive and curative services in that area. Why one should feel so compulsive for the 'propagated' technologies and tools, which are recognised not to have much utility in the local situation? …I mean to question this to be able to understand and comprehend the purpose, roles and functions of a 'civil society', not just *"any"* society or 'community'.

I don't need answers for the questions I have just posed. No one will want to look for such answers – BUT the prime concern remains: What we, as Community Health Fellows, have to offer to the field of 'community health' in such situations?

My activity calendar at *Prayas*

- 16th Sept. – Reached Chittorgarh
- 17th Sept. – attended a workshop at Rajsamund on declining **child sex ratio**.
- 19th Sept. – *"Bal Mela"* at Bhadesar
- 20th Sept. – Co-ordination Meeting of senior staff members at their head office in Devgarh
- 22nd Sept. – Health Camp at Mongana
- 24th Sept. –a meeting of "*Mahila Suraksha aivam Salah Kendra*" (**women protection & counselling center**) & networking NGOs. With the SP at Chittorgarh Collectrate.
- 27th Sept. – visit to villages of Baran district where **Hunger Death** had been reported.
- 29th Sept. – workshop at Dhoulpur, with the local NGOs on declining child sex ratio
- 30th Sept. – a similar workshop with health professionals, doctors and government officials
- 9th Oct. – People's Tribunal on **population control policies and family welfare programmes**, ISI Delhi.
- 11th, 12th Oct. – monitoring of **Pulse Polio Programme**; as a State Monitor
- 16th Oct. – *"Mahila Swasthya Mela"* at Manpura village, block Choti Sadri, dist. Chittorgarh
- 30th Oct. – an orientation workshop at State Resource Centre, Jaipur with the government officials, civil society representatives and DPMUs of the **IPD** Project for the establishment of Family Counselling Centre in their area.
- – Review meeting of the activities done under the IPD project in Chittorgarh District, at the DM's office
- 2nd Nov. – review meeting at Mongana office of *Prayas*. There work on health had started few months back and this initiative is named as *"Swasthya Suraksha hetu Jan Pahal"* **(People's initiative for Health promotion).**
- 5th Nov. – review meeting at Choti Sadari office of the activities done under the n(O)vib project i.e. "*Jan Swasthya Sashaktikaran Abhyan*" **(People's Initiative for Health Security Project)**

  Also attended a session of life skill education training being given to the village animators under IPD project

- 6-7th Nov. – field testing of **Verbal Autopsy** form for infant mortality; and meeting with the Adolescent girls group in Mongana village
- - Camp for People with Disability: they were told about various government schemes for them, and various certificates and concession forms were provided. Medical check-ups were also performed and crutches, hearing aids, cycles etc. were also distributed to some.
- 29th Nov. - workshop at Patapgarh, with bank officials to prepare a model for **financing a Rural Housing Project** for Devgarh village

  A Planning meeting at Pratapgarh office of *Prayas* for starting the **HIV/AIDS** project
- 30th Nov. – on field work in Choti Sadri for the ongoing external **evaluation** of the n(O)vib project.
- 4th December – left Chittorgarh.

CHAPTER IV

The organization - *Samavesh*

The NGO "*Samavesh*", which I visited for three days, is an offshoot of a renowned non-profit, voluntary organization "*Eklavya*", registered in 1982. The group is well known for its work in the field of children's education.

They basically started work with improving the teaching methodology of Science and Social Science subjects in schools of west Madhya Pradesh. For this purpose they also had a fellowship scheme for school and college teachers, approved by the UGC and funded by the Ratan Tata Trust. Their experiences in field testing of innovative curricula – stimulating learning materials, activities and training programmes, and implementing systems in the mainstream was found useful by number of governmental and non-governmental institutions across the country. They have thus worked as resource agency in education for such institutes or organizations, across the country. Such intensive collaborations demanded from them to provide support in developing all the elements of an education programme. They have thus also contributed greatly by working on women's health issues.

If we track down the history of *Eklavya* – it is interesting and very enlightening to see how gradually they evolved and expanded their work area through their own experiences and learning; Starting from Education programmes to Rural Development and now heading towards the Health programme in the same field area.

They started with Hoshangabad Science Teaching Programme for middle schools, (in 1972) to promote scientific temper in children, making the child a confident life long learner and creator of knowledge. To make comprehensive impact on quality of elementary education, they took up Social Science subjects also. For these purposes they developed resource materials for teachers as well as students, conducted workshops, exhibitions, teachers training and student evaluation programmes. They conducted studies to document classroom transaction processes, which the new teachers can cross-refer and will help them to further innovate the curriculum package.

Working with the middle schools, they noticed that students had not developed the linguistic abilities required for these classes. So, they started a Primary Education Programme *"Prashika"*, which focused on cognitive and affective skills that could ensure overall

We Believe…..

