

Outcome Evaluation of the Mitanin Programme:

**-A Critical Assessment of the Nation's Largest
Ongoing Community Health Activist
Programme-**

**Based on an objective sample survey of 1219 Mitanins and their
work.**

Introduction-

The Mitanin programme is the latest in a long series of approaches to government conducted community health volunteer programmes. The earliest major government programme was the Community Health worker programme launched by the flamboyant and controversial minister of health Raj Narain in 1978. Soon after its name was changed to the village health guide programme and this peaked in 1984 and continued till the late 80s. By the end of the decade the programme had tapered off in most areas.

In Madhya Pradesh in the mid nineties there was a major revival of the government run community health programmes in the form of the Jan Rakshak programme- and it was this programme – rated very poorly in its evaluation studies but still very much a priority of the ruling Madhya Pradesh government-- that the newly carved state of Chhattisgarh acquired when it was formed in the year 2000.

In parallel to the ups and downs of community health volunteer schemes in the government sector the community health worker schemes have played an important role in health action by civil society. The first and most remarkable of these was undoubtedly the well known Jamkhed programme. Initiated by the husband and wife doctor's team of the Arole's the Jamkhed programme established that barely literate women given adequate training and support could make a substantial contribution to the improvement of rural health and this could even be seen in indicators like infant mortality. Soon similar programmes like this were successfully undertaken in many parts of the country by many different groups- by RUHSA in Vellore district of Tamilnadu, by FRCH in Mandwa district of Maharashtra, by Sewa rural in rural Gujarat, and by SEARCH in Ghadchiroli so on. Almost all these programmes – largely undertaken in 40 to 100 village clusters demonstrated similar improvements in health status.

The problems of peripheral health care delivery in the government sector on one hand and the successful reports of community health worker programmes from NGOs on the other was to repeatedly inspire the government to itself undertake such programmes- though each time these government run programmes failed to meet expectations. It is in such a context that the Mitanin programme needs to be reviewed. The Mitanin programme is essentially an attempt to scale up the community health worker experience to the macro –scale of a full state. When a programme like Jamkhed gets scaled up by a factor of 540 times and additionally worked primarily through the institutional framework of the government there are considerable alterations to the adaptation and to not only the processes involved but also the objectives aimed for. This evaluation report helps us to understand what was attempted and what we have learnt from this programme as of date for further replication.

The Beginnings of the Mitanin Programme:

The Mitanin programme was announced as far back as November 2001. To the day it is three years now. However work on selection of Mitanins in 14 pilot blocks (community development blocks) started only in May 2002. Even then the basic training materials were not yet ready and the programme took off only by November 2002. In real terms therefore this first systematic assessment of the programme is two years old. In January of the year 2003 the programme was expanded to 80 blocks – including the pilot 14 blocks. Then in January of the year 2004 the programme was again expanded – now to cover the entire state.

The programme design originally mooted by the government in 2001 was put up to a critical discussion in participatory workshop in January 2002, where a wide range of social activists with experience in health issues participated. At the end of three days of discussion that sometimes grew stormy and threatened to break off not only was the contours of the Mitanin programme redefined but the agenda was expanded into one of a strengthening the public health system of which the Mitanin programme now became a component. To the credit of both civil society groups and the government there was an attempt to reach out from settled positions on either side and find a mutually acceptable way forward.

The political mandate of the day however required negotiating. Its mandate was characterized by considerable urgency in meeting the final output goals of a health worker in every hamlet. The deadline was set at two months- what we have now finally taken 3 years to reach. This meant a relative insensitivity to the processes needed. Besides not being process-sensitive meant that by default selection would be done largely by locally privileged sections whose attraction would be that learning these skills would either become a form of employment or at least become the opportunity to learn a trade which in rural India and the prevailing culture of health care is an increasingly remunerative trade to ply. Since employment meant not only considerable government expenditure, but also the ‘dangers’ of unionization and pressures to upwardly increase wages with decreasing accountability of the workforce, the resultant political-administrative consensus would veer towards unregulated and liberal user fees- leading to the generation of unqualified practitioners whose dangers both as the second most important cause of rural impoverishment and as a source of hazardous and irrational therapeutics was underrated – or dismissed as medical professional reluctance.

The final shape that the programme design and the blistering pace of the programme was the resultant of this negotiation between the “January 2002 design” and the political urgencies/compulsions of the day. This interaction continues to shape the programme even upto the present and is likely to define it in the coming period also.

The Objectives of the Mitanin Programme.

The Broad Objectives of the Mitanin programme were defined as:

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

The Operational Objectives (or key processes)of the Programme were defined as :

- *Facilitate a community led selection of the Mitanin and train and deploy this woman as a health activist in every habitation in the state.*
- *Ensure effectiveness of the Mitanin by supporting her internally in the habitation by a women's health committee, the village health committee and the elected panchayats as well as support the Mitanin externally by a cadre of trainers, and the government employees.*
- *Ensure effectiveness of the Mitanin programmes by providing her with at least 20 days of camp based training and 30 days of on the job village training.*
- *Ensure that the Mitanin receives adequate supply of the basic drugs needed for the first contact care that she is providing.*

We note that the above processes are not merely means- but ends in themselves- with collateral benefits that in themselves are significant gains. Thus training 54,000 Mitanins in 54,000 habitations would diffuse knowledge into the community even if they did not deliver all that was expected of them. Or the formation of women's habitation committees would be a significant gain not only for the health sector for all programmes and for women's empowerment.

The objectives broadly conform to the past experience of health worker programmes with these significant changes:

- a. government run CHW programmes did not have a strong component of women's empowerment, or capability building of panchayats, or initiating collective community level action. Even their health awareness components were weak.
- b. NGO run programmes did not emphasis the improvement of government provided health care services or the accountability of the public health system and inpractice links with panchayats could be weak- though they were strong on health awareness and on women's empowerment aspects.

The objectives as formulated for the Mitanin programme by emphasizing strengthening and accountability of the public health system, by emphasizing women's empowerment and collective action and by the nature of its interaction with panchayats have merited the designation of health or social activist in contrast to being called health workers.

This interim outcome evaluation studies how far these objectives are likely to be realized.

Programme Outcomes and Activities with their Indicators:

The Outcomes and outcome indicators, the key activities and indicators are given below: This is as is currently understood and it largely conforms to what was declared at the start of the programme. This is important to understand these indicators so that we are able to understand the evaluation design:

Outcomes	Indicators	Activities	Output Indicators with means of verification
Health Education and Improved public awareness of health issues	Increased health knowledge of every family as measured on a list of questions	<ol style="list-style-type: none"> 1. family level counseling – focus on preventive and promotive aspects – on young 2. village level meetings on health 3. radio programmes 4. kalajathas 	Sample survey to measure <ul style="list-style-type: none"> • how regularly visits are made • how many are listening to radio programmes in groups. • Report on no. of kalajatha programs held in the block
Improved Utilization of existing public health care services.	<ul style="list-style-type: none"> • Immunization, • Complete ANC • Increased Institutional delivery • TB, leprosy blindness: case detection • ICDS utilization 	<ol style="list-style-type: none"> 1. Establish coordination and facilitation of ANM's activities 2. Good coordination with AWW/ICDS 3. Village register maintenance and use 4. Cases referred to CHC/PHC/ANM 5. Sick Cases accompanied to CHC/PHC 6. Increased representation of service failures to proper authorities 	Sample survey to measure <ul style="list-style-type: none"> • Level of coordination established. • Activities done in co-ordinate fashion. • Number of Mitanins maintaining register and the quality of maintenance. • Number of cases referred per Mitanin • Number of cases accompanied to referral center • Representations made.
Initiating collective community level action for health and related development sectors.	Vector control activities Safe water & Sanitation related activities Grain bank and food security related activities	<ol style="list-style-type: none"> 1. Village health plan on vector control and sanitation and food security. 2. Activities relating to vector control being undertaken 3. Activities related to sanitation and food security that were undertaken 	Meeting held for village vector control planning and Village health plans for vector control Survey report of number of hamlets undertaking any of the three activities.
Provision of immediate	a. How many	1. Visits on day 1 of a	

relief for common health problems	<p>receive the four day 1 services.</p> <p>b. How many avail of any of Mitans curative services</p> <p>c. How many were referred for the key referral indicators</p> <p>d. Decrease in utilisation of irrational/wasteful medication</p>	<p>newborn, of a case of diarrhea, or ARI or fever and giving appropriate advice/drugs</p> <p>2. Number of mitans who have adequate drugs – at any time-thoroughout the year.</p> <p>3. Number of cases referred appropriately</p> <p>4. Number of cases for which appropriate home remedies were used</p> <p>5. Knowledge on wasteful medical use</p>	
Organising women for health action and building up the process as a process of womens empowerment	<ul style="list-style-type: none"> Functioning womens health committee or inclusion of health into existing SHG agenda All trainers women and 50% of all management levels. Collective action undertaken by women 	<p>a. Formation and functioning of habitation level womens health groups</p> <p>b. Formation and functioning of SHGs where they are not existing</p> <p>c. Networking of the groups at the block and district level</p> <p>d. Affirmative action to ensure women in management .</p>	<p>Sample survey of habitations for presence and functionality of womens groups and SHGs</p> <p>Listing of management at different levels</p>
Sensitising panchayats & capabilities building in local health planning & programmes	<p>Panchayats develop understanding of health programs & priorities.</p> <p>Able to give leadership to panchayat and Mitans programmes.</p>	<p>Endorsement of selection & involved in no.of activities action Panchayat HDI</p>	<p>Sample surveys and Mitans and panchayats perception of each other Measurement and publicity topanchayat HDIs as drivers.</p>

At the outset of the programme the understanding was that it would take three years of sustained work including the Mitans first year of training to register at the level of outcomes and after that a further two years to register at the level of impact indicators. In May 2003 a baseline of the outcomes expected was taken- but this was for the state as a whole and not district or block specific. This evaluation therefore has its focus on output indicators predominantly.

The Programme Methodology:

The operational unit of the programme is a block. Fourteen blocks run directly by seven select NGOs provided the pilot experience .The programme was then expanded to 80 blocks as the first phase and the last 66 blocks were taken up as the second phase.

The Mitandin programme is made up of seven key steps or processes.

1. **Building up an understanding of the programme at state, district and block level and building up state civil society partnerships to implement the programme at the state, district and block level.** This was done through a well defined process as per a set of guidelines that has considerable flexibility but which needs to be changed only in consultation with the state programme management.
2. **Facilitated selection of the Mitandin by the community & Building understanding of the programme at the village level :** The facilitator that after the all the families of the habitation are adequately informed and interested in this programme they sit together and select the Mitandin. As part of this a team of carefully selected and trained facilitators with a known public service record, visit the villages and interact with local communities to help the community identify a woman in each hamlet who is willing to be trained and function as the Mitandin on a voluntary basis and has the family support to do so. The accompanying media campaign and kalajathas ensure that many women volunteer for becoming Mitandins. They also identify and build up a group of active women who would support her. Special emphasis is paid to involving the panchayat and its health committee in this task and the panchayat officially and in writing endorses the Mitandin selected..
3. **Training Mitandins on Child health** so that they can :
 - a. Ensure that child health components of the ANM and ICDS programme reach the children (done in coordination with the health dept and the ICDS programme)
 - b. Identify children(below five years at risk) by weight for age measurements as well as all children in the first year and counsel and support mothers of such children to prevent infections and optimise feeding practices.
 - c. Ensuring that all families with children below three are visited on the day of child birth, on the first day of a diarrhoea, ARI or fever and appropriate advice given. The first round of training also helps the Mitandin understand the objectives and organisational strategy of the programme. It also informs her about existing public health care facilities and how to go about educating the community on this.
4. **Training Mitandins on Womens health:**
 - a. Help women especially adolescent girls understand the causes and determinants of womens health problems
 - b. Ensure that government programmes to train dais, and to provide care in pregnancy are effective and accessible to the public.
 - c. Ensure that there is a capacity to identify common womens health problems and provide relief for them
5. **Training Mitandins to organise community initiatives for the control of Communicable disease** in coordination with the health department. Special focus initially on three diseases – malaria, tuberculosis and Hansen’s disease- where existing government programmes would be modified to utilise these initiatives and made more

effective. A special programme on control of water –borne disease would be undertaken also.

6. **Training Mitans to maintain and use a simple medical kit ,supplemented by home and herbal remedies, to provide care for minor illness and first aid.**
7. **Training Mitans to help the local women health committee maintain a basic village health register** that acts as an instrument for programme monitoring and local health planning.
8. **Local capacity building and local planning** : the womens health committee, the elected panchayat members , the panchayat health sub committee and other interested persons would develop an understanding of health and health care services by participation in the above programmes as well as special training camps organised for this purpose. This capability combined with tools like the data from the village health register and processes like the collaboration with the health department would help in the identification of local health priorities and the drawing up of local health plans.

Administrative Structure

- 1.** At the State Level the State Health Society and its secretary the director of health services is in charge of the campaign. To assist the state health society an insitution of state-civil society partnership called the State Health Resource Center has been created. This is in charge of programme design, development of training materials, state level training, monitoring and evaluation. It has three programme coordinators and 30 field coordinators who act as the full time state training team. When about 3000 trainers receive over 7 rounds of training and when there are approximately a 1000 training camps per month that need to be monitored such a structure is essential for quality control.
- 2.** At the district level the district

Physical Achievements as of October 2004 :-

TABLE-1

MITANIN PROGRAMME:Progress at a glance as on 23 oct 2004

Sl	District (Total No. of blocks)	1st phase blocks	Selected Mitanin	Mitanin completed 4th Round Training	Mitanins Completed 5th Round Training (Dawapeti)	2nd phase Blocks	Selected Mitanin	Mitanins Completed 1st Round Training
1	Koria(5)	<u>Vaikunthpur</u>	410	410	395	Janakpur	510	415
		Manendragarh	433	416	428	Sonhat	300	268
						Khadgawa	413	395
			843	826	823	Total	1223	1078
2	Jashpur(8)	Pharshabahar	502	466	466	Jaspur	330	330
		kunkuri	400	400	400	Duldula	311	311
		Bagicha	400	400	400	Manora	362	335
						Kanshabel	350	320
						Pattalgaon	528	528
	Total	1302	1266	1266	Total	1881	1824	
3	Korba(5)	Korba	400	400	380			
		Kartala	400	400	400			
		Pali	421	411	400			
		Katghora	415	409	380			
		Podiuproda	824	740	600			
	Total	2460	2360	2160				
4	Janjgir(9)	Pamgarh	413	413	401	Nawagarh	399	(399)
		Bamhanidih	410	390	344	Sakti	370	(370)
		Akaltara	413	320	370	Jaijipur	383	(383)
		Baloda	392	385	369	Dabhra	400	(400)
		Malkharounda	400	386	375			
	Total	2028	1887	1695	Total	1552	1552	
5	Mahasamund (5)	Bagbara	368	316	348	Basna	410	280
		Pithoura	401	346	333	Saraipali	427	397
		Mahasamund	394	330	295			
	Total	1163	992	976		837	677	
6	Bilaspur(10)	Bilha	400	392	(392)	Gaorela	400	400
		Masturi	400	353	(353)	Pendra	283	483
		Patharia	409	400	(400)	Lormi	497	497
		Mungeli	400	379	(379)			
		Kota	400	381	(381)			
		Takhatpur	400	321	(321)			

Sl	Distrcet (Total No. of blocks)	1st phase blocks	Selected Mitanin	Mitanin completed 4th Round Training	Mitanins Completed 5th Round Training (Dawapeti)	2nd phase Blocks	Selected Mitanin	Mitanins Completed 1st Round Training
		Marwahi	488	488	390			
		Total	2897	2714	2616		1180	1180
7	Raigarh(9)	Kharsia	415	415	400	Lailunga	410	365
		Pussour	421	421	407	Daramjaigarh	449	338
		Raigarh	407	400	380	Baramkela	432	392
		Tamnar	390	390	TOT			
		Gharghoda	380	368	(360)			
		Sarangarh	400	380	(50)			
		Total	2034	2374	1597	Total	1291	1095
8	Raipur(15)	Abhanpur	409	367	-	Bilaigarh	479	TOT
		Balodabagar	413	407	408	Devbhog	361	(360)
		Bhatapara	409	390	342	Darsiwa	540	504
		Chhura	469	453	402	Palari	401	383
		Kasdol	483	404	350	Simga	408	TOT
		Mainpur	450	433	409	Aarang	469	TOT
		Tilda	402	365	-	Garyaband	410	(335)
							Fingeshwar	360
		Total	3035	2419	1911	Total	3428	1942
9	Kanker(7)	Charama	361	263	303	Kanker	400	400
		Narharpur	417	355	344	Durgkondal	385	360
						Antagarh	390	350
						Koyalibeda	400	370
						Bhanupratapur	400	400
		Total	778	618	647	Total	1975	1880
10	Durg(12)	Dondilohara	650	623	534	Balod	350	295
		Gundardehi	542	499	496	Gurrur	421	421
		Doundi	330	330	323	Berla	476	345
		Patan	534	392	395	Nikkum	TOT	-
		Dhamdha	407	387	387	Bemetara	NS	-
		Nawagarh	436	398	398	Saja	NS	-
		Total	2418	2629	2533	Total	1247	1061
11	Rajnandgaon (9)	Dongargaon	330	302	330	Khairagarh	400	(400)
		Rajnandgaon	610	540	415	Dongargarh	400	(400)
		Manpur	400	392	400	Chhuhikhadan	400	(400)
		Chauki	400	390	390	Chhuriya	400	(400)

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		Mohala	400	394	400			
		Total	1340	2018	1935	Total	1600	1600
12	Bastar (14)	Bastar	400	369	339	Kondagaon	400	378
		Bakawand	400	400	400	Farasgaon	331	331
		Badekilepal	338	320	320	Makdi	406	366
		Darbha	396	394	394	Vishrampur	403	363
		Lohandiguda	394	390	389	Keshkal	396	359
		Nangur	399	399	399	Orchha	202	(202)
		Tokapal	356	348	348			
		Narayanpur	329	329	300			
		Total	3012	2965	2919	Total	2138	2019
13	Kawrdha(4)	Bodla	416	416	344	Sahaslohara	407	306
						Pandria	430	283
						Kawardha	390	323
		Total	416	416	344	Total	1227	912
14	Dantewada (11)	Bhairamgarh	450	400	395	Bijapur	200	TOT
		Chhindgarh	320	320	280	Ussur	238	(238)
		Dantewada	310	295	267	Bhopalpatnam	274	(274)
		Geedam	320	298	310	Konta	408	(408)
		Kuwakonta	316	307	316	Sukama	302	(302)
		Katekalyan	340	340	-			
		Total	2056	1960	1568	Total	1422	1222
15	Dhamtari (4)	Dhamtari	399	388	398			
		Magarlot	270	231	239			
		Nagri	514	290	320			
		Kurud	363	349	363			
		Total	1546	1258	1320			
16	Sarguja (19)	Ambikapur	580	540	560	Surajpur	415	-
		Lakhanpur	452	438	400	Udagi	470	(470)
		Udaypur	322	290	300	Bhaiyathan	400	400
		Premnagar	311	300	311	Pratappur	458	458
		Ramanujnagar	346	320	322	Wadrfnagar	509	509
		Rajpur	405	381	(405)	Ramanujganj	509	(509)
		Shankargarh	310	285	310	Balrampur	435	(435)
		Kushmi	420	300	420	Lundra	456	(456)

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		Mainpat	400	387	(400)	Sitapur	361	361
		Batouli	400	400	400			
		Total	3946	3586	3828	Total	4013	3528
		Grand Total	32648	31039	28138	Grand Total	24912	21600

Figures in bracket: Training near to complete

ToT: Training of trainers complete, training to start

The Mid-Term Outcome Evaluation of the Programme:

In this context we have organised a rigorous block by block evaluation of the programme to assess our achievements and identify programme areas that need strengthening as also to plan for a continuation phase. .