- That education can be a means for motivating people to change the conditions in which they live
- That science and technology are not esoteric spheres of thought and action. They need to be approached with wisdom and a concern for social equity and justice.
- That development must, necessarily, be sustainable and in consonance with environmental imperatives. Such development must be based upon the participation of local communities.
- That education cannot be looked in isolation from the society and environment in which they are located.
- That education should first be centered around the needs and thought processes of the child.
- That education should help to develop problem solving skills, the spirit of enquiry and scientific temper.
- That…

Source- *Eklavya: a profile*

development of child at this stage of schooling. For this they conducted workshops, developed toys and workbooks called *"Khushi Khushi"* for the primary sections. They conducted teacher's orientation programmes and focused on planning and strategy to identify and deal with different levels in one classroom that a teacher has to address. They provided support to schools for implementing the programme. They developed a system of peer follow-up by Cluster Academic Coordinators. They also mobilized the parents and community to help children in education agenda outside the school – to overcome the alienation.

They talked about children's inquisitive minds, their understanding and the role of education plus the relationship between the two. They worked to find out the relationship between schools and society programmes, thus, working towards social change through education!!

Eklavya's main areas of work are:

- Innovations in school education,
- Publication of educational literature,
- Children's libraries, activity centers,
- Popularization of science and society issues,
- Involving the community in planning and development,
- Developing alternatives in rural technology

In their mission to increase or improve the educational status of the people they realized that development of the society has to be a parallel process if they are expected to make the best use of the knowledge gathered so far. They did this through conducting the Rural Technology Projects under which they focused on Natural Resource Management and Water Management. They conducted workshops on organic farming, carpentry, fishery, cheap building constructions and leather making. They also participated in the literacy movements and soon realized the need to work with those sections of the people who don't access schools on a firm basis.

As a result of all this they finally decided to initiate programme to work with Panchayats and in related areas of community mobilization. They thus started the umbrella programme called *"Participatory Planning for Rural Development"* (PPRD) which included:

- Orientation and training of Panchayats
- formation of community groups like children clubs *"Chukmuk"*, groups to develop local leadership "*Jan Pahal*" and "*Sakhi Pahal*" Women's SHGs and Seed Banks for small and marginal farmers.
- Natural Resource Management with support from local Communities and Panchayats
- Community involvement in Health and Education

With increased social organization, disadvantaged groups are in a better position to take up suitable economic activities and related marketing efforts. These activities require increased public awareness through open debates about nature of participatory processes and their role in development.

These activities are concerned with community mobilization, which require to be followed up by increased responsibilities in social sector like health and education, as well as increased availability and improved quality of natural resources.

Organizational Chart of *Eklavya* became thus:-

EKLAVYA
|
GOVERNING BODY
|
ACADEMIC COUNCIL
(Senior full time members of the organization)

_____

| | | | |
| Programme Coordinators | Director | Field Center-in-charge | |
School Education & Development | | Planning & Development
Publication Sub-Committee | | Sub-Committee

Thereafter the Planning and Development sub-committee formed a separate group *"Samavesh"* in June 2004. This was so because the working style and the type of inputs required by this sub-committee were very different from the committee working on children's education.

PPRD is thus the major work area of *"Samavesh"*.

The overall objective of PPRD, and *Samavesh* for that matter, is to evolve a model of community based development, integrating various activities under the guidance of elected representatives and local community leaders.

Their strategy is to identify practical steps that would help panchayats and village communities to develop their capacities and know-how required to do their own planning and implement these plans effectively. PPRD began in the year 1998 and work has been done in all the planned areas, except health. This delay in starting the health programme is not only due to lack of person-power but also because it was not the well recognized demand of the community.

The reason for this was clearly visible in my field visit. ***The people*** there are generally very poor and their real concern is food and income. Hygienic environment and

sanitation even are not on their priority list. Malnourished people and sick child is a common site – they feel that the capability required to avert this is not in their hands. For this, and otherwise also, they need money which is anyhow their major quest and struggle. Nothing else apart from their daily livelihood bothers them – they don't care what the panchayat or the government is doing for them. Good enough if they do, if they don't there are many more things for them to be concerned with.

EPILOGUE

Public health or Community health, for that matter, is a multi disciplinary field.

It is strange that all its allied subjects, though quite well developed in themselves and the need for their application are well recognized, still they have had less opportunities for its practical application. One probable reason I can think of as a medical person is that - medical professionals, the hard core health professionals, are weakly exposed or hardly ever trained to deal with such aspects. They are taught only about the biological sciences for dealing with 'disease' conditions, and the wide array of socio-economic, cultural and political issues that affect 'health' stay away from their domain. This has lead to the beauracratization of the health system - as the medical professionals are unable to respond to or influence the policy level issues. Health always remains as a major political agenda… and many professionals feel that this is something they need to stay away from or cannot interfere with it. Then there are market forces also that influence policies – and would rather actively try to persuade it to suit their interests.

Whatever the factors that have led to the establishment of such a Public Health System, as it is today – they have been very complex; but what is more important is to establish and maintain a 'System' that is required for the present times and hopefully responsive for the future situations.

- Millions wish to change the world into a better place, while a few show the way, how to!
- Many men have the light enough to be a visionary, but only he who clearly sees, can behold the vision.

Nonetheless –

- When young men have vision, dreams of older men come true.

So then, for all Community Health fellows:

Dream this with the joy that I may aid in its coming to those who shall live after us.

- Rosenau