The objective of the evaluation is to understand our achievements in relation to our operational goals. This is an outcome evaluation that assesses the programme's operational outcomes and does not assess impact on health indices.

Outcome Evaluation Methodology :- It was decided to evaluate the programme in the first 25 blocks past the post- the programmes that had reached the fourth round of training and completed or were about to complete the fifth round of training.

A trained investigator visited 50 Mitanins in each block *selected at random* (out of the expected/estimated 400 Mitanins in place)– in a modified cluster sampling method- and administered a standardized field tested 63 point questionnaire. It took each investigator five days to meet the 50 Mitanins chosen from 10 villages. In each of these 10 villages the investigators also interacted with a cross-section of the village and filled up a second form that looked at completeness of coverage of hamlets by the Mitanins and perception of this programme by others.

This evaluation report is of based upon the data collected from 1250 Mitanins and 250 villages in 25 blocks during the period June to August of the year 2004.

Selection of the evaluation blocks :

The 25 blocks selected were the first 25 who had reached the point of training on the use of the medical drug kit or in others words – those having completed 15 days of training.

These included the following:

TABLE-2

Name of blocks	Name of district	Implementing agency
Pusaur& Kharsia	Raigarh	Lok Shakthi
Gunderdehi	Durg	ZSS
Dondilohara	Durg	ZSS
Pharsabaha	Jashpur	RAHA
Batauli	Sarguja	RAHA
Nagari	Dhamtari	Rupantar
Magarlod	Dhamtari	Rupantar
Marwahi	Bilaspur	BGVS
Podiuproda	Korba	BGVS
Narayanpur	Bastar	RKMission
Nawagarh	Durg	Swapnil Ed.Society.
Dhamtari	Dhamtari	Dhamtari Christian Hosp.
Ghumka	Rajnandgaon	Dt. RCH Society
Dongargaon	Rajnandgaon	Dt. RCH Society
Mahasamund	Mahasamund	Dt. RCH Society
Pithora	Mahasamund	Dt. RCH Society
Baghbehara	Mahasamund	Dt. RCH Society
Bastar	Bastar	Dt. RCH Society
Dabra	Bastar	Dt. RCH Society
Tokepal	Bastar	Dt. RCH Society
Badekilipal	Bastar	Dt. RCH Society
Lohandiguda	Bastar	Dt. RCH Society
Manendragarh	Koriya	Dt. RCH Society
Mainpur	Raipur	Dt. RCH Society
Dondi	Durg	Dt. RCH Society

We note that the two blocks of Raigarh were done together as one unit, i.e. 50 Mitans sampled from a combined frame of 800 Mitans. This was an early sample drawn as part of a process of evaluation with implementing agency as the unit. This was modified soon after but for these first two blocks alone a combined sample was taken as adequate.

We also note that in this sample there is some over representation of Bastar district and some under-representation of Korba district – though both their programmes were at similar pace. Here we found it more important to study the experience from the Bastar area which was otherwise under-represented in the study. For reasons of logistic and time we have not expanded the sample further but eventually every one of the 146 blocks taken up for the programme would be so studied before that block passes on into the continuation phase.

We also note that as against 1250 Mitans who were to be interviewed we reached only a total of 1219 Mitans – a shortfall of 31 Mitans. The lowest figure of Mitans interviewed were for Mainpur block (41), Dongargaon (43), Mahasamund (43), Badekilipal (47), Podi and Mandagarh (48) and Nawagarh (49). In all other blocks 50 Mitans were interviewed. These 25 districts had between them ---- number of Mitans. The 1219 interviewed is therefore a % sample of the total Mitans in these 25 blocks and indeed on the approximately 30,000 Mitans who have reached this stage of training.

Evaluation Findings:

Mitanin basic information:

Most Mitanins interviewed were literate- 88.97% in all. The lowest literacy rate was for the six blocks of Bastar district – where of 250 Mitanin 187 or about 62.3 % were literate and manendragarh where 56.25 % were literate. Even within the six blocks of Bastar there was a wide range with the figure being as low as 17.02% for Badekilipal and 100% for Bastar.

If we look at the range out of 23 blocks for which we have the data 14 had over 90% literacy of which 7 had 100% literacy. Another 2 had literacy in the 80 to 90% range, another 5 in the 60% range(of which 4 were from Bastar) and only two Manendragarh of Koriya (56%)and badekilipal has literacy (17%) had high levels of illiteracy.

The other important parameter that we looked at was the marital status. Our instructions that as far as possible it should be the daughter in law of the house – not the daughter- an idiom in which we are saying that it should be married woman- had been followed. 91.96% of the Mitanins were married and another 4.18% had been married but were now single .Only a small 3.75% of the Mitanins were unmarried.

The number of houses that each Mitanin was allotted is another critical determinant of their functioning and defines their character as health volunteer. Our sample of 1219 Mitanins were together looking after approximately 55560 households or at a family size of 5 roughly 45.57 Households per Mitanin. Looking at the range for households per Mitanin, we find that 36.83% of Mitanin cared for 21 to 40 households and another 31.50% cared for 41 to 60 households. A 18.21% of Mitanins had less than 20 households to look after and at the other end a 13.45% had over 60 household to look after. The three blocks which had significantly larger number of Mitanins with low coverage(<20 houses per Mitanin) were Podiuproda(88%) a tribal highly dispersed block under BGVS and Mandragarh another dispersed tribal block(46%), Pithora in Mahasamund(36%) and Badekilipal in Bastar(32%). All the rest has figures close to the total group average or less.

At the other end magariod, Gunderdahi, Kharsia, Pusaur Baghbahra, Dondilohara and Dongargaon has households with larger than the group average for coverage over 60 households per Mitanin.

There seems to be a clear pattern in these variations. The norm was to have one Mitanin per hamlet . For a population of one lakh the estimate was about 400 Mitanins at approximately 250 population per Mitanin or 50 households per Mitanin. It can be seen that indeed most Mitanins(68.33%) have 21 to 60 households to cover which is what is aimed for and only a smaller proportion have less of more coverage. It is expected that blocks with greater dispersal of people into smaller hamlets would have less number of households per Mitanins. This could explain the situation in the five blocks where many Mitanins had smaller households allotted- but there are many other equally dispersed blocks where this had not happened. Whereas in the smaller blocks the programme has been able to cover all habitations within the allotted 400 Mitanins, in larger blocks there has been a tension line between the two instructions that become contradictory in their implementation. First instruction : There must be one Mitanin per hamlet and second instruction that the norm for number of Mitanins per block is 400. The larger blocks like Gunderdahi and Podi have needed far higher Mitanins to cover every hamlet per block, but

under pressure to limit their number to 400 they have settled at various numbers – shown in the table below.

TABLE-3

Name of blocks	Name of district	Population of block	Expected no.of houses (a family size of 5.5)	No.of Mitanins selected	Expected (Population 2001/no.of mitanin)	Actual no. of households per Mitanin.
Gunderdehi	Durg	178833	32515	542	60	54
Dondilohara	Durg	166000	30181	650	46	56
Pharsabahar	Jashpur	105101	19109	502	38	43
Batauli	Sarguja	59990	10907	400	27	27
Nagari	Dhamatari	165625	30113	514	59	43
Magarlod	Dhamtari	103559	18828	270	70	53
Marwahi	Bilaspur	114236	20770	488	43	38
Podiuproda	Korba	153537	27915	824	34	24
Narayanpur	Bastar	80004	14546	329	44	44
Nawagarh	Durg	153980	27996	436	64	38
Dhamtari	Dhamtari	160723	30427	399	76	30
Ghumka	Rajnandgaon	158000	28727	610	47	36
Dongargaon	Rajnandgaon	110691	20125	330	61	53
Mahasamund	Mahasamund	172157	31301	394	79	54
Pithora	Mahasamund	185502	33727	401	84	34
Baghbehara	Mahasamund	163023	29640	368	80	66
Bastar	Bastar	139153	25300	400	63	57
Darbha	Bastar	68124	12386	396	31	34
Tokapal	Bastar	67518	12276	356	34	35
Badakilipal	Bastar	41267	7503	338	22	27
Lohandiguda	Bastar	74175	13486	394	34	30
Manendragarh	Koriya	67037	12188	433	28	22
Mainpur	Raipur	104240	18952	450	42	46
Dondi	Durg	130000	23636	330	71	38
Pusaur & Kharsia	Raigarh	104412+107284	18984,19506	836 (421+415)	46	48

The selection of Mitanins:

Mitanins were to be selected by the hamlet after consultations with all stakeholders. The selection was to be approved by the panchayat. A trained facilitator was to facilitate this process. The evaluation study data shows that in 61.27% of Mitanin selection village level meetings had taken place- the single most sensitive indicator of a correct selection process. In other words in

as many as 38.73% Mitanin selection had been inadequate. In some of these villages a women's committee meeting may have made the selection and this is an acceptable alternative. However only in 21.61% was this reported and in most of them village committee meetings had also taken place. The most common error that could occur is that the prerak decides on behalf of the village- usually in consultation with the panchayat or I consultation with the govt employees- ANM/AWW. Thus we can see in the most flagrant of these violations – Mainpur block only 4 Mitanins had any hamlet level meetings preceding their selection and 27 were selected by the panchayat and 31 by government employee. This pattern is typical of civil society exclusion and can be used a negative model though we note that it does not mechanically follow that outcomes are poor. Good selection also does not automatically mean better outcomes.

In 44.43% we find the decision is made by preraks. This tends to be higher in NGO programmes where the preraks are from the NGO and they are familiar with and obliged to many village level functionalities or themselves bureaucratic with little understanding of empowerment and processes required. We need to keep in mind that many Mitanins may have an overestimation of the preraks role in the selection process as they may have actively and for perfectly rational reasons identified them and facilitated their selection by the village. However in most villages where neither village meeting was held nor a women's group meeting almost certainly it was a limited prerak based selection. Panchayats were required to approve the selection and where the Mitanin had been selected by the village level meetings the fact that either panchayat or sarpanch also were involved in 59.79% of Mitanin selection is welcome.

Similarly the fact that in 27.03% of Mitanins, government employees were involved or made the selection is also acceptable provided they were only part of the consultation and not deciding the Mitanin on their own.

The block pattern of process indicators on selection given in table – below thus demonstrate important lessons on the nature of leadership and its close co-relation to the processes one is able to ensure.

TABLE-4

			1	2	3	4	5	6	7
Name of blocks	Name of district	Mitanin	Village + Womens meeting	Surpanc h Selected	Prerak selected	Govt. employee selected	Panchay at role	Score (col.1+2×100/3×Total no.of mit.)	Rank
Dondilohara	Durg	50	50	19	45	7	11	46	8
Pharsabahar	Jashpur	50	48	28	29	2	25	51	6
Batauli	Sarguja	50	48	4	3	0	4	35	13
Nagari	Dhamtari	50	50	10	43	10	19	40	11
Magarlod	Dhamtari	50	23	0	4	0	22	15	20
Marwahi	Bilaspur	50	69	31	41	18	10	67	2
Podiuproda	Korba	48	74	24	44	17	20	68	1
Narayanpur	Bastar	50	59	5	20	6	10	43	9
Nawagarh	Durg	49	19 (V)	3	23	0	22	15	21
Dhamtari	Dhamtari	50	37	39	20	36	41	51	7
Ghumka	Rajnandga on	50	30	1	0	27	1	21	19
Dongargaon	Rajnandga on	43	44	24	4	0	9	53	5
Mahasamund	Mahasam und	43	33	43	41	8	41	59	3
Pithora	Mahasam und	48	29	14	23	25	14	30	15
Baghbehara	Mahasam und	50	38	1	2	3	33	26	17
Bastar	Bastar	50	21(V)	2	5	5	19	15	22
Darbha	Bastar	50	52	12	14	27	7	43	10
Tokapal	Bastar	50	40	6	0	23	1	31	14
Badekilipal	Bastar	47	45	7	24	7	3	37	12
Lohandiguda	Bastar	50	42	2	22	1	3	29	16
Manendragar h	Koriya	48	7	5	36	1	8	8	25
Mainpur	Raipur	41	5	1	0	31	27	5	23
Dondi	Durg	50	23	15	32	35	10	25	18

THE TRAINING OF MITANINS:

The programme aimed to provide 20 days of camp –based training and 30 days of on the job training over an 18 month period. This 18 days of training is provided in a series of rounds. The first round is of 3 days duration, the second of 2 days duration, the third round is of 3 days duration again and the fourth round is of three days duration and the fifth round is of four days duration and the sixth round is of two days duration and the seventh round is of three days duration.

The training content of each of these seven rounds was as follows:

Round	Duration of training in days	Content of training	Training Material
1	3	Programme approach and objectives, child health,	Books 1 , 2 and 3
2	2	Child health	Book 3 and Kahat he Mitanin
3	3	Womens health	Book 4
4	2	Malaria and gastroenteritis	Book 5A
5	4	Drug kit	Book 6
6	2	TB/Leprosy	Book 5B
7	4	Drug kit and village health planning	Book 6 and Book 7
Total	20		

At the time of the interim evaluation all the blocks taken up for evaluation had reached upto round 5 – in other words 15 days of training.

Training attendance of the surveyed Mitanins :-

72.33% of the surveyed Mitanins completed 11 to 15 days of training indicating that they had completed upto rounds 4 and/or 5 of training. Another 22.58% had completed 6 to 10 days of training indicating that at least three rounds were completed and only 5.09% had less than three rounds of training.

In terms of rounds of training 45.28% had completed 5 rounds of training and 85.56% had completed four rounds of training. Thus only 1.98% had completed only one round of training and another 4.22 % had completed two rounds and 8.09% had remained with three rounds .

This questions helps us with three different types of evaluation. First and most important it is the most basic of output evaluators. So much money has been spent on training. The simple and most basic question that the evaluator is faced is – did the training happen at all? The answer is yes in 72 to 80% of the times. What about the remaining ten to twenty percent. If we look at the block wise data for the fifth round of training we find that 8 blocks report 0 and one block reports 2 Mitanins trained only. Obviously the programme had not reached the fifth round of training in all the 5 Bastar block and in the Podi block of Korba. In the two ZSS run blocks of Dondilohara and Gunderdahi and in Dhamtari block the fifth round had been completed but the

fourth round had not been completed –thus making for 13 days of training over four rounds. The fifth round of training in Bastar and the fourth round of training in Dhamtari had been announced and was slated to take place in august. Adjusting for this we note that therefore the physical achievement of at least four rounds of training in 85.56% is validated.

The second question that assessing number of days of training exposure is the immediate sustainability and the success of the programme. We note that these five rounds of training are spread out over at least 12 months – and in some of these blocks over 18 months. That means there are long gaps between trainings. If despite these gaps the same Mitanins come back for every subsequent round of training – without any payment whatsoever – not even livelihood compensation – then this testifies to their interest in the programme and that they are benefitting in some way – even though there are no monetary benefits. The number of Mitanins who drop out of subsequent training becomes the first indicator of a failing programme. If we take drop out after training round one the figure would be as low as 1.98%. If we consider missing one of three rounds the figure would still be only 8.09%. We need to note that even these 8% are unlikely to be drop outs – but rather those who missed attending for unavoidable reasons and are likely to make up given the opportunity. We note also that only four of these 25 blocks- Dabra and Bastar and Narayanour – all three from Bastar district and the Pithora district together account for 50% of this 8% who had completed only 3 rounds of training compared to 4 or 5 rounds by the rest. Enquiring further even in these four blocks- the bastar blocks are reported to have had problems in informing the more interior hamlets in a timely manner while in Pithora there is a programme lag in a few clusters that is being attended to.

However even where there is a positive response from Mitanins and no drop outs as such , operational problems– like inability to inform Mitanins in time, or their inability to get away from the work in the forests and the fields, or sickness or marriages or festivals etc are valid reasons for poor turnouts in training sessions leading to a number of days of training missed. We find that the attendance of the Mitanins is heartening. Almost no one has stopped with one or two rounds of training. The lowest performance in this score was in tokapal where 32% had achieved only less than 5 days of training despite 4 rounds of training having been completed, followed by Podi with 19% and Pithora with 10%. In all other blocks the number of days of training and the number of training rounds achieved were remarkably similar. We can conclude that not only did over 85% attend all training rounds but that those that did so came for the training on all days of training!!

A third reason for assessing the number of training days is so as to better comment on knowledge and skills acquired and their functionality. The hypothesis is that the less functional Mitanins are those who are less trained and have therefore less knowledge. In such an understanding motivation is not the limiting deterrent – but the quantity and quality of training. This correlation we shall do later.

Finally a note- that in assessment of number of training days we have excluded two blocks- Nagari and Magarlod. These followed a different pattern based on more decentralised and repetitive one day sessions with a payment of training compensation of Rs 50 per day. Both these trainings, organised by Rupantar reached 10 days of training and the effectiveness of this

alternative approach would be seen in the next session. However this is an NGO led programme operating in an area where they have an established network and therefore needing less intensive monitoring and mobilisation. Such a dispersed training(in time and space) would be too dispersed for effective monitoring or mobilisation in most of the blocks where such a grassroots NGO network is not available- irrespective of the effectiveness of this approach..

KNOWLEDGE AND SKILLS OF MITANINS :-_

There were eight questions that assessed the Mitanin's level of knowledge:

The

- **treatment for diarrhoea,**
- **the treatment of fever,**
- **the correct dose of chloroquine in a child**
- **the six main infant feeding messages,**
- **the six messages for the neonate ,**
- **the recognition of grade II as severe malnutrition,**
- **the treatment of anemia**
- **where to refer for high risk pregnancy case for delivery: CHC/dt hospital or relevant pvt hospital)**

There is a reason to test just these pieces of knowledge. The major impact on health status especially on the health of the children that we expect from the Mitanin programme relates to precisely these seven messages plus one more – the early diagnosis and treatment of acute respiratory infection. (This last question on ARI was rejected after field testing of the questionnaires due to ambiguities in understanding and interpreting the question and the reply .)

The quality of the answer for diarrhoea was graded into four grades- a completely correct answer , a correct answer , an inadequate one and a wrong answer. (A completely correct answer not only stated oral rehydration but could also tell the exact way home made fluids was constituted. If there was a minor mistake in one or other constituent or a minor one – like lemon that was missed then it was graded as a correct answer. If on the other hand a major component was left out or wrongly stated or the composition could not be told then it was considered an inadequate response. If oral rehydration was completely missed it was called a wrong response.).87.04% of the Mitanins gave a correct answer with as many as 64.07% giving a completely correct answer. 10.58% of the answers were inadequate and only 2.38% were wrong. Three blocks performed poorly – Pithora in mahasamind(40% inadequate), Badakilpal in Bastar(46.8%) and 42% in Dhamtari district.

On treatment of fever 80.48 % of Mitanins gave an acceptable answer . Only 19.52% failed to give an answer. The correct answer has four components- paracetamol, tepid sponging, chloroquine and blood smear examination. 15.67% named only one of these four components, another 25.35% named two of these components, 17.56% named three components and 21.90 % named all four components. The blocks from which maximal complete responses were obtained

were the two RAHA blocks of Batauli 88 % and Pharsabaha 94% respectively, and Dongargaon (93%)(79%), Mahasamund and Baghbara (68%)blocks. All the blocks who had not received the fifth round of training – the five blocks of Bastar also fared poorly in this question as did nagari and manendragarh.

When asked the dose of chloroquine for the two year child 44.54% gave the correct dose and duration while another 26.53% gave correct dose but not the complete duration. However 21% gave an answer that was inadequate in dose and another 8.12 % could not state the dose at all. In this Magarlod fared worst with 80% giving an inadequate response and (28% in Nagari and Dhamtari), 73.46% in Nawahgarh, and 56% in Tokapal , 46% in Dhabra, 44% in Pithora and 55% in Badakilipal. In contrast in Pharsabaha and Batauli programmes (both RAHA organised)there was a 100% response and a 98% score respectively!!

The Mitani's knowledge on what corrections in feeding practices are needed was fair—23.3% being able to relate all six messages correctly and another 41.02% stating between 3-5 messages. Another 30% could relate only 1 to 2 messages which is indeed inadequate and a small 6.40% missed all the messages. Thus about 64% had acquired adequate knowledge of the key messages on child feeding practices with relation to the prevention of child malnutrition.

Those with less than 50% having adequate knowledge included –Nagari(46%),Pithora 36%;Darba 20%,Tokapal and Badakilipal17%, Lohandiguda 54%,Nawagarh 24%,Magarlod 36%. The high performing blocks – over 90% adequate were Karsiya/pusaur(96%),Baghbaha(96%), Marwahi 98%, Batauli and Pharsabaha(100%) Podi84%, Bastar and Dondi 68%, Mahasamund 91%; Ghumka 84%.

Perception of malnutrition as a problem and understanding of growth monitoring as a strategy was tested by a question on the meaning of stating grade II malnutrition. 31.54% of Mitani's knew that in Grade II Malnutrition child is very weak and needs urgent action(the correct response) while another 34.98% said the child is weak – an acceptable response though less than what we had trained for. But 18.39% said they did not know and another 15.11% said that the child was normal. An unfortunately common misperception is that grade I and II are normal but only grade 3 and grade 4 are called abnormal.

The poor performers for this question was Kharsiya /Pusaur (38%);Nagari 36%,Pithora 52%,Darba 46%, Badakilipal/15/47; Batoli 10%,Lohandiguda 26%; Magarlod (52%),Dondidlohara (44%).

In messages appropriate to the neonate - a perfect score was six messages and only 5.58% achieved this.(breastfeeding in first hour, adequate food for mother, weighing the child, referral if below 2 kg, keeping the baby warm including no bath for first week, BCG and polio immunization). The single most important message was breastfeeding in the first hour and 46.18% stated this. As many as 53.81% missed even this message. This was disappointing as we can see later that this is one of the changes that have happened in a big way. However there was a serious programme lacunae in that this message had not gained prominence in the main training material and therefore got lost out in the transmission. It has been subsequently strengthened by a special programme.

Good performers were Pithora and Baghbaha (84% and 80%)and Narayanpur(68%) and podi (58%).

The question on anemia required four components – increased iron rich foods intake, iron tablet supplementation and search for causes of blood loss/basic cause of anemia; Only 15.01% got all three components correct. But if we look at the first two components as an adequate answer then we find that another 45.02 % got it correct- a total of 60.03% for adequate answer. For any two components as adequate the figure rises only by another 1.56% - meaning that searching for blood loss or cause of anemia was the most common component missed. Yet another 33.38% had got one of the three components right. Only 4.92% missed it entirely.

On appropriate referral center for high risk case 37.98 said a district hospital and another 6.08% quoted an appropriate private sector facility and 32.35 named the local CHC. All of these can be held as correct answers though most of the CHCs are not yet functional as referral centers. In correct answers were trained dai(0.09%); PHC- 17.96%, sub-center 1.61% and could not answer 3.93%..

Now if we tabulate and sum the scores of all seven questions we find the following:

TABLE-5

Name of blocks	Name of district	1	2	3	4	5	6	7	8	score (sum of col. 1-8×100 / 400)	Rank
Pusaur& Kharsia	Raigarh	47	46	28	48	19	14	10	NA	60.57 (out of 350)	16
Gunderdehi	Durg	50	44	29	42	33	11	6	NA	61.42(out of 350)	14
Dondilohara	Durg	45	33	41	27	22	28	28	45	67.25	11
Pharsabahar	Jashpur	49	3	50	50	49	25	50	49	81.25	3
Batauli	Sarguja	50	6	49	50	5	15	49	47	67.75	10
Nagari	Dhamatari	43	4	36	23	18	11	19	18	43	25
Magarlod	Dhamtari	45	32	35	22	27	27	24	20	58	19
Marwahi	Bilaspur	49	46	48	49	49	20	47	50	89.5	1
Podiuproda	Korba	47	43	42	42	32	28	43	30	76.75	6
Narayanpur	Bastar	45	35	41	33	47	34	34	49	79.5	4
Nawagarh	Durg	36	40	13	12	39	23	31	25	54.75	22
Dhamtari	Dhamtari	29	45	36	28	48	21	46	45	74.5	7
Ghumka	Rajnandgaon	49	37	44	42	43	25	43	50	83.5	2
Dongargaon	Rajnandgaon	42	42	38	35	42	20	0	16	59	18
Mahasamund	Mahasamund	41	40	35	39	40	19	0	36	62.5	13
Pithora	Mahasamund	30	41	28	18	26	42	16	43	61	15
Baghbehara	Mahasamund	49	14	34	48	46	40	37	11	69.75	9
Bastar	Bastar	37	45	44	38	47	24	43	39	79.25	5
Dabra	Bastar	42	27	27	10	23	14	42	26	52.75	23
Tokepal	Bastar	41	32	22	8	31	22	28	46	57.5	20
Badekilipal	Bastar	25	36	21	4	15	20	20	46	46.75	24
Lohandiguda	Bastar	47	5	47	26	13	20	32	31	55.25	21
Manendragarh	Koriya	40	25	29	25	32	20	27	44	60.5	17

Mainpur	Raipur	39	35	25	27	28	20	38	39	62.75	12
Dondi	Durg	44	32	37	38	26	20	39	49	71.25	8

Method 1 for consolidation

Q1 diarrhoea: 1+2

Q2 fever: 2+3+4

Q3 chloroquine: correct+ mixed

Q4 feeding messages: (3to 5)+ 6

Q5 grade II mal: 2+1+3 (weak+ weak and diseased, risk of death)

Q6.neonate: (1-2)+(3-5) + 6 :

Q7: anemia: 4+5+6+7:

Q8: High risk referral: 3+4+5

Put scores in each box and then rank vertically. Average rank in last box.

Interpretation:

We get a modest but fairly accurate description of the state of knowledge after 15 days training.

It is difficult to declare determinants of the patterns seen.

The poorer literacy rate blocks have performed less well.

The repetitive one day training approach of Nagari and Magarlod does not confer any advantage- it may be substantially weaker in training outcomes than the mainstream camp based approach.

There is considerable variation in performance even within the same organization and within closely related questions. There are also blocks that do very well on some questions and very poorly on others. These variations are best explained by relating it to which issues the key resource persons chose for emphasis. When there is so much new information poured in necessarily the emphasis is retained on a smaller set. The determinants of this set are the key resource persons and what they choose to emphasize. The prominence of the message in the texts also influences this.

If the training is seen as a continuous process then one is encouraged by the fact that in 15 days so much has been achieved. By now bringing attention on the gaps identified- they can be closed. However if training is limited to these many days then one would find that the correct scores are not good enough as the scores would be weaker precisely where there is a greater need for these messages. However in any such massive training/learning process the time taken for different participants to reach the desired levels of knowledge would vary within the group. This would depend on literacy levels, the existing knowledge in the group, and the efficiency of the training process. The aim of the programme organizers must be to keep the achievement levels as fixed and to treat time and number of training days as the variable. Thus the weak low literacy, low background knowledge blocks of Bastar where training programmes had to contend with different languages -probably needs 30 camp based training days to reach the desired level as compared to Mahasamund and Baghbehara which needed only 15 to reach that level. Mechanically expecting everyone to cross the finishing post at the same time is unrealistic.

In such a light what has been achieved is good and in another 10 days – over a six month period we expect to reach 100% achievements in the core messages in all these areas of knowledge.

THE FUNCTIONING OF MITANINS.

Mitanins were assessed for functionality on the following tasks.

- Counselling and Health Education :-
- Maintenance of Gram Register :-
- Improving health service delivery --Coordination with ANMs and Anganwadi Workers and Referral Services offered by the Mitanins :-
- People Organization and Empowerment by Local group or committee formation
- Involvement of Panchayat in their activities :-
- Advocacy :-

Counselling and Health Education :-

The Mitanins central role is interpersonal health communication. This was expected to take two forms. Firstly regular house to house visits . Secondly consultations offered a person who got a minor or major ailment with special emphasis on reaching out any family on the first day of child-birth or an episode of diarrhoea, fever, or ARIs with or without drug treatment.

On the whole 82.36% of the Mitanins reported making house visits for counseling in the previous week. The majority of them – 58.65 % had visited a small number of houses – less than 10 households, while another 14.77% had visited 11 to 20 households and 8.94 had visited more than 20 households. Since number of households vary it would be wrong to conclude that the Mitanins were visiting too few households- yet on an average each Mitanin had about 40 households to visit. Thus a Mitanin who visited 20 households in the previous week is visiting every house once a week to once in two weeks and those who visited 11 to 20 households I visiting every household anywhere from once in two weeks to once a month. Quite and adequate frequency. Thus in this first of process indicators of functionality we can state that 23.71% are making adequate visits and 58.65% are making visits whose frequency is sub-optimal and 17.64 are not making house- visits as desired.

TABLE-6

	Col 1	Col.2		
Name of blocks	Mitanin	Houses visits last week	Score (col.2 ×100 / col.1)	Rank
Pusaur& Kharsia	50	18	36	23
Gunderdehi	50	18	36	23
Dondilohara	50	22	44	19
Pharsabahar	50	28	56	12
Batauli	50	26	52	15
Nagari	50	12	24	19
Magarlod	50	29	58	8
Marwahi	50	30	60	5

Podiuproda	48	28	58	8
Narayanpur	50	31	62	4
Nawagarh	49	29	59	6
Dhamtari	50	24	48	18
Ghumka	50	29	58	8
Dongargaon	43	22	43	16
Mahasamund	43	28	65	3
Pithora	48	35	73	1
Baghbehara	50	29	58	8
Bastar	50	25	50	17
Darbha	50	11	22	25
Tokapal	50	33	66	2
Badekilipal	47	28	59	6
Lohandiguda	50	22	44	19
Manendragarh	48	27	56	12
Mainpur	41	22	54	14
Dondi	50	22	44	19

When it comes to consultations for illness the figures show that 63.58% had in the previous week advised on illness management and of these 23.22 had counseled for at least here different illness types and 24.28% for two different illness types. The numbers for number of illness episodes would have been higher but recall of how many persons were advised on is so hazy that such a question did not have a reliable or measurable response. However if we did query how many persons with diarrhoea they had advised on ORT and the response we got indicates that on an average each Mitanin had counseled at least 8.34 persons with diarrhea on ORS therapy in the past month. Again not surprisingly there was a wide variation between individual Mitanins in a block and more difficult to explain between blocks. Thus in Dongargoan the number of persons counseled was almost 29.93 persons per Mitanin whereas in neighboring Ghumka it was as low 4.72 per Mitanin.

A more sensitive and reliable indicator was to find out how many newborns were visited by Mitanins in the first day or first week. We find that out of 1516 recorded births in the previous three month period in 23 blocks the numbers visited were 1043 or 68.79%. We note that though 68.70 is, for this stage of the programme, an acceptable figure the total number of newborns reported is much less than expected and therefore simple birth registration needs to rise considerably. Birth registration should be given far more emphasis than the campaign has given to it as of now.

TABLE-7

	1	2		
Name of blocks	Mitanin	Effective counselling (First day or week visit for new born)	Score (col.2 ×100 / col.1×2)	Rank
Pusaur& Kharsia	50	17	17	21
Gunderdehi	50	12	12	25

Dondilohara	50	32	32	6
Pharsabahar	50	26	26	10
Batauli	50	24	24	12
Nagari	50	14	14	24
Magarlod	50	23	23	14
Marwahi	50	22	22	17
Podiuproda	48	26	27	8
Narayanpur	50	30	30	7
Nawagarh	49	23	23	14
Dhamtari	50	18	18	20
Ghumka	50	17	17	21
Dongargaon	43	42	49	2
Mahasamund	43	18	21	18
Pithora	48	40	42	3
Baghbehara	50	55	55	1
Bastar	50	25	25	11
Darbha	50	15	15	23
Tokapal	50	19	19	19
Badekilipal	47	33	35	4
Lohandiguda	50	33	33	5
Manendragarh	48	26	27	8
Mainpur	41	20	24	12
Dondi	50	23	23	14

To judge effectiveness of visit we also sought to know what was the experience with the latest birth in their hamlet- did the mitanin go and if she went was effective counseling given and did they accept the advice for breastfeeding of milk from the first hour. The number that went and gave effective counselling within the first week was taken as the indicator for comparing between blocks.

A similar situation exists as regards prompt attendance of fever. Mitanins attended on roughly 2.83 cases of fever per month and of every 100 cases of fever they attended to they ensured that chloroquine ws given in 65.7 cases and that a blood smear was taken and sent for examination in 30.02 cases.

These figures are all far short of the desirable 100% but if we understand that largely these services would not have been received if not given by the Mitanin we can see that there is a tremendous increase in outreach of services. However again the number cases of fever the Mitanin is managing is very small amount and though other cases may be going to other health care providers the chances are that the majority of them are just not accessing any care whatsoever. In other words though this is a great advance there is a much longer way for the Mitanin to go so as to reach every case of fever.

In increasing utilisation of the Mitanin for this first contact care if one critical limitation is her knowledge the other limitation is her access to drugs from the public health system. The figures in this respect are very poor. Only 25.27% had access to chloroquine , only 21.16% had paracetamol, only 14.14 % had cotrimoxazole and for all the other 7 drugs in her kit only 9.5 to 13.45 % had got them. Even these figures of about 10% for most of the drugs come from only

four blocks- Gunderdahi, Dondi lohara, Dhamtari, Nawagarh where drug kits had been distributed. In the absence of distribution of these drug kits the public health system at its field level would have considerable reluctance to extend the drugs to the Mitanin. Thus even chloroquine for which no drug kit was necessary had reached 25% of the Mitanins- despite such a high functionality as shown. List- Chloroquine, Paracetamol, Cotrimoxazole, Metronidazole, Albendazole, IFA, Antacid, GV Paint, BB lotion.

Another specific area of counselling is in pregnancy- but this we shall examine along with outreach to government maternal care services.

Maintenance of Gram Register :

Of the Mitanins surveyed 82.44% maintained the village health register and as many as 17.86% did not maintain the register. Of this 17.86% , the main defaulters were from Karsiya/Pusaur and Gunderdahi and Pharsabaha (– where the register in some inexplicable programme gap had never reached or reached too late. They accounted for 9.02% of the total. The rest of the unfilled registers were largely less than 5% per district and represent the non functional Mitanins and also the illiterate Mitanins with inadequate support.

To assess quality of register filling is more difficult . We looked at how many houses had entered in each register as compared to how many houses they were looking after . This is because we had noted that when registers were very mechanically and inadequately filled they tended to just enter a few houses and not all the houses in their coverage areas. But of those who had filled registers- 296 (24.26%) had entered less than 20 houses which compares favourably with the 222 who had coverage assignment of less than 20 houses. Those who had entered data on 20 to 50 houses were 575(47.13%) as compared to the 449 persons who had been assigned 20 to 40 houses. Those Mitanins who had entered 50 to 70 houses in their registers were 234(19.18%) and those who had entered above 70 were 72 as compared to 384 in the 41 to 60 houses allotted group and 164 in the above 60 houses group.

Though the groups are not strictly comparable , the data is however clear enough to show that broadly most Mitanins have entered in their registers all the families they had been allotted.

The next indicator of quality is to look at how many Mitanins have entered in data of immunisation and weight of children below 3, as well as regular entries of birth and deaths. We find that 52.17% of Mitanins have entered data regarding child weights, 68.09% have entered data regarding immunizations and 46.76% are regularly entering data on births and deaths. Adding it together and ranking them we get the score card given in the table below.(one point if immunization is filled , one point if weight of children is taken and one point if births and deaths are recorded) For 50 Mitanins the maximum mark is 150. But as number of Mitanins sampled varies the total score of the block is divided by the number of Mitanins to get the average score per Mitanin. This is a relatively sensitive and reliable process indicator of register use as these three data are the key to ensuring the effectiveness of the Mitanin programme.

TABLE-8

Blocks ranked by quality of Mitanin register entry

Rank	Block	Total score	No of Mitanins	Per Mitanin score	Rank
1	Batauli	149	50	2.98	1
2	Pharsabahar	129	50	2.58	2
3	Tokapal	106	50	2.12	5
4	Badekilipal	105	47	2.23	3
5	Baghbara	99	50	1.98	6
6	Bastar	98	50	1.96	7
7	Mahasamund	96	43	2.23	3
8	Podi	94	48	1.95	8
9	Lohandiguda	88	50	1.76	9
10	Nagari	87	50	1.74	10
11	Pithora	87	50	1.74	10
12	Dabra	87	50	1.74	12
13	Karsiya/Pusaur	85	50	1.7	13
14	Dondi	81	50	1.62	14
15	Gunderdahi	80	50	1.6	15
16	Marwahi	78	50	1.56	16
17	Dongargaon	77	50	1.54	17
18	Narayanpur	72	50	1.44	18
19	Ghumka	68	50	1.36	20
20	Manendragarh	67	48	1.39	19
21	Dhamtari	63	50	1.26	21
22	Magarlod	62	50	1.24	22
23	Dondilohara	41	50	0.82	23
24	Mainpur	31	41	0.75	24
25	Nawagarh	6	49	0.12	25

Increasing access to and utilisation of primary health care services :

The main approach to achieving this is through better coordination with the peripheral health workers mainly the ANM and the AWW in their tasks and by referring cases to the health facilities – subcentres, PHCs or CHCs.

Coordination with ANMs :-

66.57% of Mitanins report that ANMs meet them regularly during visits.

Predictably all the 6 blocks where most Mitanins report poor coordination are NGO led programmes where funds are directly received by NGOs- but we note that the remaining 8 NGO led blocks report much better coordination. Among health dept led blocks also a number of blocks – Dongargaon,Badekalipal,Lohandiguda ,Mandragarh also report poor support .

What ANM functions have Mitans been helping on—69.95% have been helping on immunisation, 56.60% have been helping for conducting surveys, 36.83 % have been helping in antenatal care, 20.75% have been called upon to help during health camps and another 5.58% report other categories of assistance.

TABLE-9

Name of blocks	1 Mit.	2 ANM meet to mit.	3 Immuniz ation	4 Survey	5 Pregnancy	6 health camps	7 Other helps	Score col.2+col.3 ×100/Tot. no. mit.× 2)	Rank
Pusaur& Kharsia	50	31	35	35	29	14	7	66	19
Gunderdehi	50	23	13	27	1	1	2	36	24
Dondilohara	50	38	34	37	38	0	4	72	14
Pharsabaha	50	50	50	50	43	39	4	100	1
Batauli	50	50	50	42	28	40	5	100	1
Nagari	50	44	28	18	6	2	0	72	14
Magarlod	50	42	25	12	6	3	9	67	18
Marwahi	50	41	47	24	45	10	0	88	6
Podiuproda	48	27	36	30	6	4	1	66	19
Narayanpur	50	43	39	9	6	6	2	82	8
Nawagarh	49	17	7	1	2	0	3	24	25
Dhamtari	50	33	43	31	0	0	0	76	12
Ghumka	50	42	44	36	31	8	1	86	7
Dongargaon	43	43	42	42	20	21	4	99	3
Mahasamund	43	37	40	38	37	1	1	89	5
Pithora	48	39	29	30	7	11	2	71	16
Baghbehara	50	41	41	39	28	31	5	82	8
Bastar	50	44	4	33	6	2	1	48	23
Darbha	50	34	42	37	33	17	0	76	12
Tokapal	50	47	19	26	3	1	1	66	19
Badakilipal	47	34	40	14	18	13	0	79	10
Lohandiguda	50	29	39	30	11	23	9	68	17
Manendragarh	48	28	28	1	3	1	2	58	22
Mainpur	41	40	41	33	30	2	1	99	3
Dondi	50	46	33	5	12	3	4	79	10

Coordination with Anganwadi Workers :-

AWW in hamlet, help to aww,

Only 63.08% of the hamlets, in the surveyed blocks, have an Anganwadi.

Whether the Mitans helped or not also relates to whether there is an AWW in the hamlet.

In dalia distribution 56.11% of Mitans helped, 47.99% promoted their visiting the AW regularly, 45.37% in weighing the child, 36.08 in diagnosing and counseling on malnutrition, 45.94% on immunization and 6.32% in other categories of assistance.

“Successful” Referrals made by the Mitanins :-

54.47% of Mitanins have referred cases to ANMs/health sub-centers and 40.53% have referred cases to PHC. A small but very significant 17.0% have actually accompanied the patient to the health facility on one or more occasion.

How frequent is their referral? About 3.41 cases every month are referred by each Mitanin. The common causes for referral in terms of frequency are – pregnancy and its complication; fever, vomiting, weakness/anemia or other non specific malaise; respiratory infections, pain and others.

Of the cases who were referred to ANM 77.5% said they had a good response, and 21.86% thought it was a fair response and only a very small 0.1% reported a bad response.

Of the cases referred to a PHC or CHC- largely to CHCs the 78.49% had a good response, 17.17% got a fair response and only 2.75% reported a poor degree of care.

Local Capability Building and Womens Empowerment:

One of the most important ways by which the Mitanin programme empowers women is that they are organized for collective action to improve their health status. The central vehicle of that is the functioning of the hamlet level women's committee.

There have been two recommended approaches to formation of the committee. Firstly if there is already a functional hamlet level committee available then to use this as the focus for selecting the Mitanin and subsequently for supporting and working with the Mitanin by adding a health dimension to the committee. The most commonly available pre-existing committee is the women's self help group involved in savings and credit provision. But other than this there could be other village committees, or development committees or even health committees organized as part of NGO programmes or other government department programmes.

In hamlets where there is no such pre existing committee a women's health committee is to be initiated. Subsequently it should acquire the character of the women's self help group activity.

Eventually all these hamlet level women's committee should link up to the village committee and themselves become more of a development committee.

Thus 75.72 % of Mitanins reported a hamlet level committee in their hamlet which is linked to this programme and supports it. This includes 63.66% who had a self help group in the hamlet which functioned as the committee or was there in addition to the health committee. A 34.62% of hamlets reported a third committee that was functional and assisted the programme.

The extent of overlap between these committees has not been assessed adequately.

For assessing the degree of functionality of these committees with respect to the Mitanin programme we asked how many meetings were held in the last two months which the Mitanin had organised or attended. By our guidelines in two months at least four meetings should be held. In practice 55.37% had held one to three meetings and only 24.10% had held 4 to 6 meetings. As many as 24.53% had had no meetings whatsoever in these two months. These figures are a better indicators of what is the extent of functional committees. We therefore also analyzed their block level pattern of achievement on this score.

TABLE-10 Functionality Of Committee

Name of blocks	Name of district	Mit.	Col.1 0 meetings	Col.2 1-3 meetings	Col.3 4-6 meetings	Score (col.3×2+col.2 ×100 /sum of 1+2+3)	Rank
Pusaur& Kharsia	Raigarh	50	30	15	5	50	24
Gunderdehi	Durg	50	20	22	8	76	19
Dondilohara	Durg	50	0	41	9	118	6
Pharsabahar	Jashpur	50	2	38	10	116	7
Batauli	Sarguja	50	1	15	34	166	1
Nagari	Dhamatari	50	16	34	0	68	22
Magarlod	Dhamtari	50	17	31	2	70	21
Marwahi	Bilaspur	50	12	16	22	120	4
Podiuproda	Korba	48	25	15	8	65	23
Narayanpur	Bastar	50	10	13	27	134	2
Nawagarh	Durg	49	8	38	3	90	16
Dhamtari	Dhamtari	50	39	11	0	22	25
Ghumka	Rajnandgaon	50	6	37	7	102	13
Dongargaon	Rajnandgaon	43	0	41	2	104	11
Mahasamund	Mahasamund	43	12	17	14	104	11
Pithora	Mahasamund	48	7	43	0	86	17
Baghbehara	Mahasamund	50	3	41	6	106	9
Bastar	Bastar	50	11	37	2	82	18
Dabra	Bastar	50	13	25	12	98	14
Tokepal	Bastar	50	6	23	21	130	3
Badekilipal	Bastar	47	2	34	11	119	5
Lohandiguda	Bastar	50	3	46	1	94	15
Manendragarh	Koriya	48	16	12	20	108	8
Mainpur	Raipur	41	20	11	10	76	19
Dondi	Durg	50	8	31	11	106	9

One other related activity which the Mitandin programme has used as part of its empowerment strategy is the group listening to radio programmes. 62.67% of Mitandins reported this as happening albeit infrequently in their hamlets. The radio programme is a 15 part series where each part is broadcast twice a week. The whole series had been broadcast once at the time of the evaluation and is now undergoing a repeat broadcast.

Involvement of Panchayat in their activities :

The experience with panchayats is limited. Only 29.29% reported having any interaction with them , esp attending their meeting and of these 27.07% reported that the panchayat was helpful. Only 5.17% said they were not helpful after meeting them. The main fact so however than in 58.49% of Mitandins they had never approached the panchayat at all. This is a major area in which the programme has to move forward.

Advocacy :-

A great concern amongst the government employee is whether this programme will act as a source of complaints against them. From the other end there is great expectation both from distant civil society and senior(therefore distant) governance also that this programme would lead to greater accountability. There is no doubt that this process is happening.

We tried to quantify it and found that only 5.09 % had directly and another 5.74% of Mitanins had indirectly ever represented the failure of one or other service provider or service to any authorities and even if they did report the gram sewak(1.96 and 2.81%) or the govt doctor(1.31%) or the local health employee(1.78%) were the main persons reported it to. Another small 0.94% took it up as far as the sarpanch. Almost no one has reported it to any higher government authority or political leader. .

TABLE-11
Relative ranking of blocks by 6 key indicators.

			Tab 4	Tab 5	Tab 6	Tab 7	Tab 8	Tab 10	Tab 9		
Name of blocks	Name of district	Mit	Selection of mitanin	Training score	Household visits freq	Effective counselling for newborn	Quality of register entry.	Functionality of committees	Help to ANMs for immunisation	Score	Rank
Pusaur& Kharsia	Raigarh	50		16	23	21	13	24	19	116	21
Gunderdehi	Durg	50		14	23	25	15	19	24	120	23
Dondilohara	Durg	50	8	11	19	6	23	6	14	87	12
Pharsabahar	Jashpur	50	6	3	12	10	2	7	1	41	1
Batauli	Sarguja	50	13	10	15	12	1	1	1	53	4
Nagari	Dhamatari	50	11	25	19	24	10	22	14	125	25
Magarlod	Dhamtari	50	20	19	8	14	22	21	18	122	24
Marwahi	Bilaspur	50	3	1	5	17	16	4	6	52	2
Podiuproda	Korba	48	2	6	8	8	8	23	19	74	9
Narayanpur	Bastar	50	9	4	4	7	18	2	8	52	2
Nawagarh	Durg	49	21	22	6	14		16	25	104	17
Dhamtari	Dhamtari	50	7	7	18	20	21	25	12	110	19
Ghumka	Rajnandgaon	50	19	2	8	21	20	13	7	90	13
Dongargaon	Rajnandgaon	43	5	18	16	2	17	11	3	72	8
Mahasamund	Mahasamund	43	4	13	3	18	3	11	5	57	5

Pithora	Mahasamund	48	15	15	1	3	10	17	16	77	10
Baghbehara	Mahasamund	50	17	9	8	1	6	9	8	58	6
Bastar	Bastar	50	22	5	17	11	7	18	23	103	16
Darbha	Bastar	50	10	23	25	23	12	14	12	119	22
Tokapal	Bastar	50	14	20	2	19	5	3	19	82	11
Badakilipal	Bastar	47	12	24	6	4	3	5	10	64	7
Lohandiguda	Bastar	50	16	21	19	5	9	15	17	102	15
Manendragarh	Koriya	48	25	17	12	8	19	8	22	111	20
Mainpur	Raipur	41	23	12	14	12	24	19	3	107	18
Dondi	Durg	50	18	8	19	14	14	9	10	92	14

Grading of Mitnin :-

Subjectively how did local programmemanagers evaluate the Mitnins functionality. There are guidelines issued for this .

According to the grades given by their trainers majority of Mitnins were in Grade A 60.13%, 25.26% were in grade B and 13.05 in grade C and only 1.57% in Grade D.

Discussion:

This report represents and interim evaluation of the Mitnin programme. This is predominately an output evaluation. At this point of time the interpretation is not completed as data from part B – the community perceptions, and remaining gaps in terms of hamlets needs to be entered in. The inter- block variations are under analysis and that too would soon be presented. It shows broadly that the demarcation line between good performance and poor performance depends on adherence to basic processes- of selection of Mitnin and of quality of leadership and support- and less of whether it as an NGO led programme at the block level or a government led programme. Also no one factor is overwhelming- not even selection. It is a combination of factors that makes for a good programme.

Limitations of Study

The main limitation of the study is that it is an output evaluation – and it has not evaluated outcomes, much less impact.

The sample size is adequate, but the programme parameters that should have been achieved in each of the block varied so much that the inter-block variations are more difficult to comment on. The non-distribution of drug kits in most blocks has also been a significant problem and led to an overall decreased efficacy of the programme.

Conclusions

The Mitanin programme has reached its primary target of 54,000 trained Mitanins in three years since its announcement and two years since its inception at the field level. A close the programme would cross 60,000 Mitanins. The first one year was spent on developing tools and design issues and institution building at the state level. The Mitanin programme currently has reached 15 days of training in the first 80 blocks and the first round of training in the next 61 blocks. Of the last five blocks three have completed Mitanin selection and only two Bemetara and Saja of Durg are still in the selection stage.

Evaluating outputs in those blocks where about 15 days of training are reached we find the following:

Literacy Levels of Mitanins : 88.97% of the Mitanins selected were literate- though literacy was not an essential condition- with the range varying from 17.02% to 100%.

Marital Status of Mitanins : 91.96% of the Mitanins were married and another 4.18% had been married but were now single . Only a small 3.75% of the Mitanins were unmarried.

Family Outreach per Mitanin : Looking at the range for households per Mitanin, we find that 36.83% of Mitanin cared for 21 to 40 households and another 31.50% cared for 41 to 60 households. A 18.21% of Mitanins had less than 20 households to look after and at the other end a 13.45% had over 60 household to look after.

The three blocks which had significantly larger number of Mitanins with low coverage(<20 houses per Mitanin) were Podiuproda(88%) a tribal highly dispersed block under BGVS and Mandragarh another dispersed tribal block(46%), Pithora in Mahasamund(36%) and Badekilipal in Bastar(32%). All the rest has figures close to the total group average or less.

At the other end Magarlod, Gunderdahi, Kharsia, Pusaur Baghbahra, Dondilohara and Dongargaon has households with larger than the group average for coverage over 60 households per Mitanin.

Selection Process adhered to : The evaluation study data shows that in 61.27% of Mitanin selection village level meetings had taken place- the single most sensitive indicator of a correct selection process. In other words in as many as 38.73% Mitanin selection had been inadequate. In some of these villages a womens committee meeting may have made the selection and this is an acceptable alternative.

Training Achievements : 72.33% of the surveyed Mitanins completed 11 to 15 days of training indicating that they had completed upto rounds 4 and/or 5 of training. Another 22.58% had completed 6 to 10 days of training indicating that at least three rounds were completed and only 5.09% had less than three rounds of training.

In terms of rounds of training 45.28% had completed 5 rounds of training and 85.56% had completed four rounds of training. Thus only 1.98% had completed only one round of training and another 4.22 % had completed two rounds and 8.09% had remained with three rounds .

Knowledge and Skill Levels Attained :

There were eight questions that assessed the Mitanin's level of knowledge and the scores were as follows:

The treatment for diarrhoea : 87.04% of the Mitanins gave a correct answer with as many as 64.07% giving a completely correct answer. 10.58% of the answers were inadequate and only 2.38% were wrong.

The treatment of fever: On treatment of fever 80.48 % of Mitanins gave an acceptable answer . Only 19.52% failed to give an adequate answer.

The correct dose of chloroquine in a child: 44.54% gave the correct dose and duration while another 26.53% gave correct dose but not the complete duration . However 21% gave an answer that was inadequate in dose and another 8.12 % could not state the dose at all.

The six main infant feeding messages: 23.3% being able to relate all six messages correctly and another 41.02% stating between 3-5 messages. Another 30% could relate only 1 to 2 messages which is indeed inadequate and a small 6.40% missed all the messages. Thus about 64% had acquired adequate knowledge of the key messages on child feeding practices with relation to the prevention of child malnutrition.

The six messages for the neonate: a perfect score was six messages and only 5.58% achieved this.(breastfeeding in first hour, adequate food for mother, weighing the child, referral if below 2 kg, keeping the baby warm including no bath for first week, BCG and polio immunisation). The single most important message was breastfeeding in the first hour and 46.18% stated this. As many as 53.81% missed even this message. This was disappointing as we can see later that this is one of the changes that have happened in a big way. However there was a serious programme lacunae in that this message had not gained prominence in the main training material and therefore got lost out in the transmission. It has been subsequently strengthened by a special programme.

The recognition of grade II as severe malnutrition: 31.54% of Mitanins knew that in Grade II Malnutrition child is very weak and needs urgent action(the correct response) while another 34.98% said the child is weak – an acceptable response though less than what we had trained for. But 18.39% said they did not know and another 15.11% said that the child was normal.

The treatment of anemia: - A total of 60.03% for adequate answer
Where to refer for high risk pregnancy case for delivery: On appropriate referral center for high risk case 37.98 said a district hospital and another 6.08% quoted an appropriate private sector facility and 32.35 named the local CHC. All of these can be held as correct answers though most of the CHCs are not yet functional as referral centers. Incorrect answers were trained dai(0.09%); PHC- 17.96%, sub-center 1.61% and could not answer 3.93%.

The Functioning Of Mitanins.

Mitanins were assessed for functionality on the following tasks.

Counselling and Health Education :- 82.36% of the Mitanins reported making house visits for counselling in the previous week.

Maintenance of Gram Swasthya Register :- Of the Mitanins surveyed 82.44% maintained the village health register and as many as 17.86% did not maintain the register.

Improving health service delivery --Coordination with ANMs and Anganwadi Workers and Referral Services offered by the Mitanins :- 66.57% of Mitanins report that ANMs meet them regularly during visits. 69.95% have been helping on immunisation, 56.60% have been helping for conducting surveys, 36.83 % have been helping in antenatal care, 20.75% have been called upon to help during health camps and another 5.58% report other categories of assistance. 54.47% of Mitanins have referred cases to ANMs/health sub-centers and 40.53% have referred cases to PHC. A small but very significant 17.0% have actually accompanied the patient to the health facility on one or more occasions.

Women's Organization and Empowerment by Local group or committee formation : Thus 75.72 % of Mitanins reported a hamlet level committee in their hamlet which is linked to this programme and supports it. This includes 63.66% who had a self help group in the hamlet which functioned as the committee or was there in addition to the health committee. A 34.62% of hamlets reported a third committee that was functional and assisted the programme.

Involvement of Panchayat in their activities :- Only 29.29% reported having any interaction with them , esp attending their meeting and of these 27.07% reported that the panchayat was helpful. Only 5.17% said they were not helpful after meeting them.

This being an interim evaluation – corrective measures to close the gaps have already been initiated in most areas. Since most gaps are block specific such correction is easier. A separate programme is being tailored in for involving the panchayats.

The gaps in the programme occur due to many reasons. Thus a knowledge and skill gap could be due to inadequate emphasis in training material and the resource person training as for the neonatal message or due to the degree of emphasis given to that topic in the block leadership. The latter accounts for the feature that the programme could function very well in one knowledge area and very poorly in another.

One of the weakest areas was in the drug supply to Mitanins – a major persistent source of problems for the programme.

Another major factor that emerges from the inter –block analysis is that where the key processes have been adhered to and the leadership is also dynamic the problem invariably does well approaching 100% in many or most of the areas. On the other hand where with liberal short-cuts key processes are violated – confident that no one would check it out in each village – the results are poor.

This usually goes along with two leadership attitudes – either deep cynicism about the campaign and the leadership having been imposed on him by authority(typical of the government), or an over-confident underestimation of the need for techniques and processes (found in equal measure in both NGO and government leadership.)

For the programme planner- there are two key messages. One the need to insist on the processes including as the programme advances – corrective processes. And secondly the needs for a close , tight monitoring structure, with an alert state leadership forever responding and troubleshooting violations of the processes at every level. The third message is that the key supportive elements of the campaign drug supply to the Mitans and a responsive referral institution back up – need to be strengthened as rapidly as is possible. Ideally the programme should proceed in parallel with the ability to deliver on these fronts.

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